Title

Nursing documentation in rehabilitation: What work is visible?

Abstract

Purpose Nurses document their practice every day, however it is unclear whether this output fully reflects their contribution to client rehabilitation. This paper reports on one component of a larger study which aimed to understand the nature of nurses' documentation practice within the context of a brain injury facility in Aotearoa New Zealand.

Design Critical realist methodology underpinned case study methods within this doctoral research project.

Methods Descriptive analysis was used to explore the nurses' documentation patterns.

Results Our study demonstrated the typical documentation practices of rehabilitation nurses encompassed an impersonal, task completion style. This focused on recording that the physiological aspects of clients' routines were addressed, with little attention paid to coaching, education, and support roles. However, some documentation aspects revealed a shared language structure where nurses similarly articulated their inputs, such as a phased approach to teaching client's medication self-administration.

Conclusions The largely impersonal-regulatory style of documentation that was the normative cultural pattern within the facility, alongside the absence of nurses' rationales and team recommendations, rendered the breadth of the nursing contribution invisible. In contrast, when shared language was used, it gave nurses a structure assisting in making those activities visible. This structure has potential to recognise and formalise these activities as legitimate 'rehabilitation nursing work' of relevance to nurses and other members of the team.

Relevance Rehabilitation nurse leaders should consider provision of documentation exemplars within text and standards documents. Additionally, documentation that guides shared language within nursing intervention areas has the potential to collectively empower nurses.

Introduction

Whilst documentation is an everyday practice for rehabilitation nurses, the purpose underlying that practice is complex. Primarily, nursing records are a legal document chronicling what has occurred in a set time period (NZNO, 2021). The New Zealand Nurses' Organisation (2017) assert, "if care is not recorded, then it is assumed the care was not given" (p. 2). This legalised approach frames the nurse's contribution as tasks requiring evidence of completion, thereby framing a *legal-mechanistic approach* (Davenport, 2020). However, particularly in the rehabilitation context, documentation should also contain content signifying the relationship with the client. In this way, documenting a nurse's input helps ensure client-led engagement and decision making. Nurses' documentation also has a communication component, where others in a team can review progress, concerns and/or recommendations (Karkkainen, Bondas, & Eriksson, 2005; Kerkin, Lennox, & Patterson, 2018). In addition, documentation provides data that may be used for financial, research or quality processes (Kerkin et al., 2018; Wang, Hailey & Yu, 2011). The process and practice of documentation is indubitably multifaceted, demanding critical consideration of best practice.

Healthcare for Aotearoa New Zealand citizens and residents is predominately publicly funded. Rehabilitation for accident-related injury such as for those with traumatic brain injury (TBI) is funded by The Accident Compensation Corporation (ACC). ACC is a government organisation that provides 'no-fault' cover to anyone in Aotearoa New Zealand who has an accident, meaning "it doesn't matter what you were doing when you were injured or who was at fault" (Accident Compensation Corporation, 2024, para. 4). Under this scheme, clients with an approved injury claim are fully funded through hospital, rehabilitation, and community phases. There are three post-acute units specialising in TBI rehabilitation in Aotearoa New Zealand where clients can receive intensive rehabilitation before transitioning back to their community. These rehabilitation units have a variety of healthcare professionals within their interprofessional team including rehabilitation nurses.

There is no formalised certification for rehabilitation nurses in Aotearoa New Zealand. Rather, rehabilitation nurses learn the specialist skills required in the workplace, and documentation from a rehabilitative-nursing viewpoint as part of their on-the-job training. Nurses are legally required to document their inputs and interactions with their clients (New Zealand Nurses Organisation, 2017). Whilst literature highlights the important role

documentation plays for an interprofessional team, including rehabilitation teams (Dean, Siegert & Taylor, 2012; Paxino, Denniston, Woodward-Kron & Molloy, 2020), and whilst there is a legal requirement for nurses to document their inputs, the documentation practice of rehabilitation nurses is poorly understood.

Within rehabilitation settings, internal client records may be audited for completeness, however, given the multifaceted purpose that documentation holds, evaluating 'completeness' is complex. Internationally, work has been undertaken within the rehabilitation nursing field to establish frameworks to capture data, thereby evidencing nurses' contribution (Lunney, McGuire, Endozo & McIntosh-Waddy, 2010; Tosin, 2016). Regrettably there is no current consensus as to an appropriate approach. Specific guidance relating to free-text documentation is often absent from these discussions and rehabilitation competency frameworks.

