Cultures that Care

EDITION TWO. MARCH 2013

NSW Government Health
To find out more about the Essentials of Care Program visit the NSW Nursing and Midwifery Office website at http://www.health.nsw.gov.au/nursing/pages/default.aspx or click on Essentials of Care on the ARCHI website at http://www.archi.net.au/
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Welcome to the second edition of ‘Cultures that Care’. This publication highlights just some of the many positive outcomes achieved with the implementation of the Essentials of Care (EOC) program in wards and units across NSW.

The motivation and commitment demonstrated by clinical teams engaged in the program and what they have achieved is both heartening and impressive and I am delighted to be able to share their stories with you. The initiatives described illustrate how clinical teams have made improvements in areas such as patient safety, engaging patients in decisions about their care, the patient experience, team communication, efficient use of resources, staff health and improved all-round workplace satisfaction. Thank you to all the teams who have taken the time to share their achievements through this publication.

As Essentials of Care matures there are now many examples of where this nurse led work has evolved to include allied health, administration staff, support staff and medical officers. It is also pleasing to see that teams outside of acute hospital wards are also engaging in EOC including community health, mental health and Justice Health.

As you will see, Essentials of Care has featured in programs nominated for the NSW Health Awards and has contributed to whole of hospital initiatives that improve safety and quality and most importantly patient care.

The stories in this, the latest edition of the Cultures that Care, add to the body of evidence that EOC which is underpinned by Practice Development methodology, creates an opportunity for staff to review their practice, identify priorities and implement change leading to improved patient outcomes and staff morale.

We are currently working on gaining even greater patient, consumer and carer involvement to strengthen the program further. At each step of this work we must ensure that the perspectives of those that we care for are heard and that we maintain a patient centred focus. It goes without saying that improving workplace culture and creating better working environments is also a significant and very important focus of this work.

I take this opportunity to acknowledge the hard work of all those who are involved with implementing, supporting and developing the EOC program. It is a privilege to sponsor a program that has made such a wonderful contribution to the experience of our patients and staff and I look forward to seeing it grow from strength to strength.

I would like to leave you with a quote from an attendee at our last EOC Showcase in June 2012;

“If I was a nurse looking for work or starting my nursing career, I would want to work where EOC has been embraced and implemented. If I was a patient, I would want to be nursed in these wards”
The Essentials of Care program

The Essentials of Care program is a facilitated, systematic approach that utilises evidence to inform changes in practice to provide dignified, safe and compassionate care.

The program is facilitated by trained members of the care giving team who engage others in critical reflection, discussion and action around the evidence of care and the care environment.

The Essential of Care Program is underpinned by transformational Practice Development methodology and the principles of Collaboration, Inclusiveness, and Participation. When the teams engage in the program using these principles it brings about ownership, empowerment and integration of sustainable change. (Manley, McCormack and Wilson, 2008)

Below is a diagram representing the program.

The Essentials of Care program cycle
My vision as we move towards 2014 is that teams continue to be supported to implement the Essentials of Care program to promote cultures that provide dignified, safe and compassionate care.

Working in the health system can be very rewarding especially when we are able to work in a way that is consistent with our personal, professional and organisational values. The Essentials of Care program with its underpinning methodology helps us to move towards this realisation.

“Hearing the patient stories helped to remind me of my commitment towards my job and to enhance my values and beliefs as I relate to my patients” (Article 8 Patient stories as a tool for reflection to enhance person-centred care)

Essentials of Care can help us begin to shift from a culture that focuses on what is wrong and what we need to do to fix it, to a culture that celebrates what we do well and stimulates ideas to do things differently.

“The Essentials of Care process has enabled us to improve our workplace culture as demonstrated by the enthusiasm and keenness of staff to be engaged in patient care improvement initiatives. The staff see the value in the changes we are making and are motivated to continue to improve our service.” (Article 39 All aboard the EOC bus)

Teams throughout New South Wales are undertaking initiatives arising from the evidence they have collected, collated and critically reflected upon. This publication captures some of these and demonstrates that team members are passionate and proactive in creating and evaluating positive changes for patients and themselves. Through these stories in this publication you can feel this passion in how engaged the teams are in providing high quality essentials of care.

“One of the greatest changes that has occurred which is difficult to measure using empirical data, is the involvement of staff in discussion, decision making and teambuilding … continued good morale among staff and the desire to continue to make improvements has increased the potential to sustain change.” (Article 6 Sustainable refinement)

The Nursing and Midwifery Office NSW is committed to continue to support the Essentials of Care program. I believe that the best utilisation of our current resources in the first six months of 2013 will be to support the teams that are currently engaged in implementing the Essentials of Care program and to those who have committed to re-engage to measure, capture and share their achievements.

I am looking forward to being involved in both local and state wide celebrations in 2013 and I would like to take this opportunity to invite you to our Essentials of Care State Wide Showcase on 3rd of May 2013 at the Australian Technology Park, Sydney where teams from across the state will be presenting their achievements.


References:
Introduction:
Workplace culture and care environments have been shown to impact on patient experiences, staff engagement and satisfaction, evidence use, and productivity (Manley, Sanders, Cardiff & Webster, 2011 a). The Essentials of Care (EOC) program, which is underpinned by the methodology and principles of Practice Development (PD), aims to engage individuals and teams in critical inquiry and action to create more effective workplace cultures and person-centred care. Many practitioners express difficulty with demonstrating and articulating the impact of this work on the people they care for, the teams they work with, and the health care organisations. The EOC Program, which incorporates strategies to support evaluation of action plans as they are implemented around nine care domains, as well as an end of cycle evaluation phase, is interested in the description of processes that enable transformation of individuals, teams and practices for the purpose of gaining insight into what works, for whom it works and in what circumstances it works. In the current health setting, there is an increasing focus on outcomes and the desire to link work to strategic plans and Key Performance Indicators (KPIs). There is also an increasing dialogue about person-centred care and creating the cultures necessary to support its application. The publication of the ‘Cultures that Care’ journal provides an opportunity for NSW Health staff implementing the Essentials of Care Program to share their achievements as well as their experience of the value of the program. On critical analysis of these accounts, the authors have identified many significant cultural and patient-centred outcomes. Novice practice developers, unfamiliar with the process of, and the need for, sharing evaluative data and outcomes, may overlook the rich evidence contained in the stories and the importance of articulating these to both managers and policy makers. The purpose of this paper is to highlight some of these outcomes.

Background:
The recent publication of the National Safety and Quality Health Service Standards (NS&QSHS) (Australian Commissions on Safety and Quality in Health Care 2012) henceforth referred to as the National Standards, provides opportunity for practice developers, and the healthcare workforce in general, to identify and to report on achievements in the areas of health and safety risk, and also to report on approaches that enable the clinical workforce to engage in initiatives whose aim is to improve specific areas of care and clinical practice. Two published frameworks—Effective Workplace Culture (EWC) framework (Manley et al 2011 a) and the Person-Centred Care Framework (PCCF) (McCormack & McCance 2010)—are recognised by the PD community as significant in helping to describe the influences and impact of an effective workplace culture on patient care and person-centred outcomes, as well as on the level of staff engagement and satisfaction (Walsh et al 2012). The EOC program deliberately focuses on approaches that critically and authentically engage all stakeholders in the understanding of their practice, and their workplace environment and to take timely action towards appropriate improvement. In this paper, links are made between the literature, the National Standards, and the outcomes described in the articles in this publication.

There is an increasing body of evidence that can demonstrate the impact of PD on patient safety, satisfaction, effective health care outcomes, and
the effective utilisation of resources (Manley, Crisp & Moss 2011b). A number of pre-requisites and antecedents have been identified as necessary to bring about the outcomes desired by health services (McCormack et al 2010, Manley et al 2011a) that aspire to a workforce that is committed, focused on safety and quality, takes responsibility, works as a team, and is constantly learning and informing its practice through the development and acquisition of new knowledge—in essence, an effective workforce. These attributes have long been valued as contributing to the provision of high quality care, and yet their expression, and how to sustain them, are difficult to both achieve and to measure. Wheatley argues that these attributes “emerge as people feel connected to their work and to each other” and that, ultimately, they make a personal choice as to whether or not to contribute (Wheatley 1999). In reality, most improvement initiatives tend to consist of short term projects that focus on just one aspect of practice and fail to recognise and respond to the need to effect changes to the workplace culture and pre-requisites for person-centred care described in the PD literature (Dewing 2009).

Supporting an effective culture at the patient care interface, that is, the creation of an effective care environment, is a critical role for clinical leaders and managers in today’s healthcare setting (Manley et al 2011 a), a role which the National Standards (ACSQHC 2012) also recognise as being fundamental in the achievement of high standards of healthcare outcomes. This approach can mean the difference between simply achieving short-term, specified outcomes, and the greater outcomes achievable by a sustainable and effective person-centred workforce. This is because, when clinical staff gain some control over the operation of their workplace environment, they are more likely to acknowledge and accept the need for change and for the implementation of those changes (Walsh, Kitson, Cross, Thoms, Thornton, Moss, Campbell & Graham 2012). It differs from the traditional, impersonal way in which change is imposed on clinicians and their workplace practices (Wilson 2005). Choosing PD as the approach to this work aims to bring about long-lasting transformation within individuals, teams and their practices (Wilson 2005, Dewing 2008, McCormack 2010, and Manley et al 2011 a).

There is an urgency to communicate the potential and actual outcomes of these workplace changes to consumers as well as to stakeholders—who influence strategic decision-making—so as to secure their ongoing support and funding (Grant 2009 and Garbett & McCormack 2002 in Manley et al 2011 b). Anecdotes, reflection and storytelling have enabled teams involved in the EOC program implementation to celebrate and share their many and various achievements, such as individual clarity and engagement, team building and effectiveness, changes in workplace cultures and patient care environments, and person-centred outcomes for both staff and consumers.

Methodology:

The EOC Program Development Team mapped the EWC across to the PCCF to create a matrix for documenting PD outcomes within the EOC program. To this was added the outcomes desired by stakeholders identified at a state-wide planning workshop (October 2012), (See table 2, column 1). During a critique of the articles for this publication, it became apparent that many comprehensively describe outcomes that align with both the matrix created by the development team and with the National Standards. At the same time, a visiting practice developer from the UK, Professor Brendan McCormack, acknowledged the extent to which the submitted papers demonstrate outcomes that align with the application of a person-centred care framework (Pers. Comm. 22 Oct 2012).

Results:

All 41 papers reviewed for this ‘cultures that care’ publication contained evidence of outcomes relating to all aspects of the EWC and PCC Frameworks as well as to the National Standards. There is a wealth of evidence supporting the assertion that the use of person-centred approaches, that engage all stakeholders to collaborate, participate, and to be included in healthcare improvement initiatives, enable the achievement of outcomes of interest to a multitude of stakeholders in both meaningful and sustainable ways.

Some examples of improvements already achieved by teams implementing Essentials of Care are:
- Time and cost savings (medication rounds),
- A reduction in incidents (medications, infection),
- The use of evidence in the planning and delivery of care (access, referrals, safety, nutrition), and
- The implementation of directives from NSW Health and other bodies (clinical bedside handover).
- Consumer involvement in care planning
- Team collaboration and involvement in quality initiatives
- Health Care Associated Infection prevention initiatives

These examples demonstrate the achievement of measurable outcomes in clinical practice areas as described in National Standards NS3—NS10, and more specifically, how these were achieved using the EOC program’s facilitated approach which aligns with National Standards NS1 and NS2. The EOC Program has nine care domains that help terms describe the many aspects of caring, which incorporate all of the National Standards, and more. Table 1 lists the EOC Domains of Care and the National Standards.

<table>
<thead>
<tr>
<th>TABLE 1: THE EOC DOMAINS OF CARE AND THE NATIONAL STANDARDS NS1 - NS10</th>
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<tbody>
<tr>
<td><strong>EOC DOMAINS OF CARE</strong></td>
</tr>
<tr>
<td>Personal Care</td>
</tr>
<tr>
<td>Documentation &amp; Communication</td>
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<tr>
<td>Promoting Self Care</td>
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<tr>
<td>Medications &amp; Intravenous Products</td>
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<td>Preventing Risk &amp; Promoting Safety</td>
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<td>Clinical Monitoring &amp; Management</td>
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<td>Clinical Interventions</td>
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<td>Privacy &amp; Dignity</td>
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<td>Learning &amp; Development</td>
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Teams are supported to take actions to improve practice in the care domains as required and relevant in their setting using a facilitated approach and PD principles. In addition to these practice areas, teams often identify opportunities for improving how they organise care and work as a team, aspects that tend to impact on a team’s ability to provide the standard of care they espouse to and that reflects their shared values. Enabling the clinical team members to take ownership of the required changes is the start of the culture change needed in the healthcare environment (Dewing 2009, Wheatley 1999, Walsh et al 2012, Manley et al, 2011).

Use of a PD approach is increasingly gaining the input and commitment from clinical staff at the patient-care interface who have confirmed that experiencing the EOC program has reconnected them to their values as well as to their initial reasons for entering the health care profession.

