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2023

Received: 6 June 2022 | Revised: 2 March 2023 | Accepted: 7 April 2023

DOI: 10.1111/jan.15685

JAN Leading Global Nursing Research WILEY

ORIGINAL RESEARCH:
EMPIRICAL RESEARCH - QUALITATIVE

'It's all about ticks': A secondary qualitative analysis of nurse perspectives about documentation audit

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Abstract

Aim: To understand how nurses talk about documentation audit in relation to their professional role.

Background: Nursing documentation in health services is often audited as an indicator of nursing care and patient outcomes. There are few studies exploring the nurses' perspectives on this common process.

Design: Secondary qualitative thematic analysis.

Methods: Qualitative focus groups ($n = 94$ nurses) were conducted in nine diverse clinical areas of an Australian metropolitan health service for a service evaluation focussed on comprehensive care planning in 2020. Secondary qualitative analysis of the large data set using reflexive thematic analysis focussed specifically on the nurse experience of audit, as there was the significant emphasis by participants and was outside the scope of the primary study.

Results: Nurses': (1) value quality improvement but need to feel involved in the cycle of change, (2) highlight that 'failed audit' does not equal failed care, (3) describe the tension between audited documentation being *just* bureaucratic and building constructive nursing workflows, (4) value building rapport (with nurses, patients) but this often contrasted with requirements (organizational, legal and audit) and additionally, (5) describe that the focus on completion of documentation for audit creates unintended and undesirable consequences.

Conclusion: Documentation audit, while well-intended and historically useful, has unintended negative consequences on patients, nurses and workflows.

Impact: Accreditation systems rely on care being auditable, but when individual legal, organizational and professional standards are implemented via documentation forms and systems, the nursing burden is impacted at the point of care for patients, and risks both incomplete cares for patients and incomplete documentation.

No Patient or Public Contribution: Patients participated in the primary study on comprehensive care assessment by nurses but did not make any comments about documentation audit.

KEYWORDS
data accuracy, documentation, nursing audit, nursing records, patient care planning, quality improvement

1 | INTRODUCTION

Nursing documentation serves as a clinical record, a plan of evidence-based care and as a tool to communicating care with the intention of maximizing the quality, integrity and patient sensitivity in nursing care situations (Bjorvell et al., 2003; De Groot et al., 2019). Originally a Nightingale convention, now nursing documentation is a legal requirement of the profession (Harrington, 2019; International Council of Nurses, 2012; Nursing and Midwifery Board of Australia, 2016). Documentation also serves to inform whole-service regulation and funding and can take many forms, such as paper, digital, free-text or a checklist (De Groot et al., 2019; Johnson et al., 2010; Kärkkäinen et al., 2005).

2 | BACKGROUND

Nursing documentation should reliably represent nursing care (Paterson et al., 2021); however, it cannot realistically capture the nurse's whole role. Complexities in accurate documentation include issues such as time constraints and competing care priorities, compounded by the fact that documentation is inherently biomedically based and often does not accurately capture the holistic care that nurses provide (Charalambous & Goldberg, 2016; de Marinis et al., 2010; Iula et al., 2020; Johnson et al., 2018; Kebede et al., 2017). Therefore, nursing documentation is inadequate to represent all the complexities of the nursing process (assessment, planning, implementation and evaluation), critical thinking, decision-making; and time spent monitoring and communicating in, and between clinical teams (Bail et al., 2021; Clarke et al., 2010; de Marinis et al., 2010; Fore et al., 2019). Nonetheless, documentation is regarded as a proxy for provided nursing care, particularly when measuring specific care items (Iula et al., 2020; Johnson et al., 2010). As such, audits typically focus on documented patient outcomes, cost benefits and workflows (De Groot et al., 2019; Iula et al., 2020; Wang et al., 2011).

The intention of documentation audit is to identify and reduce gaps in nursing care through the implementation of quality improvement tools, including feedback and cycles of change (Brown et al., 2019; De Groot et al., 2019; Ivers et al., 2020). However, this approach assumes that documentation accurately represents nursing care (de Marinis et al., 2010; Iula et al., 2020). Typically, published research uses documentation audit to examine care without examining the quality of actual care received by the patient (e.g. Moldskred, 2021). Such approaches retrospectively audit nursing care notes but do not examine care interactions or audit whether what was documented was the same as what was delivered (Iula et al., 2020). Thus, documentation audits alone cannot provide reliable insight into nursing care delivered or the whole 'real world' implementation of the nursing process, yet, it continues to be used as a primary lens to understand patient care.

Evidence to date demonstrates that the process of documentation audit and feedback in the nursing profession can have a negative impact on nurses' psychological well-being (Christina et al., 2016; Giesbers et al., 2021; Sinuff et al., 2015). Nurses have articulated that such quality improvement strategies in health systems can result in feelings of frustration, cynicism and disengagement (Christina et al., 2016; Giesbers et al., 2021; Sinuff et al., 2015). Nurses have reported that they felt 'attacked', and that the whole process was generally negative (Christina et al., 2016). Nurses commonly felt that they were under surveillance, which resulted in stress and inhibited them from performing their normal duties at full capacity (Sinuff et al., 2015).

Systematic reviews of nurse documentation and audit can help set the scene for this issue. In a systematic review of 11 reviews of quality criteria, instruments and requirements for nursing documentation found that there is uncertainty in nursing practice about which criteria have to be met to achieve high-quality documentation (De Groot et al., 2019). A systematic review of 65 papers on qualitative evaluations of feedback interventions, including audit, found that they are only found to be effective when it works in a cycle of sequential processes, and where the feedback directly supports clinical behaviours (Brown et al., 2019). An integrative systematic review of five papers found that audit and feedback impacted nurse's professional role and psychological well-being; nurses were engaged when the perceived function was for self-improvement, shared patient goals or evidence-based practice, but resistant when they perceived audit and feedback negatively (as surveillance, bureaucracy or complaint confirmation); or lacking transparency (Michl et al., 2021). De Groot et al. (2019) concluded that the lack of evidence-based quality indicators for nurse documentation presents a challenge in the pursuit of high-quality nursing documentation and that increased attention to the nursing process and development with nursing staff was essential.

Correspondingly, a large qualitative study (Paterson et al., 2021) explored the experiences of person-centred care and risk assessment practices using organizational healthcare documentation as part of a service evaluation reviewing current documentation forms and seeking to streamline nursing workflows. During the semi-structured focus groups, the nurse participants frequently mentioned audit practices in relation to the documentation and referenced the impact this audit practice had on their experiences. This demonstrated a need for further exploration, given the issues of documentation and audit highlighted in the literature.

2.1 | The study

2.1.1 | Aim

To conduct a secondary analysis to reveal how nurses talk about documentation audit in relation to their professional role.

