A systematic approach to the improvement of patient care

This article highlights the successes and continuing frustrations of work to improve patient care on a ward. Key factors contributing to success included a systematic approach to practice development, ward leadership, attention to organisation of patient care and the valuing of core nursing skills.

In 2000, following concerns about standards of care in a directorate of general surgery, one of the first consultant nurse posts in England was created. The remit of the post was to:

- Achieve a culture of patient-centred care;
- Promote multidisciplinary working.

On taking up the post the consultant nurse adopted a systematic approach to practice development (McCormack et al, 1999) with the aim of facilitating patient-centred care. Utilising the multi-angle review of practice (MARp) review tool (Field and Reid, 2002), baseline data was collected.

Development of practice

The overall strategy was deliberately entitled ‘a strategy for the development of practice’ rather than ‘a practice development strategy’. The latter is the commonly used term but there is a danger that it is assumed to be owned by ‘practice developers’ and that it merely consists of professional development (McCormack et al, 1999) with the aim of facilitating patient-centred care. Utilising the multi-angle review of practice (MARp) review tool (Field and Reid, 2002), baseline data was collected.

While professional development of staff is one component of developing practice, it alone does not guarantee practice development. As Binnie and Titchen (1999) found in their study, hearts as well as heads require educating and the former has to occur at an experiential level in order for meaningful and lasting change to occur.

This education of ‘hearts’ relies on concepts of work-based learning, which is facilitated by skilled practitioners in practice.

While Binnie and Titchen’s work relied on the key role of one ward sister as a case study, sole reliance on one ‘hero innovator’ is a potentially flawed approach and one that Binnie and Titchen would not advocate across a directorate.

Therefore responsibility for the development of practice must be owned by a critical mass of individuals and exercised in such a way as to enhance the capacity of others to also adopt this responsibility. This reflects the concepts of a transformational culture as outlined by Manley (2000).

Binnie and Titchen (1999) clearly articulated key elements that were both antecedents and parallel to work in practice and these elements were utilised as the basis for the development strategy in the directorate – the ‘practice development diamond’ (Fig 1).

Binnie and Titchen (1999) referred to the key elements as a series of parallel journeys. Moreover, they analouged the process of change to one of horticulture (sowing seeds, coping with the climate, nurturing seedlings and so on) to illustrate that it is not a linear process and needs to operate at several different levels at one time. Again this is congruent with the processes that Manley (1997) identified as essential to a transformational culture that produces effective patient-centred services.

Patient-centred nursing is a style of practice that demonstrates a respect for the patient as a person. Through ‘being with’ rather than merely ‘doing to’ the patient and offering personal support and practical expertise, the aim is to transform the individual’s experience of illness.

For such a philosophy to be more than rhetoric it needs to be shared, using real-life examples at every possible opportunity, rather than assuming that it is self-evident. By nurses examining what they do, hearing the impact their behaviour has for patients, and with the aid of coaching, they can begin to articulate the difference they make.

They also need to identify when the system becomes a barrier to best practice and to constructively challenge this and the reality of their colleagues’ practice.

The development strategy identified how, through coaching and feeling cared for within a professional work ethos (reliant on effective leadership, sound infrastructure and organisation of care), nurses could become more creative and involved in influencing and improving the care that patients receive. Furthermore, the strategy identified how practice and patients needed to be central to the focus of all work.

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REFERENCES


Cormack et al, 1999; Unsworth, 2000).
The following approaches were identified:
- Valuing essential care and being with patients;
- Strategies for learning from practice;
- Sharing stories that articulate patients’ perspectives and how nursing makes a difference;
- Supporting practitioners (clinical supervision);
- Challenging poor practice;
- Working with challenging patients;
- Linking individual actions to the bigger picture.

Initially these were addressed through developing the skills of F and G-grade nurses. Work is now under way in the trust, led by the consultant nurse, to use patients’ experience of care to develop nurses’ awareness of what it means to be a patient and how they can enhance this experience.

Achievements
The care observed and reported in the 2003 practice review supported patients’ privacy and dignity and addressed their needs when acutely ill or experiencing a high level of dependency on nurses for their personal care requirements.

It was noted that there was a strong ethos within the team that patients matter and there was a real intent to meet their needs.

Compared with the 2001 review, more attention was given to acutely ill patients. Education and the introduction of an early warning score (EWS) (Day, 2003) assisted in this process. Nurses reported that they felt more confident in carrying out the assessment process and in contacting a member of the medical staff.

From the 2003 review there is clear evidence that the use of the EWS system has improved the documentation of observations and from audit within the hospital that the use of EWS has prevented some patients from entering into a critical care environment.

From the observations of care in the 2003 review there is evidence that staff introduced themselves to the patients at the beginning of their shift and that the patients were also clear as to which nurse was caring for them. This is a distinct improvement from 2001 when the best analogy would be a ‘free for all’ in which roles and responsibilities were not clear to anyone.

This achievement has been assisted by the adoption of and attention to the role of shift coordinator. This role focuses on shift leadership (who does what and when) – one person having an overview of what is going on, contributing to individual nurses having a greater opportunity to become acquainted with and nurse their allocated patients.

