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Implementing an Education Programme and SOAP Notes Framework to Improve Nursing Documentation

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Royal College of Surgeons in Ireland
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“Implementing an Education Programme and SOAP Notes Framework to Improve Nursing Documentation.”

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A Dissertation submitted in part fulfilment of the degree of MSc Healthcare Management, Institute of Leadership, Royal College of Surgeons in Ireland

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“Implementing an Education Programme and SOAP Notes Framework to Improve Nursing Documentation.”

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Abstract

Aims: The aim of the project was to introduce an education programme for the nursing profession which would increase adherence to The Nursing and Midwifery Board of Ireland (NMBI) documentation standards. This was to be achieved through the delivery of six unique education sessions, and the introduction of the SOAP (subjective, objective, assessment and plan) Notes Framework for documentation.

Rationale: Following the reviews of three adverse events the key areas of concern included the occurrence of a failure on behalf of the nursing profession to communicate essential information to the greater multidisciplinary team following client interactions. Furthermore, the absence of a standardised approach to the formation of the nursing professions clinical entries allowed for misinterpretation of clients mental state and wellbeing. Change Process: The HSE Change Model was used to guide the change. Monthly education sessions were facilitated over a six-month period. Focus groups and consultation with key stakeholders such as the State Claims Agency assisted the process. Evaluation: The education programme was evaluated using Kirkpatrick's (1959) Evaluation Model. The overall initiative was evaluated using an audit tool based on NMBI documentation standards via pre and post intervention auditing of clinical records. Results & Conclusion: The results showed a 56% improvement in adherence to NMBI documentation standards following the introduction of the education programme and SOAP Notes Framework. The initiative supports good systems of clinical governance and quality assurance in order to assist in the prevention of similar adverse events and hence ensure positive experiences and outcomes for future service users.
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Chapter 1

1.1: Introduction

In the provision of effective care delivery, the healthcare record is an indispensable element. It forms an essential means of communication between healthcare professionals while also demonstrating that duty of care has been fulfilled (Medical Protection Society, 2013). The interchange of high quality information underpins the delivery of high quality, evidence based health care for service users (Health Service Executive, 2012). However, many organisations have been shown to lack firm compliance with their legal obligation to maintaining accurate healthcare records. The number of adverse events recorded by the Clinical Indemnity Scheme in 2012 was 76,842. 3.6% of these events related to documentation issues, and consequently rated in the top ten adverse event types reported by Nursing staff (Oglesby, 2012).

While the quality of healthcare documentation is dependent on robust record keeping systems from an interdisciplinary perspective, for the purpose of this project particular focus is placed on improving nursing documentation. The rationale for this decision is that a direct link was established between the formulation and standards of nursing documentation and the outcome of three adverse events within the author’s organisation following a systems analysis review. Thus, the organisational change project involves the use of an educational programme which incorporates the introduction of the SOAP (Subjective, Objective, Assessment and Plan) Notes Framework in order to bring about an improvement in nurses clinical documentation. It is envisioned that this in turn will increase nurses’ awareness towards the
requirement to adhere to documentation standards as outlined by local and national policies.

The title of this paper is “Implementing an Education Programme and SOAP Notes Framework to Improve Nursing Documentation” and outlines the change initiative undertaken in a Dublin Mental Health Service. The change project commences in September 2014 with a completion date of March 2015.

Within Chapter one, the organisational context and rationale for the proposed change is described. The overall aim and desired objectives are articulated, and the author’s involvement in the overall project is outlined. Chapter two, provides an in-depth critique of the literature that draws extensively on national and international archives of writings on healthcare records. Thus, establishing a theoretical understanding of the topic area that indicates the application of the review findings to the planned change. This in turn informs Chapter three, which describes the research methodology undertaken and outlines the governance of the project under the HSE Change Model. Chapter four, provides details of the methods of evaluation employed and the examination of the data acquired. To conclude, Chapter five captures the discoveries of the initiative and critically discusses the learning obtained in the experience of leading the organisational change development while also highlighting recommendations for further developments.
1.2: Organisational Context

The author was involved in a System Analysis review following three serious adverse events within the CMHT (Community Mental Health Team). Following the review, key areas of concern included the occurrence of a failure on behalf of the nursing profession to communicate essential information to the greater multidisciplinary team following client interactions. Furthermore, the absence of a standardised approach to the formation of the nursing professions clinical entries allowed for misinterpretation of clients mental state and wellbeing. One of the recommendations was an improvement in the standard of documentation and communication amongst nurses and the greater multidisciplinary team. The ultimate goal of this project is to action this recommendation and to introduce a standardised approach to nurses documentation practices.

While the collection of data, in terms of patient outcomes, adds a level of complexity outside the scope of this project, the long term aim is that adverse events resulting from inadequate documentation will be avoided in the future prevision of service.

The practice of regularly auditing clinical records has been shown to improve standards of record keeping and hence patient care (Prideaux, 2011). Therefore, Nurse Managers are encouraged to develop systems of regular audits in order to monitor and maintain standards (An Bord Altranais 2002; Cowan 2000). It is evident that participating in an audit is a particularly useful way to identify learning needs, whether for the individual nurse, the team or the health care service.
The project is governed by the concept of Donabedian’s Structure, Process and Outcome approach. This model provides a framework for examining health services and evaluating the quality of care (Ranji et al., 2007). According to the model, information about the quality of care can be drawn from three categories: “Structure”, “Process” and “Outcomes”. Structure describes the context in which care is delivered, Process denotes the transactions between patients and providers throughout the delivery of healthcare, while Outcomes refers to the effects of healthcare on the health status of patients and populations (Donabedian, 1997). The expected results are that there will be a rise in the quality of documentation and furthermore, an effective communication pathway will be formed across disciplines.

1.3: Ethical Considerations

While no service user or staff were identified during the data collection, analysis or write up of this project, a submission outlining the project was prepared and submitted to the organisation’s Ethics Committee. The project was observed to be in line with quality assurance and ethical exemption was granted.

1.4: Rationale

The quality of clinical documentation in healthcare is essential to ensure the continuity and delivery of safe and effective client care. It provides a pathway in which to facilitate communication and to justify care delivery in the context of legislation, professional standards, guidelines, evidence, research, professional and ethical conduct (An Bord Altranais, 2002). Following reviews of these adverse events and an initial survey of medical records, a common theme has been an unacceptable standard and formation of documentation and communication among the nursing profession. As a result, the Clinical Governance group have issued
recommendations for a review and improvement in the adhering to The Nursing and Midwifery Board of Ireland (NMBI - formally known as An Bord Altranais) standards in recording clinical practice.

This highlighted internal drive for change was not limited to the recommendation of the Clinical Governance group. Nurses also have a desire to remain competent and professional in the manner in which they practice; hence, there is a need to support and guide them in this quest. The external drivers for change are highlighted by The NMBI Code of Professional Conduct and Ethics for Registered nurses and midwives (Nursing and Midwifery Board of Ireland., 2014). There is an increasing consensus that care provision should be made transparent, both for external (i.e., accountability to society), and internal (i.e., learning from mistakes and gaps in performance) puropses (Ginsburg et al., 2009).

The practice of producing accurate, concise and systematic nursing documentation promotes consistency in patient care and communication among the Multidisciplinary Team; thus, the quality of records maintained is seen as a reflection of the standard of care given to clients (An Bord Altranais, 2002). It is therefore evident that quality documentation is necessary to aid communication and appropriate decision making in clinical care and that proper documentation can provide information that may help towards future management decisions for clients.

By means of education sessions, nurses will be encouraged to reflect on their practice and therefore act with more insight and effectiveness in the future. McDonough (2004) highlights that by facilitating reflection on practice, one is helping
to create a stronger, more aware and engaged community. The introduction of an education programme and the SOAP Notes Framework will support nurses in the development of a structured technique in which to communicate their interactions with clients.

1.5: Aims and Objectives

1.5.1: Aims

The overall aim of the project is to introduce an education programme for the nursing profession which will increase adherence to NMBI documentation standards.

The purpose is to improve the quality of communication with the multidisciplinary team and thus reduce the possibility of adverse outcomes as a result of the absence of vital information transferring between professions.

The education programme will incorporate the introduction of the SOAP Notes Framework to improve the formation and quality of documentation within the clinical environment.

1.5.2: Objectives

1. Establish an audit committee that will conduct an audit in the beginning (September 2014) and end point (March 2015) of the project on a randomly selected sample of clinical records.
2. Deliver a series of six unique education sessions on a monthly basis from the period of October 2014 to March 2015. This will be facilitated by the author and two Clinical Nurse Specialists.

It will focus on legal and regulatory acceptable standards of documentation and the effective use of the SOAP Notes Framework (Appendix 1, illustrates a summarisation of SOAP definitions and examples).

3. Evaluate the application of the SOAP Notes Framework in January 2015 and March 2015 using the SOAP Notes Evaluation Form (Appendix 2).

4. Evaluate the complete Organisational Development project and its impact on the author’s organisation (March 2015).

1.5.3: Planned Outcomes

The planned outcome is that:

(1) Firstly, by March 2015, all nursing staff will have attended a minimum of five education sessions and the baseline standard of documentation (observed from the initial audit) will have increased to 100% compliance with nationally acceptable standards.

The audit tool to be used is devised from the HSE Eastern Region Adult Mental Health Services Regional Standards (2005) and recognised NMBI documentation standards. This tool consists of forty-five questions based on these recognised guidelines (Appendix 3).
(2) Secondly, by March 2015, all nursing staff will score a minimum of “acceptable or good” to “very good” in the application of the SOAP Notes Framework as illustrated in the SOAP Notes Evaluation Form (Appendix 2).

Thus, the overall project will have facilitated the establishment of increased awareness of the significance of documentation and embedded a robust knowledge base on effective means of communication within the organisation.

1.6: Role of the Student in the Organisation and Project

The author is an Assistant Director of Nursing with particular responsibility for a Community Mental Health Team (CMHT) which serves a population of 90,000 and is a member of the Service Clinical Governance Group.

Within this project, the author plays a key role as the main change agent. Throughout the project, continuous feedback was obtained from staff following each education session and the information obtained was used to inform further sessions. This process facilitated a co-design mechanism between facilitators and learners in terms of the structure and content of the education. The author played a central role in governing this progression and facilitating collaboration.

Furthermore, the author participated in the delivery of the education programmes with a particular focus on minimising risk and maximising effectiveness. They also formed part of the audit committee and held responsibility for monitoring quality assurance and management throughout the development.
Having gathered and evaluated the data from the overall initiative the author compiles and publishes the findings.

1.7: Summary and Conclusion

Our service users are entitled to services that are safe and are provided by competent and confident staff who will always work in their best interest. Managing risk is not just about addressing adverse events; it is also concerned with improving the safety, quality and user experience of health care services. Nurses require continuous personal and professional development in order to provide the highest quality of care. It is hoped that this initiative will support nurses by providing an evidenced based approach to maintaining a high standard of documentation and therefore ensure clear accountability and improved outcomes for service users.
Chapter 2

2.1: Literature Review Introduction

In order to command a greater understanding of the subject area, the author conducted a literature review of the topic. The review focused on documentation methods, barriers to documentation and legal implications. From initial review of articles, four central themes emerged and hence it was decided to focus on:

1. Importance of Documentation
2. Scale of Inappropriate Documentation
3. Contributory Factors to Inappropriate Documentation
4. Strategies for High Quality Documentation

These four themes capture the primary consensus among the theorists and emerge from the literature as individually distinct; however, collectively they are a significantly linked body of knowledge in relation to healthcare documentation.

2.2: Search Strategy

This review was conducted using a number of electronic databases such as Ovid, Pub Med, Google Scholar, and CINAHL. Key words were used, singly and in combination, in order to identify articles relevant in this area, such as: nursing documentation, staff perceptions, audit, documentation quality and documentation education. Much of the recent focus within the literature was on the transformation from paper to electronic databases to record documentation. However, access to electronic databases to record client’s information is not available in the author’s organisation.
Many of the environments in which studies were conducted were distinctly different than the environment in which the author works. Hence, the methodologies implied had their limitations in terms of drawing similarities. The author was cognisant of this when extrapolating data from sources outside their area of practice.

In order to establish a factual representation there is a need for further studies within this area of practice to be conducted in Community Mental Health Services in Ireland. Nonetheless, the literature reveals numerous reports from around the world that raise apprehensions about nursing documentation practices.

2.3: Review of Themes

2.3.1: Importance of Documentation

Nursing documentation may be best described by Currell & Urquhart (2003) as the recording of nursing care that is planned and given to individual clients by qualified nurses or by other caregivers under the direction of a qualified nurse. The documentation of patient care is seen as one of the fundamental roles of the nurse, and as the foremost source of reference and communication, it has been recognised as one of the most important functions of nurses since the time of Florence Nightingale (Cheevakasemsook et al., 2006).

Recording of a nurse’s intervention with a patient is as important as the delivery of nursing care, primarily because this information is accessed and used by other professionals as part of multidisciplinary care for patients (Saranto & Kinnunen, 2009). It is distinctive that good delivery of care has always been dependant on the
quality of the information available and nurses have long been recognised as key collectors (Currell & Urquhart, 2003).

It is evident that nursing documentation serves multiple purposes, for example; ensuring continuity and quality of care, furnishing legal evidence, supporting the evaluation of effectiveness of patient care, management of risk and protection of patient’s rights (Häyrinen et al., 2008). Nonetheless, the importance of documentation and record keeping may have the tendency to be overlooked by the focus on direct services to clients (Pirie, 2011).

2.3.2: Scale of Inappropriate Documentation

Despite its importance been noted over the test of time, from a legal and professional perspective, the presence of poor documentation remains within healthcare organisations. Many issues are cited throughout the literature which include the lack of timely entries, absence of comprehensive and accurate information, and an inability to formulate accurate assessment information and follow-through care planning (Blair & Smith, 2012). The use of abbreviations and acronyms is a key problematic area and a clear patient safety issue as they can often lead to misinterpretation and hence medical/nursing errors (Dimond, 2005).

However, despite continuous and consistent advice from professional bodies over the years, achieving and maintaining good standards of clinical documentation remains a huge problem in health professions (Cowan, 2000). This situation is increasingly concerning as supported by Stromborg (2001), who highlights that the number of negligence and malpractice proceedings that name nurses as defendants
because of their failure to adequately document patient care has increased over the years. Similarly McGeehan (2007) outlines how failure to maintain reasonable standards of record-keeping may be used as evidence of misconduct, which may lead to professional misconduct proceedings and/or disciplinary action. Subsequently, nurses must seek to be more prudent in how they document patient interactions as failure to do so could be interpreted by a court of law as neglect of a patient.

2.3.3: Contributory Factors to Inappropriate Documentation

➢ Time Pressured Environments

From the literature, many studies have cited different reasons for the presence of inadequate documentation. Blair & Smith (2012) advocates that the standard of nursing documentation is suffering as a result of the time pressures that nurses in many clinical environments are experiencing. The literature suggests that nurses working in most healthcare settings have identified the excessive burden of documentation as a source of dissatisfaction in their practice.

Studies have found that nurses working in acute care settings can spend up to 25–50% of their time on documentation which can result in less time spent with patients, or working overtime to complete progress notes (Gugerty et al., 2007). Likewise, in a working sampling study conducted by Korst et al. (2003) in which they observed nurses over a fourteen day period, they found that nurses spent up to 50% of their time in homecare environments documenting care rather than delivering care directly to patients. Through the use of focus groups, they identified that nurses reported that they felt this time could be more appropriately spent on direct patient care. Nurses
also reported that documentation is often redundant and done primarily to benefit regulators and third-parties. Education programmes were used to provide a forum in which nurses could dialogue with regards to issues and become involved in streamlining documentation procedures and identifying recommendations for best practices. This resulted in an increase in the overall standard of nursing documentation.

Fourie et al. (2005) supports this process of involving staff in the implementation of best practices and highlights that emphasis on staff is important and can be done through promotion of in house training and education programmes.

➢ Nurses Perceptions

In a study conducted by Cheevakasemsook et al, (2006) they found that factors resulting in poor documentation included limited nursing competence, motivation and confidence, ineffective nursing procedures and inadequate nursing auditing, supervision and staff support. Within their studies, nurses described feeling insecure about nursing documentation and recognised limited access to training as a barrier to effective documentation.