2.1.2 | Design

The service evaluation (parent study) was a qualitative, descriptive study with the aim of to exploring experiences of person-centred care and risk assessment practices using existing organizational healthcare documentation from the perspectives of healthcare professionals and patients (Paterson et al., 2021). Qualitative focus groups were audio-recorded and digitally transcribed. The kinds of questions asked (reported in full in Paterson et al., 2021) included: Can you tell me what you think about the current documentation? Do you use the documentation in your daily duties for patients? What are your perceptions about the barriers/facilitators of using the form?

During analysis, a code related to 'audit' was established, which did not answer the primary aim of the parent study, but was clearly an important concept to the participants. Hence, a secondary (nested) study was established to answer the research question: how do nurses talk about documentation audit in relation to their professional role? Reflexive thematic analysis (Braun & Clark 2006, 2019) was used to conduct secondary analysis.

2.2 | Sample/participants

The Australian metropolitan health service attends to a population of 550,000 in south-eastern Australia. The nurses represented in this study included clinical divisions of surgical, medical, rehabilitation, acute and community aged care, cancer and ambulatory support, critical care, antenatal and gynaecological, mental health, justice health, and drug and alcohol services.

2.3 | Setting

The health service used documentation audit as a component of clinical governance (Australian Commission on Safety and Quality in Health Care, 2017). The goal of audit was to provide oversight across the hospital of consistency of documentation, and provide scrutiny of care delivery across the different regions of the hospital. Audit was used to demonstrate service-level competency in relation to meeting accreditation requirements. The documentation audit was generally conducted twice a year by a senior nurse. Findings were compiled at ward levels and compared at stream and hospital levels, with feedback provided back to the ward about completion rates. The Nursing Care and Assessment Plan which included risk screening (e.g. pressure injury prevention, cognitive impairment screening) and vital signs observation charts were the predominant documentation items audited to meet the local organizational requirements. Completion rates of particular fields were examined with set criteria (e.g. completed numerical documentation of respiratory rate was always audited but pain scale was not). Items for audit were based on measurability and potential impact on patient safety. Some of the set criteria were related to the National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care, 2017), particularly, the Comprehensive Care Standard, with many regions having their own specific timeframes for accountability (e.g. NSW Government, 2021) which stipulate documentation timeframes, for example 'Patients are to be screened for pressure injury risk as early as possible on presentation/admission: Within 8 h of presentation to a health facility for an inpatient' (p. 5). These measures are informed by evidence about timeframes of risks of complications for patients and focussed on systematizing best practices to promote patient safety across organizations.

2.4 | Data collection

Data collection was undertaken at two time points: May and August 2020, with a total of 14 face-to-face focus groups with 94 nurses (enrolled nurses, registered nurses and nurse managers). Researchers (Kasia Bail and Catherine Paterson) facilitated the focus groups, both female registered nurses with qualitative research experience with no relationships to participants, though one has been a practising nurse in the healthcare service for 20 years and may have had past incidental contact with some participants. The focus groups were audio-recorded and digitally transcribed and supported by researchers' field notes.

2.5 | Ethical considerations

As a secondary analysis of data, no new data collection was undertaken using human or animal subjects. The data collection was granted institutional ethics approval by the ACT Health Research Ethics and Governance Office (project number 2020.QAI.00069). The service evaluation contracted CP and KB to undertake research and report on the risk screening and care planning tool implementation and provided consent for any findings to be reported in research papers such as this secondary analysis. The participants consented to their data being used as part of this service evaluation, and while themes around audit were not part of the original investigation, they were offered voluntarily by participants without prompt. Deidentification was applied to the data set (participant names and ward locations provided pseudonyms). The secondary analysis approach is justified to mitigate research barriers of participation about sensitive content and wasted resources

such as participant time (Long-Sutehall et al., 2011; Ruggiano & Perry, 2019). As a legal document, discussion about nursing documentation completeness and accuracy can be a sensitive topic, and nurses may be reticent in sharing their perceptions due to their perceived or actual vulnerability as an individual or for their organization (Long-Sutehall et al., 2011; Sinuff et al., 2015; Smyth et al., 2021).

2.6 | Data analysis

Reflexive thematic analysis was used to support the exploration of nurse experiences and perceptions of documentation audit, and what this means to them in their professional role (Braun & Clarke, 2006, 2019), with the phases followed (Table 1). Focus group data were screened, reviewed, keyword searched and sorted to exclude data not relating to the research question, with a focus on the inclusion of concepts (not just keywords). Any conflicts that arose during each of the phases were discussed and resolved with all authors to ensure that the interpretation of possibilities was exhausted and that transparency was evident. Themes were scrutinized to ensure that they were genuine, organically developed concepts, not simply obvious domains, but created through active creation between the researchers and the data (Braun & Clarke, 2019). The researchers included an experienced cancer nurse practitioner and nurse researcher, an experienced acute care nurse clinician and researcher, and a new graduate acute care nurse undertaking Honours study, providing a range of nursing lenses through which to examine the data. All researchers formed themes from the quotes and codes collaboratively and reflexively, and the multiple themes and theme systems were examined, discussed, re-visited and amalgamated to form the final five themes reported here.

2.7 | Validity and rigour

Trustworthiness is an essential aspect of communicating and establishing the process of rigour and trust between researchers and readers in qualitative research (Nowell et al., 2017). Credibility is supported in this project by researchers engaging with a large volume of interview participants in a range of settings in the scope of the research question; researcher triangulation of interpretations; and peer debriefing with other nurses and manager of the organizations including presentation to the organization to test and discuss the findings and interpretations (Lincoln & Guba, 1985). Participants were provided information from the first round of focus groups and had the opportunity to provide feedback in the second in terms of resonance of content and ongoing relevance of emerging themes. Transferability is supported in this project by clear descriptions of the setting and transparency through direct quotations to enable readers to determine transferability to their own sites (Nowell et al., 2017). Dependability is supported in this project by clear descriptions and 'auditability' where another researcher can follow the decision trail of the research process (Sandelowski, 1986). Records of the raw data, notes and transcripts and the reflexive discussion between researchers were kept to support auditability. Confirmability is supported in this project by the use of quotations and related researcher interpretations, and the credibility, transferability and dependability demonstrated (Guba & Lincoln, 1989). In these ways, the validity and rigour of the research are demonstrated (Nowell et al., 2017). The COREQ checklist has been used to support reporting of this qualitative research (Tong et al., 2007).

3 | FINDINGS

Ninety-four nurses from nine clinical areas contributed to the 14 focus groups (Table 2). Focus groups included nurses subjected

TABLE 1 Phases of thematic analysis (Braun & Clarke, 2006, 2019).

Phase	Description of the process
1. Familiarizing yourself with your data	Reading and re-reading the data, noting down initial ideas, data sorting, and extraction of, and familiarization with only data pertaining to the research question
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code. Occurred in iterations, using audio files and transcripts, and the process was quality assured by all three co-authors. Notes made during data exploration were reflected on, and the transcript was searched for repeatedly occurring phrases, topics and sentiments. The documentation audit-related data was searched for frequently noticed phrases and meanings to organically develop the coding system
3. Searching for themes	Collating codes into potential themes actively created by the researchers, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme in a collaborative and reflexive manner
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis

TABLE 2 Focus group characteristics.