In the absence of a universally recognised standardised framework, deciding what is rehabilitation nursing documentation 'best practice' is not an easy question to answer. Publications suggest that adopting a specific framework adds value in terms of consistency, structure, and a systematic approach (Bjartmarz, Jónsdóttir & Hafsteinsdóttir, 2017; Johnson et al., 2009; Lunney et al., 2010). Within these publications three different classification systems are proposed to improve documentation systems: a best practice guideline (Bjartmarz et al); a nursing taxonomy (Johnson et al); and a minimum dataset (Lunney et al). Whilst some authors have advocated for rehabilitation-specific nursing frameworks (Lunney et al., 2010; Tosin, 2016), others caution nurses, instead encouraging combined, inter-professional documentation practice to augment teamwork and communication (Mueller, et al., 2008).

The nurse's role in rehabilitation has been identified as key to an optimally functioning rehabilitation team (Ehrlich, Lewis, New, Jones, & Grealish, 2022; Gutenbrunner, Stievano, Nugraha, Stewart, & Catton, 2021; Pryor & O'Connell, 2009). To enhance collaboration and augment integration within the team, documentation plays a pivotal role. The Australasian Rehabilitation Nurses' Association (ARNA) and the Association of Rehabilitation Nurses (ARN) have both published competency documents clarifying components of the rehabilitation nurses' role (2003, 2014). Both models frame aspects of the role. For example, the ARNA categorises nurses' teaching and coaching, and advocacy and coordination roles. Meanwhile the ARN identifies nurse-led interventions, and health promotion. However, documentation practice is not directly articulated as a competency in either document. While

the essential role of documentation is accepted, its absence in the competency documents may reflect the invisible nature of documentation, and potentially reveal an ambiguous normative requirement with assumed knowledge and skill.

Recent literature related to Australasian documentation trials on rehabilitation units revealed two note-worthy papers. In 2012, two Aotearoa New Zealand authors relayed a ward's switch from a Subjective, Objective, Assessment, Plan (SOAP) Framework to Focus Charting (Blair & Smith, 2012). The Focus Charting documentation frames notes into A, I, E - Assessment, Implementation, and Evaluation. The authors deemed the switch successful for nurses, finding that Focus Charting allowed for easier documentation of the multiple issues and multiple interactions throughout a shift. The second paper also utilised a documentation framework mnemonic which sought to assist nurses to structure their free text notes (Murray, 2022). Based on the Functional Independence Measure (FIM^{TM}; Uniform Data Set for Medical Rehabilitation, 1996), Murray's 'Rehab ABC' mnemonic sought to combine the FIM^{TM} language of the broader team with rehabilitation-nursing-specific documentation requirements. These papers provide contextual information relating to free text documentation practice within Australasia, and although they take different approaches, it is encouraging that research into improvements to rehabilitation nursing documentation has begun. Despite such efforts, understanding of what rehabilitation nurses are documenting of their practice remains unclear.

Whilst there has some been progress in transferring handwritten documentation to electronic records (Burridge Foster, Jones, Geraghty, & Atresh, 2017; Choi & Kim, 2012; Rundquist et al., 2011), there is also a growing body of concern that some electronic frameworks are discordant with the way nursing functions (Burridge, Foster, Jones, Geraghty, & Atresh, 2017; Forde-Johnston, Butcher & Aveyard, 2023). Our paper reports on research findings that were part of a larger doctoral thesis. This part of our research focussed on everyday, free-text documentation and timetable entries undertaken within nursing shifts. We sought to develop a description of the nature of nurses' free-text documentation in order to understand what they were choosing to record of their rehabilitation contribution, and how they were documenting that information. Within an Aotearoa New Zealand rehabilitation nursing context, client engagement and integration of family within all aspects of rehabilitation is a core component of a culturally appropriate rehabilitation model (Foster et al., 2012; Lavelle Wijohn, 2017). To this end, understanding the nature of what nurses are documenting is particularly important. The research team were cognisant there were likely to be a range of

interacting factors that might influence documentation, including cultural, social, environmental and organisational aspects (Davenport, Jones, Larmer, & McPherson, 2022). These mechanisms all have potential to affect the coordination of client-centric interventions, and the client experience.