Hyde et al. (2005) claimed that nurses felt that documentation did not accurately reflect what nurses did, but rather it was used merely for legal purposes. This is reflected by McGeehan (2007) who suggests that nurses regard documentation as an undesirable task at the end of a shift.
Kärkkäinen et al. (2005) qualitative meta-synthesis study identified that poor record keeping practices were caused, to some extent, by nurses who simply disregarded the importance of documentation in comparison to hands-on nursing care.

It may be echoed that nurses underestimate the valuable contribution that quality documentation can provide to improving patient care. Documentation should not be regarded as a task detached from clinical care but rather as an integrated component of the holistic care of patients (Prideaux, 2011). Educational programmes should be readily available which focus on diagnostic reasoning and critical thinking in order to improve and maintain standards (Darmer et al., 2006).

It is recognised by Dimond (2005) that a major component of clinical governance is effective monitoring of clinical care with high quality systems for clinical record keeping, therefore, there is an onus on healthcare organisations to create positive learning environments in which nurses are educated and inspired by the principles of quality documentation. Such interventions will subsequently safeguard against liability and ultimately improve patient care (Stromborg et al., 2001).

2.3.4: Strategies for High Quality Documentation

➢ Education Programmes

Numerous studies have used educational interventions designed to improve documentation; however, timely education creates a challenge in our current healthcare organisations as it is often difficult to assign time away from the patient care environment. Moreover, given this time and age when computerisation is
inevitably fast approaching, it is also a challenge to improve nursing documentation on paper (Thoroddsen & Ehnfors, 2007).

Nonetheless, in the past decade there is an evolving quality agenda in healthcare that has significant implications for acceptable documentation requirements. This emphasis on quality has resulted in documentation being seen as an important mechanism used to evaluate care performance conducted by the caregiver. Thus, attention should be focused towards nursing education on documentation in order to ensure that nurses have the competencies to provide holistic care (De Marinis et al., 2010).

Many studies results suggest that education and training can play a significant role in improving nursing documentation. In a quasi-experimental longitudinal study conducted by Björvell et al. (2002) three hospital wards participated in a two year education intervention. The findings showed a significant increase in quantity as well as in the quality of the nursing documentation directly after the training.

Jefferies et al. (2012) study, in which a ward based education programme was introduced over a two week period, supports this approach. The programme was aimed at promoting an understanding of the purpose of nursing documentation and how current documentation practices could obstruct understanding of readers external to the profession. Having assessed the programme using a pre and post programme documentation audit, the results illustrated vast improvements in documentation developments.
Conversely, Dehghan et al. (2013) quasi-experimental study, in which two hundred and twenty randomly selected nursing documents were assessed structurally and by content, found that nursing documentation did not improve after a two year clinical governance programme, which included education.

Conversely, Jefferies et al. (2011) study, in which sixty-seven entries of nursing documentation were investigated using textual analysis, argues that there was a need for education programmes that not only gave nurses the competence to document adequately but that also encouraged nurses to view their documentation as a crucial aspect of care and recognise its huge value to other disciplines outside the profession.

Westra et al. (2008) suggests that nurses need to be supported by means of education programmes to describe practice through documentation of interventions and demonstrate how nursing interventions affects client outcomes.

- Documentation Frameworks/Tools to Support Documentation

It is apparent that nurses need guidance and support in the continuous development of their skills in documentation. Mechanisms must exist in which clients must not only have individualised care plans but also that documentation in their medical notes should reflect interactions, judgment and evaluation of their care and should be able to inform other professionals subsequently involved (An Bord Altranais, 2002).

Westra et al. (2008) proposes specific tools are needed to support the continuous and efficient shared understanding of a patient’s care that simultaneously aids
interdisciplinary communication and decision-making about patients future care. This is supported by Spain et al. (2004) who proposes that communication and documentation that utilizes language and communication strategies that are shared with other health professionals ultimately aids in promoting collaborative practice among multidisciplinary teams.

There is a variety of frameworks available to the profession for the management of nursing documentation. Of the most prominent, Blair & Smith (2012) identify narrative charting as an effective means of documenting interventions and their impact in chronological order over a set timeframe. However, Iyer (2001) highlights how this form of documentation does not prioritise what is important to document and may result in notes been repetitive, vague or contain inaccurate language.

PIE charting is a less commonly encouraged form of documentation. This stands for Problems, Interventions and Evaluation of nursing care. The major advantage of this system is that it provides a structure to progress notes and promotes the systematic evaluation of each identified problem (Iyer et al., 2006). However, Ioanna et al. (2007) disputes that this system often eliminates the planning step involved in the nursing process and tends to skip directly to the interventions carried out.

A third framework is the VIPS model that is designed to structure nursing documentation systematically and aims at producing a problem-based nursing care plan and a discharge note (Blair & Smith, 2012). The model provides a list of fourteen key words on which to formulate nursing documentation. In a study conducted by Darmer et al. (2006) in which fifty nursing documentation entries from
four departments were audited annually over a three year period following application of the framework, the results showed that nursing documentation significantly improved during the course of the study. However, although the model has received enough interest and appreciation as a standard for what to document, difficulties of how to use it in daily practice are well recognised (Björvell, 2002).

What is required is a framework that encourages critical thinking and provides evidence of the rationale for nursing actions in order to provide an accurate indication of patient’s progress.

The literature compliments the use of SOAP Notes among Mental Health nurses as a structured format for documentation and their use is highly recommended and widely used in other disciplines. SOAP Notes are a highly structured format for documenting the progress of a patient’s care.

Cameron & Turtle-song (2002) distinguishes them as a format that provides a clear rationale for clinical decisions and evidence of critical thinking. They are seen as an approach that supports good problem-solving and are a method used by many health related fields as a means of recording patient care information.

Harris et al. (2009) indicates that they provide mental health professionals a means for documenting and assessing clinical information so that problem-solving can occur and that therapeutic decisions can be supported.
Some studies have found that this concise documentation style has the potential to destroy the wider holistic picture of the patient (Iyer et al., 2006). Blair & Smith (2012) argue that this method does not necessarily meet the documentation needs in the current health environment because they focus on single problem entries and patients are often complex with multiple problems. However, Solon (2011) believes finding an effective form of notation that will be used consistently helps to protect both the client and the caregiver. Similarly, Kettenbach (2004) believes this format is commonly used and understood by the majority of healthcare professionals.

SOAP Notes are intended to improve the quality and continuity of client’s care by enhancing communication among the multidisciplinary team (Kettenbach, 2004). By ongoing education on the use of The SOAP Notes Framework, nurses will be equipped with the skills to produce clear and comprehensive documentation which identifies, prioritises and tracks client’s needs so that they can be addressed in a timely and systematic manner.

By enabling nurses to construct clear and precise accounts of care given, they will not only be ensuring the quality of the care they provide but also assert the importance of their role in the provision of health care.

2.4: Implications for the Project

From reviewing the literature, many studies have shown that an effective measure to addressing the concern of unacceptable documentation is the implementation of education programmes. These studies suggest that a comprehensive intervention in the form of education can yield improvement in nursing documentation practices.
Education programmes should focus on the development of competencies in formulating accurate documentation and must strive to increase awareness and understanding of the impediment to quality care which is caused by inaccurate documentation. The significance of nursing documentation to disciplines outside the nursing profession and its ability to contribute to the holistic care provision of clients should also be given emphasis.

Such programmes are reliant on solid evidence based documentation frameworks which provide more standardised and formalised language than is characteristic at present. Although four core documentation frameworks are highlighted throughout the literature, their success is conditional on the situational environment in which they are applied.

The review has revealed that The SOAP Note Framework is strongly supported and recognised as an effective means of providing structure and guidance to nurses in formulating accurate documentation. Their introduction into the clinical environment of the author’s organisation will encourage critical thinking and provide evidence of the rationale for nursing interventions while also enhancing communication among the multidisciplinary team.

2.5: Summary and Conclusion

The purpose of this literature review was to understand and make visible the issues surrounding the unchanging component of all nurse’s daily routine of formulating nursing documentation. Quality nursing documentation in today’s healthcare
organisations has been highlighted as essential as it details the patient’s journey through our healthcare institutions.

It is apparent that documentation is an important issue for nurses both nationally and internationally; however, throughout the literature it is emphasised how many nurses still experience barriers to upholding accurate documentation. Despite the fact that nurses understand the duties associated with their role, their ability to provide for complete and accurate reporting and documentation appears hindered. The increased focus on legal, medical and organisational recommendations has led to an ever communal concern.

Having acquired from the literature the theoretical understanding required to direct the organisational development, Chapter three provides an in-depth analysis of the methodology and methods employed to instil successful transformation in the everyday documenting activities of the nursing profession.
Chapter 3

3.1: Methods and Methodology Introduction

Within this chapter, the author provides an overview of the methodology and change methods applied as part of the organisational development and an appraisal of organisational change in the context of healthcare environments.

The author’s rationale for selecting the HSE Change Model and its ability to facilitate a structured approach to successful organisational change is clarified. The reader will be guided through the four stages of the Organisational Development Model: initiation, planning, implementation and mainstreaming and their application to the project is discussed in depth. The chapter is concluded with the learning from the successful application of the change model within the author’s organisation.

3.2: Organisational Development

As change in healthcare is inevitable, it is important that organisations have managers and leaders who can adjust and respond to rapid ongoing change. They require the ability to develop strategic management skills that help the organisation navigate change and create successful visions for the future (Farias & Johnson, 2000).

Many organisations, in an attempt to adapt to the constant evolutions of their environment, are adopting cultures of a learning or agile organisation. Whether or not an organisation tries to evolve constantly, successfully implementing changes can be a major determinant of its short and long-term success (Appelbaum et al. 2012).
Change management may be best captured as the process of continually renewing an organisation’s direction, structure, and capabilities to serve the ever changing needs of external and internal customers (Moran & Brightman, 2000). As change is an ever present feature of organisational life, both at an operational and strategic level (Burnes, 2004) the key to successful implementation of change is not just to get the system, process and structures right but to nurture personal transitions of members towards the change in culture. Change success is contingent upon the participation of people throughout the organisation.

Kearns (2005) suggests successful organisational change can only take place if there is a balanced approach to addressing the people and cultural aspects of change and the context in which people work on a daily basis. Understanding the type of organisational culture prevalent in an organisation and then adopting approaches to be effective in managing changes in the organisation is essential.

Through effective internal processes and external relationships that leverage knowledge resources, organisations can maximise their opportunities to innovate change (Serino, 2010). Progression through the phases of change represents an opportunity for growth; this requires continuous monitoring and revised control procedures to ensure individual’s behaviours support the organisations change culture.

3.3: Rationale for Selecting The HSE Change Model

Despite the apparent mass of knowledge of the complexity of organisational change, Balogun & Hope Hailey (2008) report a failure rate of around 70% of all change
programmes initiated. It may be suggested that this poor success rate indicates a fundamental failure of the application of a valid framework of how to implement and manage organisational change.

As there are a number of frameworks and approaches, it is essential that the change agent has the ability to understand the strengths and the weakness of each approach and the situations in which each can be best applied (McAuliffe & Van Vaerenbergh, 2006).

One of the most renowned and extensively referred to models of change is Lewin's (1951) three phase process that is; unfreezing, moving and refreezing. In his work, Lewin maintained that in order to adopt new behaviours or change one must first discard the old behaviour (unfreezing) and heighten individual’s awareness of the need for change. The moving stage is essentially the process of making the actual changes and involves the establishment of new strategies and structures that will move the organisation to the new state. Finally, refreezing requires securing these new strategies, structures and systems in order to stabilise or institutionalise the changes within the organisation (Senior & Swailes, 2010).

Similarly, Kotter's (1996) eight-step process for leading change recommends a step by step approach to follow in implementing fundamental changes in how an organisation operates.

Key criticisms of these organisational development model approaches is that change was seen to have a start and end point in a sequential linear process. It is assumed
that organisations operate in a stable state thus, fail to recognise the complexity of change in today’s healthcare system (Burnes, 2004). They also fail to anticipate fully the potential roles of power and politics in change processes (Senior & Swailes, 2010).

These early theories on change placed a high emphasis on attempting to control and predict change. However, in recent years there has been a shift towards understanding change as a dynamic process, requiring participation from all levels of the organisation. It has become more obvious that there is no perfect model of change that can be applied in all situations (McAuliffe & Vaerenbergh, 2006).

Having reviewed the many change models, the author has decided to use the HSE Change Model (Figure 1). The Model details a step by step approach to planning, managing and implementing change with particular focus within the content of the Irish healthcare system. It is based on a comprehensive review of best practice change management and organisation development research (Health Services Executive, 2008).

The model was developed in conjunction with the publication of “Improving Our Services - A Users' Guide to Managing Change in the Health Service Executive” (Health Service Executive, 2008). It embraces the concept of other models such as Lewin’s and Kotter’s but also goes further to place a particular emphasis on organisational culture and the nature of relationships between people, teams, services and agencies while also incorporating project management attributes which brings structure and discipline to the process (Health Service Executive, 2008).
Figure 1: The HSE Change Model

Within the model, change is recognised as not being linear but rather a continuous and adaptive process in which all of the elements are interrelated and can influence each other (Health Services Executive, 2008).

3.4: Initiation

The initiation stage is a key component of organisational development as it involves the scoping out of the project, the identification of key stakeholders and their readiness and level of commitment to the proposed change. Preparing to lead the change enables the change agent to establish a sense of shared responsibility for the change, while also identifying the drivers and resistors to the change. It ensures that the development relates to the overall strategy.

Strategy formulation enables an organisation to choose the most appropriate courses of action to achieve its defined goal and provides a framework for the actions that will lead to the implementation of such strategy and the anticipated
results. Successful implementation of a strategy requires vision and involvement of the organisation as a whole (Johnson et al., 2011). Creating a vision is the core of leadership and is at the heart of strategy (Rahama et al., 2012).

A key strategic component within the initiation stage of the project was the formulation of a presentation comprised of the key areas of concern which were observed from the initial audit. By means of both verbal and graphical delivery of the results the author used the opportunity to draw focus on possible corrective action plans. The purpose of this presentation was based on the belief that healthcare professionals are prompted to modify their practice when given performance feedback showing that their clinical practice is inconsistent with a desirable target (Ivers et al., 2012).

3.4.1: Preparing to Lead the Change

In preparing for change, establishing a vision and articulating a strategy are crucial to organisational developments. Leaders must be competent in their ability in creating a vision of the organisation future, devising a strategy for achieving that vision and communicating that vision to all members of the organisation (Prewitt et al., 2011).

Therefore, the author placed high emphasize on engaging with staff within the planning stage because planning puts form on vision; produces formalised structures and also considers environmental expectations (Mintzberg, 2007).
The environmental analysis was an important task in creating the vision as it allowed identification of the environment in which the organisation operates and assisted in predicting situations and circumstances that might affect the change.

Having identified the external factors via a PESTLE analysis (Appendix 4), the author used a SWOT analysis (Appendix 5) to examine the internal factors affecting the change. The motive was that the internal and external factors must be considered simultaneously when identifying aspects of an organisation that need to be changed (McAulliffe & Van Vaerenbergh, 2006). This provided an opportunity to analyse the organisations current situation and assessing its strengths, weakness, opportunity and threats in an in-depth manner and played an important role in the strategic planning.

The use of a force field analysis (Appendix 6) further recognised forces driving or hindering the change. In other words; the forces driving its strengths, weaknesses, opportunities and threats (Harrison, 2010). This was a key step as it allowed the author to build the foundations for effective change and to mobilise support across the organisation. By utilizing Lewin’s force field analysis and identifying and understanding the forces likely to influence change, the author was in a position to leverage driving forces and mitigate hindering forces.

From this analysis, it could be observed that the driving forces outweighed the hindering forces towards the change. Having identified the drivers and resistors, the author then prioritised and developed strategies to address the three main priorities (Appendix 7). Schein (2004) suggest that developing a mental map of the changing
atmosphere is crucial to the effectiveness of the leader's ability to bring about transformation.