Focus group	Clinical area	Number of participants	Duration
A	Acute geriatric care	8	58 min 10 s
B	Oncology	8	54 min 15 s
C	Emergency department	7	50 min 0 s
D	Sub-acute rehabilitation	9	55 min 46 s
E	Acute mental health	7	1 h 16 s
F	Speciality medical ward	5	1 h 14 min
G	Specialty surgical ward	7	51 min
H	Oncology	5	57 min
I	Acute geriatric care	7	1 h 7 min
J	Antenatal and gynaecology	7	1 h 19 min 1 s
K	Emergency department	11	1 h 1 min
L	Speciality medical ward	5	1 h 10 min
M	Sub-acute rehabilitation	5	58 min 24 s
N	Acute mental health	4	55 min 32 s

TABLE 3 Overview of findings.

(1) Nurses value quality improvement but need to feel involved in the cycle of change
(2) Failed audit does not equal failed care
(3) Audited documentation 'just' bureaucratic or useful to workflow?
(4) Rapport versus requirements
(5) The focus on completion of documentation for audit creates unintended and undesirable consequences

to audit as well as senior nurse managers and educators who conducted the audits. The focus groups had a mean duration of 59 min in May and 60 min in August. Focus group demographics are presented in Table 2. The five themes are outlined in Table 3. Presentation of findings is supported by quotes from participants, presented in *italics*. Some quotations include more than one participant in the focus group conversation. Editorial input by researchers for clarity is presented in [parentheses], truncations for brevity are replaced with [...], and **bolding** is provided for emphasis by the authors. Quotes are lettered *(A1)* to indicate the focus groups' clinical area (see Table 2).

3.1 | Theme 1: Nurses value quality improvement but need to feel involved in the cycle of change

Nurses discussed audit and feedback from a quality improvement perspective. They recognized and valued the need for change to adhere to evidence-based practice and to evaluate a continually evolving health service, but provided insight into current inefficiencies.

The nurses discussed the importance of full cycles of change, where feedback informs the implementation of change. Nurses demonstrated an understanding that audit alone cannot produce

TABLE 4 Theme 1: Nurses value quality improvement but need to feel involved in the cycle of change.

'Since those audits were done there's been no feedback at all from them'. (B5)
'I was on the working group that reviewed it [...]. Nothing changed. When it came out in its next format there was hardly anything different in it. And, I felt that was a great waste of my time'. (B8)
'They haven't said why they've changed it, like what's their reasoning behind why? Why have you changed it? And then educate us on why you've changed it because a lot of people will accept a change if you actually say'. (L3)
'It's just like, we're doing it anyway so why not just make it really more user-friendly'. (H10)

change and that quality improvement relies on cyclical feedback provision (see Table 4, B5). Without feedback from audit, one nurse felt ill-equipped to adapt their practice and questioned the value of the seemingly redundant audit. Another nurse complained that where feedback had been provided by nurses, it had not been incorporated into practice and so the nurse felt that the whole exercise had been pointless (see Table 4, B8). Nurses also highlighted the importance of understanding the rationale for the change, and its proper implementation. When education wasn't provided on a change, nurses were less willing to participate due to feeling unprepared. Nurses stated that the rationale for the change was central to motivating their engagement with quality improvement interventions. However, when nurses were unclear about the reasoning or rationale behind the audit items, they felt less confident:

> They haven't said why they've changed it, like what's their reasoning behind why? Why have you changed it? And then educate us on why you've changed it because a lot of people will accept a change if you actually say. (L3)

Nurses proved optimistic for change and hoped that their focus group feedback would inform improvements for future iterations of the risk-screening and care-planning documentation They clearly delineated their preferences in the focus groups, and as the end-users they wanted their feedback to reflect their needs and preferences to improve their user experience. One manager highlighted that incorporating nurse feedback to render the mandatory form user-friendly is critical (see Table 4, H10).

3.2 | Theme 2: Nurses highlight that failed audit does not equal failed care

Nurses experienced the disconnect between the standard of care they provided and the standard of care reflected in the audit of their documentation. Nurses expressed anger and frustration when they felt that their work was not fully acknowledged and valued, primarily due to the documentation misrepresenting their work. Nurses talked about the lack of transparency of the audits, which only assessed certain items of the document, and which were subject to change at the discrepancy of the audit committee and without informing the front-line nurses.

> By making a form, it doesn't mean that we are improving the care of the patient. We are actually doing the care, but I know that the nurse [manager] says that 'where there is no document it is not done'. But we don't have enough time to document. (F5)

All nurses discussed that prioritization of actual nursing care over documentation tasks inevitably led to inaccurate documentation audit results compared with the standard of care actually provided. Shift busyness impacted documentation accuracy, and nurses believed it was evident when people had spent time documenting compared with rushing. See for example Table 5, B6. Frustrations arose about the audits only assessing documented work, rather than the care provided. Nurses regarded documentation audit only as a measure of completeness in their organization, without the required flexibility to capture the needs of patients on an individual 'person-by-person' basis. For example, one nurse described undertaking a malnutrition screen, which was clinically indicated despite not being a pre-filled item on the auditable form. Not having a 'tick box' on the form meant that this nursing work would not be considered in the documentation audit process. In this instance, there was no capacity to overdo the form, only to miss items, leaving the nurses unable to exceed audit expectations.

> As I said, we are doing it, but it's not ticked. And, that's what they're auditing. So, we thought-all [that] we are doing is not getting audited-only the tick box is getting audited. (F7)

Nurses commented that documentation audit is per individual patient, and overlooks nursing considerations in the context and content in which individual care is delivered such as environment, shift context and competing demands. Audit was focussed on select items which were not perceived as the bulk of nursing care work. See, for example Table 5, F14: Nurses voiced that a snapshot audit does not measure clinical decision-making and clinical prioritization of care across all patients. For example, a nurse might have five patients to care for, and if one had a medical emergency, the care of the others would be impacted. Each patient's documentation legally cannot contain information about other patients, and so the context of the nurse's workload is missed completely (see Table 5, A9).

Many of the nurse unit managers, clinical development nurses and clinical nurse consultants were responsible for auditing their own wards or units and spoke in solidarity with their colleagues. Nurses in leadership positions described being subject to organizational demands in conducting audits, however, sympathized with nurses being audited. They recognized that audits did not necessarily capture the complexity and diversity of the nurses' work, and sympathized with consequent frustrations, particularly when the audit showed care items or care item documentation missed in error.

> They work really, really hard to do it properly. And then it's frustrating I guess for them if I come along and audit and say yes, you missed this and its one tiny little tick-box and they've done everything so beautifully. Yes, it's disheartening. (A1)

Finally, some nurses believed they were providing patient care and fulfilling their duty to the organization, the profession, themselves and the patient, but doubted themselves when audit results were

TABLE 5 Theme 2: Nurses highlight that failed audit does not equal failed care.