Table 2 on the following pages describes examples of where outcomes identify with the matrix, as well as articles following in this publication that readers may wish to explore (numbers in column 5 relate to this publication’s contents list). Column 1 lists components of the Effective Workplace Culture* and, in italics, stakeholder desired outcomes† identified at the state-wide planning workshop; column 2 lists components of the Person-Centred Care Framework‡; column 3 refers to the National Standards#; column 4 lists suggested indicators for EOC achievements≠; and column 5 gives examples of outcomes identified in the ‘Cultures that Care’ papers¥.
<table>
<thead>
<tr>
<th><strong>EWC</strong> AND STAKEHOLDER DESIRED OUTCOMES* (ITALICS)</th>
<th><strong>PCCF</strong></th>
<th><strong>NS&amp;QHSS</strong></th>
<th><strong>POSSIBLE EOC INDICATORS</strong></th>
<th><strong>EVIDENCE IN ‘CULTURES THAT CARE’ PAPERS</strong></th>
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<tbody>
<tr>
<td>Staff are empowered &amp; committed. Staff feel content and engaged.</td>
<td>Commitment to job. Engagement.</td>
<td>NS1</td>
<td>Staff satisfaction. Staff engaged in progression through EOC Phases Numbers of staff involved in improvement initiatives.</td>
<td>Go to articles 10, 15, 20, 26, 31, 35, 36, 41 Example from articles: 5 &quot;This day acted as a catalyst for other projects and initiatives as the staff felt encouraged and empowered to raise their suggestions and feel safe in actioning their ideas...&quot;</td>
</tr>
<tr>
<td>Standards, goals &amp; objectives are met in a person-centred way KPIs reflect a person centred culture for staff and patients</td>
<td>Holistic care. Creating a therapeutic culture. Feeling of wellbeing. Sympathetic presence.</td>
<td>NS1 – NS10 Example Article 21-NS4.13.1</td>
<td>Consumer satisfaction. Evidence of empathy and caring in observations of care and patient stories. Respectful communication evident in observations of care and patient stories.</td>
<td>Go to articles 8, 15, 21, 27, 31, 34, 35, 38, 41 Example from articles: 8 “patient goal setting and discharge planning has improved as evidenced by patients’ handover survey and observations...”</td>
</tr>
<tr>
<td>Shared values are realised in practice</td>
<td>Clarifying values &amp; beliefs Working with patients’ beliefs &amp; values.</td>
<td>NS1 and NS2</td>
<td>Consumer satisfaction and feedback. Compliments and complaints Staff satisfaction &amp; retention Values clarification</td>
<td>Go to articles 4, 7, 10, 15, 20, 21, 24, 26, 28, 31, 36, 41 Example from articles: 24 “The assessment phase highlighted that ...recreational activities conversation and developing a strong rapport with nursing staff were important to patients...a weekend activity program was developed and implemented...”</td>
</tr>
<tr>
<td>Knowledge/ evidence is developed, used and shared Make public the achievements pertaining to improvements and care effectiveness</td>
<td>Professionally competent.</td>
<td>NS1 - NS10 Example Article 5 – NS: 3.5.3</td>
<td>Evidence influenced standards &amp; policies. Engaging in learning and development. Peer review, journal clubs. Policy &amp; Procedure manuals used. Use of data from various sources. Incident data acted upon.</td>
<td>Go to articles 5, 8, 11, 16, 15, 20, 27, 35, 38, 39 Example from articles: 39. &quot;We have several working parties addressing 16 of the 25 actions, 3 of these are now research projects.</td>
</tr>
<tr>
<td>High support and high challenge Health care workers, at all levels, effectively articulate the key issues for patients.</td>
<td>Knowing self. Interpersonal skills. Effective staff relationships.</td>
<td>NS1</td>
<td>Engage in regular active learning. Observation of high support and high challenge in staff interactions and practice. Facilitation activities observed.</td>
<td>Go to articles 8, 10, 14, 15, 20, 26, 27, 31, 34, 35, 37, 40, 42 Example from articles: 40 “I witnessed staff thinking outside the box, asking the right questions...”</td>
</tr>
<tr>
<td>Transformational Leadership</td>
<td>Role clarity. Power sharing. Potential for innovation and risk-taking. Shared decision-making.</td>
<td>NS1 and NS2</td>
<td>Vision shared &amp; actively pursued. Role clarity within EOC teams. Effective two-way communication. Evidence of facilitative approach. Feedback. Performance appraisal and planning. Learning &amp; Development opportunities.</td>
<td>Go to articles 12, 14, 20, 27, 35, 39, 42 Example from articles: 39 “Groups supported by internal facilitators, CNC, CNE and NUM and are... supported to develop individual practice development skills and knowledge to enhance their ability to lead change and engage others in shared decision making...”</td>
</tr>
<tr>
<td>Stakeholders involvement, collaboration, participation</td>
<td>Involvement with care. Satisfaction with care. Shared decision-making.</td>
<td>NS1 and NS2</td>
<td>Consumer satisfaction. Patient stories. Multi-disciplinary involvement Engagement with support services (Quality, Clinical Governance, Researchers, and Executive). Effective &amp; efficient work routines, processes, resource use</td>
<td>Go to articles 4, 8, 14, 16, 20, 21, 27, 34, 36, 41, 42 Example from articles: 21 “key to the success of EOC was recognising CSNSW as a major stakeholder and collaborating with CSNSW... meetings took place to explain the program and how we hope to involve the CSNSW. Support and permission to conduct workplace observations collect officer stories and involve officers in theming data and action planning was given...”</td>
</tr>
<tr>
<td>Teamwork</td>
<td>Developed interpersonal skills. Role clarity. Effective staff relationships. Shared decision-making.</td>
<td>NS1</td>
<td>Staff satisfaction. Team effectiveness. Collaborative approach to care delivery and improvement initiatives.</td>
<td>Go to articles 7, 10, 15, 20, 21, 27, 42 Example from articles: 21 “clinical staff, administration staff and CSNSW staff contributed to the collection and organizing of data for all to review. This collaborative effort enabled identification of themes from different perspectives, creating opportunities to review how we worked from a unique viewpoint, not experienced previously...”</td>
</tr>
<tr>
<td>Systems for continuous evaluation</td>
<td>Supportive organisational systems.</td>
<td>NS1</td>
<td>Action plans have built in evaluation strategy. Initial assessment and 2 year evaluation reports are completed. Workplace culture mapping.</td>
<td>Go to articles 11, 12, 15, 16, 20, 25, 37 Example from articles: 16 “…consumer snack surveys were given to both consumers and staff... (providing) evidence that changes need to be made to the quality of snack foods... which is currently being implemented...”</td>
</tr>
<tr>
<td>HR Management support</td>
<td>Appropriate skill mix. The physical environment. Creating a therapeutic culture.</td>
<td>NS1</td>
<td>Staff satisfaction. Engagement in L&amp;D activities. Sharing achievements from EOC Workplace data(e.g. leave, vacancies, skill mix, retention) is utilised</td>
<td>Go to articles 12, 14, 15, 31, 40, 44 Example from articles: 44 “over time the role of the coordinators and program development team became clearer to me and the role modelling facilitation style and shared learning opportunities were pivotal for my personal development. My eyes opened to the possibility of reinventing the way I worked with and engaged people.”</td>
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</table>
Conclusion and Recommendations:

This paper asserts that, in this scenario, narratives are a meaningful and effective way to describe outcomes that reflect person-centred outcomes and effective workplace culture change consequences. Furthermore, it affirms that the EOC program leads the way in contributing to the health services achievement of the National Standards, and that it is, therefore, a valuable program for teams to engage in. To increase the effectiveness of the use of narratives as a way to describe achievements, there needs to be an established, systematic methodology for describing the links between a process, its outcomes, the associated evidence, and the various impacts of that process—in effect, a more precise description of what’s working, for whom it’s working, and in what circumstances it’s working (Rycroft-Malone 2004).

The following recommendations are proposed:

1. Teams align their EOC processes and outcomes with local strategic plans and the National Standards as well as with the Effective Workplace Culture and Person-centred Care Frameworks.

2. The implementation of EOC and other similar PD programs is promoted as a viable and effective way to achieve outcomes that are of interest to healthcare services, staff, and consumers.

3. Development of effective ways to report outcomes that achieve and exceed the National Standards.

4. Increase health professionals’ access to, understanding, and use of routinely collected data in ways that align with the principles of PD and that enable teams to strengthen the evidence of person-centred care and effective workplace cultures.

5. Development of consistent ways to measure and compare healthcare workplace satisfaction.

References:


**Introduction:**
Geraghty Ward is an inpatient rehabilitation unit in Hornsby hospital. We were one of the pilot wards to introduce the Essentials of Care (EOC) program in 2009. We have used the Practice Development principles to evaluate and improve the way we store, count, handle and administer medications in a manner that is safe, cost-effective, legal, efficient and in line with both hospital policy and NSW legislation. “Preventing risks and promoting safety” is one of the essential components of person-centred care within the EOC program. All ward staff participated in developing a more effective workplace culture that improves both patient and staff experiences.

**Our Values:**
We began by defining our team values which represent what we want our patients, families, carers and staff to see, feel and hear when they are in our ward. This was a facilitated process and included all the various disciplines who practiced within Geraghty Ward. We believe our values, shown below, reflects the team’s collaboration.

**Collecting evidence:**
A number of data collection methods (including observations of staff work practices, patient interviews, and IIMs reports) were used to assess and gain insight into both the culture and the current issues within Geraghty.

**Raising Awareness:**
The data collected was reviewed during our monthly EOC meetings where all staff, including the pharmacist, participated. These meetings provided a collaborative opportunity for discussion amongst all staff, with critical thinking and analysis of the information, in relation to our team values, leading to the creation of an action plan.

**Our Findings:**
The collected data identified that there were a number of interruptions occurring during medication rounds. Nurses were observed leaving a patient’s bedside to obtain medications that were expected to be on the medication trolley. There was consistent evidence that these interruptions accounted for an increased risk of medication errors as well as increased costs.
We explored this issue further by surveying the staff and conducting a time-and-motion study. The survey response was that 87% of the staff indicated that they had experienced the need to interrupt a medication round in order to restock the medication trolley. Graph 1 illustrates the number of times over a 3-month period that staff reported these interruptions.

Graph 1: How many times in the past 3 months have you had to leave your drug round to restock a medication?

Interruptions during medication rounds increase the risk of medication errors

Implementing a solution:
With support of our Nursing Unit Manager (NUM), the following changes were implemented:

- Two logbooks were designed and introduced for recording the number of medications available in the medication cupboard.
- The Wednesday & Sunday night shifts restock the medication trolleys.
- A communication white board is used to inform nursing staff when medications were low or out of stock.
- The medication cupboard is alphabetised to match the medication trolley in order to facilitate the timely restocking and recording of stock numbers.

Project Evaluation:
In 2010, an average of four (4) medication related incidents occurred over a 7 month period. In 2011, medication related incidents were reduced to an average of 1.7 over a similar 7 month period. Refer to graph 2.
The cost for Imprest and non-Imprest medications, summarised in table 1 below, totalled $36,335.78 (May ’10 - Oct ’10). The implemented changes reduced this cost to $32,278.02 (May ’11 - Oct ’11). This is a Unit operating cost saving of $4,057.76 over a six (6) month period.

Medication rounds were initially taking an average of one (1) hour to complete. With the implementation of the new procedures, medication rounds are now completed in an average of 30 minutes, as illustrated in graph 3 below, due to fully stocked medication trolleys.

**Process Evaluation:**

Using the EOC program’s collaborative, inclusive and participatory approach, our team, with the support of our NUM, now has the tools to continue to drive further change. We were able to overcome the initial challenges of implementing the EOC program through communication and the use of strategic planning. We are now applying our team values to our work practices and the principles of Practice Development are becoming embedded in our culture.

**Conclusion:**

The results of our project show that a correctly and fully stocked medication trolley has reduced medication round interruptions and errors, has improved staff time management, and has resulted in an overall reduction in the Rehabilitation Unit’s medication costs.
For paediatric patients, medication errors are the most common and preventable category of error. (Hughes and Edgerton, 2005) These errors are related to the correct prescription of the dose and to the administration processes (Dickinson et al., 2010). The literature is abundant with recommended strategies to improve the processes of medication administration to reduce the risk of error; however due to the complexity in decision making, the level of vigilance and responsibility required plus environmental factors, errors still occur.

As improved patient safety and outcomes underpins the Essentials of Care (EOC) program framework, it is not surprising that medication safety has often been identified by nurses throughout the State who are engaged in the EOC program. One ward at Sydney Children’s Hospitals Network (SCHN), Randwick, involved in the EOC program identified from their assessment of medication administration as being problematic. From the nurses shared learning they have created an action plan that has resulted in the implementation of a “7 Rights” procedure that added two additional steps to the existing “5 Rights” process. The two additional steps are the Right to Focus (not to be interrupted), and the Right to Information (for health care professionals, carers, and patients).

Reflecting on this work and the notion of improved patient safety, we came to believe that there was a need for three additional Rights, with the third right being the “Right to a Culture of Safety.” To further investigate this procedural framework to see if focusing on the additional Rights will make a difference to medication safety, we propose to engage staff from four other wards involved in the EOC program that had also identified the need to improve medication administration safety.

To enable us to do this work the Practice Development Unit, in 2012 applied for, and were successful in receiving a NSW Health Nursing and Midwifery Innovations Scholarship. The approach we have taken involves a Clinical Nurse Specialist facilitating the engagement of staff in each ward (which includes nurses, doctors, pharmacists, ward clerks, patient services assistants, parents/carers and children) to gather data (from audits, observations, focus groups, critical incidents, and interviews) in order to gain a better understanding of what really happens in their ward relating to medication administration.

Nurses will collate and interpret the data and then develop action plans with particular attention being paid to the implementation of the additional three Rights. An assessment of the changes brought about by the introduction of the three additional Rights will then be carried out to ascertain their validity.

The level of enthusiasm from nursing staff is really encouraging—with support coming from the leadership teams as well as from nurses volunteering to be an internal facilitator for their ward. The EOC program, together with the underpinning Practice Development approach, has provided a great platform for this work as the collaborative, inclusive and participatory process is understood and introduced into the wards. Following the
preparation phase of the work, the staff are now about to gather the data and we anticipate that next year we will have a greater understanding of the context of medication administration at SCHN, Randwick, and that a number of strategies will have been implemented that focus on the “8 Rights” of medication administration.

References:


Communication

Good communication is vital in providing appropriate care to patients and is pivotal to ensuring quality and safety, it is essential in every aspect of our working day. We communicate both verbally and non-verbally in diverse ways with patients and their families, medical teams, allied health, via phones, paging systems, patient notes, electronically, handover sheets, and during face to face interactions. However, given current time constraints, the potential for communication errors increases (Matic, Davidson, Salamonson, 2010). Yet, the most central juncture for information exchange occurs during nursing handover.

Checking Policy

The Clinical Handover Policy (MOH, 2009) advocates bedside handover as a triangle of introduction and information being passed between the patient, the nurse handing over care and the nurse assuming care of the patient. As a team however we acknowledge the importance of all staff visually assessing the patient care. Our rationale was based on Incident Information Management System reports which identified a number of incidents associated with communication e.g. staff who lacked information about a colleague’s patient or unrealistic responsibility for team leaders to be able to guide and oversee the delivery of care to all patients.

What Needs Improvement?

With the policy in mind, a gap in the afternoon handover process was identified where there was scope for improvement in order to meet the expected communication standards. The handover was convoluted and lacked organisation making it less effective. Information could easily be missed as there was no systematic structure (Pothier, Monteiro, Mooktiar, Shaw, 2005). Patient’s charts, checklists, ID bands, cannulas and equipment were not always checked together and this supported an atmosphere of separation for the nurse taking over care whilst reducing the responsibility for the nurse handing over care. There was a lack of patient involvement, with the patient having no opportunity to take part in the information exchange (Wildner & Ferri 2012). Essentially we had unwittingly excluded the patient from taking part and created an environment of “me” and “them” instead of “us”.

Observation

Surveillance was the second step in the implementation of the Essentials of Care program after the development of our core values. The observer was as a neutral bystander and viewed our practice from a different angle and with fresh eyes. Baseline information was collected during the handover process over several weeks which captured different staff each time.

Discussion

Collaborative meetings were held to facilitate reflection, questions and feedback. Verification took place between the observer and the ward staff through critical dialogue. This enabled staff members to clarify the information that had been jointly collected and make sense of it, agree on key issues to be investigated and to further develop an action plan and proactive strategies to address identified issues.

Ongoing review of the progress continued periodically through observation of the handover reporting process. Nursing staff members have identified a variety of internal and external obstacles that create shortfalls in the handover process that contribute to delays and interruptions. These include:

- Late starts of handover due to staggered start times for afternoon staff
Car parking difficulties causing the late arrival of afternoon shift staff
Morning shift nurses having short shifts
Casual and agency staff 6 hour shifts resulting in late starts and early finishes.
A lack of on the floor staff members causes other staff to pick up patient load.

Other contributing factors that affect the quality of information exchange:
- The breaching of patient confidentiality in an open area
- Unnecessary detailed and repetitive information.

Based on our value statement, the nursing staff recognised the advantages of a quality handover for the patient, the nurse and for the team as a whole. It became apparent that the core values played a significant role in the way staff members were able to take part in the re-evaluation process with each staff member acknowledging their contribution as valid and important. This was an empowering force in the process of practice development. It has created an energy that cultivates sustainability when individuals have an invested interest in the decision process.

Strategies for improvement:
- Ensure that all staff are aware of standardized approach to hand-over.
- Use a systematic approach to minimize confusion and omissions.
- Allocate sufficient time for staff members and the patient, to ask and to respond to questions.
- Limit the exchange to information that is necessary to providing safe care to the patient.
- Create an environment where interruptions are minimised
- Adapting to the variations of nursing skill mix and nursing hours shift to shift by adopting a team nursing approach.
- Foster a learning environment where staff members are permitted to question each other

The process is becoming more refined as it progresses. Allowing ourselves the time to see how things transpire has provided us with more information about how to improve. However, we have set goals and are working towards them.

Our priority is to ensure quality communication for care delivery. The effectiveness of this approach is clearly visible—our patients appear happier and are more reassured by our new method and the content of our handover.

One of the salient outcomes of this endeavour is the intricate involvement of the staff in critical discussions and the generation of a positive energy driven by the innate value of each individual. This has lead to sustainable change within the unit driven by the process of individual empowerment and continued team building.

References:
The Essentials of Care (EOC) program journey began in June 2011. The first stage of our journey was to define our team values. Over a series of four sessions, we explored and identified these values as themes based on the positive aspects of working in the ward as experienced, and agreed to, by all staff members. We identified eight shared values which we believed to be most significant for the group. The exploration process was facilitated by the Essentials of Care program Nurse Manager and two dedicated St Vincent's Hospital facilitators, Natalie Hay and Lucy Winyard.

The values chosen are:
- Teamwork,
- Holistic Care,
- Efficiency,
- Support,
- Communication,
- Expertise,
- Job Satisfaction, and
- Diversity.

The next step was to display the values for all to see. Lucy Winyard surprised everyone by creating a heart and lungs in the form of 3D cushions. The staff of Xavier 10 South were amazed and thrilled with Lucy’s creativity. It was unanimously agreed to use to display our values and space was made, with the agreement of our Nursing Unit Manager, on a display board in the corridor where they are visible to all.

The ward’s displayed values have become a talking point for both patients and visitors entering our ward. Discussing the displayed values has the effect of building rapport and acts as a distraction from stress. Staff sometimes notice visitors and patients looking quizzically at our values and we are always ready to give an anatomy lesson. It is great that our values serve an educational purpose and we also take the time to discuss the EOC project with patients at this time as well.