By means of the analytical tools described and the development of the strategy, the author had built the business case in support of the change. The development of a business case provides the data and argument in support of a particular strategy proposal (Johnson et al., 2011) and is essential to aid structure to organisational developments.

3.5: Planning

3.5.1: Building Commitment

Effective force field analysis considers not only organisational values but also the needs, goals, ideas, and concerns of individual stakeholders. Thus, it is important to identify the key stakeholders and to develop a plan to gain their support and commitment (Harrison, 2010).

Hence, the author carried out a Stakeholder’s analysis (Appendix 8). This enabled the author to identify and understand the individuals and groups with particular interest, what their needs and expectations were and how their ongoing support could be gained to contribute to the success (Feeney & Murphy, 2014).

The importance of involving stakeholders is highlighted by Nutt (2003) who found through their studies that over half of decisions were either not implemented, only partially implemented or otherwise produced poor results as a result of failing to attend to the interests and information held by key stakeholders. By placing each
stakeholder on a power/interest matrix (Figure 2) their influence, importance and level of impact upon the project could be clearly emphasized.

![Stakeholder's Power/Interest Grid](image)

**Figure 2: Stakeholder's Power/Interest Grid**

Determining who needs or wants to be involved, and when and how that involvement can be achieved provided the author with the basis for developing collaborations and the strategy in which to do so (Golder, 2005).

The participation of stakeholders improves the overall quality, effectiveness, efficiency, transparency and acceptance of new initiatives (Civitas, 2000). Time invested in this process is essential because programme success is contingent upon the participation of people throughout the organisation who share the programme's vision and believe in its benefits (Sharma, 2008).
The significance of starting with information sharing and progressing to more dynamic forms of communication such as feedback mechanisms, meaningful consultation and participation, collaboration and partnership (Health Services Executive, 2008) was a key element in building commitment. Table 1 outlines the communication strategy which the author implied in order to engage stakeholders.

Table 1: Communication Strategy with Stakeholders

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<tr>
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<tbody>
<tr>
<td>CNS’s</td>
<td>Assistance in delivery of monthly education programs forum on documentation standards</td>
<td>Face to face conversation via meeting forum</td>
<td>Fortnightly meeting</td>
<td>Formulate education program delivery, seek feedback from participants to inform further development of education</td>
</tr>
<tr>
<td>CNM II’s</td>
<td>Seek support to conduct audits, monitor standard, clinical supervision for staff</td>
<td>Face to face conversation via meeting forum</td>
<td>Fortnightly Meeting</td>
<td>Establish current baseline standards of documenting practices, monitor progress</td>
</tr>
<tr>
<td>Nursing Staff</td>
<td>Highlight current standard of documentation, introduce revised practice</td>
<td>Via initial presentation &amp; delivery of monthly education</td>
<td>Monthly</td>
<td>Increase awareness &amp; overall standard, develop skills in appropriate documentation, develop ability to use SOAP notes framework</td>
</tr>
<tr>
<td>State Claims Agency</td>
<td>Assistance &amp; expertise in increasing awareness, knowledge of ethical &amp; legal factors</td>
<td>Face to face conversation via meeting forum, email &amp; phone communication</td>
<td>Three monthly</td>
<td>Create presentation to staff, establish example scenarios of negligence to present to staff</td>
</tr>
<tr>
<td>NPDC</td>
<td>Seek assistance to Govern project, expertise in use of audit tool</td>
<td>Face to face conversation via meeting forum, emails and phone communication</td>
<td>Initially weekly meetings &amp; decrease to monthly</td>
<td>Delivery of workshop to CNM II’s on Clinical Audit, continues monitoring of overall initiative</td>
</tr>
<tr>
<td>Area Director of nursing</td>
<td>Initial risk identified, continuous developments of initiative</td>
<td>Via Risk register and Health &amp; Safety forum, meeting &amp; email communication</td>
<td>Simonthly progress report</td>
<td>Maintain continuous support and acknowledgement of importance of initiative as service priority</td>
</tr>
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</table>

➢ Power Bases

The decision to request two Clinical Nurse Specialists to lead the education sessions was a strategic decision by the author. This was taken in order to draw on the availability of power sources within the organisation.

French & Raven (1959) bases of power sources identified five main sources of power, which they classified into two main groups: Formal Power and Personal
Power. Formal Power is comprised of coercive, reward and legitimate power while Personal Power is comprised of expert and referent. Under the concept of the model, the author is seen to possess legitimate power, which draws on the positional stance they hold within the organisation. They are also seen to have referent power which French & Raven (1959) identified as individuals who have desirable resources or personal traits. These individuals have the respect and admiration of others and often the power holder is looked up to as a role model (Gravenhorst, 1998). As a result of perceiving these individuals as possessing skills or ability, they are awarded authority.

The author recognised that to draw on their own power bases solely in the quest to bring about change would not be sufficient. In order to reform clinical practice, one must hold expertise in that area. Thus, the author sought the assistance of two Clinical Nurse Specialists. These individuals are seen to hold expert power within clinical practice.

Braynion (2004) describes expert power as power based on an accepted belief that individuals possess skills and/or abilities that followers value and need. By enrolling their expertise to develop and deliver the education programme, the author enabled themselves to combine power sources in order to bring about successful change. While Clegg (1994) states that the use of power can easily lead to resistance, Falbe & Yukl (1992) equally highlight that power and influence can lead to compliance and commitment to change.
3.5.2: Determining the details of the change

In order to conduct a detailed assessment of the current situation, the author sought the assistance of two Clinical Nurse Managers to conduct the preliminary audit of medical records in September 2014.

For a clinical audit to be successful and achieve its aim and purpose, it needs to involve the right people with the right skills from the outset (Health Service Executive, 2012). Therefore, to ensure the audit tool was applied effectively and accurately, the author arranged a workshop on Clinical Auditing via the Nurse Practice Development Coordinator (NPDC). This ensured that all aspects of the proposed clinical audit had been considered and the process was robust and of high quality. Caution was taken to ensure that all service user data was anonymised prior to the clinical audit process commencing.

Having revealed that the current standard of documentation was only 38% compliant with NMBI standards, the author was prepared with the information necessary to progress to the establishment of a focus group and hence commence the meaningful dialogue amongst staff that ultimately would steer the organisation to a more desirable state. It is at this stage that the organisation was in a position to take action based on the information presented and a real sense of urgency was created.

Creating a sense of urgency motivates staff to redevelop their practices in order to bring about improvements. Kotter (1996) suggest that this process develops an internally driven compulsion that nurtures each employee to strive to greater heights.
To further enhance this sense of urgency, the current situation and the associated risks were identified and detailed on the organisation’s risk reporting mechanism i.e. The HSE Risk Matrix. This enabled the group to identify existing and additional control measures required in order to manage the risks. It also aided the process of identifying individual action plans and timeframes in which to respond appropriately.

The author deemed it essential to keep everyone in the organisation informed about the goals, strategies and progress milestones for change (Lowe et al., 1996). The risk descriptor formed a communication platform in which to inform the risk to the core management group thus, gaining their support for the initiative. Having developed a means of communicating the initiative, a commitment to provide a bimonthly report to the Area Director of Nursing was established.

3.5.3: Developing the implementation plan

The next stage involved the formulation and delivery of the implementation plan. Figure 3 outlines the implementation plan and the stages involved in the change process.
Figure 3: Implementation Plan

The progression of developing a visual aid in order to map out the stages of the change proved central to its success. Detailing each step provided staff with an opportunity and incentive to contribute to the delivery of the change and helped towards achieving our collective vision and delivering the key actions.

This process enabled the provision of a working environment where the workload was effectively and equitably distributed. Managers and staff were encouraged to engage in meaningful and challenging practices that stretched through achievable workload activities, which proved imperative to the organisational development (University of Glasgow, 2013).

3.6: Implementation

3.6.1: Implementing the change

The content of the education sessions was not a pre formulated curriculum but rather devised on a progressive basis from continuous evaluation and feedback from staff.
Hence, a partnership approach was used to devise, ratify and approve each education forum and resulted in six unique learning assemblies which were delivered over the six months period. Figure 4 illustrates the resulting syllabus.

![Diagram of Documentation Education Sessions]

**Figure 4: Documentation Education Sessions**

The first education forum was conducted in October 2014 and ran on a monthly basis thereafter. Included in the first session was a detailed outline of the programme and the expected outcomes and level of participation sought. The key focus of the initial session was to outline the current status and international understanding of documentation practices. Relevant literature was used to draw attention to areas of practice requiring change.

Youngblut & JoAnne (2001) distinguishes that this process of identifying international evidence based practices is important because when evidence is used to define best
practices rather than to support existing practices, nursing practice keeps pace with the latest advances and takes advantage of new knowledge developments.

Incorporated into the initial education session was a True or False Questionnaire that consisted of 20 questions relating to the content of the programme. Participants were asked to complete the questionnaire at the initial session and the overall end-point of the education programme. The purpose of this was to measure basic knowledge and application of knowledge acquired as a result of the programme delivery and proved vital for the overall evaluation of the programme and will be discussed in greater depth in Chapter 4.

Two key elements were embedded throughout the delivery of the programme i.e. minimising risk and maximising effectiveness. These underlying principles were achieved by ensuring the structure and delivery of the programme eased documentation of the chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes. The programme also incorporated the significance of monitoring standards, audit, quality assurance and the investigation of complaints/adverse events (Health Services Executive, 2012).

- **Introduction of SOAP Notes Framework**

The SOAP Notes Framework was introduced in the third education session by means of discussing its origin and application in depth. The framework itself did not involve the restructure of the clinical record but instead presented as a new style of writing, hence, staff were provided with examples of clinical entries and sample
scenarios were devised in order to provided them the opportunity to practice using the framework.

The author recognised that it would not be sufficient just to provide staff the opportunity to use the SOAP Notes Framework as part of the education programme. This new learning needed to be translated into practice, therefore continuous support and leadership was given to staff in their everyday practice. Facilitating an environment conducive to peer support was deemed imperative as assimilating new knowledge and appraisals through the mutual exchange of wisdom occurs more effectively when presented by peers with whom individuals identify with and share common experiences (Dennis, 2003).

The core role of the author was to work with staff in exploring the reasons and necessity for changing practices, to motivate staff to become involved in the implementation of the change and to support staff appropriately (Kearns, 2005).

Successful leadership involves communicating high performance expectations as well as confidence in follower’s ability to meet such expectations. Effective leadership varies, not only with the person or group that is being influenced, but it also depends on the task, job or function that needs to be accomplished (Hersey & Blanchard, 1993). Leadership was recognised as critical to the change development and focused on the ability to influence staff and inspire them to work together as a team to achieve the common objective (Conger & Kanungo, 1998).
As with any organisational development, the author had to overcome resistance with certain staff members. Organisational change evokes emotional reactions with respect to both processes and outcomes and can be a major contributor to employee commitment or resistance to change (Smollan, 2013). Resistance is particularly challenging and prevalent in the redevelopment of clinical practices.

Certain individual staff members within the author’s organisation questioned the need for change in practices and interrogated if time spent learning the new framework was invested appropriately. The author recognised that these anxieties were valid concerns and embraced resistance in its ability to play a crucial role in drawing attention to aspects of change that may be inappropriate, not well thought through, or perhaps plain wrong (Waddell & Sohal, 1998).

To address this, the author had identified two staff members who had, by now, incorporated this style of documentation into their practice. These staff members were asked to present real life case samples to the group and to demonstrate the effectiveness of the framework in practice. By accumulating their positive experiences, these early adopters amongst the group proved to be a valuable resource to the author. Rogers (1995) ascertains the significance of the role of early adopters in their ability to decrease uncertainty about new ideas by adopting it, and then conveying a subjective evaluation of the innovation to near-peers by means of interpersonal networks.
Sustaining momentum

In order to sustain change over the long-term, deeply embedded traditions and practices must be addressed through an inclusive partnership process (HSE, 2008). It was essential to sustain energy and motivation for the change by means of maintaining its significance. Hence, developing effective communication and information-sharing processes in light of the organisational changes was given priority attention.

Ibarra & Herminia (2007) suggests that leaders must learn to build and use strategic networks that cross organisational and functional boundaries and then link them up in novel and innovative ways. A core function of external communications and engagement with secondary stakeholders is the receipt of vital information, perspectives and feedback with regards to service provision and performance (Kearns, 2005).

Hence, in a bid to establish links outside the organisation to assist in implementing the change, the author considered it a unique and timely opportunity to contact The State Claims Agency (SCA). This organisation provides risk management advice and assistance to State authorities with the aim of reducing claims and litigation. Prior to the author making contact with the State Claims Agency, they had not previously presented on the legalities of documentation specific to the Mental Health arena and hence an opportunity was identified to establish a working relationship and formulate an appropriate presentation to deliver to staff. This not only met the needs of the author’s organisation but also provided an opportunity for the State Claims Agency to pilot their presentation (Appendix 9).
The ability to develop meaningful relationships and effectively manage stakeholder relations by appealing to their interests in a coherent and strategic fashion is key to the success of organisational developments (Freeman & McVea, 2001).

A number of meetings were established and in collaboration a presentation on a variety of clinical risk management topics, which focused on documenting practices, were formulated and presented to staff. This presentation included national examples of clinical negligence and recommendations for improved practices.

This process of sourcing information and knowledge from expert opinions and evidence based practice to assist in identifying national trends and patterns will support staff in the making of better decisions, thereby improving organisational performance (Kovner & Rundall, 2006).

3.7: Mainstreaming

3.7.1: Making it “the way we do our business.”

The final stage of the HSE Change Model is an important phase to the continuous embedding and mainstreaming of the change initiative. Change is a continuous process that goes through a series of phases that in total, usually requires a considerable length of time. Skipping steps creates only an illusion of speed and never produces a satisfying result (Kotter, 1995). Until new behaviours are rooted in social norms and shared values of an organisation, they are subject to degradation as soon as the pressure for change is removed (Kotter, 1995).
It is important to repeatedly assess and monitor the new practices to ensure the culture continues to grow and develop. Once the goal is reached, leaders should find ways to anchor the work behaviour changes into the organisation (Zigarmi & Hoekstra, 2008).

The site-specific employee Induction Pack for each new staff member commencing duty within this area of service was modified to incorporate a guide on the SOAP Notes Framework. Hence, the framework is now the recognised acceptable formation of documentation within the clinical environment. The result is that the standard of communication by means of documenting interactions has been standardised and consistent amongst each member of the nursing profession.

Furthermore, the author has established six-monthly clinical audits conducted by two Clinical Nurse Managers within the area. The purpose of these audits is to continually monitor and assess the change in practice. They provide an opportunity to measure practice against standards and identify any actions required to correct shortfalls. If required, improvements are implemented at an individual, team or organisation level.

➢ **Acknowledge success and achievement**

The essence of organisational change developments in healthcare is to bring about an improvement in the services in which we deliver. Individual and group recognition is a key component in our ability to bring about change. Celebrating success not only enhances buy-in but also provides an opportunity for shared learning throughout the wider organisation. At all stages and key milestones of the change process it is
important to take time to celebrate success and the achievement of desired changes, in a manner appropriate to the organisation (Health Service Executive, 2008b). Therefore, following each clinical audit the findings are presented to staff and provide an opportunity to reflect and feel a sense of achievement.

The author proposes to cross-pollinate the lessons learned and successes gained throughout the greater Mental Health Service. Stage two of the project involves incorporating the initiative into the organisations Operational Service Plan for 2015 and devising the necessary action plans to entrench the new learning and standardised approach to documentation across the wider service.

3.7.2: Evaluating and Learning

As organisations undergo developments, it is important to monitor and evaluate the results of the change. This involves relating the changes to the original strategy and objectives. Evaluation is the reflective link between the dream of what should be and the reality of what is (Kahan, Barbara, 2008). With a greater prominence on clinical governance, health professionals are continuously seeking ways of assuring the quality and accountability of healthcare delivery.

This quest strengthens the current systems of quality assurance, as it is based on the evaluation of clinical standards, better utilisation of evidence based practice and lessons learned from poor performance. The evaluation of health service improvement initiatives requires evaluation methods to assess both the process and contextual aspects of the activities, in addition to the evaluation of outcomes (WHO, 1998). Without tools and methods to assess the health impact of policies and
programmes, we cannot determine which strategies work best to achieve beneficial outcomes (Lazenbatt, 2002).