'By making a form, it doesn't mean that we are improving the care of the patient. We are actually doing the care, but I know that the nurse [manager] says that 'where there is no document it is not done'. But we don't have enough time to document'. (F5)
'I think if you looked at a form that I've filled out really quickly on a really busy day, it would not reflect accurately, patient-centred care. They wouldn't quite align maybe. You can tell when people have had time to do them properly because everything is ticked. You can tell when people have had time to do them properly'. (B6)
'The progress notes are not getting detailed audits. On the progress notes, what we were auditing was the sticker identifiers and that they have been seen by a consultant for the last week. And, whether all the documentation were legibly signed and print name'. (F14)
'We are judged on what the COW [Computer on Wheels] says. If the COW says you're an hour late on that med, someone is going to judge you on it. If you are half an hour late on those obs, you're going to be judged on it. They don't necessarily care that I've got four patients and one was in a MET call and I got to those obs [vital signs observations] when I can. All they can see if that those obs were overdue'. (A9)
'We are providing care, it's there, even if I go home, I just say 'Yes, I've done the work' but once they're doing auditing it's like I haven't done it so it gets to asking 'What am I doing? Did I do this? Did I?' but you provide everything to the patient, but I didn't have time to sit down and tick to say "Oh, I've done this"'. (F15)

incongruent with their self-reflected beliefs (see Table 5, F15). The impact of the negative experiences of audits on morale and confidence of nurses were illustrative of the finding that 'failed audit' should not be perceived as 'failed care'.

3.3 | Theme 3: Nurses describe tension between audited documentation being *just* bureaucratic and constructively building workflows

The third theme identified conflicting and complexly interwoven opinions on the usefulness of audited documentation. Staff valued prompts and improved patient care gained from completing paperwork (see Table 6, 3a), but predominantly examples were articulated about the bureaucratic formality requiring completion which was 'over concerned with procedure at the expense of efficiency or common sense' (New Oxford American Dictionary, 2015) (see Table 6, 3b).

3.3.1 | 3a. Audit and audited documentation are useful

Nurses clearly understood the value, legality and importance of the reliability of their documentation as a record of patient care. Some suggested that audited documentation served a patient-centred purpose, with risk-screening and care-planning documentation demonstrating that individual care needs were being addressed holistically and as a prompt for further assessment. One nurse discovered the screening tool's value, where the patient unexpectedly failed to draw an analogue clock showing a certain time, revealing a cognitive impairment that would have otherwise remained undetected (see Table 6, H8). Documentation was also seen as useful for specific purposes, such as to calculate a Waterlow score, which quantifies a patient's risk of developing a pressure injury, as part of the institutional procedure to obtain an air mattress (see Table 6, C2).

3.3.2 | 3b. Audited documentation is just 'bureaucratic'

Most nurses discussed audited documentation as a formality which did not add to patient care and provided little value in the clinical setting. It was viewed as paperwork for the purpose of audit only with no other benefits being perceived. Most nurses admitted to hastily filling in forms by 'tick and flick' (see Table 6, N4), often retrospectively and sometimes blindly, and stated that patient assessment and care were done regardless of the documentation's prompts.

> What I'm saying is once that's filled in that goes in the one folder and then it never gets looked at again. Then we do this on a daily basis. (I12)

TABLE 6 Theme 3: Nurses describe tension between audited documentation being *just* bureaucratic and constructively building workflows.

3a. Audit and audited documentation are useful and constructively build workflows
'It was really making sense because I thought, 'What is this thing?' [the requirement for clock drawing by patients] when I started. The patient was looking really good but when I asked him, he couldn't follow that instruction at all'. (H8)
'Honestly, I will do this form if I need a pressure mattress, if I'm trying to work out a Waterlow score. Otherwise, I don't'. (C2)
3b. Audited documentation is just 'bureaucratic'
'What I'm saying is once that's filled in that goes in the one folder and then it never gets looked at again. Then we do this on a daily basis'. (I12)
'I think they just tick and flick, to be honest with you, I'm not going to lie, it's a tick and flick'. (N4)
Interviewer: 'Who does use the care plan after it's done?' Nurse: 'The auditor'. [laughter from all] 'Because it's daily grind'. 'It's ingrained in us'. 'Yes, and you just do it. The patients' needs change daily'. (I11)
'Once I have a patient told me that I have signed for my treatment consent at the start of my admission. "Why you want me to sign again and again?"'. (L7)
'I say to everyone to always tick the [education boxes] because they don't even realise that they are actually doing it [...] So then when they forget to tick that box, I tell them you're doing the work, [but] it looks like you haven't done it'. (A1)
'They [team leaders] all keep checking the COW [computer-on-wheels] just to make sure the staff are doing the obs [observation of vital signs] on time so that if the audit comes it's been attended to' (A10).
'It's completely general nursing at best, it is not in any way suitable for us. If we, there are times when we get people who are delirious, because of an infection or whatever, [...] we will adapt or care according to their physical health needs. But we don't need to be doing that every day'. (N5)
'I physically can't fill out the form before I transfer a patient to the ward, and there's a time limit on it' 'It's a bit unreasonable, and I physically have not filled out the whole thing, because we have patient flow, and we have NEAT [National Emergency Access Target] times to get people/patients to the ward. And I just think it's too much'. (K1)
'Never get it done. It isn't justified'. (E1)
'Even though we're filling these boxes, we still feel like we're missing things, because it doesn't list all the possible prompts'. (I7)
'Everything else seems to be prioritised over the form'. (K2)
'They're often not there at the time when you would generally do your care plans. They're at the gym [on a rehabilitation ward]'. (D3)
'I might miss it because I think that tick thing is also very small there'. (F2)
'So that was maybe what I was auditing because I actually missed that part because it wasn't clear'. (J3)

Nurses had cavalier attitudes about the chore-like documentation being repetitive, unfruitful and part of a nursing condition (see Table 6, I11). Nurses reported automatically ticking the 'patient unable to sign' box because they believed the signature was just a formality, or that it was inappropriate and potentially redundant to get a daily signature from a confused patient, and confusing for an alert and oriented

patient (see, e.g. Table 6, L7). Team leaders encouraged nurses to complete the forms, even when work was done incidentally or implicitly, so that forms accurately represented nursing work. They spent time each day checking that tasks were done so that the audit would be passed (e.g. Table 6, A1, A10).