Our ward staff found the clarification of values invaluable as they have provided a mental and emotional reference for the Nursing team. As a result, our unit now works together more effectively as a team because we know what we stand for, what we are working towards, and what our boundaries are. If a team member steps outside the agreed values, we are able to gently point this out and to ask them, as a reminder, to please ‘note’ the agreed values list again. As a further consequence of creating and articulating our values, the team now uses a more person-centred approach towards both the patients and each other. This is shown during the handover process where staff listen to each other and do not speak when others are speaking as well as by offering assistance to others with a heavier workload at times when their own duties have been completed.

We are currently moving into the assessment phase of the Essentials of Care Program and are looking forward to what else this program can bring to the Unit.
At the Prince of Wales Hospital in Randwick, a key philosophy which underpins our nursing care is that of ‘embracing a culture that enables all persons to flourish’. The patient stories approach inherent within the EOC framework is one such research methodology that helps to support this culture of ‘flourishing’.

Patient stories allow for individual perspectives to be heard and then retold enabling reflection and action to occur. This retelling supports the identification of practice improvement initiatives that benefit individuals, units and the organisation as a whole. The use of patient stories to inform service review and quality improvement activities is now receiving more attention within contemporary healthcare literature. The richness of data within a patient story provides invaluable insight into the care we deliver, which is difficult to obtain from textbooks (Hawkins and Lindsay 2006).

As external facilitators supporting the implementation of the EOC program we are invited to record patient stories on an ongoing basis, a ‘task’ we consider a privilege, as we feel that our role contributes to practice transformation. When we listen to these stories we are letting the person know that what they are sharing really matters to us and to the organisation. We have come to appreciate that the patient feels valued knowing that their story may serve to improve, directly or indirectly, the quality of care delivered within the organisation.

As external facilitators for the implementation of the EOC program we continually reflect on our nursing vision and ask ourselves “how do we really know if our organisation is flourishing?” Patient stories are an invaluable source of information that helps us to grow and ensure that we are moving towards achieving a culture of flourishing through the application of a person-centred approach and ongoing practice improvement.

**Facilitating a story – what we have found helpful**

During the feedback process of retelling a patient story staff become active participants in this creative process. Stories appeal to us all regardless of one’s beliefs, values and life experience. They are a means for reflection on how or what we could change or improve upon in relation to patient-centred care, workplace practice and quality improvement.

Stories can contain the whole range of human emotions and events – life and death, hate and love, birth and loss and there are many different perspectives on just how to retell a story. (Fox Eades, 2011).

We have adapted the following model, which can support the facilitator when using patient stories for reflection from the work and ideas of Fox Eades (2011). It has five key components, as shown below. The centre shows the connection of heart and mind as we listen and reflect on the story.
We begin the story telling experience with silence and end in silence. This can help to create an atmosphere of anticipation, wonder and heightened engagement, allowing for individuals to ‘settle’ and await the story telling experience.

**Using Words and Pauses**

Starting the story off with a pause helps to set the scene and invites one into the ‘here and now’. Words need silence around them or they are meaningless. It is within the pauses in a story that enjoyment and anticipation builds up and the story itself sinks into our hearts and minds and making connections with what we have already experienced and learned.

**Emotional Engagement & Tuning into others**

As the story resonates with past experience and learning, shared beliefs and values then emotional connections can be made. You take a breath and tune in to your listeners, to the environment, to the mood of the group around you and to your own emotional state – and then you begin. As the story resonates with past experience and learning, shared beliefs, values, and emotional connections can be made.

**Listening**

As a facilitator you need to create the kind of atmosphere that supports the listening skills of the group. For example we can use props, such as, a scarf to transition us into the role of story-teller. At the beginning we also discuss with the group about what they should be actively listening out for in the story, such as elements of person-centred care. Some person-centred care cues are listed below. Listening also allows the storyteller to adjust the way in which the story is told to facilitate the listeners experience.

Person-centred care cues that we have used in the reflective process adapted from Nay & Garrett (2009)

- Acknowledging the individual as a person despite their disease.
- Providing unconditional positive regard for the person and experience.
- Interpreting all behaviours as significant and meaningful.

**Props and Story sheet**

Using simple props to assist in the telling of a patient’s story is a creative way to engage the listener’s sensory experience, and depict the patients’ perspective and experience in a more rich textured way. The props we choose can be very simple and often don’t bear direct resemblance to what they represent. To begin the story you may wish to use, for example, a hospital pillowcase laid out flat as a symbol denoting the platform or world where the story takes place. Items such as USB’s, stones, shells can then be placed on the pillowcase to represent characters and environment in the story (See photo).
Learning

Storytelling can be used as an effective means for self-reflection, helping practitioners develop increasing self-awareness about how their words, feelings, actions, and behaviours impact on their own and others’ practice and upon the care they provide to their patients.

When trying to achieve person-centred care we can place staff at the centre of care when we tell them the patients story. As a facilitator and storyteller we ‘set the stage’, creating the silence and the engagement with the story. We have found that when providing feedback to staff in relation to patient stories, it is a powerful means of emotionally engaging individuals, especially when it is retold in the first person. Patient stories allow for new insights to develop and for work practice changes to occur as staff can experience in a tangible way what it may be like to be a patient.

There is always an opportunity to find the good in a story and to celebrate what we do well. For some staff it may well be their only source of feedback for knowing that they are doing a good job.

Conclusion

We would like to leave you with a collection of quotes for your own reflection on the value of person-centred care and what it means to you. They were obtained from patients, facilitators and staff at the Prince of Wales Hospital.

“I’m so glad I can get to tell you what it’s been like for me as a patient even if it doesn’t help me, my experience might help the next patient who comes into this bed.”

“It gives you a personal insight from the patient’s perspective into how they feel and how they interpret the way care is provided. Hearing the patient’s story helps to give suggestions in relation to improving practice. Stories highlight what we do well and because it comes from the patient it is more meaningful. This information is coming from a patient rather than an audit result”.

“Hearing stories reminds staff that there is more to a patient than recording numbers and monitoring equipment; that, there is actually a person in there!”

“Enlightening, we need to have more sessions like these”.

“Colourful and enjoyable way to think creatively about my work environment.”

“The use of props replicating the patients’ experience and the placement of these in relation to the story was very moving.”

“The staff here are great, they are experts in their field and would bend over backwards to help me.”

“As an EOC facilitator it is a privilege to take a patients story because it gives the patient a voice and makes them feel that what they have to say really matters to us as staff. It really helps to enhances person centred care as it develops a partnership between the staff and patient.”

“Hearing the patient’s story helped to remind me of my commitment towards my job and to enhance my values and beliefs as I relate to my patients.”

Bibliography and References:


Acute Post-Acute Care (APAC) is a Primary health, multidisciplinary service providing short term, hospital in the home type services to appropriate patients requiring acute or post-acute care for specific diagnoses, including cellulitis, pneumonia, deep vein thrombosis and/or pulmonary embolism, exacerbation of chronic obstructive pulmonary disease (COPD), and renal/urinary tract infections. Our service operates across the Central Coast.

Care is generally delivered in the patient's place of residence including Residential Aged Care Facilities (RACFs). This environment must be safe for both the patient and the APAC clinicians. Treatment regimens are ordered and overseen by a Medical Officer and may be given by any member of the team including Registered Nurses, Physiotherapists, Occupational Therapists, Community Care Aides, Social Workers, and Pharmacists within their individual scope of practice.

APAC has had enormous growth and changes over the past five years. With this growth there have been mixed outcomes this has been due to both the nature of the group and the speed of change.

Through necessity, this team is comprised of senior, very experienced clinicians, most of whom are sufficiently confident to express their opinions and to speak their minds. I am telling you this because this has been one of our biggest challenges. The team members are highly knowledgeable and skilled and there is a sense of trust amongst the group. We are also a very tight knit team with an active social demeanour and fun attitude to our daily activities and when you walk into the APAC office, you will struggle to identify the nurses from the allied health personnel. However, everyone is an ‘expert’ and ideas can get stuck with everyone so busy sharing their opinion that decisions are difficult to agree on.

The EOC program was introduced in June 2011 with a view to using its transformational practice framework to address the need for shared decisions and satisfactory resolution of issues. Previously, we had done a lot of brainstorming exercises and engaged the voices of the clinicians at the bedside. However, much of the decision-making was done by the managers and could therefore be described as “top down.” Fortunately, the EOC program provided us with a forum to develop shared solutions, and to develop and activate local plans.

So the EOC journey began with small tentative steps, and a mixture of comments from the team members. For some it was about “that touchy feely stuff again” but for others it was an opportunity to explore their own values and the potential to develop an agreed set of team values. This activity began with a “tree” of values and individual reflections written on hand templates.

The tree remains in place today to constantly remind us of our values. Making our values visible has enabled us to celebrate our success as the comments from our patients and caregivers endorse the good and effective care that we provide.
The tree of values has provided us with a cornerstone of team identity. Who we are is often reflected upon in meetings and office gatherings when the energy is growing and the dynamics are divisive. This dialogue has enabled us to critically reflect upon the value and challenges of working within such a diverse team.

As a part of our first steps into the EOC program, we also invested a lot of energy in a staff satisfaction survey. This activity provided a challenge for the facilitators and provided us with a lot of learning opportunities. Some of the things we learnt were identified as—the need to keep the survey simple and short, to focus on the target group of questions, and the feedback process.

Unfortunately, these lessons were learnt during the process rather than before. For example, our survey was long and focused upon the nurses within the team. This perhaps reflected the fact that the team is numerically weighted in favour of nurses, and, as a result, the survey did not provide the information we imagined it would. Feeding back specific items was problematic as some of the answers were easily linked to the person or professional group providing them and this had the potential to divide the group and to cause discord rather than to be helpful in developing insight. The activity led to a lot of thought amongst the team, and its lack of success in terms of creating useful data and insight slowed our progress. In retrospect, there have been lessons learnt, and after a period of months we have begun our journey again.

To draw the team back together, and to draw a line under our experiences, we have recently come back together as a team to discuss how we can further develop and share our values. This has proved to be an enjoyable activity and has created lots of opportunities to share thoughts and creative moments. The discussion led to a wide range of art and craft items being created and it seemed that, despite our bumpy journey, creative and compassionate energy flowed. Some of it simply because the team members wanted to contribute, and some because they felt compelled to support the Facilitators who had worked so hard to keep the EOC program afloat and to see the values expressed as an integral part of the Mission Statement for the team and its service delivery.

**APAC staff members are known to go the extra mile to care and support their patients and colleagues.**

Our person-centred service strives to provide optimum care delivered in a holistic manner.

We value and use a multidisciplinary approach to Always create a Positive, supportive And Collaborative environment.

We engage in continuous quality improvement to assure patient safety and the best possible clinical outcomes.
APAC Service = A Lifebuoy

The service does a great job keeping people ‘afloat’ (at home, in the community) during health crises.

APAC doesn’t “rescue people’ but helps to keep them afloat by providing individual care & education.

A ring tin cake represents “holistic” care & a continuum of care.

Cake is well used in APAC to encourage staff (birthdays & celebrations) & promotes team building.

New cakes are made & people are encouraged in the workplace.

A healthy team has the energy to continue to hold the lifebuoy on a daily basis.

APAC client’s value being able to “stay afloat.”

Pam Reynolds SW/APAC

One very positive message throughout the process was that the team almost demanded that all have a say and be included. An effective form of shared communication was needed and the facilitators had to consider how this could be achieved, as individuals in the group did not come together frequently.

The questions posed to the team were: how to give equal opportunity to all team members, and what opportunities were there to share thoughts and have open dialogue when most of them were scattered over the whole area of the coast on a daily basis.

Ahh… modern media communication! We knew that emailing was not effective—clinicians frequently complained about not having time to check their emails—however, text messaging was already well utilised for reminding staff members when meetings and in-services were on, and so this became our most effective means of communication. That and ongoing dialogue in the offices when staff returned in the afternoons. We also used the conventional notice boards, notifications in meetings, and we continued using group emails.

There were times when the enthusiasm flowed into social events, which for some was confronting, so it was decided that the decision processes must not cross work/social boundaries. However, it is also important to note that this enthusiasm is also a reflection of the great growth of pride within our team.

All Mission Statement entries have found valuable homes across our service for all, including patients, carers, and other health care workers to enjoy and to reflect upon.

This truly has been a wonderful person-centred journey.
Miri Miri is a 15 bed Acute Mental Health Unit for people over 65. We are situated in the north of the Central Coast of NSW. Our patients have complex, often challenging co-morbidities. Our multidisciplinary team works closely with the community teams in older people’s mental health, local GPs and carers. Continuity of care is a challenge, and managing this complex aspect of care is the responsibility of the nurses working in the inpatient unit.

Leadership is provided by our NUM, Glenys, who is very ‘hands-on’ and is highly respected by all members of the staff. Our unit is much like other work places where the team has a wide variation of motivation levels when faced by change. The level of motivation amongst the team changes as challenges, enablement and barriers impact upon the individuals in the group at different times. At the start of the team’s involvement in EOC there was a small proportion of the group who were reluctant to engage. Our unit is much like other work places where the team has a wide variation of motivation levels when faced by change. The level of motivation amongst the team changes as challenges, enablement and barriers impact upon the individuals in the group at different times. At the start of the team’s involvement in EOC there was a small proportion of the group who were reluctant to engage. Our unit is much like other work places where the team has a wide variation of motivation levels when faced by change. The level of motivation amongst the team changes as challenges, enablement and barriers impact upon the individuals in the group at different times. At the start of the team’s involvement in EOC there was a small proportion of the group who were reluctant to engage.

As an EOC facilitator, I learnt to concentrate my energy on the 70%. This was done with focus groups where we informally discussed our personal values, the best way to further implement the EOC program, and how to include the wider group in discussions. To explore values amongst the wider group, a noticeboard in the staff activity room was allocated to display EOC program information and for staff to provide individual feedback. To keep this process anonymous for those less likely to respond in a public forum, ‘post-it’ notes were made available which, once completed, were grouped in themes.

Working with clients on our values tree.
more likely to embrace the process if the facilitators were representative of the ward team. The results have been very positive and one of the dissenters has pledged support simply out of respect for the new facilitator.

A decision was made to include Allied Health members as part of the facilitation team as this reflects the multidisciplinary formula within the clinical team. This has been a positive experience as we now have a breadth of understanding about how we might work collaboratively and improve patient care. As a result of shared learning we now work more effectively as a collaborative team and this has a positive impact upon the care we are able to provide.

A change to the local health district EOC program co-ordinator has added to our ability to progress as we have been able to connect with established support within the EOC program.

Her experience has helped teams clarify their issues and has provided me with ongoing motivation. I feel the CNE/facilitator role is the driver of the process, and, in setting up the steps in the process for the staff, it is essential. It was very refreshing to receive a great deal of individual encouragement as implementation of the EOC program was losing its focus due mainly to the demands of my work and a lack of knowledge about what to do next. The primary challenge has been facilitating staff to create their own ideas and supporting and honouring that involvement.

To publicly display your values is challenging, especially in a mental health environment, and the team spent some time considering how this could be done in a way that has a positive effect and how to include patients and their caregivers in the EOC process. The concept of creating a tapestry tree was discussed. Our vision was to use the tree as an appreciative metaphor, with the roots representing the values of the unit, the trunk of the tree representing the patients and the unit staff, the branches being the domains of care, and the leaves and fruit being the program outcomes. We wanted to engage the EOC program patients in the process via craft groups however this idea was initially blocked due to concerns about which materials would be appropriate and safe for patients to work with. This was overcome by choosing wool and felt.

One of the most wonderful moments in this process was being able to engage with the less motivated team members by the use of creativity tools and discussion methods. One of the group has become involved with the EOC process by drawing upon her knowledge and interest in craft and materials. She has shared her skill and knowledge with the wider team by contributing to the discussion and offering practical help.

The team has now made a decision to create a flannelette tree with felt leaves. Strands of wool will be used to demonstrate the link between outcomes (the leaves) and our shared values (the roots). As all these materials are safe and cannot be used to self-harm, their use is permissible in a Mental Health Unit setting. This use of creativity has also enabled the nurses to engage more fully with the implementation process of the EOC program.

Reflecting on the journey so far, the implementation of the EOC program has been slower than desired (it commenced in September 2011). However, through trust and mutual respect, as we progress with the EOC program, more of the team are becoming involved and their natural gifts and strengths are coming to the fore. The tapestry tree is a powerful metaphor for the interesting and diverse characters that comprise the staff of the Miri Miri Unit and how they come together and contribute in their own unique ways.