Having guided the organisational change development through the phases of the HSE Change Model, the author’s focus is now on reviewing the effectiveness of the change process and forming the basis for continuous improvement, thus ensuring the changed practices become part of the normal business of the organisation (Health Service Executive, 2008b).

The author used a pre and post medical records audit tool to evaluate the effectiveness of the change. The purpose was to improve safety by detecting deviations in appropriate standards of care, providing objective information about the consequence of this action and to understand its causation (NSW Health Department, 2001).

In order to evaluate the effectiveness of the education programme and to assess if it achieved its identified objectives, the author used Kirkpatrick’s (1959) four-level training evaluation model. Chapter 4 outlines a detailed account of the evaluation process and the gathering of information required to determine the effectiveness and organisational impact this project has achieved within the author’s organisation.
Chapter 4

4.1: Evaluation Introduction

Within this chapter, the author details the evaluation design undertaken to evaluate the Organisational Development project. A rationale for the choice of Kirkpatrick’s (1959) evaluation model is presented, as is the data collection methods and information analysis techniques applied.

The overall comprehensive evaluation process is governed by the concept of Donabedian's Structure, Process and Outcome framework approach and a mixed quantitative and qualitative methodology is undertaken to establish if the objectives outlined in Chapter 1 have been achieved. The chapter is concluded with a summary and discussion of the findings.

4.2: Significance of Healthcare Evaluation

Evaluation may be best described as a method of measuring the extent to which an intervention achieves its stated objectives (Lazenbatt, 2002). In today’s complex healthcare environments, it is vital that management underpin the elements of evaluation. Service users deserve services that are of the highest quality and that provide care that is effective and is founded on sound evidence based practices.

In order to deliver such services, healthcare leaders need to have an understanding of the tools which support them. These tools and methods aid in the calculation of the health impact of policies and programmes; thus, evaluation methods provide an understanding of why an improvement initiative has or has not worked and how it can be improved in the future (Parry et al., 2013).
By evaluating, healthcare managers are assisted to achieve the highest standards of effectiveness, efficiency, equity and value for money in the services that they provide, while also demonstrating that attainment for accountability purposes (Butler, 2002). Conducting a detailed evaluation of activities is essential to understanding and identifying which methods and innovations work to bring about improvements.

These continuous quality improvements require that we must first “measure to manage” (Heinemann et al., 2006). An effective measurement system integrates initiatives, aligns organisational units and resources and improves performances (Kicab, 1999). Hence, performance needs to be measured to determine whether and to what extent improvement has occurred so that further quality improvements strategies can be targeted appropriately (Smith et al., 2008). Healthcare managers are responsible for ensuring that measures exist at organisational level for three main purposes, as outlined by Kicab (1999):

1. Strategies to drive procedures into action and change organisational culture.
2. Diagnostic: to evaluate the effectiveness of these actions and the extent of change.
3. Operational: to continuously improve.

This responsibility to engage in measurement and evaluation is further highlighted by A Vision for Change (2006) which sets out a comprehensive policy framework for Mental Health Services. A key message is to monitor service developments, ensure service equity across the HSE and evaluate performance. Mental Health Services are encouraged to evaluate the effectiveness of proposed innovations and to
improve our understanding of the unique and changing mental health needs of our community (Department of Health, 2006).

Furthermore, The Mental Health Reform focus in recent years to embrace the recovery ethos requires both cultural and structural change in the mental health services. There is now an energetic necessity for services to develop strategies to regularly evaluate their recovery practices and visibly demonstrate to stakeholders that they are in truth recovery-orientated (McDaid, 2013).

4.3: Rationale for Choice of Evaluation Model

There is a diversity of theory and practice that has embraced the evaluation field, which captures a variety of differing opinions on the best evaluation models and approaches one should apply. However, one broad consensus is that the major goal of evaluation should be to influence decision-making or policy formulation through the provision of empirically driven feedback (Zinovieff, 2008).

A further consensus is that the challenge to the evaluator is to identify the audience and find out what their expectations are for the evaluation and the kind of information they seek, thus the information needs of the stakeholders should determine the path to follow. This in turn will ensure that the end result is that the evaluation report is used and its recommendations or implications are given due consideration (Owston, 2008).

➢ Donabedian’s framework

Under the concept of Donabedian's (1966) framework, the quality of care can be evaluated and classified into three categories, Structure, Process and Outcomes.
Structure denotes the attributes of the setting in which care occurs (e.g. physical and organisational characteristics, human resources). Process denotes what is actually done in giving and receiving care (e.g. services or treatments) while outcomes denotes the effects of care on the health status of patients and populations.

The relationship between the three categories is seen to be significant since good structure increases the likelihood of good process and good process increases the likelihood of good outcomes (Donabedian, 1988). The author has illustrated the components relating to this project in Table 2.

Table 2: Donabedian's Framework

<table>
<thead>
<tr>
<th><strong>Structure</strong></th>
<th><strong>Process</strong></th>
<th><strong>Outcome</strong></th>
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<tbody>
<tr>
<td>Clinical Nurse Specialists.</td>
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<tr>
<td>Clinical Nurse Managers.</td>
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<tr>
<td>Nursing Staff.</td>
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<tr>
<td>State Claims Agency.</td>
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<tr>
<td>Area Director of Nursing.</td>
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By utilising the concept of the model, the author was assisted in identifying the positive and negative effects of each step in the overall project. Focus was directed on the structural dimensions involved and the requirements needed to bring about change. By identifying the current status and analysing the process of documentation practices, the author was supported in describing the quality
improvement intervention, the experience to this intervention and the experience of the participants (Hulscher et al., 2003). The outcome evaluation process involved the consideration of data collected before and after and the impact of the overall initiative. The evaluation process is assisted by choosing an appropriate model for the education programme.

The author explored a number of well-established and researched models, namely CIPP (1971) (Context, Input, Process and Product), Jacob’s (1988) and Kirkpatrick’s (1959) model. In doing so, it was important to note the models used to guide evaluations bear a close relationship to the effectiveness and utility of those evaluations (Bates, 2004).

The CIPP (1971) evaluation model is a framework for guiding evaluations of programmes, projects, products, institutions and evaluation systems. The model’s core concepts are the context (goals), input (plans), process (actions), and product (outcomes) evaluation (Stufflebeam, 2000). It incorporates a variety of evaluation techniques such as surveys with stakeholders, system analysis, review documents and data, implementation of diagnostic tests and multiple interviews. It owes its success to its ability to achieve improvement by providing decision makers with documented, clear and unambiguous information concerning programme processes and results (Wang, 2010).

However, Glatthorn et al., (2012) maintains that it fails to recognise the complexity of the decision making process in organisations by assuming more rationality than exists and thus ignores the political factors that play a large part in decision making.
Furthermore, multiple data collection methods are usually required to do a good job with CIPP studies and hence, can be time consuming (Frye & Hemmer, 2012).

Jacob’s (1988) five tiered approach evaluation model provides a comprehensive opportunity to centre on personal and professional developments and holds the legitimate stakeholders at its core. The model supports the careful and systematic collection of data, selection of indicators and choice or construction of measurement instruments, which in turn generate information that will be useful for programme and policy decisions and for establishing whether, and to what extent, a programme fulfils its promise (Jacobs, 2003).

However, as suggested by McNamara et al., (2010) the evaluation model chosen is influenced by the evaluators own philosophy about evaluation and it is necessary to select a model which best matches the requirements of a situation to produce evaluation findings which are most likely to accurately appraise a programme’s merits, worth, probity, feasibility, safety, significance and equity. Thus, the author has decided to use the Kirkpatrick (1959) four level evaluation model (Table 3).
The model has proven to be by far the most popular approach to the evaluation of training in today’s organisations. While its major criticism perhaps suggests that it is occasionally not fully implemented in organisations (Holton, 1996), its major contributions to educational evaluation are the clarity of its focus on programme outcomes and its clear description of outcomes beyond simple learner satisfaction (Frye & Hemmer, 2012).

The model delineates four levels of training outcomes: reaction, learning, behaviour and results. It provides the potential for simplifying the complex process of training evaluation by representing a straightforward guide to the kind of questions that should be asked and the criteria that may be appropriate (Bates, 2004). Under the concept of the model, Kirkpatrick deems a training programme to be effective when (Level 1) the trainees are satisfied (Level 2) they learn what they intended to learn (Level 3) they behave differently/more efficiently on the job (Level 4) the organisation benefits from their use of what they learned (Polowy et al., 2006).

**Table 3: Kirkpatrick’s Evaluation Model**

<table>
<thead>
<tr>
<th>Level 4: Results</th>
<th>To what degree targeted outcomes occur, as a result of the learning events(s) and subsequent reinforcement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3: Behaviour</td>
<td>To what degree participants apply what they learned during training when they are back on the job.</td>
</tr>
<tr>
<td>Level 2: Learning</td>
<td>To what degree participants acquire the intended knowledge, skills, and attitudes based on their participation in the learning event.</td>
</tr>
<tr>
<td>Level 1: Reaction</td>
<td>To what degree participants react favourably to the learning event.</td>
</tr>
</tbody>
</table>
The model has played a key role in focusing training evaluation practice on outcomes and fostered the recognition that single outcome measures cannot adequately reflect the importance of examining multiple measures of training effectiveness (Bates, 2004).

4.3.1: Aims of The Evaluation Process

The aim of the evaluation process is to determine if the implementation of an education programme on nursing documentation and the introduction of a documentation framework achieved what it set out to do. That is, to increase awareness of adherence to documentation standards and embed a solid knowledge base on effective means of communication within the organisation.

As one of the prime purposes of the objectives is to set targets or benchmarks against which performance can be measured (Luffman et al., 1996), the evaluation involved assessing each objective to establish a measured judgment if they had achieved their defined propose.

4.3.2: Methods & Measures

**Objective 1**: Establish an audit committee that will conduct an audit in the beginning (September 2014) and end point (March 2015) of the project on a randomly selected sample of clinical records.

A quantitative formative evaluation approach was initially commenced. This evaluation approach assessed and assisted with the formation of goals and priorities
and provided direction for planning and guided the education programme development (McNamara et al., 2010).

It involved a baseline clinical audit of a randomly selected sample of clinical records (n=30) using the forty-five question audit tool (Appendix 3). This established a benchmark in relation to the current status of nurses’ adherence to NMBI documentation standards. The clinical audit was a comparison of actual practice against agreed, documented, evidence based standards, with the intention of improving the quality of service provision (Health Service Executive, 2008).

From the results of the preliminary audit in September 2014, it could be observed that there was only a 38% overall compliance with recommended standards. To represent the data the author used a bar chart as illustrated in Figure 5. The audit results are categorised into four sections.

1. Client Assessment (Assessment)
2. Individual Care and Treatment Plan (ICTP)
3. Client Involvement in Care and Discharge (Client involvement)
4. Legibility of Documentation (Legibility)
The results highlighted a number of key areas for improvement. Within Client Assessment, there was good evidence that nurses had undertaken an initial nursing assessment of physical, psychological and social needs. However, this level of assessment failed to be maintained throughout the client’s journey of recovery. Furthermore, there was an inconsistency in the evidence to show that nurses documented new needs/problems as the client’s situation changes.

Within the area of Individual Care and Treatment Plans, there was a high percentage (73%) of clinical records which failed to show evidence of a documented plan of care. Failure to present evidence of planning based on ongoing assessment was also highly evident (73%).

Where identified goals and objectives were documented, only 33% of clinical records outlined specific interventions of how to reach these goals. Furthermore, 90% of
clinical records failed to show evidence that nursing care plans were evaluated on or before dates set.

Within the area of Client Involvement in Care and Discharge, only 6% of clinical records showed evidence that clients had been advised of their identified key worker and a further 60% of clinical records showed no documentary evidence of 1:1 client engagement.

The Legibility of Documentation also disclosed high evidence of concern. A record of staff signatures and initials, as per recommendations, was not maintained nor was there evidence that erroneous entries were initialled or dated. While there was no evidence of unambiguous statements or jargon being documented in clinical records, 60% of clinical records showed evidence of unapproved abbreviations being used within the nursing documentation. A further 93% of clinical records audited showed evidence that nurses failed to use full signatures when signing entries.

Subsequently, a qualitative formative evaluation process in the form of a focus group was prompted. This provided an opportunity for nurses to discuss documentation practices and to explore the issues of importance to them, in their own vocabulary, generating their own questions and pursuing their own priorities in a bid to formulate action plans going forward. Kitzinger (1995) suggests a method that facilitates the expression of criticism and the exploration of different types of solutions is invaluable if the aim is to improve services.
4.3.3: Kirkpatrick’s Evaluation Model

Objective 2: Deliver a series of six unique education sessions on a monthly basis from the period of October 2014 to March 2015.

The author will discuss the steps involved in the evaluation under the stages of Kirkpatrick’s evaluation model.

- **Level 1: Reaction**

  Using Kirkpatrick’s evaluation model to evaluate the established monthly education programme, phase one of the process involves determining how participants felt about the programme. It was important to measure and monitor participants’ reaction to the education sessions as it provided a good indication if nurses would attend again or recommend the training to others. Kirkpatrick & Kirkpatrick (2005) recommend that reactions of participants should be measured in all programmes for two reasons: (1) to let the participants know that trainers value their reactions and (2) to measure their responses and obtain suggestions for improvement.

  In order to do so, the author devised a “nursing documentation education session evaluation form” which would quantify their reactions (appendix 10). Analysis of the information gathered proved valuable for the CNS facilitators to determine the effectiveness of the programme design and to identify ways and means of improving future delivery of the programme.

- **Level 2: Learning**

  Within this phase, the aim was to establish if the education programme had brought about learning. Recommendations for level two of Kirkpatrick’s model include the
use of a before-and-after approach so that learning can be related to the programme (McNamara et al., 2010). Therefore, the author developed a true or false questionnaire (Appendix 11).

Nurses (n=22) were asked to complete the questionnaire at the initial session and final session of the overall education programme. The purpose of this was to measure basic knowledge acquired as a result of the programme delivery. There was 100% participation in the questionnaire both pre and post and the results are shown in Figure 6.

![Figure 6: True or False Questionnaire Results](image)

There was an overall 42% improvement observed in the percentage of nurses answering correctly following the education. The results show that the education sessions were effective in increasing nurse’s knowledge. Furthermore, this improvement in knowledge was also reflected in the education programmes final evaluation form score, in which an increase from 43% to 92% of participants
indicated an increase in interest and satisfaction with the presented material and improved understanding in relation to documentation.

- **Level 3: Behaviour**

**Objective 3:** Evaluate the application of the SOAP Notes Framework in January 2015 and March 2015 using the SOAP Note Evaluation Form.

Within this level of Kirkpatrick’s model, the objective is to measure if there was a transfer of learning from the education sessions to the clinical environment. This is a key stage in the evaluation process as it enabled the author to observe if the new knowledge and attitudes of the nursing staff were demonstrated in their recording of clinical practice. This evaluation stage represents the truest assessment of a programme’s effectiveness and requires careful planning decisions in terms of when to evaluate, how to evaluate and how often to evaluate (Winfrey, 1999).

Therefore, the author decided to evaluate at a midway point in the initiative (January 2015). The use of the SOAP Notes Evaluation Form (Appendix 2) provided an opportunity to assess the application of the SOAP Notes Framework in the clinical documentation practices of nursing staff. The results of the process are illustrated in Figure 7.
Figure 7: SOAP Notes Evaluation Form Results in Jan 2015 (midpoint)

It can be observed that there was a 52% acceptable application rate of the SOAP Notes Framework in January 2015. Further analysis of the data confirmed that the application on some domains of the framework was lower than others e.g. Plan 49%.

This formative information provided an opportunity for the CNS’s to alter and implement correctives to the delivery of the education sessions. Hence, focusing on particular aspects of the framework in order to generate higher levels of achievement. Wiliam (2006) suggests that the crucial feature of formative evaluation is that the information is used in some way to make changes in order to bring about improvement.