Nurses dismissed documentation requirements which they deemed as irrelevant or not adding to patient care. In the mental health and emergency departments in particular, the auditable form, focusing primarily on physical risks such as falls, pressure injuries and venous thromboembolism, was deemed largely inappropriate for the nursing care environment. Mental health nurses focussed on other risks such as capacity and willingness to undertake activities of daily living, suicidality, social risks, psychosis and mental health risks that have physical consequences, such as eating disorders (e.g. see Table 6, N5). In acute, high patient-turnover settings such as the emergency department, nurses also had high disregard for the form as they perceived it did not add value to care, and hindered care by consuming already precious time which they prioritized other audited factors (e.g. nationally imposed treatment and admission times). Despite knowing that the forms were auditable, nurses deliberately disregarded them (see Table 6, K1). Some nurses did not see the rationale for the auditable forms and they did not like certain parts of the form or felt uncomfortable answering the questions, or made their own judgement about the usefulness of the form:

> Never get it done. It isn't justified. (E1)

Others understood the rationale but described a disjoint between the reality and the intention of the mandated documentation, where tick-boxes, while potentially relevant, could never encompass holistic care (e.g. Table 6, I7, K2). Nurses felt more responsibility for legal requirements than organizational audit requirements. The descriptive patient notes were considered the primary legal document and prioritized accordingly as a central source of information for the patient's care, accessible by all members of the multidisciplinary healthcare team. Any forms duplicating these notes were delayed, particularly where the transition to digital charting was imminent and nurses felt that their charts were scattered.

Nurses frequently questioned how to complete the form, or whether to complete it at all given the complexity of the patient compared with the simplicity and standardized nature of the form. The nurse's access to the patient limited their capacity to partner with them in their care, for example if the patient was off the ward or with doctors or allied health (e.g. Table 6, D3). The form layout itself was reported as not being conducive to completion. With 55 items for risk-screening and care-planning documentation, nurses missed small tick-boxes (e.g. Table 6, F2), or initial and date requirements when they were rushed in either their nursing care or their documentation.

Auditing nurses agreed that the form's design led to congestion and confusion, and those without a patient load reported sometimes being unfamiliar with the audited form and the intended use of the form's components. They questioned the validity of their own audits and the sincerity of feedback when they were unclear on the audit requirements (e.g. Table 6, J3).

3.4 | Theme 4: Nurses value building rapport (with nurses and patients) but this is often contrasted with requirements (organizational, legal and audit)

Nurses faced competing managerial, organizational, professional and legal demands. They juggled these to protect the therapeutic rapport with patients and prioritize safe, appropriate and quality patient care, while still adhering to legal and professional requirements. Senior nurses reported a delicate balancing act to manage competing demands:

> There are a lot of obstacles to satisfy both [patients and staff] at the same time. And I feel like I put pressure on staff to meet the requirements of organisation but I also put pressure on staff to meet patients' need as well. So it's very difficult to balance. (A13)

Nurses consciously prioritized patient convenience and satisfaction over documentation audit timeframe requirements and were always willing to complete the documentation late to avoid disrupting patients unnecessarily. Nurses knew they would 'fail' audit requirements for completing paperwork in 6h, but preferred that choice rather than risking patient discomfort (e.g. Table 7, H13). The nurses discussed the need to record care reprioritisation. If medications, which are audited to a time, were delayed for a patient-centred reason, such as the preference to shower first, nurses used the 'delay' button in the electronic medication chart and enter the reason. However, if a non-auditable item, such as showering, was delayed, the nurses did not document this, considering it better to spend time with, rather than write about, the patient.

> If someone says 'Oh I don't want my shower now love, I want to stay in bed until later in the afternoon', we don't actually write that anywhere because otherwise you'd spend all your time writing, not actually doing the care. (L8)

Some nurses chose to forgo the auditable documentation altogether to preserve therapeutic rapport. When deemed low value or low priority, or nurses were time-poor, they chose not to complete the documentation sporadically in environments where care was continually reprioritised (see Table 7, K6).

Nurses willingly defied audit requirements if they believed such tasks were detrimental to the patient, or if adhering to the auditable form's criteria would compromise nurse–patient rapport. Nurses often forewent completing the form in partnership with the patient to audit standards, particularly in the mental health unit. This choice was made to prevent distrust or escalation stemming from patients

TABLE 7 Theme 4: Nurses value building rapport (with nurses, patients) but this is often contrasted with requirements (organizational, legal, audit).

'If they come in overnight, you're not going to sit there with them when they just want to sleep … by asking them questions for half an hour. […] They're not going to be happy if you're sitting there asking question at two in the morning'. (H13)
'If someone says 'Oh I don't want my shower now love, I want to stay in bed until later in the afternoon', we don't actually write that anywhere because otherwise you'd spend all your time writing not actually doing the care'. (L8)
'It's bits and pieces, when you can [get it filled in between other tasks] I think almost says to the patient: 'We value you, but we kind of don't, because we are going to do this about 20 times. It's going to take 20 interruptions to get this complete sorry'. Which doesn't then say to them: 'We find you're important to us'. That's saying, 'Sorry, I'll get back to you. You're not my priority right now because I can't finish this'. Which doesn't necessarily start them on the right journey either. It's not that we're trying to ignore them, it's just that continual reprioritising of other urgent cares'. (K6)
'If you're getting them to sign it, they'll see [child protection or domestic violence services involvement] as well'. (J6)
'One of the patients asked me for the past 2 days I have signed it, why should I sign it every day? And some of the patients just even I'm asking name and date of birth every single time they say okay I'm the same person, I'm not changed'. (L7)
'But if it's going to place somebody at a vulnerable position, I'm not going to push them to go and do it. [I ask them to write] 'unable to formally assess due to behavioural concerns or due to current mental state [or] beliefs'. (E15)
Interviewer: 'What makes you fill in the form?' Nurse: 'Policies and procedures, and Kate is scary [pseudonym of manager's name]' [group laughter]. (E9)
*'I've got patient to sign couple of times, but just **because I have to**. I don't think that is a useful thing for the patient to actually sign'. (B3)*
*'Because it's compulsory that **we have to** do it, that's why, we **have to** do it, it's part of **the requirement**'. (N2)*
'This [hospital care plan form] is only done because we are a hospital and it's done because that's what the hospital wants us to do'. (N7)

seeing diagnoses or interventions they might disagree with, avoid arming at risk patients with a pen and to avoid providing false information on which further care is based, defeating the purpose of the documentation (see Table 7, J6, E5). Asking the patient to sign the form might also highlight work not yet done or not yet documented by the same or another nurse, so nurses protected not only their own nurse–patient therapeutic rapport but acted in solidarity with other nurses. Some nurses were happy to oblige with documentation audit requirements to a point, but became tired when the purpose was unclear, did not add value, or made the patient feel like a patient and not an individual person. They sympathized with the patient's confusion about daily signatures and felt burdened with enforcing it to the point of annoyance (e.g. Table 7, L7, E15). When completing the documentation to audit standards would be of possible detriment to the patient, or the therapeutic relationship with the nurse, or when the form was deemed irrelevant, nurses bypassed the audit requirements.

Throughout the focus groups, nurses noticeably discussed 'the requirements', 'satisfying the requirements' and referred to a general mandate to complete documentation with the terms 'have to', 'need to', 'should' and 'supposed to'. A digital search of the transcripts signposted these terms two to three times on each page. In this way, nurses communicated top-down pressures that motivated them to complete documentation to a certain standard. When asked directly about motivations, they provided organizational and managerial reasons and readily admitted these overt precipitating factors (see Table 7, E9, N2, B3).

