What is a Discourse Community?

There are many different definitions of discourse community. According to Porter (2011) a discourse community is “a group of individuals bound by a common interest who communicate through approved channels and whose discourse is regulated.” (p.91).

Swales (2011), incorporates six common characteristics of a discourse community: 1) Discourse communities have a common set of goals 2) There are mechanisms for communication between members 3) Members consciously participate by providing information and feedback 4) The community uses one or more genres to communicate 5) The community has a specific language of its own 6) Membership of the group changes, but is sustainable.

I would also like to incorporate something from Gee (2011), he uses the terms primary Discourse, secondary Discourse, and dominant Discourse. One's primary discourse is the first discourse learned, secondary discourse is a discourse learned outside of the primary discourse, and dominant discourse is a secondary discourse which yields social goods, generally someone's profession. I would also like to add that discourse communities follow some sort of hierarchical structure between novices and experts within the community.

Understanding discourse communities is important to the success of the members. Understanding and being able to implement the proper discourse by the appropriate means can help one fit into the group better and also be respected by those advanced in the hierarchy of the community.

Nursing as a Discourse Community

Nursing is a dominant Discourse, the social good earned is monetary and also the satisfaction of giving back. The common goal of the group is to perform their job efficiently and effectively. The nursing field requires prompt, professional, concise communication. This is to ensure effective transfer of information to and between other nurses, doctors, health unit coordinators (HUCs), pharmacists, therapists, patients, family members, and other members of the health care team. To become a member of the nursing discourse community, one must have the desire to help others and the ambition to complete rigorous education. After completion, a national exam is taken to become a registered nurse. The hierarchy within the nursing discourse is complex; I want to focus only on registered nurses. The pattern of hierarchy is typically divided by experience when all have equal educational backgrounds. Documentation is the formal way that nurses communicate, in the form of care plans and progress notes. Computers are the main mode of these types of communications; they allow quick changes to be made and
provide a legible format. To be successful in the nursing discourse one needs to have knowledge of medical terminology, the format of specific forms, and be able to document objectively.

### Documentation: 3 Rules to Success

The language used in nursing documentation is in a scientific type format and generally contains many healthcare acronyms and medical terminology. According to Angeli, E. Tompkins, and J.C. Tompkins (2010), there are three main criteria to follow when writing as a nursing student, and as a professional nurse. To be **precise**, be **objective**, and remember your **critical audience**. This website [http://owl.english.purdue.edu/owl/resource/922/01/](http://owl.english.purdue.edu/owl/resource/922/01/) has more details about this, and many other great resources for writing as a nurse.

### Care Plans and Progress Notes

The information provided in care plans and progress notes is important in accessing the patient’s status and next point in their plan of care. According to Mosby's Medical Dictionary (2009) a nursing **care plan** is a plan based on a nursing assessment.

It has four basic parts: Identification of the problem or nursing diagnosis and the suggested solution; the expected outcome of the patient; the specific steps of the nurse to be taken to achieve the outcome; and the response of the patient to nursing care.

The nursing care plan is established when the patient is first admitted to the health facility and updated throughout the patient’s stay.

**Progress notes** are important in the continuity of care for the patient; they serve as a means for all members of the health care team to communicate about the patient and their progress. This type of documentation is done alongside a care plan, with the care plan as the initial guide and the progress notes being recorded every shift.
The progress notes are kept in the patient’s medical record and can be accessed by any member of the health care team. This allows for all members to keep up to date with the patient’s progress, and adjust their own objectives accordingly.

Nurses generally use the progress notes to document how the patient is responding to the nursing care plan interventions. Other nurses will look at this, and they may consult with one another to discuss the next course of action. Doctors will read the nursing progress notes to determine if they need to launch a new directive; they rely on the nursing progress notes because the nurse spends more time with the patient. This is why being precise and objective in these notes is important; others are relying on it to make critical decisions.

Here is a link with tips for writing these documents: http://owl.english.purdue.edu/owl/resource/922/02/

Here is a link to some examples of care plans: http://www.rncentral.com/nursing-library/careplans

Final Thoughts

The discourse community of nursing is complex, and involves several other discourse communities. It is important to understand how the nursing discourse communicates within itself and how this interaction is fluid between other communities. Care plans and progress notes are perhaps the most used form of communication about the common goal of the nurses; the patient and their needs. Remembering the three rules listed above can help someone new to the field succeed with their writing, and as like anything, practice and observation will certainly help.

References