Methods

This research used a critical realist meta-theoretical approach with case study methods (Yin, 2014). We chose critical realism to philosophically underpin the research due to its ability to engage within various layers, and guide consideration of the complex factors and potential influences on nursing documentation. Critical realism enabled an exploration of what it was within the structure and culture of the organisation studied that influenced how this group of nurses documented their interactions with their clients (Davenport et al., 2022).

The research was conducted in one facility in Aotearoa New Zealand, assisting with the in-depth inquiry which researchers felt was required for the study topic. The single case study design enabled the theoretical work of the wider research, which sought to explain causal influences. Theorising potential causal influences allowed the researchers to understand the tendencies they were seeing at an empirical level. Employing Vincent & Wapshott's (2014) framework, abductive techniques were utilized in data analysis in the phase that is reported in this paper. Abduction enables identification of patterns by re-describing events within the given context, thereby identifying general practice and patterns of what was occurring within the study facility (Danermark, Ekstrom, Jakobsen, & Karlsson, 2002; Sayer, 1992). Within this current paper, we present results from Phase B of our research, which focused on data from the electronic client records.

Multiple discussions with key stakeholders were held prior to research commencement, and permission to proceed was granted from facility management, the Māori Advisory Committee and research personnel at the facility. The research was approved by the Auckland University of Technology Ethics Committee (AUTEC). Primary datasets within two historical time periods (2014 and 2015) were used for data collection purposes. Within each time period two datasets were gathered; firstly, nursing free-text documentation completed within a shift, and secondly, nurses' free-text input into clients' timetables. Only records written by nurses working permanently in the facility were analysed. The data was extracted from both datasets by a Data Manager for each of the two historical time periods. Data was de-identified and exact time periods within the chosen year were not shared with the research team.

The researchers did not seek to determine agreement or discrepancy between nurses' activities and their documentation. Rather, emphasis was placed on understanding what this group of nurses chose to document. Descriptive analysis was used to identify the patterns of documentation. We considered using a framework for coding such as the International Classification of Functioning, Disability, and Health (ICF; WHO, 2001), reflecting that utilising a common language system might also provide rehabilitative nurses with much-needed role visibility. However, we considered it important to keep the data itself central at this stage, as a framework might overtly prescribe our coding. Codes that described the type of activity or intervention that nurses documented were assigned to items of data. The first author initially coded all items of data then discussed the codes and categories with author 2 and 3, until mutual agreement was reached. Utilising NVivo 11 software (Lumivero, 2015), the codes were refined and classified into nine primary categories using an iterative process. The coding patterns were analysed, including frequency of recording, to gain understanding of what nurses were documenting most and what was infrequently documented.

Findings

Data from both the nurses' entries into the clients' timetables, and their free-text shift documentation across the two historical time periods (2014 and 2015) generated 8,980 items of data. These were coded and classified into nine primary categories. (There were a number of secondary categories which will not be presented in this paper given word count constraints). The definition of each primary intervention category is presented below in alphabetical order, along with an example from the data. Following this we present the patterns of documentation. The nine primary categories were:

- Assessment
- Clinical rationale
- Coaching – Doing with
- Documentation notification
- Education
- Interprofessional team (IPT) review or discussion
- Making recommendations
- Support
- Task – Doing For

Intervention categories: Definitions

Assessment: This category incorporated documentation where nurses indicated their assessment of a client interaction or activity. There were a wide variety of assessment types for example: cognition, pain, continence, mood, and mobility assessments. An example taken from the nursing notes was:

> *Dense right sided weakness, some movement returning to the right leg, able to bend this leg at the knee, pushes to her affected side and has difficulty maintaining an aligned and comfortable position in the wheelchair, able to tolerate 2 hours in the wheelchair on Saturday afternoon.* (Assessment - Mobility: Ref 34).

Clinical rationale: In this category the nurse documented their opinion or clinical rationale of what they did. For example: *"She was not capped [tracheostomy] as her heart rate and her temperature are still elevated".* (Clinical Rationale: Ref 25).

Coaching – Doing with: Coaching was defined as working with, encouraging or prompting the client. It incorporated coaching with a number of different activities such as, behaviour management, health promotion and activities of daily living (ADLs). For example:

> *Was able to check his blood sugar by himself, he was able to put needle in each insulin pen, able to read the name of insulin in each cartridge, administered both insulin by himself. Talked through with him while he was doing all the procedures. He did it well. He was also keen to tick off the list provided to him regarding his medications, he was writing down his BSL readings on the same paper*. (Coaching: Ref 14).