> This [hospital care plan form] is only done because we are a hospital and it's done because that's what the hospital wants us to do. (N7)

Nurses expressed a sense of responsibility to their patients, the nursing profession, the institution and themselves, but were concerned that competing priorities prevented them from fulfilling all obligations all of the time, and frequently felt that rapport with patients was sacrificed to meet organizational requirements.

3.5 | Theme 5: The focus on completion of documentation for audit creates unintended and undesirable consequences

Nurses described negative functional and well-being consequences as a consequence of the audit. Perverse audit incentives resulted in inaccurate documentation, consequent inappropriate care, standardization detracting from person-centred care, time stolen from nurses and patients, and reduced nurse well-being. Nurses reported *completing the form incorrectly or misleadingly to pass the audit*, believing that the burden of audited paperwork caused people to rush, transpose the previous day's forms, or simply tick boxes out of habit. Audit assessed completeness and legality (e.g. time, date, black pen, legible) but did not detect inconsistencies caused by high volumes of increasingly complex documentation (see Table 8, B2, A2).

Nurses found the daily documentation requirements burdensome, with patient situations often unchanged. They spent little time and focussed less on accuracy when the purpose was unclear. Inaccurate documentation could be completed quickly, it might pass the audit but can lead to inappropriate care and negative patient outcomes.

> "If you did it properly […] you could be sitting with them for anywhere between 20 [mins] to an hour." Interviewer: "And how long does it take them to do an inaccurate care plan?" Nurse: "A minute." (E13)

Nurses also left auditable documentation incomplete rather than sign their name to work partially completed by someone else (e.g. see Table 8, L11). Team leaders struggled to rectify this behaviour because the form design meant that audit would not distinguish which nurse

TABLE 8 Theme 5: The focus on completion of documentation for audit creates unintended and undesirable consequences.

'Quite often if you're busy you're just sort of looking at the day before and transposing some of the information from the day before'. (B2)
'And because of audit, staff get pressure […] So who is going to check whether the accuracy of the information there? It's all about ticks but it might not be accurate information […] If you really look at the care plan, I can challenge, more than 50% information won't be accurate, but it's all filled'. (A2)
'I come and check this, and I see that it's half-filled in […] I can't ask anyone to complete it because someone else has written it. […] If it's half done that's it, you can't fix it from there'. (L11)
'Our patients are really complex and they're variable, and so they don't fall into a nice little tick box'. (E6)
'They [the patients] might need more from us. They might also need a lot less from us. We focus on recovery, we focus on getting somebody to be able to go back into the community and maintain what we've put in place for them. If we go too much on this [form] we're taking a lot of that away from people that do have that independence'. (N8)
'They feel very incomplete at the end. […] You're just doing it for the sake that I have completed [it] to be honest. I've completed, it's done […] But that's not what we want with this paperwork. We need thorough work'. (I15)
'We never finish our paperworks and stuff'. (D4)
'Because it's more forms that we have fill in now, there's more documentation. That somewhere, you know, we stay back, we don't get paid to stay back…It's so normal, I think'. (G7)
'You've got to have a good sort of half hour, 40 min to get through the care plans. […] We've been pulled before about green note documentation not being detailed enough. They [medical and administration teams] would come down and they'd want more detailed notes'. (I14)
'They're going to be safer for it and we're going to get less complaints and less paperwork in the end anyway'. (A16)
'Documentation is part of the legal accountability and all that but I think if we get more time to spend with our patient, especially the geriatrics, that would be the great part in our working practice'. (A15)
'We are like [in] some sort of mad state at the end of each shift'. (A11)
'This actually added to my work frustration because I worked on it last week, and I felt like it was another thing I didn't get done, rather than something I did get done'. (K4)
'I got a handover that said, sorry, […] it was taking too much time. It's time consuming'. 'The nurse was crying'. (M6)
'I've seen my friends or other nurses who have [woken] up forgetting to record something, waking up in the night and thinking I haven't recorded this, I have to go to ward and record it'. (A14)
'You are very stressed, yes, by this paperwork'. 'Sometimes I have stress, I say, oh, my God, I didn't do the care plan'. (F17)
*'When I almost got one [form] completely filled out, what was so frustrating is I went to the floor [from ED to the ward] when I went with the patient, oh, we're not using that [form on this ward during the trial]. 45 min of work and it ended up in the bin, to be honest. Yes […] At that point I said, f*** it. I'm sorry but it was a busy shift and it was 45 min [of my time…] it ended up in the bin [so] I stopped doing the forms'. (K7)*

did which parts of the form. Many nurses believed that *standardizing nursing care* into task-based tick-boxes and checklists through auditable documentation hinders the nurse's capacity to tailor individual care based on individual needs, undermining the intended patient partnership.

Nursing care was prioritized by audit requirements. Nurses reported frequently missing or not documenting oral hygiene, which would not be audited. Observation of vital signs had a time-specific alert if it was overdue, and so were more frequently prioritized. Nursing care was therefore standardized across patients, and provided in a planned, task-based routine rather than guided by person-centred conversations with the patient. Nurses rejected the notion that auditable documentation promoted person-centred partnership and recovery (see Table 8, E6, N8). Reprioritization to meet audit demands *reduced the nursing process to task-based function*, with reliance on prompts impeding critical thinking and clinical decision-making, undermining the nursing process of assessment, planning, implementation and evaluation (see below example as well as Table 8, I15).

> It kind of just feels like a daily duty, compared to, am I really caring about the patient? (D2)

An increased mandate on *documentation, causing accumulating workflow delays, consumed large amounts of nurse time*, reducing time spent with patients and encroaching on personal, unpaid time. They were saddened by this norm but felt regardless that they must meet legal, organizational and funding body, and medical team documentation requirements as part of their workload even when satisfying these meant duplication or onerous detail (see, e.g. D4, G7, I14).

Nurses regretted sacrificing time from patients to meet documentation requirements and expressed value in spending more time providing direct patient care, resulting in safer patients and ultimately less paperwork (see Table 8, A16, A15, I1).

> Everything you seem to have to have thrown at us, gives us less time with the patients. (I13)

Anticipation of audit added to work frustration, feelings of not meeting job requirements, and left nurses overwhelmed (see Table 8, A11, K4). Nurses felt they had not done their job if they did not meet documentation requirements, but that documentation was not valued when they did. Multiple focus groups provided anecdotes of psychological distress and colleagues tearily apologizing for missed work (see Table 8, M6). Nurses' personal lives were also impacted. Fears and stresses associated with missed documentation (not missed patient care) demonstrated that the pressure to meet auditable documentation requirements intruded on work-life balance and nurses' sleep (e.g. Table 8, A14, F17). Inconsistent expectations caused guilt in nurses who had not attended to auditable documentation, and frustrations

in those who had. The following excerpt from the emergency department highlights undesirable consequences of documentation audit expectations in the emergency department (e.g. Table 8, K7).