Working out our team values.
"Sacred Time" Reducing our S8 Medication errors

MARINELLE DOCTOR, CLINICAL NURSE EDUCATOR & EOC FACILITATOR

NICOLA DRAYTON, EOC COORDINATOR, NEPEAN HOSPITAL, NEPEAN BLUE MOUNTAINS LHD

Located at the foot of the beautiful Blue Mountains, the Nepean Hospital is a 490 bed, tertiary referral hospital. It serves the community of the Penrith local government area, which has a resident population of over 186,221 persons (Australian Bureau of Statistics, 2010). In recent years, the Nepean Hospital has seen substantial growth and development in its clinical services and activities, including increased theatre activity, admissions, diversity of clinical specialties, and emergency department presentations. The staff of Ward W4C, a 30 bed unit that caters for Neurosurgery, Plastics and Urology patients, is experiencing a greater increase in the demand for efficient health care delivery than it ever has before. Healthcare is now delivered in a fast moving environment, involving a range of complex technologies, and relying upon many individual decisions by both clinical and support staff. Working successfully in this environment is dependent upon excellent teamwork and a commitment to patient safety and the delivery of quality care.

Through participation in the Essentials of Care Program (EOC), W4C staff has more understanding of, and engaged in learning, enhanced ways to improve and evaluate the quality of essential care delivery. One project that the staff completed for the EOC Program focused on reducing S8 medication errors and has been named “Sacred Time.”

What we discovered was, that most of the mistakes occurred during the checking process of S8 medications at the start of each change of shift.

In analysing our Incident Information Management System (IIMS) reports during the assessment phase of the EOC program, we noticed an increase in the number of Schedule 8 (S8) medication errors. This correlated with an S8 incident that the staff voiced their concerns about and agreed to the need to change our current practices. To provide us with more insight into the possible causes for the incidents, we used activities such as ‘claims, concerns and issues,’ reflective discussions, and, observations.

What we discovered was, that most of the mistakes occurred during the checking process of S8 medications at the start of each change of shift.

Continuing to use the principles of the EOC program in engaging with staff and ensuring ideas are inclusive and collaborative with all team members, we held many discussions to analyse exactly why the errors were occurring during the checking process. One contributing factor, discovered through observations, was the number of interruptions that occurred whilst the outgoing and incoming Registered Nurses were checking S8 medications in the treatment room at the start of each change of shift. These interruptions arose from nursing staff coming into the treatment room and asking for other drug checks, medical staff asking questions regarding their patients, administration staff asking staff to answer phone calls, domestic staff cleaning the area, and many other staff using the treatment room for access to equipment. To raise awareness, and to provide a true picture of what was occurring, we took photographs of the treatment room during drug checks, which were then posted in our tea room to generate discussion. Staff members were drawn to the photographs, and were amazed at the number of staff in the treatment room. In one photograph alone, twelve staff members were...
counted in the treatment room. This presentation provided the staff with a direct realisation of what was occurring.

"Sacred time" was conceptualised, and agreed to by staff, as being one possible solution for the prevention of interruptions during the S8 medication process. A conspicuous sign was prepared for posting on the treatment room door stating—“Do not enter, drug check in progress." As a staff member enters the treatment room to perform S8 drug checks, this sign is placed on the door and then the door is closed to alert all staff that a check is in progress, and therefore not to enter the room. This EOC initiative was communicated to all staff via the regular staff and EOC program meetings. Individual explanations were also given to medical, allied health, administration, and domestic staff regarding “Sacred time.”

Although the initiative is just in its early stages, no further S8 medication errors have been reported.

Importantly, the change in the process of S8 drug checking has been embraced by all nursing staff, and is also supported by medical, allied health, administration, and domestic staff members. Evaluation of our intended outcomes has also identified unforeseen benefits with staff members demonstrating a better understanding of their responsibility and accountability with regards to the storage and handling of Schedule 8 medications, as well as demonstrating more compliance with the local medication administration policy. Realising the value of having a protected time to focus on the task of checking drugs, without the worry that this task will compete with the completion of other tasks, staff members have become more proactive in minimising or eliminating interruptions to the process.

Moreover, staff members have demonstrated a change in attitude towards the reporting of medication incidents. Where once they were fearful and ashamed to report incidents, they have now come to the understanding that reporting medication incidents facilitates the identification of system and process deficiencies, and that through critical reflection, discussion and collaboration, these deficiencies can be remedied.

This project has raised the profile of the implementation of the EOC program on our ward with staff members now talking about the EOC program and using this as a banner to engage in team building activities and to discuss new ideas/initiatives. As an outcome, we have also noticed a boost in staff morale that can be directly attributed to the feeling of being supported by all members of the health care team in moving towards sustaining positive change.
Leading the way – the Experience of a Leadership team in supporting Essentials of Care

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KIM GLASOFF, ESSENTIALS OF CARE (EOC) COORDINATOR
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Essentials of Care in the Hunter New England Local Health District (HNELHD) is supported by a Leadership Group which has been instrumental in the implementation, monitoring, and evaluation of the program since its introduction. This paper describes some of the challenges and successes of the program and the journey of the leadership team over the last 4 years. After four years of challenges and triumphs, the opportunity to reflect on the minutes and personal stories has been used to record some of this journey.

In 2008, HNE, along with the South East Sydney Illawarra Area Health Service, enthusiastically embraced the EOC program as it developed from its origins at Prince of Wales Hospital Randwick. These sites were selected for this new and exciting program based on their experience in innovation, availability of some facilitators with experience in Practice Development, and willingness of Nursing and Midwifery leaders to engage with the person centred philosophy underpinning the program.

With the initial appointment of a Lead Facilitator, HNE established a Leadership Group whose agreed purpose was to “......provide support, advice, and direction for the establishment, implementation and evaluation of the Essentials of Care Program within Hunter New England Health. The group will also provide strategic advice to ongoing implementation of the program statewide.” The Leadership Group is chaired by the Director of Nursing and Midwifery, and includes Managers, Academics, Facilitators and representatives from Clinical Governance, Workforce, and Innovation Support.

Since 2009, the group includes the Director of Allied Health as the program aimed to expand beyond nursing and midwifery.

While the group initially met monthly, it continues to meet 4 times per year. The group has continued to provide support and challenge to the facilitation team, whilst offering advice to staff within the District about the program.

At the implementation of the program, a Governance Framework was developed which illustrates the role of the HNE Leadership Group and other Committees that report to it—see diagram 1.

This model has evolved with the implementation of the program and the Local Leadership groups take responsibility for either groups of health services/ hospitals or specialty networks, such as Mental Health Units.

Some of the achievements reported to the Leadership group include:

- Leading the consultation and sensitisation of the Domains for Mental Health and Community Health for use across NSW.
Governance Model - Responsibilities

Chief Executive

Area Director of Nursing and Midwifery (HNE Health)
- Methods development
- Project mgt support

State EoC Advisory committee
Meet monthly to:
- Provide leadership and direction
- Agree project objectives
- Promote integration and collaboration
- Ensure transparency of resource allocation
- Make recommendations to the Area Directors of Nursing and Midwifery regarding priorities for action
- Monitor activities and outcomes

HNE Leadership Group (Supervising Project Sponsors)
Meet Monthly to:
- Participate in setting project objectives
- Monitor and direct project according to objectives
- Provide expert direction on Nursing and Midwifery issues
- Communicate the case for change to stakeholder groups
- Present progress and the case for change to the State Advisory Committee
- Sponsor the implementation of agreed solutions
- Develop systems to monitor and evaluate project outcomes
- Align and apply reward and recognition systems

NSW Health (NaMO Essentials of Care Program)

Project Management
- Reports to Area director N&M
- Conducts project according to agreed objectives, methods and work plan
- Ensures project milestones and reports are delivered within designated timeframes

Nursing and Midwifery Unit
Guide, direct, monitor project activities
Support communication & administration

EoC Cluster leadership groups
- Participate in development of program
- Support facilitation development
- Support implementation of program at unit level
- Provide reports to HNE leadership group

NSW Health Hunter New England Local Health District
- 16 Facilitation Development Workshops, attended by 423 staff across 106 teams.
- Recruitment of 10 Coordinators from diverse backgrounds, who have all brought different perspectives and talents to the program.
- Presentation of 3 Showcases, where 15 teams were able to present their innovations and challenges to more than 400 staff. Showcases were streamed via the web and recorded, to ensure the maximum exposure to clinical staff.
- Publication of 6 journal articles by facilitation team and clinical teams.
- Inclusion of 4 HNE Health presentations in NSW Health Essentials of Care Showcases.
- Several Presentations about EOC work at conferences.
- Development of online Resources and Collaborative Space for Facilitation Development.
- Development Frameworks to Guide Implementation of the Program and to support Sustainable Facilitation Development.
- Participation of 10 units in NSW Health led research on implementing the EOC program.

Review of the minutes revealed some recurring themes among the issues being discussed, including:

- The importance of visible leadership in successful implementation.
- Challenges of meeting demand for facilitation support with limited resources.
- Challenges of competing agendas and maintaining momentum for the program.
- The importance of celebrating and sharing successes of clinical teams.
- Challenges of interdisciplinary collaboration within the program.
- The difficulties in providing definitive measures of success of the program.

On reflection, some key developments can be summarised by comments from group members:

“When we started, we did not have lots of people who felt confident with facilitation of Practice Development. Now, we hear people talking about facilitation in regular meetings.”

“We struggled to define success using outcomes, but now hear people talking about the process as a measure of success… knowing that teams have a forum to discuss practice and processes is a measure of success itself”

“As a new coordinator, I see the leadership group as responsible to maintain and raise the profile for Essentials of Care for both the LHD and the state. It offers support for the coordinators to raise the profile, assist with clarification for management and staff, as well as provide critical feedback”

The leadership group has been instrumental in defining the way that the Essentials of Care program methods can be used to complement the work of other initiatives and programs. This has included defining synergies and differences between Essentials of Care and the Excellence program. Excellence is HNE’s evidence based leadership model, which aims to enhance culture and clinical practice through the use of evidence based tools for leaders. Some teams have had challenges articulating how these methods and other initiatives such as EQuIP and the National Safety and Quality Health Service Standards fit together and can complement each other. The Leadership group has spent time articulating the differences and has developed communication tools to assist managers and teams. The group has also been addressed by managers who have been able to successfully implement methods from both approaches into their ways of working, which has further enhanced their understanding.

Another recurring theme has been the importance of the work done in the preparation phases of the Essentials of Care program and the preparedness of facilitators as they begin their facilitation development journey. The Coordinators reported frustration that despite efforts to provide inexperienced facilitators with preparation to enable their participation and learning at Workshop 1, a number of participants at each workshop had not completed the prerequisite tasks and some even reported a lack of clarity about the reason for their attendance. The Leadership Group have endorsed preparation activities which included the development of an online resource package which incorporates pre-reading about Practice Development, information about the Essentials of
Care program and the role of the facilitator and have supported the coordinators meeting with the facilitator and their manager to clarify expectations. The group has further discussed this challenge, strengthened the systems already in place, and has provided the Coordinators with the support required to ensure that the preparatory work is undertaken before the workshop is attended without which participants will be excluded from the workshop.

**Where to from here?**

The members of the Leadership Group have reaffirmed their commitment to the Essentials of Care program and are actively exploring strategies to demonstrate the value of the program within the clinical setting and the value of facilitation development strategies. Priorities for the coming year include expanding the participation of health professionals from disciplines other than nursing and midwifery, the further sharing of innovation between clinical teams, both within and outside HNE Health, and continuing to enhance the understanding of the way which the Essentials of Care program methods can be used within this and other programs. The group will be re-clarifying their shared vision for the Essentials of Care program within HNE Health, strengthening links between facilitation development and other initiatives including Clinical Supervision, and mapping the Essentials of Care program resources across to the National Safety and Quality Health Service Standards.

We are at a point in time, following reflection upon the current achievements, where we need to consolidate and re-establish the priorities for the Essentials of Care program, given the new challenges faced by health services in NSW. Health reform, the adoption of the National Safety and Quality Health Service Standards, and the changes in funding for a large proportion of our services have all highlighted the importance of aligning everything that we do to our strategic priorities. Resources—including training and education—need to be targeted and focussed upon delivering outcomes that improve patient care. Essentials of Care programs conducted by many of our units have clearly demonstrated the benefit of local ownership and the empowerment of staff to the enhancement of patient outcomes, and consequently to improved levels of staff satisfaction.

In striving for our vision of ‘Excellence for Every Patient, Every Time,’ the Essentials of Care program Leadership team has a very important role to play. We have a moral obligation to provide a health service to the community that is safe, appropriate, and accessible. This will not be a short journey – changing culture and behaviour takes time, effort, and perseverance.
The Post Acute Care Services (PACS) is a department within the Prince of Wales Hospital which is part of the South Eastern Sydney Local Health District. PACS provides an innovative, multidisciplinary approach to patient care, facilitating early discharge of patients from hospital to their usual place of residence. PACS also provides a home ortho-geriatric rehabilitation service—Hospital in the Home—with a core philosophy in this model of care of prevention and early discharge from hospital. The multidisciplinary team (MDT) includes registered nurses, a geriatric consultant, a medical registrar, physiotherapists, and occupational therapists. PACS operates 7 days a week and provides a 24/7 on-call service.

PACS embraced the Essentials of Care (EOC) program in July 2011 and commenced with one EOC facilitator. Even though progress was slow, as a MDT, we were able to come together for ‘values clarification’ and ‘ways of working.’ Our primary focus was on the increasing our understanding of the EOC program and what this meant to our team so guest speakers within the organisation were invited to PACS to share their EOC program implementation experiences. We now have four EOC facilitators, with one being an allied health member.

The PACS MDT engaged in discussions about how to proceed with our data collection and a collaborative decision was made to include workplace observations, a staff satisfaction survey, patient anecdotal stories, and a patient healthcare records audit.

Due to the nature of our service consensus was sought from staff in facilitated meetings to proceed with one-on one observations and for staff to have the choice to ‘opt-out’ of the process at any time. External facilitators were utilised to allay any concerns staff had about being targeted for observations. The PACS staff embraced observations and invaluable information was obtained about how our MDT works. Data was collected from, for example, the MDT on a patient discharge, the occupational therapist, the physiotherapist, the registered nurse (RN), the RN joint visit with the PACS registrar, how we communicated during the weekly case conference, and the allocation of workloads.

The staff satisfaction survey, using the EOC program staff satisfaction proforma, was a collaborative team activity to determine how we perceived our job, and our level of job satisfaction. A total of 20 surveys were distributed with 17 returned—a response rate of 85%—which indicates how important the team felt about participating. The main concern with the surveys was for the preservation of anonymity and confidentiality. Support was sought from external facilitators who generously agreed to theme the hand written survey answers. Our actions confirmed our commitment to the process and created trust and cemented working partnerships amongst the team.

As facilitators we were mindful that the results of the survey could be interpreted in a negative way and therefore we endeavoured to maintain a high level of positivity and concentrate on what we did well as a MDT using the concepts of ‘circles of concern’ and ‘circles of influence’ as the foundation to our approach. The facilitation was supported by the PACS CNC and this collaborative approach worked well in fostering ideas and identifying that different health professionals have differing outlooks.
embraced the EOC program considering that it was new to both nursing and allied health members. As EOC program facilitators, both the ‘corridor’ conversations and the facilitated group discussions have been constructive and we are humbled by the engagement as we weren’t quite sure exactly how to proceed or what to expect. However, we managed to achieve a positive outcome which can only be attributed to the level of mutual respect that exists within our MDT.

Our plan is to continue with our data feedback sessions and to engage the whole team in conversations about the things we do well and those things that we could improve.

The next step in our process is to formally identify goals for actioning. Our progress to date, as a MDT, is encouraging and as facilitators, we have also been encouraged by the extent to which the MDT has

on workplace satisfaction which is important for how we progress, as a MDT, into the future. A ‘light bulb moment’ was the agreement that although quality patient care is paramount in what we do at PACS, it’s also important that all team members experience job satisfaction in order to continue to provide quality care. Engaging with our allied health colleagues in open, facilitated forums meant that we recognised different points of view other than those of the nursing, and that’s has been important to our whole team.

The PACS Multidisciplinary Team engaged in facilitation.

Amanda PACS Occupational Therapist Facilitating a EOC session
The High Dependency Unit (HDU) at Wyong hospital was amongst the first wards on the Central Coast to use the Essentials of Care (EOC) pathway for Practice Development. The HDU is an eight bed facility supported by the Intensive Care Services and is specially staffed and equipped to provide a higher level of observation and clinical care than can be effectively managed at a ward level.