Documentation notification: Within the study facility nurses accounted for their documentation time, and that was included within this category. Also included were notes that shared information or notifications about a client's routine, for example, independence levels, but the nurse's interaction or involvement was not stated, nor details of assessment.

> *Client was settled this shift. He had a shower this morning and had good breakfast. He stayed in the lounge until 1000H. He got up on the wheelchair and stayed in the lounge till 1400H.* (Documentation notification - Information sharing: Ref 89).

Education: These entries articulated the provision of education to the client or their support persons. For example: *"Client took his medications. He was aware that his warfarin had increased and asked about this and I explained how the dose was worked out".* (Education: Ref 25).

Interprofessional team (IPT) review or discussion: Documentation of interaction with internal or external team members. A common example was interaction with the medical team including documentation of the discussion, relaying medical instructions or new orders.

Making recommendations: This category was allocated when nurses documented their recommendations to team members. It included rehabilitation planning and goal setting with steps and strategies. *"Leave SPC [supra-pubic catheter] uncovered to reduce moisture and risk of hyper-granulation".* (Making recommendations: Ref 56).

Support: Documentation of emotional or social support / interaction with the client. *"Client appeared to enjoy himself and got very involved in the game, indulged in some post-game analysis with staff".* (Support - social: Ref 50).

Task – Doing For: Documentation was coded into this category when the nurse described the intervention as a task completed impersonally, where no interaction with the client (beyond that necessary for the task) was documented, giving the appearance of 'doing for' the client. An example is: *"2 hourly trache assessment with inner cannula cleaned on each occasion, clear thin secretions".* (Task - Tracheostomy management: 22). In this Task – Doing For category, nurses similarly included little or no documentation of their own rehabilitative inputs. For example, interaction with or feedback from the client (this could be verbal or physical), documentation of the nurse providing verbal or physical cues during the activity, provision of choices proposed, or modification of the individual physical or social environment.

Patterns of documentation

Once we had coded into these nine categories, we analysed patterns of documentation within the datasets. Three categories were documented most frequently, they were: (1) Assessment of the client (32.4%); (2) Tasks, or what nurses were 'doing for' the client (27%); and (3) Documentation Notification (23.1%). The least frequently recorded items were Clinical rationale (0.5%); Support (1.9%); IPT review or discussion (2.1%); Making recommendations (3.5%); Coaching (4.6%), and, Education (4.9%). (See Figure 1).

Figure 1

Coding into the Assessment, Task – Doing for, and Documentation Notification categories accounted for three quarters of the dataset. In contrast, giving a clinical rationale for an intervention or decision making was seldom expressed by nurses.

A line of analytic inquiry worthy of note here was the paucity of documentation which articulated interaction with team members (see Figure 2). When nurses documented communication with other members of the interprofessional team, it tended to be their interactions with the medical staff. The nurses documented interaction with the dietician, who reviewed clients every 1-2 weeks, in as much frequency as their internal, allied-health colleagues who, arguably, interacted with most or all patients on a daily basis during weekdays. Nurses also seldom documented their handover to each other, only seven instances of this were recorded in the complete dataset. Handover occurs two-three times each day, yet it was nearly invisible in the nurses' free-text documentation.

Figure 2

Analysis demonstrated what activities and interventions nurses were most likely to record, thereby generating an understanding of the cultural pattern of documentation in the study facility. Findings clearly indicated nurses were more likely to write of assessment activities and physical tasks, and, whilst documentation of coaching and education activities were less prevalent. They were unlikely to include clinical rationale within their documentation.

Discussion

This phase of the study sought to understand what nurses in a TBI rehabilitation facility chose to write. Nurses' free text documentation provides communication to others of events, interventions, activities, and progress towards the client's rehabilitation goals on a shift-by-shift basis. It is an essential, everyday requirement and the research team sought to understand what and how rehabilitation nurses chose to document. Our analysis revealed that nurses documented Assessments and Tasks that they were completing with high frequency compared to activities of Coaching, Education, or Support. This finding aligns with the research of Kearney and Lever (2010) who believed that verbal interactions were less likely to be communicated by rehabilitation nurses. Our research found that the cultural patterns of documenting interactions as a completed set of tasks, often focused on physical tasks of input[1], output[2], and medications. The focus on task completion relayed a pattern of documentation that was formal and impersonal. On analysis, it was sometimes difficult to discern if the nurses participated in the interaction, were observing, or simply relaying another staff member's communications. For example: *"He packed his bags at one point and tried to unlock the door but he was easily distracted. He settled to bed just before 2100."* (Behaviour Management: Ref 26). Additionally, this documentation style has the potential to lessen the visibility of the nursing contribution as it does not qualify the nurse's inputs, interaction or analysis.