In March 2015, the SOAP Notes Evaluation Form process was repeated, and the results showed significant improvement. Figure 8 illustrates the breakdown of the data, in which an overall 86% application rate was observed, representing an improvement from January to March of 34%.
All four domains of the SOAP framework were identified to have revealed improvements in terms of their application. Furthermore, the effectiveness of the education sessions was also validated. The positive transfer of knowledge and a change in behaviour was observed in the clinical practices of the nursing profession.

The capability of nurses to embrace this new knowledge, skill and expertise enabled a sound evidence based standardised approach to documenting interventions. The application of the SOAP Notes Framework was an important transfiguration, as the distribution of high quality mental health care is highly dependent on delivery systems that can fit seamlessly as possible into the workplace and integrate within existing professional curricula (Health Services Executive, 2009).
Level 4: Results

Objective 4: Evaluate the complete Organisational Development project and its impact on the author’s organisation (March 2015).

The final stage of Kirkpatrick’s evaluation model is seen as a significant stage in providing the most valuable or descriptive information (Bates, 2004). It assesses the impact the programme had on the organisation and if the stated objectives have been achieved and reflected in the overall outcome. While information from earlier formative evaluations was directed to improving the programme progression, this summative approach to evaluation is aimed at satisfying accountability and overall quality of the programme (McNamara et al., 2010). Summative evaluation is outcome focused and hence provides the opportunity to gather the knowledge to learn and improve future organisational developments.

To obtain this vital information, the author repeated the forty-five question nursing documentation audit. This process is often referred to as “closing the loop” which involves revisiting the audit and examining the implemented change in terms of its effectiveness (Royal College of Physicians of Ireland, 2011). This afforded the opportunity to compare the data/findings against the baseline in order to assess the scope of the improvement.

The results of the March 2015 audit are represented per category in Figure 9. Furthermore, an in-depth breakdown of the pre and post audit results are captured in Appendix 12.
A comparison was observed in the baseline data pre audit (Sept. 2014) and the post audit (March 2015). The results indicated a 94% adherence rate to NMBI documentation standards. This was a significant advancement (38% v 94%) in the adherence to standards, and accordingly represents an overall 56% improvement.

However, the objective of this project set out to achieve 100% compliance with NMBI standards; thus, the interrogation and the analysis of the findings is highly dependent on how the organisation adjudicates this proposed rate of improvement. How it evaluates the associated risks and ultimately how this relates to service user requirements.

While it is important to acknowledge that it may be unrealistic to expect an organisation to make progress on all potential improvements simultaneously, no one factor in isolation can be considered 'enough' or 'not enough' (Bohigas & Heaton, 2000). The reprieve is that the redesign of the systems and processes involved in
nursing documentation has achieved the viewpoint that the possibility of a reoccurrence of an adverse outcomes as a direct result of poor quality documentation is reduced.

4.3.4: Dissemination Plan

Effective communication is widely recognised as a key component of organisational behaviour change methodology in healthcare. It is important that the awareness and skills learned from this project be shared amongst the wider organisation. Failure to do so would result in a lost opportunity to safeguard both forthcoming staff and service users alike.

The key to this process is the significance of the project team having a shared vision and common understanding of the target audience. The aim is to engage and promote the wider organisations understanding of the quality improvement and the wider patient safety agenda (Cooper et al., 2015).

To facilitate this process, the author has formulated a poster presentation (Appendix 13) which will aid as a visual illustration of the phases of progression involved in this organisational development project. The next stage will involve an exhibition of the initiative to the wider organisation at a forum in July 2015.

The forum is held on a quarterly basis to facilitate the operational planning process involved in the delivery of the key performance indicators as outlined in the 2015 Service Operational Plan. Within this whole system approach, managers and individual staff members have both a collective and personal responsibility to create
and maintain the conditions necessary for safe services to be provided, and for the quality of those services to be improved over time (Health Service Executive, 2014).

The objective is that this forum will enable the establishment and identification of individuals and teams that will be tasked with the responsibility to reduplicate the initiative within their local sector. The author has secured the commitment and protected time requirements necessary to enable the CNS’s to work with these individual task teams in a bid to promote shared learning in the initial stage of the roll out.

4.4: Summary and Conclusion

In concluding, the author has provided the specifics of the manner in which evaluation was employed in this project. The significance of evaluation processes within health care and the important of appropriate application of the techniques required have been demonstrated.

The evaluation has revealed findings that support the original initiation of this organisational development. Through the successful delivery of the objectives set out by this project, a 56% improvement in the ability of the nursing profession to adhere to NMBI standards was observed. Their awareness of the importance of documenting practices and their ability to apply a structured documentation framework in their everyday practice was achieved.

Sequentially, the successful delivery of this project has helped the provision of a high quality health service, in which openness to learning and continuous improvement is
core to safeguarding service users and thus, reduce adverse outcomes. However, in reality, the author is aware that the process of evaluation requires ongoing review and reflection and is highly dependent on mechanisms that support continuous monitoring procedures.
Chapter 5

5.1: Introduction

Within this chapter, the author draws on the findings from the organisational development project and the experience of introducing the initiative within their organisation. Reference is made to personal reflections of leading the change throughout. Links to international literature, as highlighted, are formed, as is a critical discussion of the change process. The findings of the evaluation process are consulted in the form of their influence on the project and their inclusive contribution to practice.

The chapter is concluded with a discussion of the limitations of the project. The overall bearing of the initiative on the Mental Health organisation in which it was introduced and recommendations for future initiatives are advocated.

5.2: Project Impact

In mental health care, quality is a measure of the degree to which services increase the likelihood of desired mental health outcomes and are consistent with current evidence based practice. Conversely, there is documented evidence that worldwide, the mental health service sector lags behind in the development and implementation of performance measures. A key reason for this is that the data elements necessary to measure quality of mental health care are incomplete or even missing in many settings and even when data collection does occur, it tends to be inconsistent in different organisations (Kilbourne et al., 2010).
There is a poor tradition of carrying out economic evaluation of mental health care services in Ireland, as a result of neither the administrative structures nor the skills set in place to routinely collect and interpret data on either costs or outcomes (Shea & Kennelly, 2008).

Nevertheless, service must continuously strive to improve as quality of care is of key importance, not only to reform past neglect, as seen in historical abuses of human rights in psychiatric institutions, but to ensure the development of effective and efficient care in the future (World Health Organisation, 2003).

The origin of this project arose following three adverse events within the Mental Health Organisation in which the author works. The discoveries of system analysis reviews disclosed a direct link between the formulation and standards of nursing documentation and the resulting outcome of these adverse events. The key recommendations were for an improvement in the standard of documenting interventions and communication amongst the nursing profession.

Incorporating the introduction of a documentation framework through an education forum assisted in improving the quality of documentation within the clinical environment. Thus, the ultimate goal of the project in increasing the awareness of the significance of adherence to documentation standards as set out by NMBI was achieved.

The introduction of this project provided an opportunity to use resources efficiently to ensure adherence to minimum standards and bring about a sense of accountability
and a system for the measurement of performance. While it is difficult to estimate the economic value of an improved mental health service, it is estimated that the overall cost of poor mental health in Ireland was just over three billion euro in 2006 (Shea & Kennelly, 2008).

While this figure provides some form of baseline estimate resulting from poor service provision; the significant human and social costs associated with mental health problems resulting from poor service delivery, including pain, suffering, stigma, reduction in quality of life and suicide, cannot be valued in monitory terms.

Nevertheless, the induction of this project as a means of continuous quality improvement is likely to be cost-saving as a result of the more efficient provision of a more effective Mental Health Service.

5.2.1: Stakeholders

The author acknowledged that the key component of any change initiative is the people involved and thus, the quality of the relationships between all stakeholders determines the overall success. Adopting a culture of continuous quality improvements within organisations requires that stakeholders work together to develop and implement valid outcome measures to foster accountability to ensure practice change (Kilbourne et al., 2010).

The author placed high distinction on ongoing consultation with the relevant stakeholders. This enabled the stakeholders to play a central role in setting priorities and objectives in order to ensure relevance and appropriateness. By establishing the
degree of importance of each stakeholder, the author was in a position to better address their needs and interests in order to facilitate success.

The experience of leading this project enabled the author to gain a true appreciation of the importance of vision in gaining commitment for change. The author established a communication platform with senior management which ensured the project was in line with the overall strategy of the organisation. In order for change to be successful, buy-in from management is important as this facilitates the creation of a guiding coalition. Thus, the author encouraged a learning organisation based on shared vision and values.

The author came to greater appreciate the power and importance of networks on an operational, personal and strategic level (Ibarra, Herminia, 2007). Forming a guiding coalition with stakeholders proved imperative. The State Claims Agency proved to have the respected and reputable attributes required to be positioned to influence the support of the greater organisation.

The experience enabled the author to greater understand that culture change expands the definition of leadership beyond titles, positions and hierarchy. By identifying both formal and informal leaders within the organisation, for example; Clinical Nurse Managers, Clinical Nurse Specialists and early adaptors, the author found the right blend of strengths and interests which paid great dividends towards the success.
5.2.2: Practice

The literature review revealed that there is an increase in the number of negligence and malpractice proceedings that name nurses as defendants because of their failure to adequately document service user’s interventions. This initiative has enabled a means to safeguard nurses in their practice and additionally ensure quality in their interactions with service users. Furthermore, quality initiatives that embrace the team as a whole has strengthened interpersonal relations throughout the organisation and increased commitment to the service (Jack et al., 2013).

Creating specific metrics to assess staff performance has also enhanced transparent accountability and increased the quantity and quality of feedback given to staff, which in turn, has led to increased motivation in relation to quality service provision. As highlighted by Caldwell et al., (2008) the positive effects of strategic change are greatest when groups support the new direction.

It was important that the author was aware that if motivational forces (defined by perceived need and pressure for change) combined with personal attributes (e.g. professional growth, efficacy, influence and adaptability) on both the author as the change leader and the staff’s behalf, were not present (Lehman et al., 2002), then the new practice was unlikely to be initiated.

Therefore, the author’s capability to look for ways to involve staff in identifying ways of implementing the change in practice through continuous communication was imperative. By providing feedback following the audit periods and furthermore encouraging staff to discuss suggestions for a change in practice, the author created
an environment in which staff were involved in the process and thus, was conducive to promoting the implementation of the initiative. The comparison of the pre-intervention and post-intervention audit results reflected a positive outcome and consequently a change in the clinical practice and documenting behavior of the nursing profession was evident.

However, it is important to recognise that sustainability of a change in practice can be a challenge. Studies have found that of the organisations that implement nursing best practice guidelines, only 57% maintain the sustainability of these guidelines after a three year period (Davies et al., 2006). The key to success is building on the momentum by engaging more partners, encouraging multidisciplinary involvement and integrating the guidelines with other quality improvement initiatives.

Communication is central to overcoming these challenges in an environment in which people learn collectively. Through the experience of this project, the author has learned that to sustain clinical practice change, those at the front line as well as the executive levels need to be involved. An important element to ensure sustainability is an organisational culture supportive of evidence based practice. Changing nursing practice to be more evidence informed is a dynamic, long term and iterative process (Melnyk et al., 2011).

5.2.3: Theory

The conduction of a literature review at the initial stages of this project formed the basis for the foundation of an evidence based approach to bringing about improvements in the author's organisation. Furnished with international best
evidence, which supported the need for change, the author was in a position to leverage driving forces to aid the development and delivery of this initiative.

The project offered a considerable transformative experience for the author. Having had no previous experience of leading a change in practice of this scale, the author was steered by the use of the HSE Change Model. The model outlined a theoretical and systematic approach to managing the change and thus, enabled the author to maintain the necessary momentum for the change effort.

By embracing the theory of leadership and management of change the author was guided to the development of a vision and furthermore, to the creation of informed decisions about strategy and tactics for which to deliver that vision.

Since organisational change management within healthcare is a highly complex process, it is necessary to use a structured approach that can effectively transition organisations through the change. Key to this process was the author’s attitude to identify and estimate what impact a change in practice would likely have on individual nurse’s behaviour patterns and work processes.

Change usually encompasses the introduction of new and unfamiliar processes, procedures and technologies, which may represent to affected individuals a departure from what they generally view as the established, practical, and familiar method of doing their work. Therefore, change can engender emotions and reactions that may range from optimism to fear. The challenge for the author lay in their ability
to recognise, guide and manage these human emotions and reactions throughout the process (Mylonas, Harvey, & Hodges, 2007).

5.3: Strengths of Project

The aftermath of adverse events have, in the past, been often tarnished by defensiveness, efforts at damage limitation and fear of reputational damage both at individual and corporate level. However, a change in culture in recent years through our ability of accepting that harm is not intentional, has helped our services deal with events with honesty, openness and compassion for the heartbroken individuals and those carrying the burden of responsibility (Tysall & Duffy, 2013). The central strengths of this project was its focus on integrity and being truly professional by means of accepting responsibility and embracing accountability.

The key emphasis was on preventing a recurrence of adverse events. The nursing profession within the organisation place a high value on responsibility, the pursuit of new knowledge, belief in human dignity, equality of all patients and the desire to prevent and alleviate suffering. This project enabled the opportunity for a combination of a supportive culture, system change and a demonstration of ethical behavior, coupled with professional and personal integrity to bring about an improvement in clinical practice (Tysall & Duffy, 2013).

As clinical documentation is at the core of every patient encounter, in order to be meaningful it must be accurate, timely, and reflect the scope of services provided. The project aided the nursing profession to devise an efficient mechanism to
standardise their approach to providing important information throughout the continuum of care.

On reflection, a particular strength of this project lay in the participative approach; in that, multiple stakeholders were involved in the design and delivery of the initiative. A major determinant of the results seen was a consequence of the bottom up/top down approach involved in the collaborative process in reaching agreement and building momentum to achieve and implement the action plans drawn from the objectives set within this project.

Successfully collaborative organisations involve multiple stakeholder’s who come together to identify common issues, share information and perspectives, generate and analyse information for decision-making, develop plans and implement projects (Margerum, 2002). Obstacles and concerns raised by various stakeholders were given priority, and thus a legitimate, transparent process to communicate with stakeholders was established.

5.4: Limitations of Project

As change is never as simple, linear or comfortable as major change models would suggest (Sembi, 2012), limitations exist to the design and delivery of this project. Clinical audits have proven to be a valuable assistance to any programme which aims to improve the quality of healthcare and its delivery. They are an essential tool in identifying shortcomings in care and proving guidance to implementing the type of action needed to demonstrate improvement.
However, manual chart review is slow, labour intensive, resource expensive, contained to small samples and prone to interviewer variation (Kilbourne et al., 2010). Additionally, there is a potential for bias as a result of the possibility of clinical practice being affected by the knowledge that an audit is ongoing (Health Service Executive, 2010).

However, the foremost limitation of this project was its constricted concentration on the nursing profession. While an inconsistency in the quality of documentation is not at all times uniformly characteristic of all professions, the concern is not often isolated to one discipline. Moreover, the focus of the professional is often on local concerns rather than on the broader organisational strategy (Carney, 2007).

Due to the complexity of the process of changing clinical practice and having being successful in building the sense of urgency and momentum required to bring about an improvement, the author feels that a major opportunity was lost through their failure of not involving the multidisciplinary team in its entity.

Upon reflection, at the onset of this project the author was confident in their legitimate position of authority within the organisation, to address the quality of documentation amongst the nursing profession. The progression of time and professional development has instilled a realisation in the author, that they have the ability to enable them to identify more easily and raise cross-functional issues and hence, facilitate mutual problem solving and coordination in the future. The key to success will be the ability to set the conditions that motivate change and moreover,
produce the focus and energy needed to make change happen (Ancona et al., 2007).

5.5: Recommendations

The process of undertaking this project has highlighted the need for Mental Health Services to embark on similar incentives to promote provider accountability and thus improve the quality of documenting practices within their services. Quality measurement is a key driver in transforming the quality of healthcare systems; therefore, Mental Health service providers need to become routinely involved in measuring quality through the use of performance measurement derived from evidence based practice guidelines. Benchmarking of standards such as NMBI documentation standards will assist this process.

Clinical audit should become routinely part of everyday practice and furthermore, shortcomings should be identified and strategies developed in order to improve outcomes for individuals engaged in Mental Health Services.