The unit itself was relatively new, opening in April 2009. Having worked through the EOC processes of values clarification, data collection and review, the team developed an action plan that provided a basis for challenging practice and workplace culture.

Team values indicated the intention to work together as an effective team demonstrating professional, respectful behaviours, and integrity. Staff believe that compassion, trust, and honesty are important, demonstrable attributes of their clinical practice environment and are balanced with a sense of fun and humour. Patient story data indicated that patients were satisfied with the care provided and that clinical practices were values based. Observations of care, together the results from engaging with staff during ‘claims, concerns, and issues’ sessions, which explored their work practices and highlighted many areas of positive practice, raised concerns in relation to the nursing Team Leader role within the Unit. In particular, team leader development, role expectations, and communication were listed as priorities to be addressed by the action plan. Further discussions with staff also identified the need for improved communication with key stakeholders, and that bed management did not consistently recognise patient acuity and staffing requirements to deliver the level of care needed by patients admitted to the HDU. It became important for us to clarify what issues were within our circle (or sphere) of influence in order to establish the areas of concern that the team was able to address.

An opportunity to ensure patient safety, to lift morale, build relationships, and to provide a structured approach for Team Leader development and support was also identified. A programme for the Team Leader workshops was developed with the aim being to enhance knowledge and practical skills in leadership, supervision and assessing and supporting learners within the HDU. With support from the NUM, all current Team Leaders were rostered to attend an 8-hour Team Leader workshop. To enable access, the workshop was repeated so that more staff could attend. Staff identified as progressing towards the Team Leader role were invited to participate in the workshops.

**Outcomes of our workshops**

During the workshops, participants were invited to nominate aspects of the Team Leader role’s knowledge and skill-set that would benefit from further development. The following aspects were identified and suitable strategies were developed:

1. Guidelines were developed to support
implementation of ‘Clinical Planning Rounds’ to identify patient care needs and support requirements for the team.

2. A Team Leader accreditation list was developed and incorporated into the existing resource package. This enables staff to be aware of the criteria and expectations as they work towards the Team Leader role. New team leaders are supported in a more structured way with an identified mentor and opportunities to gain experience whilst supernumerary.

The workshops provided an opportunity for shared dialogue with emphasis on action learning, peer support, and critical thinking around care coordination. A major factor in utilising an inclusive approach is that nurses are able to articulate and validate their concerns in an open forum. Participants were encouraged to identify, and to reflect on, individual goals which will enhance their professional development within the Team Leader role.

Work within the EOC program has enabled the sharing of knowledge and experiences and these opportunities have resulted in reinforcing the values and culture within the Unit. Team Leaders are demonstrating an increase in confidence, enhanced negotiation and communication skills when participating in the patient care planning process, with their handling of Unit business rules, and in discussions with key stakeholders.

The Team Leader strategy was the first action instigated from the agreed team action plan. Involvement in the EOC program prompted thought about the handover process within the Unit and a group of Team Leaders is now leading a project to assess this process. Changes have been put in place to reduce the time spent on global handover to allow more time for an individual bedside clinical handover procedure that incorporates the use of the patient safety checklist.

The EOC program has set the scene for the change champions within our Unit to further develop practice in this challenging arena and to maintain the positive changes that have already been successfully introduced.

Guidelines for the HDU Team Leader Clinical Planning Round

In the early part of the shift, an individual Clinical Planning Round is undertaken by the team leader with each of the clinicians to facilitate appropriate, patient focused care across the shift continuum. If there is high activity in the unit and the team leader is unable to do a planning round, then another member of senior staff who is able to fulfil this responsibility should be allocated.

This interaction enables the clinician to clarify nursing care practice of which they are unsure, identify educational opportunities, facilitate teamwork and effective communication. The team leader is then able to follow-up on the implementation of planned nursing care throughout the shift, giving feedback, assistance and education as required.

Goals of the Planning Round are to:

- Facilitate patient assessment and care planning with junior staff and provide constructive feedback on their decision making (discuss patient care requirements with senior staff).
- Assist junior staff members with patient care prioritisation
- Identify knowledge and clinical skills deficits that require direction, support and education.
- Direct the novice RN to appropriate resource personnel to ensure safe practice and appropriate timely patient care.
- Notify NUM / CNE / CNC should further support be required
- Plan with RN opportunities for educational assessments
- Encourage all RN’s to notify the Team Leader immediately of changes in the patient’s condition or nursing work outside the RN’s scope of practice.
- Across the shift, provide the RN with constructive feedback about their implementation of the patient plan of care.
An exemplar of person-centred care in the context of the Adolescent Detention Centre health care environment

Jennifer Ireland, Nursing Unit Manager, Juniperina Juvenile Detention Centre Health Centre, EOC Program Local Facilitator, Debra Pittam, State-Wide Essentials of Care Program Coordinator and Workplace Learning Facilitator, Justice Health & Forensic Mental Health Network

Juniperina Detention Centre is the only female adolescent specific custodial centre in the southern hemisphere. Located at Lidcombe, Sydney, the Centre caters for adolescent girls aged 10-18yrs from the state of NSW, with the capacity for holding up to 44 detainees. The Justice Health & Forensic Mental Health Network (JH&FMHN) Health Centre at Juniperina provides the health care for these girls and young women.

Caring for this vulnerable population requires a balance of sensitivity and professionalism. A high percentage of this complex clientele come from a co-morbidity of mental health, drug and alcohol, and child protection issues of abuse, neglect and homelessness. The majority of these girls are not engaged at school, and do not tend to seek health care in the community. Being in custody provides an opportunity for each young girl to learn life skills, and to build relationships with health care providers, both of which serve to improve their current and potential future health status.

Juniperina Adolescent Health Centre is the first adolescent centre in the JH&FMHN to engage with the Essentials of Care (EOC) program and the Centre has just completed its first cycle (one year) of implementation. In establishing our shared values, and reflecting on our clinical practice, the team agreed that the diagnosis, treatment, and management of head lice infestation would be the focus of our initial inquiry.

The team shared their observations of, and their frustrations with, the current head lice management process. A trend was noted that, as a result of one young person reporting symptoms and being diagnosed with an infestation, all the girls accommodated in this Unit would then also present to the health centre for checking. This would result in the redirection of limited health care resources and, due to security considerations (e.g. the requirement for each young person to be escorted by a Juvenile Justice Officer), would cause disruption to access to other specialty clinical services and programs. Furthermore, the infested young person was also likely to be bullied and then isolate herself.

The health team also identified that many girls coming into custody were likely to have experienced problems associated with living in crowded quarters, shared accommodation, refuges, and from living on the streets. Therefore the girls were prone to having head lice infestations, however they did not have the means, or know how, to identify and treat head lice themselves.

Our goal was to improve the experience of head lice diagnosis, treatment, and management for these young people, and to lessen the disruption to the provision of health services that occurred as a result of this diagnosis.

The team explored current best practice for head lice management and examined their routine clinical practices. Of particular significance was the initial health assessment, undertaken within the first 24
hours after admission, during which all detainees are comprehensively screened for health risk factors, and a plan for their individual health care needs, during the period of their detention, is determined.

Through facilitated critical conversations around best and current practice, the health team agreed to change their clinical management of head lice. The team agreed to move from the reactive practice of waiting for a young person to request head lice checking, to a proactive practice whereby the health team would initiate the checking and treating (when indicated) of all young people upon admission.

This change has been integrated into the routine admission process. The stigma associated with requesting a head lice check has been reduced, and the detainees are now accustomed to being assessed by the health staff upon admission, and are willing to have their hair checked as a routine procedure. Since introducing this change, it has been noted that these girls and young women have expressed gratitude when head lice infestation is identified and treated at the admission stage, and there has also been a noticeable increase in their willingness to attend the health centre for staff to help them comb out lice and eggs. The necessity for making arrangements for badly matted hair to be cut has also been accepted.

The concern, and the risk, that a girl with symptoms of head lice will be targeted and bullied by other detainees, is that she will respond by isolating herself. It has been observed that, with the introduction of screening and treating upon admission, the girls, when they are aware that they have head lice, are now able to let other people know that the health staff is treating the condition. Although this is a simple alteration to work practice, the resulting change in dynamics is empowering to the young person. It is proposed that experiences such as this may influence the young person to choose proactive health behaviours in other areas of their life.

One year after commencing the implementation of the EOC program, the Juniperina Adolescent Health Centre team have paused to reflect on their values, and to evaluate their workplace and work practices. Through facilitated critical conversations, the health team agreed that, by embedding the routine practice of checking client’s hair upon admission, there has been an overall reduction in head lice checks and so they have committed to consistently collecting PAS data about both head lice checks and head lice treatments. The team has also identified that, throughout the implementation of the EOC program, they have upheld their shared values, and have worked in a person-centered way with each other and with their patients.

Acknowledgement:

The Juniperina Adolescent Health Centre team.

Some of our Juniperina team
Introduction. The Mental Health Unit at Manly Hospital (East Wing) consists of eight acute adult beds, twelve sub-acute adult beds, and a psycho-geriatric Unit (PGU) for adult patients over the age of 65yrs consisting of ten beds.

Staffing. The Unit is staffed by a combination of RNs, ENs and AINs (predominantly RNs) who work together as part of a multidisciplinary team. The Essentials of Care (EOC) program was commenced in the Unit in March 2011.

Assessment Phase. As the team progressed into the assessment phase of the EOC program, it was noted that feedback from clients, customers and staff indicated that there were issues relating to access to health snacks and the impact of current nutrition on mental health inpatients.

The team researched information relating to inpatient nutrition in the mental health setting and obtained the following information:

- It is well documented that patients with a mental illness often make poor dietary choices (Peet, 2004) following the commencement of antipsychotic medication.
- There is often an increase in appetite and persistent “snacking” between meals. (Mei-Kuei, Wang, Bai, Huang & Lee, 2007).
- This often “unhealthy” snacking problem can result in weight gain, poor self image and metabolic syndrome which mental health professionals are well placed to address, particularly in the inpatient setting, by educating, motivating, and encouraging clients to make alternative healthy dietary choices (Usher, Foster & Park, 2006).
- Research conducted by Megna & Kunwar, (2006) shows antipsychotics, mood stabilizers and some antidepressants are regularly associated with weight gain with smokers gaining more weight than non smokers, and non-smokers losing weight. This study demonstrated that significant numbers of clients are at risk of weight gain when admitted to a psychiatric unit. A client’s baseline BMI is a significant predictor of weight gain, which is seen to be cumulative over a number of admissions.
- Clients with schizophrenia made even more unhealthy dietary choices. They ate less fruit and vegetables, were less physically active, and were more overweight. They also smoked more than the general population (Henderson, Borba, Caley, et al, 2006).

Data Collection. As part of the assessment phase, data was collected from 27 hospital clients who were weighed to establish a baseline reference, and then 70 surveys were given to clients and staff in both acute and aged care mental health settings.

The return rate for the survey was 68%, and the baseline weigh-in results were as follows:

- Of aged care clients, 33% were obese, and 11% were overweight,
- Of adult clients, 39% were obese and 33% were overweight.
Data was also collected from Snack Surveys that were given to both consumers (30) and staff (40). The surveys were completed and returned from 77% of consumers and 62.5% of staff. Consumer comments received included the following:

- “Too many sweet biscuits and bread”
- “What food?”
- “Yes I do get hungry between meals”
- “It’s the medication that makes me hungry so I eat what’s there”
- “It’s all so unappetising”
- “I eat through boredom so just eat what’s there”.

Other results were as follows:

Q1. Do you believe the food that is offered to you between meals is of nutritional value?

<table>
<thead>
<tr>
<th></th>
<th>Consumer</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>39%</td>
<td>12%</td>
</tr>
<tr>
<td>No</td>
<td>44%</td>
<td>84%</td>
</tr>
<tr>
<td>Don't know</td>
<td>17%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Q2. Is the snack food available of the right quantity?

<table>
<thead>
<tr>
<th></th>
<th>Consumer</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>26%</td>
<td>44%</td>
</tr>
<tr>
<td>No</td>
<td>57%</td>
<td>44%</td>
</tr>
<tr>
<td>Don't know</td>
<td>17%</td>
<td>-</td>
</tr>
</tbody>
</table>
Q3. Do you feel hungry between meals on the unit?

- **Consumer**
  - Yes: 74%
  - No: 17%
  - Don't know: 9%

- **Staff**
  - Yes: 84%
  - No: 12%
  - Don't know: 4%

Q4. Do you get enough nutritional food during regular meal times

- **Consumer**
  - Yes: 61%
  - No: 30%
  - Don't know: 9%

- **Staff**
  - Yes: 24%
  - No: 68%
  - Don't know: 8%

Q5. If healthy snacks were introduced would you eat them between meals?

- **Consumer**
  - Yes: 87%
  - No: 4%
  - Don't know: 9%

- **Staff**
  - Yes: 92%
  - No: 4%
  - Don't know: 4%
Evidence Discussion and Conclusion.
Stakeholders were informed of survey results, including unit staff, hospital dieticians, consumer representatives, and clients. Evidence proved that both consumers and staff are aware that changes need to be made to the quality of snack foods available. Both agree that these need to be nutritious and that what is currently available does not meet the required standards. Both staff and consumers were able to offer a large selection of alternative healthy snack foods that could be made during daily group activities. This project must be implemented in partnership with food services, management, consumers, and staff.

Further evidence revealed what other Units in the Local Health District were providing for their consumers. At Macquarie Hospital, for example, meal times are later, fruit is available for morning and afternoon tea, raisin bread, crackers and cheese, pikelets and yoghurts are available for supper with seasonal and tubbed fruit available at all times. Other acute care settings appear to have the same issues as the Manly Hospital Mental Health Unit.

A presentation of these results was delivered to a large, multi-disciplinary group of the staff on seventh of August 2012. The response was very positive and support has been obtained from the Area Clinical Nurse Consultant, the Nursing Unit Manager, and the Service Director.

What next? The presentation has led the team into the action planning phase of the EOC program which will involve all key stakeholders in further critical discussion to identify what is actually in our sphere of influence and to discuss, evaluate, collaborate and implement suggested solutions. It is intended that the work carried out by the team will lead to a cultural change in our organisation resulting in an understanding of, and preparedness to respond to, evidence based consumer needs.

References:
The Renal Unit within Lismore Base Hospital (LBH) accommodates up to nine patients on four different shifts. Our team comprises of twenty-four nurses who provide a haemodialysis service as well as support for a peritoneal dialysis unit. The majority of the patients are regular outpatients with increasing co-morbidity. The remaining patients are medical/surgical inpatients, or outpatients in transition between renal services. Additionally, the Renal Unit provides after hours emergency dialysis service for unstable acute patients and for patients suffering from acute renal failure who are being cared for in the Intensive Care Unit.

The staffing ratio is three nurses to nine patients, with the most unstable patients being treated in the morning to enable the Nursing Unit Manager (NUM) and a multi-disciplinary team to provide appropriate support. The Unit maintains the application of a Primary Nursing Model of Care for comprehensive renal disease management achieved through the use of biochemical analysis, ideal body weight assessment, patient education, and referral to the multi-disciplinary team. Multiple considerations, such as acuity, transport, cultural appropriateness, and the timing of appropriate interventions are required together with the scheduling of patients to one of four shifts.

Patient flow, safety, and satisfaction are contemporary issues in the Unit, together with chronic care factors such as patient empowerment and interpersonal communication. The Essentials of Care (EOC) program seems like an excellent program to help the Renal Unit team explore these concerns and to improve the intrinsic way that we work and provide care to our patients.

Goal: Our goal is to improve the patient experience and outcomes, team work, and skill development for all nursing staff involved in practice development.

Resources: Our resources are the team members, the effective utilisation of the time available, the various skill sets and leadership qualities inherent within the team, and the use of resources required for our presentations.

Challenges: Making the implementation of the EOC program happen within competing priorities such as: clinical workload, numerical profile, hand hygiene audits and professional development calendar.

Aim: The aim for myself as the NUM is to mentor and empower rather than just ‘take over’, to facilitate transformational leadership and to use the program to incorporate and formalise much of what we already do with skill development as the added advantage for clinicians.

What we have achieved: We have two enthusiastic facilitators who effectively engaged the staff creatively in conversation and captured the staff individual thoughts on what they value about working in the Renal Unit. As a result we have developed a values statement.
We have also trained a number of observers who have undertaken some observations of care.