The most prevalent style of documentation of these nurses was in the third person, where the nurses tended to not include themselves or their input with their clients. If this data was analysed as 'information sharing' or 'highlighting an issue' only, it was coded within the Documentation Notification category. This relayed information, but in an impersonal style, because nurses didn't include their input. Table 1 presents the documentation counts in categories of Documentation Notification, compared to the entries those where nurses recorded how they interacted with the client such as Support, Coaching or Education.

Table 1

Nurses also wrote little of their rationale in decision making or recommendations to other team members. A lack of clinical rationale within generalist nursing documentation has also been noted in other research (Blair & Smith, 2012). When rationale is documented, it may benefit others through collective learning and/or add to the documented knowledge base so that progress or evaluation of care plans could be conducted. Bunniss & Kelly (2013) found benefits in shared informal learning within a health organisation, although most of the examples within the research were spontaneous and synchronous. If clinical rationales were included more commonly in nurses' documentation practice, they have the potential to enhance learning, given the context of 24/7 shift patterns. Crucially for nursing, documentation of clinical rationales do not require a synchronous team discussion which fits with shiftwork patterns and shared client responsibilities.

Not only did nurses seldom write recommendations to their allied health colleagues, but there was also a dearth of documentation of nurse's discussions with their nursing colleagues. This led to an invisibility of team decision making within the nursing records. The nurses in our research were more likely to record their interactions with medical staff than other rehabilitation team members. This may be due to a culture of ensuring they have reported concerns from a medico-legal standpoint rather than denoting teamwork within the facility. When considering nurses' task-focussed documentation style alongside the disparity in nurses recording their team interactions, we added to our analysis of nurses' documentation style as *impersonal-regulatory.* Concentrating on their regulatory obligations was a key mechanism to nurses' writing style. The absence of documentation relating to interprofessional collaboration had the effect of constraining communication of their collective contribution as part of the interprofessional team effort.

The quest for visibility of the nursing role has been examined by many researchers in nursing generally (Allen, 2015; Lydahl, 2017; McWilliam & Wong, 1994; Sparrow & Draper, 2010) and specifically within rehabilitation nursing (Pryor, 2001). Lydahl (2017) acknowledged the implicit work of nursing, highlighting incompleteness in documentation, whilst expressing

the consequence that the invisible work stays hidden. Drawing on this assumption, in the present study, it cannot be known whether nurses were simply providing incomplete documentation of their contribution, or whether certain activities were infrequently carried out as part of their role. Nonetheless, within critical realism, Bhaskar (1993) and Norrie (2012) recognise the notion of absence is akin to that of presence. The absence trends in our datasets were nurse's interactions with their clients in the areas of coaching, education or support; decision-making rationales; and nurse's documentation of their recommendations to other nurses and the wider team. These categories were recorded in much lower frequency than other dimensions nurses chose to document. Nurses in this cohort either did not carry out these activities, or did not consider their documentation as the forum for expressing the value they added in these areas to rehabilitation. This absence has the potential to keep the nursing contribution to a client's rehabilitation journey nebulous. Importantly, documentation of the nursing contribution in the form of coaching activities, decision-making and recommendations might serve to raise the nurses' own awareness of education/coaching's importance, by supporting reflection and greater recognition of how these aspects contribute to client change within interprofessional rehabilitation.

There were examples of 'presence' and positive aspects to arise from our research, one of which was nurses' documentation that demonstrated a shared language in the dataset. Entries from different nurses were consistent in their articulation of medication self-administration procedures and documentation requirements within this domain particularly. There was a consistent shared meaning and a clarity of their role which implied a collective sense of identity. Margaret Archer (1995) recognised a differentiation between primary and corporate agency. The former demonstrates individual understandings, often constrained by structure and culture, where the latter share a collective vision and common goals. Harnessing shared language within other intervention areas has potential to empower nursing teams as it would provide structure for their documentation.