The lessons learned from this organisational development project should be embraced, and hence the initiative should be reduplicated across Mental Health Service from a multidisciplinary viewpoint. Commitment from the Multidisciplinary team as a whole will prove most successful in ensuring improved outcomes for services users.
5.6: Summary and Conclusion

In conclusion, the project set out to host an education programme which would increase awareness of adherence to documentation standards and furthermore, incorporated the introduction of The SOAP Notes Framework to improve the quality of documentation amongst the nursing profession within the author’s Mental Health organisation. In order to do so, a theoretical understanding of the topic area was established and a vision of the projected outcomes was formed.

The project was initiated under the governance of the HSE Change Model. The model assisted in the formation of a strategy in which to deliver the outlined objectives. Through meaningful stakeholder engagement and communication, the planning and implementation of the project yielded positive outcomes.

The evaluation of the initiative exhibited favourable results, in that, there was an overall 56% improvement in adherence to NMBI documentation standards post-intervention. Additionally, the application of a documentation framework and a comprehensive education programme ascertained pronounced improvement in the nurse’s awareness and furthermore ability to formulate quality documentation of interventions with service users.

A variation in the scale of improvements and the timeframes of those improvements was observed in some areas of practice in compassion to others. The author concludes that the ability to foster and promote high standards and best practice concerning specific areas of practice often poses fewer challenges than other more complex practices.
For example, many of the administrative standards, such as maintaining records of staff signatures and initials, the use of black ink and promoting clinical records being contemporaneous and maintained in chronological order, are easily addressed areas of practice through the introduction of systems and protocols.

However, promoting patient involvement and adjusting practices to reflect ongoing assessment through the use of revised tools and frameworks requires multiple interchanges of discussions and engagement with staff. Existing cultures of organisations must be navigated through various stages of transition. Managers must not only coordinate but also show leadership in their approach. It is only then, that there exists a trust and acceptance amongst staff to challenge not only their current skill base and knowledge but also their values and beliefs.

The experience of this initiative has created numerous positive conclusions for both the author and the organisation as a whole. The author has developed their leadership and management skills necessary to motivate people towards a common goal and drive sustainable change to ensure safe and high quality service provision. Having implemented a structured change management approach, combined with the creation of a supportive culture which embraces the principles of learning from mistakes, the author is confident in their development as a leader and ability to improve service provision.

The experience for the organisation as a whole has demonstrated that through good systems of clinical governance and quality assurance, there is learning from adverse events. The ability to work in partnership to change and adapt practices can
contribute to supporting the prevention of a recurrence of such events and helps ensure positive experiences and outcomes for future service users.
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### Appendix 1: Summarisation of SOAP definitions and examples

<table>
<thead>
<tr>
<th>Section</th>
<th>Definitions</th>
<th>Examples</th>
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<tr>
<td><strong>Subjective (S)</strong></td>
<td>What the client tells you. What pertinent others tell you about the client. Basically, how the client experiences the world.</td>
<td>Client’s feelings, concerns, plans, goals, and thoughts. Intensity of problems and impact on relationships. Pertinent comments by family, case managers, behavioural therapists, etc. Client’s orientation to time, place, and person. Clients verbalized change towards helping.</td>
</tr>
</tbody>
</table>
| **Objective (O)**   | Factual: What the counsellor personally observes/witnesses  
Quantifiable: what was seen, counted, smelled, heard, or measured. Outside written materials received. | The client’s general appearance, affect, behaviour. Nature of the helping relationship. Clients demonstrated strengths and weaknesses. Test results, materials from other agencies, etc., are to be noted and attached. |
| **Assessment (A)**  | Summarizes the counsellor’s clinical thinking. A synthesis and analysis of the subjective and objective portion of the Notes. | For counsellor: Include clinical diagnosis and clinical impressions (if any). For care providers: How would you label the clients behaviour and the reasons (if any) for this behaviour? |
| **Plan (P)**        | Describes the parameters of treatment. Consists of an action plan and prognosis.                     | Action plan: Include interventions used, treatment, progress, and direction. Counsellors should include the date of next appointment. Prognosis: Include the anticipated gains from the interview. |
Appendix 2: SOAP Notes Evaluation Form

Evaluator ___________________ Date __________

1 = unacceptable, 2 = poor, 3 = acceptable or good,
4 = very good, 5 = excellent or exceptional

SUBJECTIVE (15 POINTS)

Identified and collected the necessary data 1 2 3 4 5
Categorized and organized data using the appropriate format 1 2 3 4 5
Incorporated all pertinent data/facts 1 2 3 4 5

OBJECTIVE (15 POINTS)

Identified and collected the necessary data 1 2 3 4 5
Categorized and organized data using the appropriate format 1 2 3 4 5
Incorporated all pertinent data/facts 1 2 3 4 5

ASSESSMENT (40 POINTS)

Filtered relevant data from irrelevant data 1 2 3 4 5
Identified missing or incomplete data 1 2 3 4 5
Interpreted relationships/patterns among data (e.g., noted trends) 1 2 3 4 5
Integrated information to arrive at assessment 1 2 3 4 5
Evaluated appropriateness of drug therapy on efficacy and adverse effects) 1 2 3 4 5
Identified a complete problem list 1 2 3 4 5
Assessed each problem 1 2 3 4 5
Assessed patient compliance 1 2 3 4 5

PLAN (30 POINTS)
<table>
<thead>
<tr>
<th>Description</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Included desired therapeutic goals/endpoints</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommended an appropriate plan for each problem</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Included recommendations for non-drug and drug therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Included recommendations for monitoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Justified proposed plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presented in an organized, logical manner (i.e., easy to follow and understand)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
# Appendix 3: Nursing Documentation Audit Tool

<table>
<thead>
<tr>
<th>Area:</th>
<th>Patient Initial/Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Metric Data Collection:</td>
<td>Data Collectors Name:</td>
</tr>
</tbody>
</table>

### Nursing Documentation Sources

<table>
<thead>
<tr>
<th>A</th>
<th>Nursing Documentation</th>
<th>Sources</th>
<th>Advice to Auditor</th>
<th>Response</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Client Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Each patient has an up to date written record of patient care</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Each patient has a documented record of ongoing patient care as per local policy/protocol/guidelines</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Is there evidence of a systematic approach to nursing care</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Each patient has a written initial nursing assessment of physical, psychological and social needs</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>An agreed framework/assessment tool is used in the assessment process</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>The patient/client interviewed as part of the assessment process</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>The assessment is updated as new problems/needs occur or as the patients/clients situation changes</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>The assessment refers to information obtained from other professionals or agencies</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>The assessment includes specific considerations for</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A nursing plan of care is identified</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------</td>
<td>-----------------</td>
<td>-----</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>The nursing care plan is part of/compliments the individual care and treatment plan</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Each patient record contains evidence in relation to the planning and provision of nursing care based on ongoing assessment</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Goals/objectives are specified for each identified need/problem</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>The goal/objective will be written, wherever possible from the clients perspective</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Both short and long term goals/objectives identified for each problem</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Interventions are clearly specified for each need/problem</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>The interventions are discontinued once the need/problem is resolved</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Evaluation dates are indicated clearly on the care plan</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Nursing care plans are evaluated/on/ before the date set</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>The patient/client was involved in the evaluation process</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

**Client Involvement in Care and Discharge**
<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Is there documentary evidence of 1:1 patient engagement</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>22</td>
<td>On discharge all patient documentation is stored as per local policy</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>23</td>
<td>The key worker/ named nurse is readily identifiable from the nursing documentation</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>24</td>
<td>There is documentary evidence of an allocated key worker/ named nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>There is documentary evidence that the patient/client has been advised of the identity of their key worker/named nurse</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Legibility of Documentation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>All documentation is legible</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>27</td>
<td>All nursing documentation is contemporaneous and in chronological order</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>28</td>
<td>Late entries are clearly identified</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>29</td>
<td>All entries in the nursing documentation are made in black ink</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>30</td>
<td>All statements in the nursing documentation are objective</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>31</td>
<td>Nursing documentation does not contain unambiguous statements, or jargon, witticisms or derogatory comments</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>32</td>
<td>All entries are timed using a</td>
<td>Clinical</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>24hour clock</strong></td>
<td>record</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>33</strong></td>
<td>All nursing entries/documentation are dated</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>34</strong></td>
<td>All entries/documentation are signed using a full signature</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>35</strong></td>
<td>The grade of the person making the entry is documented</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>36</strong></td>
<td>A record of staff signatures and initials is maintained</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>37</strong></td>
<td>Are new staff added to the index of signatures within one week of employment</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>38</strong></td>
<td>Entries made by student/candidate nurses are countersigned by a registered nurse</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>39</strong></td>
<td>The use of abbreviations is kept to a minimum</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>40</strong></td>
<td>Only approved abbreviations are used in the nursing documentation</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>41</strong></td>
<td>Current patient records are kept in a secure environment</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>42</strong></td>
<td>The patients name and record number is clearly marked on each page of the patients record</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>43</strong></td>
<td>Erroneous entries are bracketed, with a single line through them</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>44</strong></td>
<td>Erroneous entries are initialled</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>45</strong></td>
<td>Erroneous entries are dated</td>
<td>Clinical record</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
## Appendix 4: PESTLE Analysis

Implementing an Education Programme and SOAP Notes Framework to Improve Nursing Documentation

<table>
<thead>
<tr>
<th>Political</th>
<th>Economical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Commission enhanced focus on documentation thus ensure organisation performing well</td>
<td>Economic downturn affects staffing resources, thus, has direct impact on workload</td>
</tr>
<tr>
<td>Quality of Health Service has direct reflection on government popularity</td>
<td>Improved risk indicator reporting and performance reviews</td>
</tr>
<tr>
<td>Mental Health Service envisaged in Government policy-A Vision for Change 2006</td>
<td>Establishment of the HSE Clinical Programmes to encourage shared innovation &amp; solutions to deliver improved quality of care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social</th>
<th>Technological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public perception of Health Service Executive Improved Mental Health advocacy movement</td>
<td>Growth transformation from paper to electronic databases to record documentation</td>
</tr>
<tr>
<td>Representatives/family associations and carers represented on core management</td>
<td>STARS Web Statistics Summary Report for the Mental Health Commission has increased awareness/shared learning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal</th>
<th>Ethical</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMBI Documentation standards Increase awareness with regards to accountability in terms of negligence claims Data protection policy National Guidelines on open disclosure</td>
<td>NMBI Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives HSE National Healthcare Records Management Advisory Group</td>
</tr>
</tbody>
</table>
Appendix 5: SWOT Analysis

<table>
<thead>
<tr>
<th>Implementing an Education Programme and SOAP Notes Framework to Improve Nursing Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths</strong></td>
</tr>
<tr>
<td>• Increased media/public awareness due to recent cases of poor documentation impacting patient care thus urgency amplified</td>
</tr>
<tr>
<td>• Education will focus on legal and regulatory acceptable standards of documentation and hence safeguard nurses in their practice.</td>
</tr>
<tr>
<td>• Support of State Claims Agency</td>
</tr>
<tr>
<td>• Nurses desire to remain competent and professional in the manner in which they practice.</td>
</tr>
<tr>
<td>• The high degree of motivation and emotional intelligence amongst the nursing profession.</td>
</tr>
<tr>
<td>• Steering Group Committee backing.</td>
</tr>
<tr>
<td>• Early adopters for change.</td>
</tr>
<tr>
<td><strong>Weaknesses</strong></td>
</tr>
<tr>
<td>• SOAP documentation not embedded in education.</td>
</tr>
<tr>
<td>• Difficulty in assigning protective time to prioritize documentation</td>
</tr>
<tr>
<td>• Education is directed towards nursing profession and not multidisciplinary</td>
</tr>
<tr>
<td>• Direct impact on client is difficult to assess/evaluate</td>
</tr>
<tr>
<td><strong>Opportunities</strong></td>
</tr>
<tr>
<td>• Opportunity for nurses clinical practice to be seen as a lead/example to other professions</td>
</tr>
<tr>
<td>• Initiative has potential to be rolled out across larger organisation if successful</td>
</tr>
<tr>
<td>• Education programme has potential to be NMBI credited</td>
</tr>
<tr>
<td><strong>Threats</strong></td>
</tr>
<tr>
<td>• Documentation not see as a priority</td>
</tr>
<tr>
<td>• Sustainability of improved practice</td>
</tr>
<tr>
<td>• Resistance to change</td>
</tr>
<tr>
<td>• Competing priorities due to reduced resource resulting in increased workloads</td>
</tr>
</tbody>
</table>
## Appendix 6: Lewin’s Force Field Analysis

<table>
<thead>
<tr>
<th>Driving Forces (+)</th>
<th>Restraining Forces (-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional and organisational policies - legal and ethical obligations</td>
<td>Lack of awareness of legal and ethical obligation</td>
</tr>
<tr>
<td>Fear of malpractice litigation and Liability</td>
<td>Lack of knowledge of implementing accurate framework for documentation</td>
</tr>
<tr>
<td>Increased interdisciplinary teamwork through improved channels of communication and transfer of knowledge</td>
<td>Unacceptable standards of documentation not recognised as a priority</td>
</tr>
<tr>
<td>Current standard and formulation of documentation has been highlighted as a risk to quality provision of service</td>
<td>Inconsistent response from management to respond to identified risk and system errors</td>
</tr>
<tr>
<td>Increased education and awareness will safeguard nurses practice in the event of adverse events</td>
<td>Culture of professional development not supported/reinforced via means of clinical supervision</td>
</tr>
</tbody>
</table>

### Lewin’s Force Field Analysis (Stage 2)

The next stage of the analysis involves categorising the Forces according to their IMPORTANCE (how much the force will affect change) and the EASE OF CHANGE (how easy it would be to strengthen the driving force or weaken the resisting force. This can be done by listing the driving and restraining forces identified in Stage 1 and scoring each on both the factors. Each should be scored on the two scales as follows:
## (A) IMPORTANCE

<table>
<thead>
<tr>
<th>Importance</th>
<th>5</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Very important to the Change</td>
<td>Of little importance</td>
</tr>
</tbody>
</table>

## (B) EASE OF CHANGE

<table>
<thead>
<tr>
<th>Ease of Change</th>
<th>1</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Very Easy to Change</td>
<td>Very Difficult to Change</td>
</tr>
</tbody>
</table>

### RESTRAINING FORCES

<table>
<thead>
<tr>
<th>Force Description</th>
<th>A Importance</th>
<th>B Ease of Change</th>
<th>A * B</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of awareness of legal and ethical obligation.</td>
<td>5</td>
<td>5</td>
<td>25</td>
<td>1</td>
</tr>
<tr>
<td>Lack of knowledge of implementing an accurate framework for documentation.</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Unacceptable standards of documentation not recognised as a priority.</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Inconsistent response from management to respond to identified risk and system errors.</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>The culture of professional development not supported/reinforced via means of clinical supervision.</td>
<td>5</td>
<td>2</td>
<td>10</td>
<td>6</td>
</tr>
</tbody>
</table>

### DRIVING FORCES

<table>
<thead>
<tr>
<th>Force Description</th>
<th>A Importance</th>
<th>B Ease of Change</th>
<th>A * B</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional and organisational policies - legal and ethical obligations.</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Fear of malpractice litigation and Liability.</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Increased interdisciplinary teamwork through improved channels of communication and transfer of knowledge.</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Current standard and formulation of documentation has been highlighted as a risk to the quality provision of service.</td>
<td>5</td>
<td>4</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>Increased education and awareness will safeguard nurse’s practice in the event of adverse events.</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>3</td>
</tr>
</tbody>
</table>
### Appendix 7: Strategy for Addressing Three Main Priorities (Stage 3)

#### Priority 1:

<table>
<thead>
<tr>
<th>Strategy for Priority 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify appropriate documentation audit tool in order to establish a current standard of documentation.</td>
</tr>
<tr>
<td>• Conduct initial audit and set up a forum to deliver results of the audit to increase urgency.</td>
</tr>
<tr>
<td>• Identify influential personnel to develop steering group for roll out of education.</td>
</tr>
<tr>
<td>• Formulate education programme and method of delivery.</td>
</tr>
<tr>
<td>• Provide training for all nurses so they are aware of the new framework (SOAP) and provide peer support via workshops.</td>
</tr>
<tr>
<td>• Put in place continuous monitoring &amp; control procedures to ensure continued maintenance of revised standard.</td>
</tr>
</tbody>
</table>

#### Priority 2:

<table>
<thead>
<tr>
<th>Strategy for Priority 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Conduct risk assessment and identify risk on risk register via Health &amp; Safety group meeting.</td>
</tr>
<tr>
<td>• Highlight and escalate risk to service wide risk register in order to build support/momentum.</td>
</tr>
<tr>
<td>• Seek external agency/specialist support for recommendations on improving the standard and increasing awareness via State Claims Agency.</td>
</tr>
<tr>
<td>• Communicate developments of the project to core management and thus support shared learning thought out organisation.</td>
</tr>
</tbody>
</table>

#### Priority 3:

<table>
<thead>
<tr>
<th>Strategy for Priority 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide monthly education on documentation and provide an opportunity for nursing to practice technique.</td>
</tr>
<tr>
<td>• Provide an opportunity to capture particular areas of concern via evaluation sheet following each education session and thus inform further delivery of education</td>
</tr>
</tbody>
</table>
programme.