The 2003 review highlighted the need to extend this role to all shifts, particularly the late shift and to encompass a care review element (coordinator talking with the relevant nurse and patient with reference to their care plan) through which the quality of care provided is considered. While this could be perceived as ‘checking up on’ with attention to sampling and the supportive coaching of staff, such an approach can be perceived as a supported learning opportunity (Dewing and Reid, 2003; Titchen, 2001).

With rare exceptions, the 2003 review identified that staff appeared to have an improved understanding of the patients they were caring for and what was expected of them in terms of that care. A patient-centred approach is also becoming more predominant. The achievements already identified have contributed to this but it has also been assisted by the implementation of patient-centred drug administration (PCDA) (Reid et al, 2002).

The introduction of bedside medicine lockers gives nurses the opportunity to sit and discuss their patients’ medication with them as an integral part of their care. In contrast to the 2001 review, where ‘medicine rounds’ were undertaken by one registered nurse using a medicine trolley, practice in 2003 was observed to fulﬁl the system and spirit of PCDA and was commended by patients and nurses.

In an attempt to address workload issues the role of a staff nurse whose main focus of practice was undertaking wound dressings was created. Through audit in 2002 it was found that the average dressing took about an hour during which time the staff nurse would be unavailable to the other patients allocated to her or him. Although the role could be perceived as task-focused it had the following benefits:
- It released the other nurses to care for their other patients;
- It was undertaken with a facilitative approach to enable the other staff nurses to learn with and from practice and a skilled nurse;
- It improved patient outcomes and reduced the length of hospitalisation for those patients.

Feedback from staff on this role was very positive and this was echoed by comments from patients and consultant surgeons.

In addition to the significant shifts in organisation the 2003 review highlighted a real transformation in the environment of care.
Changes included:

- An absence of clutter;
- An improvement in tidiness;
- A sense of calm most of the time (despite a great deal of activity);
- Attention to detail, such as fresh flowers on the reception desk.

**Ongoing issues**

Although the 2003 review reflected positive improvements in relation to verbal communication (handover) there was evidence that, at times, it was repetitive, passive and did not create opportunities to promote the nurses’ understanding.

The ward team had expanded their repertoire to include a ‘bedside’ handover between the early and late shift. While some nurses were seen to demonstrate skill in involving patients and attempted to learn from them, others were more reticent. Considering that very little coaching in such skills had occurred this finding is perhaps unsurprising though is now being actively addressed utilising practical interactive strategies to assist learning (Reid, 2004).

Since the 2001 review the team had located care plans and evaluations by the patients’ bedsides to support a ‘writing as you go’ approach to encourage patients’ understanding and involvement in their care. However, with the exception of better reporting of acute episodes of a patient’s condition, the quality of the documentation still gave cause for concern. The documentation audit revealed that although aspects relating to critical illness had improved, the notes did not always give a clear picture of what had happened.

Within the directorate a practical workshop to assist nurses’ skills in documentation had been developed. Those participating in 2003 admitted that they had had little documentation-focused input in their nursing careers.

Rather than emphasising the legal issues nurses should consider that the workshop takes the approach of enabling nurses to review their attitude to documentation and the vicious circle most are in of not reading or valuing the written material available because it is of poor quality. The evidence from the 2003 review therefore prompted the following recommendations:

- All of the nursing team attend a workshop (only 10 per cent had done so at the time of the review);
- Core evidence-based care plans be devised to assist nurses in decision-making, prompting them to make appropriate care decisions and to decide which aspects it is important to document;
- Monthly use of the audit be undertaken by staff nurses to promote ownership and assess progress.

As with Binnie and Titchen (1999) an area that has required ongoing attention is the erroneous assumption that medical staff will understand nursing practice. Despite the groundwork involved prior to introducing the coordinator role, the 2003 review revealed that they still did not fully understand the concept.

Prior to this, doctors had been accustomed to approaching any nurse about any patient. From the 2001 review one of the concerns raised by medical staff was responses from nurses such as ‘I don’t know’ or ‘I’ve just come back from holiday’ and that nurses were trying to know a bit about everybody ‘just in case’.

This was one of the reasons for developing the coordinator role. Following the 2003 review the ward team have developed a multidisciplinary steering group (ward sisters and consultant surgeons) to promote mutual exchange of perspectives and informed decision-making.

**Practice implications**

The subsequent reduction in sickness levels and increased interest from others in joining the team is evidence of the impact that investing in leadership at several levels can have.

The team itself has experienced losses and gains. Although it has at times been concerned at the pace of change, it has remained receptive to it as represented by its adoption of new ways of working, such as introducing PCDA (Reid et al, 2002), a shift coordinator and wound care nurse. This investment in staff has achieved results, although these achievements have been despite there having been no increase in the nursing establishment.

While there has been an increase in the number of available nurses (through reduced sickness levels) and an improvement in their skills, there is clear evidence through the two dependency studies (Ball et al, 1984) and patient feedback that demand consistently exceeds capacity to respond. This has been addressed by a re-organisation of the ward, which has become two separate wards including 15 and 17 beds respectively.

In terms of practice development there have been some key lessons:

- Never underestimate the skill and attention required in order to ensure that the optimal skill mix is achieved for each shift through effective on/off duty management;
- If core skills of communication receive no investment, largely on the erroneous assumption that they are generic, intuitive and were effectively covered in preregistration education, before and after comparisons will reveal little improvement, such as quality of documentation.
- New initiatives require a substantial amount of preparation and energy but they also require subsequent vigilance and maintenance.