Utilisation of standardised frameworks are seen in rehabilitation nursing with various nursing process frameworks and classification systems (Classification of Nursing Diagnoses (NANDA), the Nursing Interventions Classification (NIC), and the Nursing Outcomes Classification (NOC)). Whilst these are useful in some settings, the emergence of research from an Australasian context by Blair & Smith (2012) and Murray (2022), may provide guidance for free-text shift reporting which also fits our Australasian context. Both of these

articles impart implementation advice, and Murray also gives an exemplar of free-text documentation using his mnemonic.

Development – recommendations and further research

There were a number of recommendations deriving from this research, both to the facility itself and the wider rehabilitation nursing sector. Those that relate to the information presented in this paper are presented here:

- Ensure documentation practice is discussed and exemplars of free text documentation are provided, in particular when nurses first join the facility (including documentation of coaching and education activities).
- Require nurses to document their full interaction with, support of, and analysis of, client responses to interventions.
- Provision of documentation exemplars within rehabilitation nursing textbooks and standards documents.

The retrospective audit of documentation reported in this paper did not validate what nurses were actually doing in relation to what they recorded. The next phase in our research interviewed nurses about their decision making relating to what they chose to document. Whilst some coaching, education and support activities were recorded we wondered if that was the extent of that work, or if was under-reported or just undervalued. Questions such as these were included in the interviews with nurses in our subsequent research phase.

Future research could include an observational study of 'nursing work', particularly focused on coaching, education and support activities to quantify the extent of that work. We also recommend further research relating to rehabilitation nursing documentation frameworks and shared language.

Conclusion

Our research sought to understand the nature of nurses' documentation within an inpatient TBI rehabilitation unit. This is important as it provides information about what rehabilitation nurses choose to document within this specific contextual environment and considers documentation completeness and activities that are absent. Within our research, nurses predominantly wrote in a task focused style, documenting activities of coaching, education and support with lesser frequency. Nurses did not often include their clinical rationale or

recommendations to other team members. If there are absences in documentation practice, such as those listed here, and nurses are not adequately communicating their contribution, then their input can never be truly evaluated, let alone measured within the journey of the client.

In our research there were also instances of shared language evident, for example, the medication self-administration assessment and interventions. Enhancing collective practice through developing shared language has great potential to support a more complete record. This will assist with increasing the visibility of the of rehabilitation nurses' contribution, so interprofessional teamwork and collaborative practice support the client's rehabilitation journey.

References

Accident Compensation Coorporation. (2024). Injuries we cover. Retrieved from https://www.acc.co.nz/im-injured/what-we-cover/injuries-we-cover

Allen, D. (2015). *The invisible work of nurses: Hospitals, organisation and healthcare*. Oxfordshire, UK: Routledge. doi:10.1111/1467-9566.12295

Archer, M. (1995). *Realist social theory: The morphogenetic approach*. Cambridge, UK: Cambridge University Press. doi:10.1017/CBO9780511557675.003

Australasian Rehabilitation Nurses Association. (2003). *Position statement: Rehabilitation nursing - scope of practice*. Retrieved October 10, 2012, from http://www.arna.com.au/ARNA/Documents/competencystandards.pdf

Association of Rehabilitation Nurses. (2014). *Standards and scope of rehabilitation nursing practice* (6th ed.). Chicago, IL: Association of Rehabilitation Nurses.

Bhaskar, R. (1993). *Dialectic: The pulse of freedom*. London, UK: Verso.

Bjartmarz, I., Jónsdóttir, H., & Hafsteinsdóttir, T. B. (2017). Implementation and feasibility of the stroke nursing guideline in the care of patients with stroke: A mixed methods study. *BMC Nursing, 16*(72), 1-17. doi:10.1186/s12912-017-0262-y

Blair, W., & Smith, B. (2012). Nursing documentation: Frameworks and barriers. *Contemporary Nurse*, *41*(2), 160–168. doi:10.5172/conu.2012.41.2.160

Bunniss, S., & Kelly, D. R. (2013). Flux, questions, exclusion and compassion: Collective learning in secondary care. *Medical Education, 47*(12), 1197–1208. doi:10.1111/medu.12281