• Encourage cross observing of practices via peer support and open forums to discuss suggestions for improvements.

• Foster the awareness of nurses by making them responsive to the benefits of implementing the improved standards.

• Praise & celebrate diligence of nurses in their pursuit to improve overall standards when documenting clinical interventions.

• Instil vision of the importance of continued professional development and improvement throughout the organisation.
## Appendix 8: Stakeholder Analysis

<table>
<thead>
<tr>
<th>Stakeholder/group</th>
<th>Power (LMH)</th>
<th>Role in project</th>
<th>Interest (LMH)</th>
<th>Positive/ negative impact</th>
<th>Expectations/ desired outcomes</th>
<th>Engagement strategy</th>
</tr>
</thead>
</table>
| **Clinical Nurse Specialists** | H           | Deliver education programme                                                    | H              | (+) share expertise (-) Interest in project may fade if immediate results not obvious      | • Improve overall standard of documentation  
• Formulate and deliver education to wider service                                               | • Support to formulate education programme  
• Facilitate protective time  
• Promote expertise                                                                                   |
| **Nursing Staff**          | H           | Implement improved standard                                                   | M              | (+) Early adopters can influence others  
(-) resist change in practice                                                                   | • Learn new practice  
• Improve communication with MDT  
• Validation of intervention with clients and importance to MTD                                       | • Engage from beginning  
• Establish focus groups  
• Facilitate protective time  
• Encourage participation in evaluating education programme to inform further learning                   |
| **CNM II’s**               | H           | Conduct audit, Support staff in implementing new practice, monitor improved standard | M              | (+) Establish standard, practice governance  
(-) may see audit procedure as time consuming                                                     | • Improve overall standard  
• Initiative ensures compliance with NMBI                                                            | • Engage from beginning by means of seeking suggestions re: roll out of initiative  
• Set up forum/workshop in utilising audit tool                                                     |
| **State Claims Agency**    | H           | Deliver education session on legality, risk factors & importance of documentation standards | M              | (+) Highlight significance of change  
(-) Create fear and insecurity among profession                                                 | • Safeguard organisation  
• Reduce incident of negligence  
• Develop presentation for delivery to other Mental Health Directorates | • Establish regular meeting forum  
• Support in development of examples of negligence in Mental Health  
• Value expertise and maintain communication pathway                                                |
| **Area Director of Nursing** | M           | Organisational support                                                         | L              | (+) Promote change in practice and support sustainability  
(-) Allocation of workload may impact project delivery                                             | • Safeguard profession  
• Improved service delivery  
• Improved patient outcomes                                                                          | • Keep informed  
• Provide monthly progress report via email  
• Promote shared learning across service via presentations                                             |
| Nurse Practice Development Coordinator (NPDC) sponsor | H | Clinical governance and project support | L | (+) Increase sense of urgency/imp ortance  
(-) Competing priorities may influence availability to support project | • Safeguard nursing profession  
• Opportunity to replicate in other areas of service | • Seek support/advice from beginning  
• Value opinion and implement corrective action when advised |
Appendix 9: State Claims Agency Presentation

20/03/2015

Documentation and Recording in Clinical Practice in Mental Health Implications for Quality and Patient Safety

March 20th 2015

Claire O’Rourke
Clinical Risk Advisor
State Claims Agency

Learning Outcomes

1. Analyse requirements from national policy and standards
2. Examine legal, ethical and professional responsibility
3. Analyse evidence from HSE inspections, National Reviews and Investigations
4. Relate the learning from claims/case law/ fitness to practice
5. Integrate the implications for practice within own practice
6. Value the requirements for compliance to ensure robust documentation

Healthcare Records Policy

HSE National Healthcare Record

Sections 3 and 4

3. Clinical Notes
   4. Nursing Notes
   - Name of the healthcare professional
   - Date
   - Signature
   - Patient’s name
   - A unit or ward number
   - Admission and discharge dates
   - Diagnosis
   - Treatment
   - Outcome

4. Additional Information to support clinical notes
   - Medical letters
   - Laboratory results
   - Radiology reports
   - Other specialist reports

Failure to follow the above Health Care Professional policy can be subject to disciplinary action.

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**Quality Framework Mental Health Services**

**Theme 1:** Provision of a holistic, seamless service and the full continuum of care, provided by a multi-disciplinary team — O = 2.1.4. Individual care and treatment plan. Evaluations documented.

**Theme 2:** The mental health service implements a clinical governance system for improving clinical practice — O = 2.3.7. i) Clinical Audit, ii) Evidence-based care and treatment, iii) Legal compliance.

---

**What is a Healthcare Record?**

A Healthcare Record (HCR) is:

- A permanent, unified record documenting all information collected, processed and held (2012).
- Evidence of ‘transactions between healthcare professionals and patients’ (2011).
- An essential part of care allowing communication between healthcare professionals (2001).

---

**Functions of HCRs**

- Maintains a history of patient care
- Records decisions relating to care
- Supports the workflow of the clinical and administrative functions within the organisation for healthcare professionals and other relevant staff.
- Supports the communication of clinical information with external sources, i.e., laboratory and radiology as well as consultations with and referrals to colleagues.
- Justifies care delivery in the context of (i) legislation, (ii) professional standards, evidence, research and (iii) professional and ethical conduct.

---

**Guidance from Indemnifier**

---

**Purpose of Clinical Records**

**Main Purpose:** Continuity of Care

**Other purposes:**

- Administrative and managerial decision-making
- Meeting legal requirements. Duty of Care, DP and EOI
- Clinical audit
- Can be used in continuing education & research
- Factual base for responding to complaints, clinical negligence claims, Coroner’s Inquests, investigations following an incident, disciplinary proceedings.

---

**HCR - Legal Perspective**

- Legal documents: documentary evidence that HCP's 'Duty of Care' has been/ has not been fulfilled (actions or omissions)
- Should not provide a factual, account of all care provided across the continuum of care
- Protection of the patient, healthcare facility and healthcare professional.
Reliance on HCRs

- Statements completed with reference to the records
- Invaluable in alleged negligence - only evidence available years later
- Litigation is a slow process - Clinician’s memory unreliable!
- NB: Accurate, contemporaneous, comprehensive notes most important

HCR Ethical Perspective

- "Doctors are ethically obliged to maintain records of their care to their patients"
  (Melbourne 2011:77)
- Respect for the Person
- Confidentiality
- Privacy
- Trust

Professional Responsibility

Registered Medical Practitioners

Section 23.1 Medical Records:

- "...adequate records and up-to-date patient medical records in an accessible, electronic form... essential to be aware of your obligations under OP Acts... as well as current Code of Practice..."

May 2013...

HSE and the Medical Council sign MOU

- "...the MOU will formalize collaboration on areas relating to doctors’ registration and their ongoing professional competence, as well as information sharing where concerns arise about a doctor’s fitness to practice."

[Sameh Saleh, Chief Executive Officer of the Medical Council]

Professional Responsibility

Registered Nurses and Registered Midwives

Principle 5: Collaboration with Others

- Your documentation and communication of care should be carried out in a clear, objective, accurate and timely manner within a legal and ethical framework
  (December 2016)
Professional Responsibility
Chartered Physiotherapists

Rule 2: Responsibility to the Patient

2.3 Chartered Physiotherapists shall maintain adequate records of the patients condition, treatments and progress.


Inquest - December 2013
Irish Independent, Saturday 8 December 2013

Recommendation
"all medical records should be kept contemporaneously"

Inquiries / Investigations

- Leas Cross (2001)
- Lourdes Hospital Inquiry (1994)
- Tania McCabe (2007)
- Savita Halappanavar - HSE (June 2013)
- HICRA (7 October 2012)
- HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date) (14 February 2010)

Lourdes Inquiry (1998)

"Standards of record keeping are very variable with essential information and explanations not being recorded. There is little or no recording of dialogue with the patient" (December 1998).

Tania McCabe (2007)

Recommendation 19
The patient record and communication systems should be reviewed to ensure that all the processes are streamlined and that all documentation complies with minimum standards.

(Ar En Ad Acrine 2002 and National Hospital Office 2002/2005).

Recommendation 25
The inclusion of maternal heart rate in the baseline intrapartum physiological data recorded at booking should be considered. This would support the introduction of physiological observation, track and trigger type programmes in obstetric practice (p.44).

Savita Halappanavar – HSE Report (June 2013)

Recommendation 5 (National)
The HSE should implement improvements and audit compliance with improved communication practices between all disciplines and grades of staff, and improvements in the handover of acutely ill patients including between staff (p.18 & 19).

Recommendation - incidental finding 3 [National]
Implement the HSE Standards and Recommended Practices for Healthcare Records Management V3.0 (May 2013) (p.18 & 82).
Rationale for Recommendation (Incidental Finding 3)

Consistent poor quality of documentation within the records of the plan of care and care delivered. Examples that did not reach the HSE standard included:
- Staff signatures were not legible on all entries.
- All staff entries were not dated.
- All entries were not timed.
- Staff making a referral or consulting with another member of the healthcare team did not always clearly identify the other member of staff in the record.
- The patient’s/ client’s name and record number (i.e., healthcare record number) did not appear on every page.

HIQA Investigation (Savita) (Oct 2013)

p11 - “The healthcare professional documentation of Savita Hologan’s care lacked detail in relation to her clinical status and the potential risk of clinical deterioration at identified times throughout her care pathway.”

“Timely and effective care and treatment depends on regular monitoring and recording of a patient’s clinical observations, reassessing their significance, communicating and exacerbating concerns, to include consultation with and by a senior clinical decision maker, about abnormal observations and the triaging of appropriate emergency responses.”

HIQA Investigation (Oct 2013) (cont’d)

p12: “The hospital did not have in place effective arrangements to ensure that patient care was documented or that those caring for patients were fully informed of a patient’s condition and treatment plan.

The arrangements for the handover of patient care between the maternity clinical teams were not always effective and were not in line with best available evidence.”

HIQA Investigation (Oct 2013) (cont’d)

p17: “Clinical entries were dated but rarely timed and the clinician’s job title was not always documented.

The Authority found during its review of healthcare records at UHG that some signatures and titles were illegible, the healthcare records were difficult to follow and were not always in chronological order.”

HSE MRHP Perinatal Deaths (2006-date) (24 February 2013)

“Many of the reviews referred to poor quality documentation, including retrospective entries, unsigned and untimed entries and examples of actions taken and care given, not documented.”

“It would appear that patient healthcare records were not managed in line with HSE standards.”

“Meetings with families identified that there were considerable delays in the release of healthcare records and that they were required to go through Freedom of Information...”

Recommendations 36, 37 and 38.

Mental Health Commission Inspections
MHC Inspections (2014):

**Article 15: Individual Care Plan**

'All residents had an individual care plan and many were very comprehensive. However, a significant number were not reviewed in a timely manner and some showed evidence of carelessness or lack of knowledge in completing them.'

'The review of goals and ICPs were not timely and, in some cases, extended to three weeks... even in the case of acutely unwell residents.'

**Article 27: Maintenance of Records**

'The clinical files were not in good order and there were multiple loose pages in most files. This made it difficult to navigate the files and there was a risk of losing important documentation.'

'Secution:

'There were discrepancies in accuracy of records noted by inspectors between the dates documented... in relation to a series of seclusion orders...'

**Mental Health Investigation findings:**

'Service user attended GP surgery for depot medication. Suicide attempt prompted a review; investigation revealed depot had been administered on numerous occasions without a prescription, (which had lapsed a number of months).'

'Service User discussed at MDT meeting, decision to transfer to another part of service. No documentation to support this decision and therefore Service User was not followed up. Three weeks later discovered during an ad hoc conversation and then follow up done.'

'Alleged negligence'

'Multiple evidence of derogatory statements, misuse of abbreviations, incomplete documentation; excessive narratives lacking in subjective, objective, assessment planning and evaluation of care. Short sentences / statements with little or no evidence of care delivery or interventions'

'Lack of standardisation and awareness of timelines and rationale for when and how often to document, dependent on individual approach.'
In Court Cases....

- Original records are *discoverable*, and produced in court.
- Good standard of record keeping is essential.
- Absence of documentation/records greatly hinders a successful defence.
- Reputational damage to hospital and healthcare professional.
- Perception - poor, sloppy healthcare records:
  i) Correlates to poor standard of patient care;
  ii) Gives poor impression although it does not necessarily mean negligent care.

Settlement of Claims

- No records or missing (in part or full).
- Poor documentation within the records.
  - Inadequate / absent entries.
  - Unclear clinical care.
  - Illegible handwriting or abbreviations not approved.
  - Inability to identify signatures.

McManus v Medical Council
(EDC 310 August 2012)

Keeping of accurate medical records was a matter of such basic importance to the discharge of functions of any medical practitioner.....

However inconvenient and burdensome it may be to write up medical notes accurately, such records constitute a vital safeguard for both the medical practitioners and patients alike in any situation where it later becomes necessary to conduct any form of investigation as to what transpired during the course of the patient’s treatment.

Every practitioner must be taken as knowing that records may later be used in court proceedings or other investigations or inquiries and hence their importance is self-evident.

Eoin Dunne v CWI&H (EDC 58)

- All relevant records written retrospectively.
- Medical and nursing notes inconsistent with each other. In some cases replete with errors.
- Drug chart was contemporaneous.
- Parent’s account corroborated by findings in the drug chart.

Complaints to Regulator – Medical Council

- Error in recording: wrote ‘upper lip frenulum’ instead of ‘upper labial frenulum’.
- Booked for ‘tongue tie’.
- Inputted as ‘tongue tie release’.
- Unnecessary ‘tongue frenulotomy performed’.
- Correct procedure carried out later in the day.
- "Had anyone examined Dr’s notes, consent form, admissions card and a discussion with the child’s mother, any confusion would have been eliminated." J. Kearns.

Professional regulation

[Date: 15 November 2012]
Findings of Fitness to Practice

MEDICAL COUNCIL
Proven as to Fact
January 2013: failed to retain records...
April 2013: failed to record adequately or at all in ...
...medical notes, the details of the examination...
Poor professional performance
15 October 2014: unable to take proper medical notes and unable to order U&Es for child

Allegations
April 2013: failed to maintain adequate records
May 2013: failed to maintain adequate records in respect of Patient

Complaints to Regulator (NMBI)
Nurses and Midwives Act 2011
- Object of the Board is PROTECTION of the PUBLIC
- Manage complaints
- Grounds for complaints (b)...
  - b) Poor professional performance
  - c) Non-compliance with a code of professional conduct
- Complaints considered by PPC ...