4 | DISCUSSION

This study showed new evidence about the nurse experience of documentation audit, namely: that nurses: (1) value quality improvement but need to feel involved in the cycle of change, (2) highlight that 'failed audit' does not equal failed care, (3) describe tension between documentation being *just* bureaucratic and constructively building workflows, (4) value building rapport (with nurses, patients) but this often contrasted with requirements (organizational, legal, audit) and (5) describe that the focus on completion of documentation for audit creates unintended and undesirable consequences.

These findings from 94 nurses in a range of acute and sub-acute hospital wards reinforce previous findings that nursing documentation is frequently delayed or incomplete due to time pressures, low priority and everchanging requirements (Charalambous & Goldberg, 2016; de Marinis et al., 2010; Kebede et al., 2017; Tajabadi et al., 2019; Taylor, 2003; Vabo et al., 2017), and that nurse participation in documentation audit is subject to: perceptions of audit motivation; audit and feedback content and delivery; applicability towards quality improvement; professional development; and patient safety. Furthermore, the experience of audit impacts nurses' psychological well-being which led to stress, burnout, demotivation and dissatisfaction (Christina et al., 2016; Drobny et al., 2019; Giesbers et al., 2021; Michl et al., 2021; Ramukumba & El Amouri, 2019; Sinuff et al., 2015).

Theme 1 highlighted how nurses understand the value of quality improvement but require it to be tailored to the end-users (De Groot et al., 2019; Nation & Wangia-Anderson, 2019; Peters, 2017; Vabo et al., 2017). Evidence-based practice relies on continual quality improvement mechanisms, such as audit and feedback, to highlight and reduce discrepancies between best and current practices. It relies on self-propelling strategies such as Carver and Scheier (1982) control theory or supported strategies such as Kluger and DeNisi (1996) feedback intervention theory. Obstacles to effective nurse participation in audit and feedback processes include delayed, conflicting, infrequent or unactionable feedback, and non-transparent, disingenuous or inappropriate feedback delivery (Ivers et al., 2014; Sinuff et al., 2015).

Nurses in this study believed that incomplete cycles of change and non-transparent audit and feedback motivations limited quality improvement. Brown et al. (2019) highlight that feedback cycles become less effective if individuals experience 'feedback fatigue'. Incorporating nurse feedback into user-friendly, clearly-reasoned documentation and audit design would support their proper use and validate their potential to align with evidence-based practice through nurse engagement (Bropwn et al., 2019; Christina et al., 2016; Giesbers et al., 2021).

Theme 2 described how nurses emphasized that failed audit does not equal failed care. Audits which are being used as a 'proxy for nursing care' aligns with the liberally-used trope 'if it isn't documented, it isn't done', which describes the discrepancies between documented and actual patient care (Cheevakasemsook et al., 2006; de Marinis et al., 2010; Paans et al., 2010). It is well-documented that nurses are frustrated by everchanging, increasingly complex and burdensome documentation requirements. However, this study provides insight by examining the way that nurses talked about audits and identified that they were frustrated or angry that auditable items which were left undocumented resulted in a failed audit, but that other aspects of care delivered were not considered. One study reported that 60% of all nursing activities were not represented by electronic health record documentation (Fore et al., 2019), supporting the justification of the nurses' emotional expression in this current study.

Theme 3 demonstrated how nurses in this current study completed auditable documentation, but often described that they did not use this documented information to guide professional assessments or inform the nursing process. The participants highlighted that the documents were constructed merely for the hospital records, rather than to inform decision-making for patient care. This is an important finding, where the realities of the nursing workflow are not aligned with the documentation's intended purpose. Other studies which have examined the real-time audit of nursing activities compared with retrospective documentation audit concluded that documentation audit does not sufficiently capture nursing activities. It calls into serious question why audits continue to rely on documentation alone for insight into nursing care and consequent patient outcomes (Fore et al., 2019; Viana et al., 2016). This aspect is compounded by the 'duplication' required for nurses to complete documentation, in this case in the 'green progress notes' which were more complete, but not audited. To be effective quality improvement tools, audit and feedback cycles must consider clinical priorities, workflows and patient care (Christina et al., 2016; Sinuff et al., 2015; Smyth et al., 2021; Tuti et al., 2017; Vabo et al., 2017). Redley and Raggatt (2017) expose the large volume of risk-screening and care-planning documentation expected of nurses, which Allen (2017) dubs 'formacology'. Saranto and Kinnunen's (2009) systematic review recommended standardized documentation formats to facilitate documentation research. However, while standardized, pre-filled documentation systems are easily auditable, such tools may limit individualized care (Kärkkäinen et al., 2005) and increase a 'tick-and-flick' culture where completion is prioritized over accuracy. Accreditation systems rely on care being measurable, but when individual legal, organizational and professional standards are covered across multiple forms this compounds the nursing burden at the point of care, and risks incomplete care (Allen, 2017; Redley & Raggatt, 2017).

Nurses in this study were frustrated that audit and feedback process seemed to generate little useful change in service delivery and they were resigned to working around logistically burdensome requirements and making decisions that sacrificed either their own

time (staying overtime), patient rapport (prioritizing paperwork over patient interaction), or documentation quality (ticking boxes inaccurately to care). Similarly, Harrington's (2019) study concludes that the near-ritualistic use of nursing documentation does not inform nurses in a way that is constructive to patient care. High opportunity costs to patients, providers and healthcare systems exist when quality improvement interventions aren't based on evidence, necessity or previous iterations of an audit and feedback cycle (Ivers et al., 2014).

The perceived pressure of organizational requirements was characterized by the language used by nurses in this study, highlighting the sense of a mandate to complete documentation with an inherent tension about actual patient benefit. The imperatives 'have to', 'need to', 'should' and 'supposed to' were frequently used without specific reference to an enforcing body and illustrated a sense of power imbalance. This is reminiscent of Roberts' (2006) analysis of oppressed group behaviour, where the status quo is unquestioned and workplace cultures inevitably serve the powerful. This insight also prompts consideration of Foucault and Bentham's themes of hierarchical observation, the institution's surveillant presence and the individual's learned self-disciplining relative to their position in the organization's hierarchy (Galič et al., 2017). In the current study, nurses felt pressure to fulfil auditable documentation's requirements, despite believing these to be inefficient, unhelpful and time-wasting. Nurses often put this pressure on themselves without direct managerial imposition. They were willing to hand over care of tasks but maintained accountability to completion of their documentation: working beyond the rostered paid shift to fulfil their duty. Nurses' duty includes contribution to the nursing profession, but we question here if this is the right interpretation (Nursing and Midwifery Board of Australia, 2016). This conflicted 'duty' may be embedded in the 'lingering tradition' and 'bureaucratic template' that underpins the organization of nursing work; and the 'puzzling contradiction' between the nurse as autonomous critically thinking professional and obedient to procedural directives (Bail et al., 2009). This 'duty to directives' was magnified by the use of managers to conduct audits of staff for greater transparency of care delivery. Managers described they would have preferred to focus on supportive, relational rapport-building activity with their staff rather than fulfilling administrative audit requirements in the cycle of quality improvement. This study reinforces Heartfield's (1996) analysis that nursing documentation remains a power struggle between nursing's oral traditions and identification of place within the biomedical discourse, and highlights that construction of nursing practice through documentation is neccessary to avoid invisibility of nursing work.