Burridge, L., Foster, M., Jones, R., Geraghty, T., & Atresh, S. (2017). Person-centred care in a digital hospital: Observations and perspectives from a specialist rehabilitation setting. *Australian Health Review: A Publication Of The Australian Hospital Association, 42*(5), 529-535. doi:10.1071/AH17156

Choi, J., & Kim, H. (2012). A workflow-oriented framework-driven implementation and local adaptation of clinical information systems: A case study of nursing documentation system implementation at a tertiary rehabilitation hospital. *Computers, Informatics, Nursing: CIN, 30*(8), 409-414. doi:10.1097/NXN.0b013e3182512ffd

Danermark, B., Ekstrom, M., Jakobsen, L., & Karlsson, J. C. (2002). *Explaining society: Critical realism in the social sciences*. New York, NY: Routledge.

Davenport, A.C. (2020). Exploring nurses' documentation of their contribution to traumatic brain injury rehabilitation in an Aotearoa New Zealand rehabilitation unit (Doctoral thesis, Auckland University of Technology, Auckland, New Zealand). Retrieved from http://hdl.handle.net/10292/13552

Davenport, A.C., Jones, M.A., Larmer, P.J., & McPherson, K. (2022). Embracing critical realism in rehabilitation nursing research. *Journal of the Australasian Rehabilitation Nurses' Association, 24*(1), 12-19. doi:10.33235/jarna.24.1.12-19

Dean, S., Siegert, R., & Taylor, W. (Eds.). (2012). *Interprofessional rehabilitation.* Chichester: Wiley.

Ehrlich, C., Lewis, D., New, A., Jones, S., & Grealish, L. (2022). Exploring the role of nurses in inpatient rehabilitation care teams: A scoping review. *International Journal of Nursing Studies, 128,* 104134. doi:10.1016/j.ijnurstu.2021.104134

Forde-Johnston, C., Butcher, D., & Aveyard, H. (2023). An integrative review exploring the impact of Electronic Health Records (EHR) on the quality of nurse–patient interactions and communication. *Journal of Advanced Nursing, 79*(1), 48-67.

Foster, A. M., Armstrong, J., Buckley, A., Sherry, J., Young, T., Foliaki, S., James-Hohaia, T. M., Theadom, A., & McPherson, K. M. (2012). Encouraging family engagement in the rehabilitation process: A rehabilitation provider's development of support

strategies for family members of people with traumatic brain injury. *Disability and Rehabilitation, 34* (22), 1855–1862. doi:10.3109/09638288.2012.670028

Gutenbrunner, C., Stievano, A., Nugraha, B., Stewart, D., & Catton, H. (2021). Nursing - A core element of rehabilitation. *International Nursing Review, 69*(1), 13–19. doi:10.1111/inr.12661

World Health Organization. (2001). International Classification of Functioning, Disability and Health : ICF. World Health Organization.

Johnson, K., Bailey, J., Rundquist, J., Dimond, P., McDonald, C. A., Reyes, I. A., Thomas., & Gassaway, J. (2009). SCIRehab project series: The supplemental nursing taxonomy. *Journal of Spinal Cord Medicine, 32*(3), 329-335. doi:10.1080/10790268.2009.11760786

Karkkainen, O., Bondas, T., & Eriksson, K. (2005). Documentation of individualized patient care: A qualitative metasynthesis. *Nursing Ethics, 12*(2), 123-132. doi:10.1191/0969733005ne769oa

Kearney, P. M., & Lever, S. (2010). Rehabilitation nursing: Invisible and underappreciated therapy. *International Journal of Therapy & Rehabilitation, 17*(8), 394-395. doi:10.12968/ijtr.2010.17.8.49278

Kerkin, B., Lennox, S., & Patterson, J. (2018). Making midwifery work visible: The multiple purposes of documentation. *Women and Birth, 31*, 232-239. doi:10.1016/j.wombi.2017.09.012

Lavelle Wijohn, E. (2017). *Brain Injury Whānau Action Project (BIWAP): Increasing the capabilities of families of adults with brain injury to live their lives in the ways they have reason to value* (Doctoral thesis, Auckland University of Technology, Auckland, New Zealand). Retrieved from https://hdl.handle.net/10292/11013

Lumivero. (2015) NVivo 11. www.lumivero.com.