Complaints to NMBI (cont’d)
1. NMBI Regulation Matters 5 November 2013
2. An Bord Altranais NEWS: Scope of Practice
   - Vol 20 No 2 (Summer 2008) pp5 GJ7 [improve the recording of clinical practice]
   - Vol 21 no 2 (Summer 2009) pp 28-3 (communication and documentation / MDR)
   - Vol 22 No 3 (Autumn 2010) pp4 [improving documentation]
3. Reporting Misconduct — Findings and
   Decisions (5 October 2013) (e) 5 November 2011

NMBI: FTP Findings and Decisions 2013 (contd)
June 2011: Staff Nurse MGP Censured
In respect of the care afforded to a patient in his care:
- Failed to administer insulin to the Patient, in a timely manner and/or at all.
- Failed to take and/or record the Patient’s blood glucose levels in circumstances where he knew or ought to have known that this was required and/or
- Failed to carry out and/or arrange any or any adequate patient assessment following his failure to administer the insulin referred to above;
- Failed to report adequately or at all his failure to administer the insulin referred to above;

NMBI: FTP
Wednesday, 3 December 2014 (with Times p9)
Nurse found guilty over drug dose
- Administered incorrect dose of adrenaline and nor-adrenaline
- Put the decimal point in the wrong place
  - child received 10 times recommended dose
- Altered the medical notes to hide mistake and did not inform colleagues

NMBI: FTP
Clinical Nurse Manager RMOM: Censured
November 2010:
- On one or more occasions, failed to monitor and/or supervise, adequately or at all, the nursing staff and/or care staff for whom she was responsible;
- On one or more occasions, failed to ensure that one or more of the staff members referred to above were discharging their duties adequately or at all;
**Implications for Practice**

- Prerequisite of delivering high quality, evidence-based healthcare, particularly where a number of different clinicians are contributing simultaneously to patient care.

- Everyone involved in a patient's clinical management should have access to the information they need, otherwise, duplication of work, delays and mistakes are inevitable.

**Good Record Keeping**

- Essential content: SOAP
  - Subjective
  - Objective
  - Assessment
  - Plan
- Problem list & Plan
- Presentation in records: COCOA
  - Clear
  - Objective
  - Contemporary
  - Original
  - Attributable

**Documentation Requirements**

- Must use:
  - date,
  - time,
  - name,
  - position & Medical Council Number (MCN) / NMBI PIN
- always v+ BrEep No
- Transparency

**Activity 1**

**Notes of Dr A**

202/07

20/2

Headache. Flu-like

Fever.

**Notes of Dr B**

202/07

Feverish headache. Complaining of flu like symptoms.

On examination: temperature normal. Heart rate 120bpm. No pharyxtis, provinces, equal, reactive to light. Fundoscopy normal, asec, no swelling, retinal.

Impression: Possible viral infection. No evidence of meningitis, mrsa or intracranial lesion. Reassured but to return if symptoms persist.

**Communicating with a Patient**

- inform
- discuss
- advise
Common problems in records

- Not recording:
  - negative findings
  - discussions about benefits/risks/alternatives (if any) of proposed treatments
  - Allergies or adverse reactions
  - Results of investigations and tests
- Illegible entries, No Medical Council Number
- Not reading the notes when seeing a patient
- Making derogatory comments
- Altering notes after the event
- Wrong patient / wrong notes

Abbreviations

**CAUTION!!**

- Should not be used (NPS 353.19)
- Avoided
- Only those approved should be used (NPS 313.73)
- Should only be used if drawn from a list approved (NPS 322.41)

Examples:

- P/D...
- CHO...

NB: If an unapproved abbreviation is used, it should be written on each side of each page where the abbreviation is used (NPS 3111.75)

Abbreviations .NEVER on

- Documentation re transfer, discharge, external referral letters
- Consent forms
- Death certificates
- Medication sheets (NPS 313.19)
- Medication sheet (NPS 313.179)
- Incident report forms
- Communications sent from healthcare organisation (NPS 313.18)

Corrections to HCRs

- Alterations / Deletions If Incorrect
  - Should be made as close to the original record as possible
  - Score/strike out original wording with a single line (NPS 2013.19) and bracketed (NPS 2013.12) - deleted word(s) to remain visible and legible
  - Correction fluids shall not be used (NPS 2013.9)
  - Follow with
    - a) signature (with name in CAPITALS) and counter signature, if appropriate
    - b) date and time of correct entry
    - c) reason for amendment

NB: Same principles apply for insertion of an addendum

Retrospective Entries

- Should be
  - Clear that the entry is a retrospective entry
  - Dated
  - Timed
  - Signed with a clear signature, PRINTED NAME, job title and bleep no, MCRN or NMBI PIN (and counter signed as appropriate)
  - Reason why the retrospective entry is being made should be clearly stated

(NPS Code of Practice for Healthcare Record Management 2013.75)

ISBAR communication / handover tool
The page contains a green box with text about remembering notes and records, and another box with a reference to a personal experience.

**Remember....**

No NOTES / RECORDS

No DEFENCE !!!

"If it's not written, it's not done!!"

---

**REFERENCES (1)**

- Department of Health (Ireland) (2015). National Patient Safety (NPSA) Audit: Report to the Minister for Health, Dr. James Reilly (Chair) Dr. Tony O’Connor, Chief Medical Officer, Dublin: Department of Health, Dublin.

---

**REFERENCES (2)**


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**Thank You!**

Claire O'Regan

Medico-legal helpline: 03-2384109

[www.juricija.ie](http://www.juricija.ie)
Appendix 10: Nursing Documentation Education Session Evaluation Form

**Nursing documentation education session**

**Evaluation form**

<table>
<thead>
<tr>
<th>Session Title:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitators:</td>
<td>Location:</td>
</tr>
</tbody>
</table>

**Section One: Please complete at the beginning of session**

<table>
<thead>
<tr>
<th>Please tick the relevant box as you feel appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous awareness of subject?</td>
</tr>
<tr>
<td>Previous Knowledge of subject?</td>
</tr>
<tr>
<td>Previous level of skill / competency?</td>
</tr>
</tbody>
</table>

**Section Two: Please complete at the end of session**

<table>
<thead>
<tr>
<th>Please tick the relevant box as you feel appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating</td>
</tr>
<tr>
<td>Content / Delivery</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Reason for rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content / Delivery</td>
<td></td>
</tr>
<tr>
<td>Practical relevance to current role</td>
<td>1</td>
</tr>
<tr>
<td>Subject matter</td>
<td>1</td>
</tr>
<tr>
<td>Mix of theory / practical</td>
<td>1</td>
</tr>
<tr>
<td>Context met identified objectives</td>
<td>1</td>
</tr>
<tr>
<td>Application / use in current role</td>
<td>1</td>
</tr>
<tr>
<td>Handouts</td>
<td>1</td>
</tr>
<tr>
<td>Overall pace of programme</td>
<td>1</td>
</tr>
</tbody>
</table>

| Facilitators |
| Level of preparation and confidence with material | 1 | 2 | 3 | 4 | 5 |
| Content presented at a level that was understandable and usable | 1 | 2 | 3 | 4 | 5 |
| Delivery style | 1 | 2 | 3 | 4 | 5 |
| Management of time | 1 | 2 | 3 | 4 | 5 |

**Please tick the relevant box as you feel appropriate**

<table>
<thead>
<tr>
<th>After the session:</th>
<th>None</th>
<th>Fair</th>
<th>Good</th>
<th>V. Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous awareness of subject?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous Knowledge of subject?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous level of skill / competency?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signed: ____________________________ (Optional)
Appendix 11: Nursing Documentation Education True or False Questionnaire

<table>
<thead>
<tr>
<th>No.</th>
<th>Questions</th>
<th>TRUE</th>
<th>FALSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q. 1</td>
<td>It is a requirement to clearly specify interventions for each need / problem.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 2</td>
<td>There is no agreed local policy / protocol or guidelines in relation to documenting ongoing patient care.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 3</td>
<td>Client’s short term but not long term goals and objectives are required to be documented in the medical record.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 4</td>
<td>Erroneous entries are required to be bracketed, with a single line through them.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 5</td>
<td>Erroneous entries are required to be initialled but not dated.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 6</td>
<td>It is necessary to conduct an assessment during a client’s interaction but the formulation of a plan is not required.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 7</td>
<td>Client’s feelings, concerns and thoughts are an objective entry in the medical record.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 8</td>
<td>Risk assessments and risk management plans should be devised when a client enters the service and should be reviewed the day a client is been discharged.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 9</td>
<td>Factual accounts of what a nurse observes / witnesses are an objective entry in the medical record.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 10</td>
<td>Information from pertinent others are subjective entries and should be documented in the clients record.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 11</td>
<td>The use of abbreviations within the medical record is forbidden.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 12</td>
<td>New staff members should be added to the record of staff signatures and initials within one month of commencing employment.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 13</td>
<td>The client’s name and record number must be clearly marked on both sides of the clinical record sheet.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 14</td>
<td>It is only necessary to document face to face interactions with clients in the medical record, documenting phone contact is not a requirement.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 15</td>
<td>Each client is required to have a written initial, nursing assessment of biopsychosocial needs in their medical record.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 16</td>
<td>It is only necessary to document considerations for discharge planning for clients who are within two weeks of discharge from the service.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 17</td>
<td>A synthesis and analysis of the subjective and objective portion of the notes are documented under assessment.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 18</td>
<td>It is not a necessity to time medical record entries but dating entries is important.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 19</td>
<td>It is not necessary to indicate evaluation dates on care plans but where they are indicated they should be evaluated on or before the date set.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Q. 20</td>
<td>It is important to document the clients / carers involvement in the formulation of a clients care.</td>
<td>T</td>
<td>F</td>
</tr>
</tbody>
</table>

Evaluator use: Pre:____ or Post:____education. Date:____________ Total Correct
## Appendix 12: Detailed by Category- Pre & Post Intervention Audit Results

<table>
<thead>
<tr>
<th>Q.</th>
<th>Compliance rate by categories</th>
<th>Pre-intervention (Sept. 2014)</th>
<th>Post-intervention (March 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Client Assessment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Each patient has an up to date written record of patient care</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>2</td>
<td>Each patient has a documented record of ongoing patient care as per local policy/protocol/guidelines</td>
<td>15</td>
<td>24</td>
</tr>
<tr>
<td>3</td>
<td>Is there evidence of a systematic approach to nursing care</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>4</td>
<td>Each patient has a written initial nursing assessment of physical, psychological and social needs</td>
<td>19</td>
<td>30</td>
</tr>
<tr>
<td>5</td>
<td>An agreed framework/assessment tool is used in the assessment process</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>6</td>
<td>The patient/client interviewed as part of the assessment process</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>7</td>
<td>The assessment is updated as new problems/needs occur or as the patients/clients situation changes</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>8</td>
<td>The assessment refers to information obtained from other professionals or agencies</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td>9</td>
<td>The assessment includes specific considerations for discharge planning</td>
<td>4</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td><strong>Category compliance rate</strong></td>
<td><strong>37%</strong></td>
<td><strong>91%</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Individual Care and Treatment Plan (ICTP)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>A nursing plan of care is identified</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>11</td>
<td>The nursing care plan is part of/compliments the individual care and treatment plan</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>12</td>
<td>Each patient record contains evidence in relation to the planning and provision of nursing care based on ongoing assessment</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>13</td>
<td>Goals/objectives are specified for each identified need/problem</td>
<td>14</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>The goal/objective will be written, wherever possible from the clients perspective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------------</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td></td>
<td>Both short and long term goals/objectives identified for each problem</td>
<td>14</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Interventions are clearly specified for each need/problem</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>The interventions are discontinued once the need/problem is resolved</td>
<td>4</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Evaluation dates are indicated clearly on the care plan</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Nursing care plans are evaluated/ on/ before the date set</td>
<td>3</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>The patient/client was involved in the evaluation process</td>
<td>3</td>
<td>21</td>
</tr>
</tbody>
</table>

**Category compliance rate**

25% 93%

### Client Involvement in Care & Discharge

<table>
<thead>
<tr>
<th></th>
<th>Is there documentary evidence of 1:1 patient engagement</th>
<th>12</th>
<th>29</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>On discharge all patient documentation is stored as per local policy</td>
<td>21</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>The key worker/ named nurse is readily identifiable from the nursing documentation</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>There is documentary evidence of an allocated key worker/ named nurse</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>There is documentary evidence that the patient/client has been advised of the identity of their key worker/named nurse</td>
<td>2</td>
<td>30</td>
</tr>
</tbody>
</table>

**Category compliance rate** 29% 97%

### Legibility of Documentation

<table>
<thead>
<tr>
<th></th>
<th>All nursing documentation is legible</th>
<th>12</th>
<th>29</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All nursing documentation is contemporaneous and in chronological order</td>
<td>21</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Late entries are clearly identified</td>
<td>24</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>All entries in the nursing documentation are made in black ink</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Score</td>
<td>Total</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>30</td>
<td>All statements in the nursing documentation are objective</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>31</td>
<td>Nursing documentation does not contain unambiguous statements, or jargon, witticisms or derogatory comments</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>32</td>
<td>All entries are timed using a 24hour clock</td>
<td>16</td>
<td>30</td>
</tr>
<tr>
<td>33</td>
<td>All nursing entries/documentation are dated</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>34</td>
<td>All entries/documentation are signed using a full signature</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>35</td>
<td>The grade of the person making the entry is documented</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td>36</td>
<td>A record of staff signatures and initials is maintained</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>37</td>
<td>Are new staff added to the index of signatures within one week of employment</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>38</td>
<td>Entries made by student/candidate nurses are countersigned by a registered nurse</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>39</td>
<td>The use of abbreviations is kept to a minimum</td>
<td>16</td>
<td>27</td>
</tr>
<tr>
<td>40</td>
<td>Only approved abbreviations are used in the nursing documentation</td>
<td>12</td>
<td>26</td>
</tr>
<tr>
<td>41</td>
<td>Current patient records are kept in a secure environment</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>42</td>
<td>The patients name and record number is clearly marked on each page of the patients record</td>
<td>10</td>
<td>27</td>
</tr>
<tr>
<td>43</td>
<td>Erroneous entries are bracketed, with a single line through them</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>44</td>
<td>Erroneous entries are initialled</td>
<td>0</td>
<td>28</td>
</tr>
<tr>
<td>45</td>
<td>Erroneous entries are dated</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td><strong>Category compliance rate</strong></td>
<td>48%</td>
<td>96%</td>
</tr>
<tr>
<td></td>
<td><strong>Overall compliance rate with NMBI standards</strong></td>
<td>Pre intervention</td>
<td>Post intervention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>38%</td>
<td>94%</td>
</tr>
</tbody>
</table>


Appendix 13: Project Dissertation Poster

"Implementing an Education Programme and SOAP Notes Framework to Improve Nursing Documentation"

13119960
MSc in Healthcare Management

Introduction & Background
The author was involved in a System Analysis review following three serious adverse events within a Dublin Mental Health service. The review findings highlighted the occurrence of a failure on behalf of the nursing profession to communicate essential information to the greater multidisciplinary team and the absence of a standardised approach to nursing documentation.

Aims & Objectives
Introduce monthly education programme for nurses to increase adherence to NMBl documentation standards, incorporating the SOAP Notes Framework to improve the quality of communication with the multidisciplinary team. Thus, reduce the possibility of adverse outcomes as a result of inadequate documentation.

Methodology
The HSE Change Model detailed a step by step approach to planning, managing and implementing the change. Environmental analysis through the use of PESTEL, SWOT, force field and a stakeholders analysis was undertaken.

Figure 1: HSE Change Model

A 45 question audit tool was used on a randomly selected sample of clinical records pre and post education sessions to assess compliance with NMBl standards and guidelines on documentation.

Methodology cont.
Figure 2: Documentation Education

Six unique education sessions were conducted over a six-month period. Stakeholder engagement and feedback influenced the design and content of the sessions. Incorporated was a presentation by The State Claims Agency, who presented for the first time to the Mental Health arena and assisted in building commitment and understanding for the necessity for the change initiative.

Evaluation Cont.
The overall project evaluation was achieved through a pre and post intervention audit. Significant advancement was noted (38% v 94%) in adherence to NMBl documentation standards on completion of the project. This represented an overall 56% improvement. The Bar chart below illustrates the results pre and post intervention.

Figure 3: Audit results March 2016

Organisational Impact
A system of improvement in nursing documentation now exists. Opportunities for the replication of the initiative throughout the greater Mental Health Service now present.

Conclusion
The initiative supports good systems of clinical governance in order to assist in the prevention of similar adverse events and hence ensure positive experiences and outcomes for future service users.

References
1. HSE (2008). Improving our services: a user’s guide to managing change in the Health Service Executive. Dublin: HSE.