This study showed, through Theme 4, that nurses prioritized patient rapport, preferences and patient safety over other competing demands, including documenting their care to audit standards. Documentation is a frequently delayed or missed nursing duty, despite being a legal and organizational requirement, but few studies describe this as a conscious choice, but rather a consequence of clinical circumstance, competing demands and multitasking (Griffiths et al., 2018; Harvey et al., 2018, 2020; Kebede et al., 2017; Verrall et al., 2015).

Theme 5 highlighted the unintended and undesirable consequences when nurses are focussed on completion of documentation for audit purposes. While audited documentation may not always measure patient care, poor nursing records can contribute to poor nursing care (Prideaux, 2011). In this study, nurses reported that the audited documentation was mostly singly-used raising the point of whether the documentation had any use other than audit. Nurses frequently prioritized documentation completion over accuracy. Reorientation of these nursing attitudes and priorities has been previously examined, where improving governance is assumed through improved accuracy of records (Kärkkäinen et al., 2005; Paterson et al., 2021). This study provides a new insight, signposting that more rigorously audited documentation does not necessarily mean more thorough documentation. Structured documentation can be helpful as a prompt but reliance on the tool for nursing care risks undermining the nursing process of assessment, planning, implementation and evaluation, particularly where the nursing documentation might represent biomedical rather than nursing care models (Bjorvell et al., 2003; Björvell et al., 2003; de Marinis et al., 2010). Outsourcing the nursing process to standardized, de-individualized formatting likens nursing documentation to a catalogue of care. This is in contrast to the current climate of person-focussed, evidence informed care, where partnership with the patient to develop a plan of care focusing on their individual needs is desirable to facilitate holistic and appropriate nursing care (Jansson et al., 2011; Kärkkäinen et al., 2005). This study highlights that nurses want to remain enabled to be person-focussed, and documentation with strict requirements threatens patient rapport if not built with the elements of daily nursing workflow in mind.

Other unintended consequences revealed in Theme 5 were related to the nurse experience. Nurses in this study expressed decreased well-being and described feelings of stress, dissatisfaction and self-perceived as not being valued by their workplace, despite the sacrifices they had made. There is risk of burnout when good intentions and motivation are not valued, and efforts are not met by results (Bakker et al., 2014). Employee well-being impacts organizational culture, which in nursing, can have consequences on patient outcomes (Singer et al., 2009). Patient safety culture is correlated to organizational safety culture about physical risks and hazards (Pousette et al., 2017), and nurses protect their patient care at the expense of negatively perceived quality improvement strategies (Brown et al., 2019). Nurse and patient outcomes are co-examined in the Magnet Hospital literature, and should continue to be explored to optimize quality improvement strategies such as document audit, to sustain and promote nurse well-being while continually improving patient care (Havens & Aiken, 1999; Kelly et al., 2012; Kutney-Lee et al., 2015).

To build on the findings of this study, future studies should prospectively explore the nurse experience of active audit rather than retrospective documentation audit. Studies on nursing care audit could investigate; accuracy of documentation aligned with care

given; inclusion of all aspects of the nursing process in documentation audit (assessment, planning, intervention and evaluation); action research on different approaches to audit and quality feedback cycles and the impact on staff, management and patients. Most importantly, better examination of process indicators (such as an audit of documentation of nurse care) associated with outcome indicators (such as patient outcomes associated with that care) will better inform health service decision-making in finding the best ways to maximize nursing resources without perversely incentivizing tick-box care and threatening the professional role of nurses.

5 | LIMITATIONS

The limitations of this study are primarily those most associated with secondary analyses of data, where focus group questions were not asked with the research question specifically; nurses may have had different things to say if specifically asked about the impact of audit, and this approach can risk mis-interpretation. However, secondary analysis may offer protection for the vulnerability of nurses who may be reticent to speak out against their organization, despite assured anonymity, due to fear of repercussion, and minimizes the burden of additional investigations (Long-Sutehall et al., 2011). The 94 participants across nine clinical areas are not expected to be representative of all nurses, but their insight can contribute to similar healthcare organizations (Nowell et al., 2017). Given the breadth and depth of the nurse discussions, the chosen quotes sought to be representative of nurse participants and to provide transparency and credibility to the study (Nowell et al., 2017).

6 | CONCLUSIONS

Documentation audits have valid objectives in quality cycles where gaps between actual and best practice can be reconciled, through tailored feedback and intervention. However, application and delivery of audit have begun to have unintended consequences and undermine the very goals it seeks to achieve. This thematic analysis of data from nurses has outlined nurse beliefs around negative aspects of documentation audit, with little said about its positive contribution to quality improvement. Nursing staff and managers valued relational and rapport-building activity with their patients and teams to build cycles of quality improvement and raised many examples of unintended and perverse consequences of a focus on administrative audit requirements. Increasingly complex documentation requirements undermine the nursing process without facilitating the nurse's work in providing individualized care.

7 | RELEVANCE TO CLINICAL PRACTICE

Documentation audit risks missing the well-intended objective of improving care quality and contributes to negative consequences on patients, nurses and workflows when used as a process indicator of care quality. The undertaking of audits and auditable documentation design should promote clinical person-centredness without being logistically burdensome. Change is required, through marrying of change-management strategies and research-into-practice theory, to ensure that audit and documentation audit contribute to evidence-based practice in healthcare, as part of ongoing quality improvement. Future studies should prospectively explore active audit rather than retrospective documentation audit; with a greater focus on care given and associations with patient outcomes, to better support the professional role of nurses.

AUTHOR CONTRIBUTIONS

Gabriella Michl, Kasia Bail and Catherine Paterson: Made substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; Gabriella Michl, Kasia Bail and Catherine Paterson: Involved in drafting the manuscript or revising it critically for important intellectual content; Gabriella Michl, Kasia Bail and Catherine Paterson: Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; Gabriella Michl, Kasia Bail and Catherine Paterson: Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

ACKNOWLEDGEMENT

Open access publishing facilitated by University of Canberra, as part of the Wiley - University of Canberra agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

FUNDING INFORMATION

GM was supported by the University of Canberra Research Degree Honours Scholarship. KB and CP work with Synergy Nursing and Midwifery Research Centre, a partnership between the University of Canberra and Canberra Health Services. ACT Health commissioned the parent study to evaluate existing and new clinical risk screening and care-planning documentation tools. The funding covered data collection, administrative costs, transcription, researcher time and dissemination. This nested study had no associated costs.

PEER REVIEW

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.15685.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author, KB, upon reasonable request.

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How to cite this article: Michl, G., Paterson, C., & Bail, K. (2023). 'It's all about ticks': A secondary qualitative analysis of nurse perspectives about documentation audit. *Journal of Advanced Nursing*, *00*, 1–16. https://doi.org/10.1111/jan.15685