3-1-2024

In-depth perspectives of faith community nurses serving in a Western U.S. state: Findings from a healthcare-academic collaboration

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Documentation Practices by Faith Community Nurses

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Background
- Faith Community Nurses (FCNs) do not consistently document the care and education they provide.
- Available research is limited and the most recent is dated 2017.
- The most current literature reveals that only 32.3% of FCNs responded that they “always document.”
- Even though regulatory agencies are few in faith community nursing, it is the right thing to do.

Methods
- Literature review of all faith community nursing documentation sources available.
- Random conversations with FCNs about documentation practices.

Results
- FCN adoption of electronic health records (EHRs) is limited due to:
  - Inadequate finances.
  - Exemption from regulatory mandates.
  - Lack of easy-to-use software system.

Discussion
- FCNs understand the mandated standard of documentation practice but the ability to utilize it as part of the continuum of care is not well defined and therefore limits the perceived need for documentation.

Purpose
- To identify if a lack of understanding of documentation exists.
- To discover perceived barriers to consistent documentation practice.
- To determine best practices to support software development.

Documentation Practices
- Engage in professional mandate
- Attempt to capture fullness of specialty encounters

Perceived Documentation Barriers
- Lack clarity for autonomous practice and process expectations
- Lack the supportive infrastructure and interprofessional collaboration

Implications for Practice
- The value of FCN services is underestimated due to a lack of supporting data.
- Continuity of care is interrupted by the gap in documentation of care.
- The creation of an easy-to-use EHR is necessary.
- The ability to charge for services will increase compliance with FCN documentation practices.

For references and additional information, please use the QR code to view the electronic poster online.