I believe the goal for the Renal Unit’s NUM is to make the EOC program a web to which much of ‘what we already do’, can stick to, and provide a framework for the nursing team to develop their skills in practice development, and to broaden their abilities in quality improvement. The facilitators will be championing and driving the implementation of the EOC program, however, I believe the NUM is required to provide guidance and to actively support its delivery.

At the commencement of the assessment phase of the EOC program, the facilitators reflected with the Coordinator on the process involved and the following questions were raised:

- How do we communicate information to all of the staff?
- Should there be discussion with all of the staff about how to implement their values in their everyday work practice?
- How can we work through the assessment phase more efficiently, and what are the barriers to this?
- What are our resources and strengths?
- How do we feedback the findings of the assessment phase to all of the staff for collaboration and participation?
- How do we co-ordinate and roster for the assessment process?
- What recent audits have been completed?
- How do we encourage the renal staff’s interest and involvement in the implementation of the EOC program so that facilitators are actively supported?
- Do we need to develop an EOC program plan?
- How can the NUM demonstrate the EOC program is not just another thing to do, but creates a framework for staff to effectively implement projects such as infection control practices, primary nursing reviews and patient satisfaction surveys?

Following a NUMs EOC program training day at LBH, the Director of Nursing requested that NUMs identify a method to best address the result of the Positive Workplace Culture Survey. In keeping with the aim of making the EOC process part of what we do, I believed it would be useful for the team to re-assess our EOC values statement whilst we continued with our data collection for the assessment phase. This idea was also born out of a very active discussion at a ward meeting by the team, where privacy and confidentiality and the new Code of Conduct were discussed.

As a result of discussions with the facilitators I suggested we could highlight key aspects from our values and ask each staff member to identify what it ‘means’ to them, and how that value is ‘demonstrated’ in practice. For instance, we value being professional and providing a safe environment. Each person’s comments were recorded on a white board and as a word document to ensure we could access them as evidence of our discussions.

Staff members have also been encouraged to confidentially raise claims and concerns, and to identify examples where they thought the team was not performing in line with the agreed values. These processes have been essential for openness and honesty, and amongst a small number of staff, where sensitivity is required; the comments will be placed in an envelope and delivered to the EOC Coordinator for de-identification prior to feeding information back to the staff.

A meeting has been planned for the EOC program Coordinator to facilitate a feedback session. The purpose of which is to review the values list as a team, to raise any claims and concerns, and to assist the team and the facilitators to develop ‘Ways of Working,’ to address, for example, the situation where it is identified that a team member is not performing in a way that demonstrates our agreed values. At these critical reflection sessions we aim to make constructive and objective observations and comments utilising the circle of concern/influence tool. Patient stories and data obtained from observations of care will also be utilised to assist in identifying any gaps between our unit’s shared values espoused and how they are demonstrated in practice.

It is hoped that the value of the framework or web nature of the EOC process becomes evident to the clinicians, and that it builds confidence in their ability to reflect and enact positive change.
in the Unit. Utilising the leadership experience of the NUM, the facilitators and clinicians can grow from their experience in practice development to enhance true teamwork and the patients’ healthcare experience. It has been essential that we revisit this preparation stage, and our values, to establish our agreed intentions before we continue on the journey forward.
“Yes, I do have a say”- promoting the client’s view in paper round reviews at the Sutherland Mental Health Rehabilitation Unit

Introduction

The Mental Health Rehabilitation Unit (MHRU) at the Sutherland Hospital has been participating in the Essentials of Care program since 2010. This framework has assisted the team to reflect on work practice, team values, and guide how we would like to work with and support clients in the future. An important part of the teams’ commitment to giving a voice to our clients, was to include the clients in the values clarification process. Collaboration between the staff and the clients of the MHRU resulted in a mural project titled, “Roads to Recovery.” The mural was unveiled in February 2012, with a joint celebration for MHRU staff and its clients. This mural is now on display in the MHRU foyer for all consumers and staff to see to reaffirm our Unit’s values.

Identifying the MHRU team values highlighted just what guides the team and they provide a anchor point for how we would like to work in providing support to clients. Recovery is recognised as one of our main values in guiding our team practice work practices, which regard the client as central to successful illness management.

One area the team recognised as an avenue for further exploration was the current process of MHRU ‘paper rounds’. This is a fortnightly multidisciplinary meeting to review and plan for admissions to the MHRU. The team also voted to explore the processes surrounding the ways in which client’s progress is reviewed during the EOC program assessment phase.

Assessment Phase

Further discussion narrowed down the assessment focus to Monday ‘paper rounds’, doctor’s patient reviews and handover practice. General observations made by the MHRU team, included the fact that consumers themselves were often absent from such reviews. We proposed that a formal assessment of the round may give us some possible clues as to why and what might be done to improve things and thus align ourselves more to our shared values. In addition, EOC program domains for mental health assisted in providing some focus for the assessment phase. These domains include:
During the assessment phase, data was collected using four different methods to assist in providing a larger context of the issues and processes contributing to consumer participation in the paper round. The MHRU team members and external EOC program facilitators, assisted in collecting the data.

1. **Observations**: Paper rounds were observed by both external and internal facilitators over a period of three weeks. Some general themes emerged that indicated some issues regarding communication, organisation of the meeting, some client participation and individualised treatment plans.

2. **Audits**: The MHRU team developed a tool to audit the forms that are utilised in paper rounds such as Care Plans, Review and Progress Notes. The audit questions were derived from the MHRU identified team values of ‘having a say’, ‘inclusiveness’ and ‘collaboration’. The tool included questions to elicit evidence of inclusion of the client’s view in care planning, whether or not the team worked collaboratively to support the client, and of involvement of family and community services.

The MHRU held a session where team members were able to audit a client’s file and feedback results of this audit. The initial findings reflected that out of the clients files audited, there was evidence of only 9 clients out of a total of 20 (Figure 1), being involved in the care planning. Further findings indicated that only 6 clients out of 20 (Figure 2), were involved in the paper round review. Discussion of these results highlighted some issues contributed to these results such as the client’s level of wellness, staff being on leave, the extra time required for staff to complete the additional this paper work, and whether paper work is to be completed with the clients.

3. **Client stories**: A questionnaire was developed to elicit client stories using a narrative interview style. This method provided an opportunity to explore clients’ general experience of being in the MHRU and in relation to ‘paper rounds’. Feedback was provided anonymously to focus on themes identified by the clients. Some of the initial findings indicated that most clients interviewed felt that they had a say in their treatment and that they were listened to.

Some client comments are included below:

“I don’t mind the ward rounds they are not that bad, I am able to put things forward, I said I didn’t want this medication and they listened and I am not on it.”
“Only went once, it was good. Gives you a plan for when you are discharged.”

Some barriers to attending paper rounds, highlighted in the audits were also identified by clients. Some reasons for not attending included clients unsure when these occur, feeling unprepared to attend or being out on leave during when these meetings were on.

Some comments received on these issues are as follows:

“I wish people could talk to me about it before I go, because it may make it a bit quicker and I can know what to ask.”

“I don’t know when it’s on sometimes I get told by the doctor sometimes by the nurse.”

4. Staff stories: A questionnaire was developed for MHRU staff to complete and reflect on their own experiences of paper round. Some of the initial findings highlighted by team members focussed on the way the paper rounds are organised, the follow up of action plans by different team members and amount of paper work impacting on client contact.

Action Planning

The MHRU team are currently collating the data obtained from the assessment phase to create an action plan which aims to enhance the work practices that already do support the client voice in the planning of their treatment and care planning. In addition, general themes from this data will also provide evidence to support the MHRU team to further develop work processes in the MDT paper round, which will ensure even more opportunities for MHRU clients to consistently have their voices heard as part of the collaborative care planning process.

Summary

EOC continues to be a journey that we value as a team. Although, at times the process has been quite an ‘ebb and flow,’ the fruitful conversations that occur between the team members and with client input as part of the process, supplies an intrinsic reward to EOC participation. Perhaps, there are few other workplace teams that we, as facilitators, have been a part of, where genuine collaborative processes have the space to occur. EOC has afforded those of us who work in the MHRU an invitation to take time and articulate, at the outset, ‘what are the ways of working that we value in our workspace?’

Having achieved some definition of our ‘ways of working’ with shared team values and our mural launch, we have now become acutely aware of the impact of our communication style on other. Our intent is for this impact to occur in ways that are respectful, proactive and as ‘client -centred’ as we can manage. This is sometimes a challenge, in the context of traditional approaches to service delivery, but we hold onto the idea (as Dylan sang) that, ‘the times they are a changing...’ Therefore, we are confident that we possess (sometimes in small ways) some locus of control in the way that we provide care in this specialised setting, being mindful to continue to support clients in having their voices heard as part of collaborative care planning process in the Sutherland Hospital Mental Health Rehabilitation Unit.

With thanks to our colleagues, clients, EOC program Coordinator team and Nursing Unit Managers – Sue, Celia and Matthew, EOC Facilitator Team.
Pam’s Story, so far…..

I became an EOC facilitator as part of a secondment opportunity as Acting Clinical Nurse Educator. Through this role I was encouraged to attend an Essentials of Care (EOC) Facilitation program that I found beneficial for learning about the program and for learning skills to enable others to become involved.

Our ward is large and contains 29 beds. Our patients are usually admitted with acute renal and medical issues and there are 43 staff members on the roster. These factors immediately posed a challenge for ensuring everyone had an opportunity to participate in the program.

At the beginning of the EOC program implementation journey, I found that motivating staff was a considerable challenge and that some sessions took longer to initiate and implement than others.

I still remember the first session we did on values. There was a lot of resistance prior to the session, however, once it got started the time went very quickly and staff members who had never participated before were providing a lot of input. At the end of the session everyone felt as though we all had the same issues and that we all wanted to fix them. Following this session I felt a sense of accomplishment, and I believed that the EOC program could help us to work as a team for the benefit of the ward.

From then on, we held regular sessions that encouraged participation and, of course, as with any meeting, lollies always helped! Finally we came up with a poster for our values and this was displayed at the EOC program showcase.

Following our values work, and some hectic preparation, we embarked on a week of observations. Staffing for internal observations was difficult, however, with the help of our EOC Coordinator and external observers who kindly gave their time, everything was made easier. Leading up to observation week, we ensured that the staff members were given access to information via an EOC program folder. Nearly all of the staff felt that being an observer was a great experience that really opened their eyes to many good and not so good, practices.

We are still slowly working towards engaging everyone in the data analysis process. We now have three more internal facilitators and this is helping with the process now that I am the acting Nursing Unit Manager. I am excited about the future of the
EOC program implementation process on our ward.

**Chrissy’s story…**

There are only 24 hours in a day and, for most of us, at least eight of these hours are spent at work, so making our work place a better place should be one of our top priorities. After all, isn’t a better work environment what we all want? A place where things are more effective, more fun, more streamlined, where things just work. The Essentials of Care (EOC) program achieves just that. It is a program that actively works with all levels of staff, as well as with patients and nursing students alike, towards a better work environment and a better functioning ward.

Currently, through the implementation of the EOC program, we are in the process of assessing and identifying key patient issues and planning for future actions and right now I am privileged to share a leadership role in achieving this.

Improving patient care is paramount to the EOC program, thus we are assessing all of the care processes and procedures to make sure all aspects are covered. We have organised, and conduct, weekly sessions with the staff to analyse our collected data in the pursuit of the improvement of our work place and our delivery of patient support. As a member of this unit, I can attest to the fantastic attitude of all involved. The amount I have learned from everyone’s interaction and communication has been nothing short of exciting and this gives me so much more confidence in my facilitator role, even though I am still finding new things to learn. With continued work, and with our focus on our EOC program goals, each of us can work together, respect one another, communicate information effectively, and very importantly, treat each other as equals.
W5B is a 30 bed cardiology ward at Nepean Hospital which is a facility in the Nepean Blue Mountains Local Health district. Our ward has been an Essentials of Care (EOC) ward since 2008, and as a direct outcome of the EOC program, we have created many positive outcomes for both our patients and colleagues.

One of our EOC facilitators went to Practice Development (PD) School and came back bubbling over with new ideas for engaging with our colleagues. This coincided with the upcoming facility showcase for “World Hand Hygiene Day.” We thought it would be a great opportunity and a challenge to use the nine principles of PD to guide us in celebrating “World Hand Hygiene Day” on our ward.

We began by researching current literature which supported our idea of promoting hand hygiene. Day (2009) supports hand hygiene campaigns and programs as a major recommendation for engaging the nursing workforce, healthcare workers, and patients to highlight the importance of hand hygiene. We liaised with our infection control team to have both a facility and a ward celebration for “World Hand Hygiene Day.” We commenced with making the links to evidence based practice by examining our hand hygiene audits which reflected the need to address some of our compliance with hand hygiene requirements. In searching the literature, we found that hand hygiene is a well researched and documented major component of hospital acquired infections worldwide. Day (2009) states that the relationship between hand washing, infection and mortality was first acknowledged by Simmelweis in the mid 1800’s. She highlights the importance of hand hygiene practices being addressed at an organisational level in order for their compliance to be successful. Our approach in launching “World Hand Hygiene Day” in our ward was to create person-centred approaches through fun activities, by generating discussions, and through reflection on current practices. We invited staff from other wards/units within the facility to visit our ward (W5B) throughout the day. To raise awareness, we used a countdown board at the front of the ward to show how many days until the launch and utilised the EOC program notice board as a conduit for information on hand hygiene using humour as a key factor in gaining attention. It was important to us not to make this

The Principles connecting Practice Development and “World hand Hygiene Day.”

Principle One: PD aims to achieve person-centred and evidence-based care that is manifested through human flourishing and a workplace culture of effectiveness in all healthcare settings and situations.

We commenced with making the links to evidence based practice by examining our hand hygiene audits which reflected the need to address some of our compliance with hand hygiene requirements. In searching the literature, we found that hand hygiene is a well researched and documented major component of hospital acquired infections worldwide. Day (2009) states that the relationship between hand washing, infection and mortality was first acknowledged by Simmelweis in the mid 1800’s. She highlights the importance of hand hygiene practices being addressed at an organisational level in order for their compliance to be successful. Our approach in launching “World Hand Hygiene Day” in our ward was to create person-centred approaches through fun activities, by generating discussions, and through reflection on current practices. We invited staff from other wards/units within the facility to visit our ward (W5B) throughout the day. To raise awareness, we used a countdown board at the front of the ward to show how many days until the launch and utilised the EOC program notice board as a conduit for information on hand hygiene using humour as a key factor in gaining attention. It was important to us not to make this
day for nurses only, so medical, allied health staff, clerical and domestic staff were all included. On the day, we had over 100 staff and visitors come to the ward and join the hand hygiene education using fun interactive activities.

**Principle Two: PD directs its attention at the micro-systems level**—the level where most healthcare is experienced and provided, and where coherent support from interrelated mezzo- and macro-systems levels is required.

The real success of the day was demonstrated by the number of staff and visitors who attended the ward. This was inclusive of all staff, from domestic to cardiology consultants. They all participated equally in the activities and, importantly, voiced their amazement at learning something new. Our cardiologist has recently been asking us, “When is the next hand hygiene day.” Without the support from our Nursing Unit Manager (NUM), facility Director of Nursing, and the infection control team, this day would not have been a success. Our NUM continuously and genuinely provides us with the feedback that she trusts us in the organisation of these activities and with the development of projects through the EOC program.

The organisation clearly demonstrates a commitment to the EOC program through the following actions:

- The appointment of an EOC program coordinator,
- Regular recognition of the achievements of the EOC program,
- Promotion of the EOC program through Local Health District news bulletins, and EOC program newsletters, and
- Presentations by teams on their projects at various committees.

Knowing this provides us with a sense of security that our ideas are supported from the very top of the organisation and we feel that it is this commitment that led to the success of “World Hand Hygiene Day.” We recognise that developing a quality service may be the emphasis of our organisation, however, the primary focus must come from the floor or ward, as this is where healthcare primarily interfaces with patients. It is in the ward that barriers to change are often recognised (Manley, McCormack & Webster, 2008).