Lunney, M., McGuire, M., Endozo, N., & McIntosh-Waddy, D. (2010). Consensus-validation study identifies relevant nursing diagnoses, nursing interventions, and health outcomes for people with traumatic brain injuries. *Rehabilitation Nursing, 35*(4), 161-166. doi:10.1002/j.2048-7940.2010.tb00042.x

Lydahl, D. (2017). Visible persons, invisible work? Exploring articulation work in the implementation of person-centred care on a hospital ward. *Sociologisk Forskning, 54*(3), 163-179. doi:10.37062/sf.54.18213

McWilliam, C. L., & Wong, C. A. (1994). Keeping it secret: The costs and benefits of nursing's hidden work in discharging patients. *Journal of Advanced Nursing, 19*(1), 152-163. doi: 10.1111/j.1365-2648.1994.tb01063.x

Mueller, M., Boldt, C., Grill, E., Strobl, R., & Stucki, G. (2008). Identification of ICF categories relevant for nursing in the situation of acute and early post-acute rehabilitation. *BMC Nursing, 7*:3. doi:10.1186/1472-6955-7-3

Murray A. (2022). Introducing the Rehab ABC nursing documentation framework. *Journal of the Australasian Rehabilitation Nurses' Association, 24*(2), 19-27. doi:10.33235/jarna.24.2.19-27

New Zealand Nurses Organisation. (2021). Practice guideline: Documentation. Retrieved February 27, 2023, from https://www.nzno.org.nz/resources/nzno_publications

New Zealand Nurses Organisation. (2017). Guideline: Documentation 2017. Retrieved November 10, 2018, from https://www.nzno.org.nz/LinkClick.aspx?fileticket=GH84aNBNd64%3D&portalid=0

Norrie, A. (2012). Who is 'The prince'?: Hegel and Marx in Jameson and Bhaskar. *Historical Materialism, 20*(2), 75-104. doi:10.1163/1569206X-12341234

Paxino, J., Denniston, C., Woodward-Kron, R., & Molloy, E. (2020). Communication in interprofessional rehabilitation teams: A scoping review. *Disability and Rehabilitation, 44*(13), 3253–3269. Doi:10.1080/09638288.2020.1836271

Pryor, J. (2001). Rehabilitation nursing in Australia: A valid and valued specialty. *Contemporary Nurse, 11*(2-3), 125-132. doi:10.5172/conu.11.2-3.125

Pryor, J., & O'Connell, B. (2009). Incongruence between nurses' and patients' understandings and expectations of rehabilitation. *Journal of Clinical Nursing 18*(12), 1766-1774. doi:10.1111/j.1365-2702.2008.02322.x

Rundquist, J., Gassaway, J., Bailey, J., Lingefelt, P., Reyes, I. A., & Thomas, J. (2011). The SCIRehab project: Treatment time spent in SCI rehabilitation. Nursing bedside education and care management time during inpatient spinal cord injury

rehabilitation. *The Journal Of Spinal Cord Medicine, 34*(2), 205-215. doi: 10.1179/107902611X12971826988255

Sayer, A. (1992). *Method in social science: A realist approach*. London, UK: Routledge.

Sparrow, S., & Draper, J. (2010). The (silent) voice of nursing? *Journal of Clinical Nursing, 19*(5-6), 603-604. doi:10.1111/j.1365-2702.2008.02562.x

Tosin, M. H. S., Campos, D. M., Andrade, L. T., Oliveira, B. G. R. B., & Santana, R. F. (2016). Nursing interventions for rehabilitation in Parkinson's disease: Cross mapping of terms. *Revista Latino-Americana De Enfermagem, 24*, e2728-e2728. doi:10.1590/1518-8345.0689.2728

Uniform Data Set For Medical Rehabilitation (1996). Guide for the use of the uniform data set for medical rehabilitation, Version 5.0. Buffalo, NY: State University of New York at Buffalo Research Foundation.

Vincent, S., & Wapshott, R. (2014). Critical realism and the organisational case study. In P. K. Edwards, J. O'Mahoney, & S. Vincent (Eds.), *Studying organisations using critical realism (Chapt. 8)*. Oxford, UK: Oxford University Press.

Wang N. , Hailey D. & Yu P. (2011) Quality of nursing documentation and approaches to its evaluation: A mixed-method systematic review. *Journal of Advanced Nursing 67*(9), 1858–1875. doi: 10.1111/j.1365-2648.2011.05634.x

Yin, R. K. (2014). Case study research: Design and methods (5th ed.). Thousand Oaks, California: SAGE.