**Principle Three: PD integrates work-based learning with its focus on active learning and formal systems for enabling learning in the workplace to transform care.**

Through active learning sessions we were able to improve our compliance with hand hygiene requirements and, in particular, for all staff to have the specific knowledge about how to effectively and correctly wash your hands. The day included quizzes with prizes, and everyone became involved in the fun of asking each other about the 5 moments of hand hygiene. Staff wore hand hygiene tee-shirts, and each person who came to the ward had glitter bug applied and was taught how to correctly wash their hands. A microbe bug necklace was given to any staff that did not wash their hands thoroughly—and they had to communicate with other staff to find out more information about effective hand washing before they could hand the necklace back. There were lots of clever and funny signs at sinks, on bathroom doors and all over the ward; some with instructions on how to effectively and correctly wash your hands; some with humorous captions such as, “Go ahead, make my day—wash your hands” and another “Toto, I think we need to wash our hands” and “Dorothy became a hand hygiene auditor.” We also included our patients by encouraging them to ask the staff if they had washed their hands—and we still continue this practice. The use of active learning activities created a fun atmosphere where even though visitors were being assessed on their hand washing technique they were not made to feel intimidated—this was just part of the celebration and everyone wanted to participate. Even after “Hand Hygiene Day” our compliant hand hygiene audit rates remained high, and we could hear staff educating each other and new staff on the importance of hand hygiene and we received acknowledgement from medical staff, including the consultants, that their hand hygiene practices had changed following “World Hand Hygiene Day.”

**Principle Four: PD integrates and enables both the development of evidence from practice and the use of evidence in practice.**

The hand hygiene audits were a component of critique in the assessment phase of the EOC program. We became aware of our current hand hygiene practices and used the importance of
current evidence to support our promotion of celebrating “World Hand Hygiene Day”. Sick ward patients were able to view from their beds, doctors, nurses, literally anyone, who walked into W5B, participate in a fun day encouraging each other to adhere to the 5 moments in hand hygiene. Most patients understood and appreciated that the underlying theme was a team effort to demonstrate our capacity to care by preventing the spread of infection.

**Principle Five: PD integrates creativity with cognition in order to blend different energies, enabling practitioners to free up their thinking and allow opportunities for human flourishing to emerge.**

We used many different mediums to ensure that we responded to all the different learning style requirements. We used our dedicated EOC program notice board to display information about hand hygiene, our current compliance with hand hygiene requirements, and the promotion of “World Hand Hygiene Day.” We had quizzes for visitors to the ward, which included prizes, and we encouraged participation and sharing of knowledge about hand washing.

**Principle Six: PD is a complex methodology that can be used by all healthcare teams and interfaces to involve all internal and external stakeholders.**

We were consistent in involving all levels of staff, as well as patients and their relatives, in our celebration. Our aim was for awareness of hand hygiene to become a normal part of our everyday work practices within the healthcare setting. The need for education about hand hygiene is not isolated to nursing staff performing the 5 moments of hand hygiene, it is also about extending the provision of hand hygiene education to all healthcare clinicians as well as patients. Through a personal approach in ensuring that every visitor to the ward was included in the celebrations, we not only changed our current staff hand hygiene practices, we were also able to influence the hand hygiene practice of the medical staff. The learning and participation was fun for all, and we were continuously encouraged by both doctors and nurses to make it an annual event on the ward.

**Principle Seven: PD uses key methods that are utilised according to the methodological principles being operationalised and the contextual characteristics of the PD programme.**

Through the promotion of participation together with the fun activities, our “World Hand Hygiene Day” was a huge success and boosted the morale and team spirit on our ward. This day acted as a catalyst for other projects and initiatives as the staff felt encouraged and empowered to raise their suggestions and to feel safe in actioning their ideas. By fostering a culture that cares during W5B’s celebration of “World Hand Hygiene Day” we had the opportunity to change our work practices and these practices have now become the norm. We encouraged sustainable hand hygiene practices at the right times and in the right way to help decrease the spread of potentially life-threatening infections, thus improving outcomes for both present and the future.
future patients (WHO, 2012). We did this in a novel fun way that gained 100% participation.

**Principle Eight:** PD is associated with a set of processes, including skilled facilitation, that can be translated into a specific skill-set which is required as near to the interface of care of patients as possible.

Our two EOC facilitators used their skills and knowledge about PD approaches to make this day a success. One of the facilitators had attended PD school and was able to share these ideas with the staff and to provide insight for the other EOC facilitator.

*Quote - Angela De Koster RN and EOC facilitator:*

“Practice Development school opened up for me the different ways that people learn. Learning not only became fun but also became a platform for building the trust needed for self-expression and the confidence to know we can make a difference to our healthcare culture”.

**Principle Nine:** PD integrates evaluation approaches that are always inclusive, participative, and collaborative.

Following each phase of the EOC program, we review all our outcomes from every project in a collaborative way, provide critical reflection sessions, and post information on our notice boards relating to changes in our work practices. Prior to holding the “World Hand Hygiene Day” event, we had decided to promote the importance of hand hygiene leading up to the actual day of celebration. We used the EOC program board as a conduit for information, with humour as a key factor in gaining attention from all clinicians. It was important for us to not make this for nurses only, but to be inclusive of all medical, allied health, clerical, and domestic staff.

Using a PD approach of creativity and fun was key to the launching of our “World Hand Hygiene Day”. Not only did it generate an awareness of the importance of hand hygiene for all staff within the organisation, but it also created an improvement in our hand hygiene audit compliance results and generated an interest from staff wanting to become hand hygiene auditors. Evaluation is a cornerstone in PD and through the EOC program we reviewed our evidence in a collaborative way and the result is that hand hygiene now has a higher profile on our ward than it ever had before. Due to the overwhelming success of “World Hand Hygiene Day,” and positive feedback from the staff members who participated in it, we plan to make this an annual event.

**References:**


WHO (2012) (www.who.int/gpsc/5may/en/).
The development of a collaborative working relationship with Corrective Services New South Wales (CSNSW) is essential if Justice Health & Forensic Mental Health Network (JH&FMHN) is to provide timely and safe health care to their patient population. It should not be surprising that the provision of health services within a correctional facility poses some unique challenges. In this article we will showcase collaboration, inclusion, and participation in addressing the challenges of providing safe and appropriate health care within the constraints imposed by restricted patient access.

At the Mid North Coast Correctional Centre (MNCCC), located at Kempsey, the JH&FMHN health centre provides a comprehensive service that includes mental health nurse clinics, population health nurse clinics, primary health clinics, drug and alcohol clinics, dental and medical officer clinics, and is responsible for the administration of medication and pharmacotherapy.

Within this secure environment, the population of 500 men and women are locked in from 3.30pm until 8.15am the next morning. During unlocked hours there are many activities competing for an individual’s time such as court attendances, musters, education programs, classification and induction meetings, and work. In addition to these competing activities, accessing the health centre is constrained by the design of the correctional facility. A patient’s journey from their cell to the health centre is not straightforward. The patient must pass through up to 8 security gates before arriving at the health centre, where all of the gates are controlled by Correctional Officers, either by using a key or electronic means. It is important to appreciate that security (for all) is the focus of the facility design. There are many individuals within the correctional centre who are unable, or are unsafe, to be allowed to mix together due to security concerns. To manage this risk, individuals are classified and then housed in separate locations. Ensuring that the different classifications of patients do not mix when accessing the health centre is a significant logistical challenge.

Introduction of the Essentials of Care (EOC) program at the MNCCC in 2010 enabled JH&FMHN to invite CSNSW to explore new ways of working together and challenging the ways business was previously done. The key to the success of the implementation of the EOC program was the recognition that CSNSW as a major stakeholder and collaborating with CSNSW, from the pre-preparation phase, to action planning, and then to implementation. Meetings with the Correctional Centre General Manager took place to explain the program and how we hoped to involve CSNSW staff. As a result, the support and the permission that was required to conduct workplace observations, collect officer’s stories, and to involve officers in theming collected data and action planning was given by the Correctional Services.

Through this process, although JH&FMHN vision of providing best practice healthcare for those in contact with the criminal justice system varied greatly from the Statement of Purpose of CSNSW, which is to deliver professional correctional services to reduce re-offending and enhance community
safety, it was recognized that the values of the two organisations were very similar.

CSNSW Values

- Justice and equity,
- Accountability and transparency,
- Collaboration and communication,
- Responsibility and respect.

JHFMHN Values

- Care,
- Clear communication,
- Honesty,
- Professionalism, and
- Respect.

Engagement in the EOC program facilitated a shared appreciation that we had more in common than we did in difference. The sharing of similar values and respecting each other’s roles and responsibilities underpinned our ability to work together to enhance safety and care for patients and staff alike, and to streamline service delivery.

In engaging with the EOC program methodology, clinical staff, administration staff and CSNSW staff all contributed to the collection and collation of data for all to review. This collaborative effort enabled identification of themes from different perspectives, creating opportunities to review how we worked from a unique viewpoint, which had not been previously experienced.

One outcome from this collaborative effort was the agreed need for three changes to routine. These changes required action from both CSNSW and JH&FMHN and working together to implement these changes has resulted in:

- the reduction of the primary health nurse waitlist (improving appropriateness of care and reducing wait times for patients),
- the reduction in the numbers of patients receiving supervised medication (improving patient experience and safety by reducing the number of cells opened at night whilst encouraging self management), and
- the redesigning of the consulting rooms (safer, more efficient workspace)

Outcomes:

Primary Health Waitlist

Evidence collected from JH&FMHN internal audits and CSNSW officers stories suggested that patients were on the primary health nurse waitlist for issues that could possibly be dealt with through different methods of communication instead of face-to-face consultation.

As a result, the nursing staff devised appropriate triage and alternative communication strategies and negotiated with CSNSW staff to pilot the new approach with patients who requested access to the health centre for minor issues not requiring physical examination. Strategies included a template letter or direct telephone contact to patients at their workplace. This approach was deemed suitable for individuals who wanted their glasses repaired or similar issues. This change has improved safety by reducing unwarranted patient movements and has reduced wait times for those patients who require clinical consultation.

Working together-enabling safe and appropriate access to health care in the correctional environment
subsequent changing of work practices to ensure patients were supervised for reasons based on legislative requirements, policy direction, and/or clinical need. As a result of this, the number of patients on supervised medication at night reduced from 87 to 47. Evaluation of the improvement to the patients experience is ongoing.

Conclusion:

The improvements achieved at the Mid North Coast Correctional Centre are now embedded in the Centre’s work practices. Collaboration with CSNSW is an integral part of our business and plans are underway to collect more officers’ stories as we enter our 2nd cycle of the EOC program implementation which has enabled the two organisations to make change happen that benefits both patients and staff. Collaborating with CSNSW from the early stages of pre-preparation through to action planning has fostered positive working relationships and has ensured that patient and staff safety is the focus of our shared business.

Acknowledgements:

MNCCC JH&FMHN & CSNSW staff and management, in particular the local EOC facilitators – Gillian Chapman, Nadina Walker, Amanda Cochrane and JH&FMHN EOC Leaders Debra Pittam and Karen Patterson.

Treatment Room Configuration

Workplace observations identified that medical equipment was sometimes difficult to locate and the location of the centrifuge (to process blood specimens) meant that nurse consultations were often interrupted. CSNSW officers had concerns about the nurses’ safety. It was agreed that the nurse’s workspace would be set up in a safer manner and the reconfiguration of the consultation rooms has resulted in enhanced patient safety due to fewer interruptions during consultations, medical equipment being located appropriately, and improved levels of staff safety.

Supervised medication

Audit reviews and workplace observations revealed that the numbers of patients on supervised medication during the evening was high compared to similar JH&FMH health centres. This practice was of concern to CSNSW officers who believed that opening so many cells at night was unsettling to the patients as well as being an unsafe work practice. Reasons for this were explored and it was recognised that the level of supervision for some patients was more historical than clinically appropriate and that there were benefits in educating and supporting patients to manage their own medication in preparation for their release. Actions taken in response included reviewing the medical records of patients on supervised medication, followed by a patient case management meeting and the subsequent changing of work practices to ensure patients were supervised for reasons based on legislative requirements, policy direction, and/or clinical need. As a result of this, the number of patients on supervised medication at night reduced from 87 to 47. Evaluation of the improvement to the patients experience is ongoing.
Introduction

The patient experience of hospitalisation is gaining recognition in the Australian health care community as a valuable tool for understanding the complexity of health care, as well as the impact of care delivery on the patient and their family (Goodrich & Cornwell, 2008). Patient surveys are a method of gaining information on the patient experience however the reliability of capturing the performance measures of care is considered less probable (Salisbury, Wallace, & Montgomery, 2010). Patient stories however provide an account of a hospital stay from the patient’s perspective and can provide rich and meaningful data (Higgs, Titchen, Horsfall & Armstrong, 2007). This paper explores the experience of a patient in a rural hospital.

The level of care received by patients in hospital is as important to them and their family as it is to the hospital staff. However, how patients prioritise care issues is not necessarily aligned to the clinicians’ priorities. For example, Detsky (2011) suggests that patients “simply want to be better,” to receive immediate and dignified care, are provided with care options, and experience good communication, privacy, limited costs, attention from competent clinicians, and have only passive involvement in their treatment (p. 2500). In contrast, a large survey of approximately 20,000 people who had experience as a hospital inpatient, was conducted by the NSW Ministry of Health and identified that patients valued hospital staff who worked as a team, the courtesy of nurses and the admission person, and the cleanliness of their room (Bureau of Health Information, 2010).

Salisbury et al., (2010) suggests that asking patients specific questions about their experience provide answers that can reflect their ‘actual experience’ and therefore, assist the interviewer in refraining from placing their own inherent value judgements in questions, for example, the question “How long did you wait for the nurse to attend your call bell” is a more meaningful measure of care performance than asking, “Are you satisfied with your care?”

During the data collection phase of the Essentials of Care program, an elderly, friendly, non-complaining patient relayed how, despite a lengthy hospital admission, they remained very grateful for all the care received in a small rural hospital. This patient told the interviewer that they were particularly happy with the allocated room as it had a lovely aspect, looking into a canopy of trees. The environment in which care is delivered can often be overlooked in the context of care. However, to gain a greater understanding of the impact of this environment on health and the patient’s experience, the history of hospitals should be considered. Previously, hospitals were intentionally built with gardens and external spaces which were reported to aid patient healing and recovery (Jone Geimer-Flanders, 2009).

Clarifying what the hospital environment meant for this patient, in relation to their care, was an important aspect of reflecting on, and analysing, the patient’s relayed experience (Taylor, 2006) and through this process, an opportunity was provided to gain insight into a performance measure which has tended to be overlooked.

Hospital managers, in their overall drive to create efficiencies and to optimise the operation of clinical practice systems, can fail to acknowledge the impact of this on the patient. Hospitals are often under tremendous pressure to move patients through their
health care journey as efficiently and effectively, and therefore quickly, as possible. Forces contributing to this pressure include the cost of health care, increased healthcare demands, and an increasingly ageing population (AIHW, 2007). As a result, an organisation’s priorities can become conflicted with the patient’s health care expectations. For example, the patient referred to above told the interviewer that, following major surgery at a large hospital as a result of a serious traumatic injury, the communication regarding their transfer to a smaller rural hospital was “poor” and now influenced their feelings about the larger institution. Further, it was also stated that the transfer resulted in their being socially and geographically isolated from their family and that they could now only speak with them by telephone. Higgs et al., (2007) suggest that this type of data can ‘break the silence’ that surrounds many aspects of the delivery of health care services (p.91). Further, data of this kind can show how a large organisation is meeting efficiency needs compared to the need to work with patients and their families to achieve mutually agreed strategies—in this instance, for an appropriate and acceptable patient transfer arrangement.

Patient stories can assist staff to contextualise data and help them to identify the organisational constraints that may influence their clinical practice and assist in raising awareness about how individuals can contribute to the way in which an organisation is operating. Reflective processes can guide the exploration of issues to identify and examine constraints to enable staff to work towards improvements in both performance and outcomes.

References:
So the journey begins. Our first introduction to the Essentials of Care (EOC) program came in December 2011, when our Acting Nursing Unit Manager (NUM) took the initiative and booked three of the staff into the facilitators’ workshop at Sydney War Memorial Hospital.

Situated in Wollongong Hospital we are a Day Only Unit working in conjunction with all areas of surgery. We service 8 operating theatres and are the main Emergency and Trauma hospital for the Illawarra and Shoalhaven District. As you can imagine we are a very busy area and offer a varied service which presently includes reviewing patients from Doctors’ rooms, home or direct transfers from Emergency Departments throughout our local health district, as well as having patients who require beds, staying in our unit overnight.

Two other colleagues and myself were fortunate to attend the EOC program Workshop 1 and returned very refreshed, motivated and ready to bring the EOC program into our area of work. Initially the work undertaken within the EOC program was suggested by the Senior Manager of Peri Operative Services. We embraced this direction and it did not deter us and with our EOC program coordinator’s support and some flexible thinking we started to tackle the task of developing a conversational script for the difficult conversations that, unfortunately arise when there are necessary postponements with patients’ procedures.

Before we began work on this project it was important to bring the team together to reflect, and capture staff member’s feelings, values, purpose and visions for choosing the Day Only Unit as their place of work. This was a fun and valuable exercise and it was at this point that we also decided to give the project a name that meant something to all of us:

**Questioning**
**Universal**
**Acknowledging**
**Listening**
**Inspiring**
**Teamwork**
**Yes**
**Service**
**Transparent**
**Action**
**Realistic**

We displayed our acronym on a board in our main corridor so that everybody would be reminded of what we as a team and the services that we provide, strive to achieve for patients and staff. We developed a list of our staff values and all agreed that we would all do our utmost to abide by them. At this point we had commitment and engagement from the majority of the team.

**Our Values:**

Empathy, Caring, Hope, Openness, Teamwork, Listening to Understand, Compassionate, Consistency, Tolerant of People’s Differences...

It was time to CELEBRATE..... Cake, coffee and the unveiling of the team’s values! Momentum was building and the staff members were getting excited and feeling encouraged.

The foundations had been established and it was time to commence work on the project that had been initially suggested by the Senior Manager of
Peri operative Services.

First, the team came up with a mission statement surrounding critical conversations so that we all knew the direction in which we wanted to head:

As a Day Only Unit we are all striving to improve our patients' experience. In doing this we are looking at the critical conversations, in particular the postponing of our patients' surgery. It is imperative that, as a team, we include the patient in the process. We are collecting evidence from our patients through a phone survey. With this we plan to devise a conversation script to be used by all Day Only staff when postponing surgery.

All staff seemed to enjoy being part of a project and via a communication book and regular meetings we were able to keep all team members in the loop.

The data collection stage took considerable time, however it was imperative that we had the evidence to support the question “is it important to have a clear cancellation script in order to improve positive patient and staff outcomes?”

Delegation was also valuable in developing an inclusive team. Two members of staff volunteered to conduct the phone surveys of patients. This task was carried out over a three week period then the surveys results were reviewed in a collaborative way. As a group we then spent the next two weeks categorising the results and grouping the common themes.

During this task the staff members enjoyed being released from clinical time in order to contribute to our ‘project’. It felt as if the overall atmosphere within the Unit became more cohesive and that people were adopting the use of positive language.

This was a classical example of fire creating fire, and I am sure the patients benefited from the positive atmosphere!

As a group we created a S.M.A.R.T goal so that we all knew exactly what we wanted to achieve with the development of such a script:

- To ensure that all our patients who have had their surgery cancelled are spoken to with the same level of respect and empathy, and are given the same information in a systematic way, and that the staff members feel confident having this conversation with patients.

Achieving this goal would be evidenced by:

- Fewer patients becoming angry annoyed and confused with the Nursing Staff.
- A reduction in the time patients wait, and are later informed that their surgery is cancelled.
- Patients expressing their understanding of the situation.
- Staff members feeling less anxious and more supported when they have having these conversations with patients.

The feedback we received back from the patients was invaluable and staff members were able to look at what was working well and critique the areas that needed changing or developing. With this evidence the team was able to develop a conversation format, bases on the following points that addressed exactly what our patients felt was important:

- EXPLAIN – be honest,
- APOLOGISE – be emphatic,
- REASSURE- no blaming,
- OFFER – refreshments, and
- Don’t go overboard.

So from all this fantastic teamwork, the Day Only Unit at Wollongong Hospital was able to work in an inclusive, collaborative and participatory way to produce a scripted cancellation conversation. Even though its use is only in its infancy and more evaluation is required, it has become obvious that staff members are feeling more valued and
supported and the patients are showing a lot more understanding towards staff who have to initiate this difficult conversation. Unlike previously, over the last three months since the implementation of this project, there have been no incidents recorded in the Incident Information Management System (IIMS) and there have been no complaints from patients or their families related to the postponement of their surgery.

The team at the Day Only unit say thank you to the Essentials of Care program for providing us with a framework to work with, and we look forward to our next Q.U.A.L.I.T.Y S.T.A.R project. Both the staff members and our patients are definitely experiencing the rewards of such a fantastic concept and our team members are now enjoying being part of the solution instead of the problem.

“...There are only two times in life now or too late...” (Terry Hawkins, 2006)

We challenge you to be the change you want to see!!!
The importance of diversional therapy for the brain injury patient

SANDRA KRPEZ AND TALIA HOSKING, ESSENTIALS OF CARE FACILITATORS, BRAIN INJURY REHABILITATION UNIT, LIVERPOOL HOSPITAL, SOUTH WESTERN SYDNEY LHD

Traumatic brain injury rehabilitation involves cognitive, physical, speech and occupational therapy as central components in the restoration of those brain functions that can be restored to pre-injury levels, and in learning how to do things differently for those functions that cannot be restored to pre-injury levels. Diversional therapy is another important aspect of the rehabilitation regime. It is to be noted that the quality of life often decreases dramatically in institutionalised brain injury patients due to the lack of recreational stimulation, physical impairments, and the social isolation that can occur when the geographical location of the institution is a long way from where they once lived.

Numerous issues can arise from decreased functional activity, extended length of hospital stay, and a lack of recreational activities. These include psychosocial issues such as loss of identity, a low/flat mood, inertia, low self-esteem, and poor motivation for personal care and rehabilitation.

The Brain Injury Rehabilitation Unit nursing staff embarked on their Essentials of Care (EOC) program journey some three years ago. The assessment phase highlighted that patients wanted to spend greater periods of time with nursing staff outside of their daily requirements for care whilst they were in hospital. Recreational activities, conversation, and developing strong rapport with nursing staff were all important to patients.

The nursing staff implemented weekend activities aimed at a person-centred approach to patient care. A garden courtyard was established through the co-joint involvement of both nursing staff and patients, which paved the way for the therapeutic relationship to further develop and prosper and the introduction of afternoon tea provided opportunities for focussing on the physical, emotional, and spiritual needs of the patients.

A weekend activity program was also developed and implemented. Discussions with patients regarding their interests and needs were held and an analysis, to identify areas of interest and issues that needed to be addressed, was completed by the nursing staff who also had the opportunity to visit other rehabilitation facilities to gather ideas on effective ways to calm patients and to interact with them. From these visits, activities identified to achieve this included puzzles, card games, going to the cafeteria with staff to buy coffee, sitting in the park, weekend BBQs supervised by the nursing staff, and general group discussion.

A one-page check sheet, to enable the nursing staff to document their interaction with their patients, was compiled to evaluate the effectiveness of the diversional therapy program. Evaluating the data collected showed that patients thoroughly enjoyed the activities, which achieved a decreased level of patients agitated behaviour.

Nursing staff subsequently sought and received permission for patients to attend supervised outings using the Brain Injury Unit bus. This has allowed patients to attend an Aboriginal Gala Day, Westfield Shopping Centre, Chipping Norton Lakes, and a Girls Day Out so that they could get their hair and nails done.

So, where to from here? There has been an increase in the use of the courtyard since changes were made to it and Phase Two of the implementation plan includes the creation of garden beds for patients to plant and grow vegetables and other plants as a
therapy option which will also include access to pots for additional planting. They will also be involved in the painting of a mural. The nursing staff also plan to make changes to the lounge room to create a calming space for patients to relax in.

It is evident that the relationship between the nursing staff and their patients in the Brain Injury Rehabilitation Unit is inclusive of the patients needs, and that the introduction of weekend activities has nurtured a relationship that focuses on the patients holistically, with a special focus on their emotional and spiritual needs. The EOC program has given the nursing staff an opportunity to voice their ideas about how to increase their patient's sense of self-worth and total wellbeing.
A collective view of patients’ experience

LILY FENECH, EOC COORDINATOR, NORTHERN NSW LHD

The Essentials of Care (EOC) program framework enables staff members to participate in collecting patients’ stories and to listen to their experiences within health facilities. Collecting patients’ stories is an enriching experience and it is a privilege to be involved in such a great innovative program for the evaluation of the essential care that is provided within clinical areas. The patient’s information is utilised in conjunction with observation of care, clinical audit and other relevant data as a baseline assessment of clinical practice, care delivery and the care environment.

Health care workers strive to better understand and to improve patients’ experiences. Measuring patients’ experiences is high on health departments and health facilities agendas. There are many advantages in engaging patients; the information gleaned will enhance patient-centred care and will provide health care workers with an opportunity to improve service delivery as well as the well-being of both patients and staff.

In the Northern NSW Local Health District (NNSWLHD) four patients are invited to share their story in each of the wards/units participating in the implementation of the EOC program. Some teams implementing EOC program display an expression of interest for staff wishing to participate in the process of collecting patient stories. The stories are collected by an external facilitator, that is, a staff member who is not involved in direct care delivery to the participating patient. Those who have participated include the EOC Coordinator, Clinical Nurse Educators, Registered and Enrolled Nurses and on one occasion an undergraduate nursing student. Training is provided for staff members who wish to participate.

The process involves the Nursing Unit Manager identifying several patients who may be suitable to engage in sharing their story. This decision is influenced by other activities in the patient’s day and their ability to consent to the process. The interviewer randomly selects patients from those identified. An explanation of the purpose and the process is provided to the patient along with a NSW Health Consumer Information brochure. The patient is assured that the information will be de-identified and that it will be useful in helping the team to improve patient care and the care environment.

To-date, all of the patients approached have been eager to provide feedback. One patient thanked the story collector and said ‘I enjoyed the time and the interview’. Broad, open ended and probing questions are mostly used to engage the patient in telling their story from their perspective. A set of prompting questions are available to the story collector to guide the process and are intended to be used only when prompting is required to expand on or further explore, an aspect of the story (Essentials of Care: A Resource Guide for Facilitators, NSW Health).

The patient’s stories are powerful and have a big impact on staff members who are keen and anxious to receive feedback from the patient’s point of view. Many staff members strive to provide high quality, safe patient care and many perceive that they work well as a team. The stories give them a better understanding of care delivery and at times, their perception of good patient care and teamwork is challenged.

Forty-six patients within this Local Health District (LHD) have shared their stories over a two year period. The length of stories can vary from 30 to 65 minutes, however, the majority last 45 minutes. The time of the story is negotiated between the patient and the story collector.

Comments made by patients about staff members include: friendly, thoughtful, helpful, attentive, knowledgeable, compassionate and kind. As a result patients and families feel listened to and their wishes are respected as reflected by one resident who said,
‘My son is able to dine with me weekly, he brings me fish and chips and it’s really nice to be able to dine with him, makes me feel like being at home’. Patients are included in the planning and delivery of their care. Person-centred care is often observed and provided ‘Sometimes they shower me early, sometimes late, depends on appointments’, ‘I like getting up early, the staff are co-operative with early showers’.

In relation to the provision of education patients feel that education about their illness, treatment and management is provided and their families are also well informed. One patient said ‘The staff helps me understand my illness and how to care for myself’. The majority of patients interviewed were able to relate detail of processes such as their operation or procedure and possible side effects. Patients are well informed about their medications and indications for their tablets. However, in one busy ward where nurses felt their patients were provided with lots of good information about a particular subcutaneous injection, when asked in a facilitated feedback session ‘How do you know you provide good patient education?’ the staff discovered that at times the patients were being given conflicting information.

There is evidence of staff members encouraging and promoting patient self-management. Patients feel that this is good as it promotes independence. The patients view is that self-care is encouraged by staff, however, assistance is provided when needed. Walking aids are provided to assist patients in maintaining self-care. One patient with shortness of breath said ‘I get assistance frequently and when I need it, the staff help me to shower, to dress and to get out of bed.’

Evidence of staff members ability to promptly manage a change in the patient’s condition is reflected in the following statement ‘During my treatment I had a reaction to the medication being administered, and the nurses acted upon it immediately and ceased it and then slowed the rate of administration of the medication.’ The patient said he was happy with the prompt management of this situation and the explanation that followed.

The patients’ stories also highlighted aspects of care that could be better provided. Several patients noted that the wards/units were noisy with staff calling out to each other and unanswered phones contributing to the noise. Meal time was an area of concern in one ward as, at times, staff members were not readily available to assist patients, and one patient reported being interrupted for non-urgent removal of an intravenous cannula. A few long-term patients commented on being bored whilst waiting for treatment or therapy. One resident would have liked more diversity in activities and more bus trips.

The need to improve communication about patient discharge and pain medication were also key findings in some areas. Bedside clinical handover is sometimes not inclusive of the patient and the majority of patients involved in story telling stated that they liked to be included.

A few patients reported delays in response to buzzers with a couple resulting in not making it to the toilet in time. Other patients accepted some delays as the nurses are very busy.

Key findings from the stories are presented to the ward/unit teams in a facilitated feedback session. As previously discussed the staff members appreciate patient’s feedback. One nurse commented ‘It gives us a chance to address and discuss patient needs and makes me think about how I care for patients and how I can improve.’

Several actions have been implemented to address the themes identified from the patients stories. To standardise and to improve patient education in relation to self-administered subcutaneous injections, the nursing staff have reviewed current practices and the actions that have been implemented include; discussion with the company sales representative, review of product pamphlet, DVD and other relevant information as well as a ‘no swabbing’ poster highlighting the appropriate practice that is displayed in the ward’s medication room. Additionally, an education form is now placed in front of the patients medication chart to prompt nurses to commence patient education well in advance of the patient’s discharge date and it is to be signed by the nurse providing the education. Overall there has been a significant improvement in documentation of patient education.

Staff meal breaks have been altered to allow staff sufficient time to prepare and assist patients with their meals. Patients’ breakfast time has also
been altered to allow for the completion of the
nursing handover to ensure they are available to
assist patients. In one ward nursing staff consulted
with kitchen staff and wards men to discuss the
introduction of a protected meal time policy. Non
urgent procedures are attended to before or after
patient meal times to improve the meal experience
for patients. Findings from a meal time patient
survey and observation of care, indicate that patient
meal times are being given priority and staff breaks
are planned and taken around the care needs of the
patients.

An evaluation of the bedside clinical handover
process shows that the nursing staff are being
more inclusive of patients. Patient goal setting
and discharge planning has improved and this is
supported by feedback from the patients’ handover
survey and validated by observation of care
data, where staff members have been observed
introducing themselves and discussing care with the
patient. Staff have also noted the improved practices
in handover. A staff handover survey reveals that the
majority of staff involves the patient in the bedside
handover process.

The patient experience is an important aspect in
improving patient care and care outcomes and in
our experience the stories influence staff members
in a positive way. They are able to gain better insight
into actual clinical practice and to identify gaps in
practice. The staff members are encouraged by the
positive and non-confrontational feedback presented
from the patient’s stories that promotes staff
participation and commitment to improving patient
care. It enables them to challenge work practices
and to be more adaptable and solution focused.

Health care workers need to better link the
qualitative and quantitative patient experience
data. Patient feedback in conjunction with other
relevant data adds real value and meaning to critical
discussions being had about improving health care
services and workplace cultures. The information
gives staff members a view of what matters most
to the patient and challenges assumptions made
by them. The stories provide a sense of the ‘real
world’. Raising awareness of patients’ experiences
contributes to an understanding of the need to
ensure that patient care improvements are sustained.

References:
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Background to the team building focus:
Calvary Health Care Sydney comprises a 95-bed hospital with integrated community services together which provide a comprehensive range of palliative care and rehabilitation services to a diverse multicultural community. This cultural diversity is equally reflected in the workforce that provides this specialised service. When the inpatient rehabilitation unit at Calvary commenced the Essentials of Care (EOC) program in 2011, the staff recognised an opportunity to acknowledge and celebrate their cultural diversity by promoting cohesive and effective work relationships that would provide a solid foundation for identifying and developing patient-centred practices.

McCormack et al. (2002)\(^1\) suggest that conflict between values systems within health organisations can lead to suboptimal professional relationships and division among the team as staff gravitate toward small groups who share similar interests. This can result in a workplace culture that is characterised by the alienation of individuals, competition for resources, and bullying, all of which inhibit the promotion of quality improvement and the pursuit of clinical excellence. Collaboration within nursing teams exponentially improves the value of care given as it promotes a more cooperative, effective, and friendly workplace environment. The aim of the staff at Calvary was to use the EOC program’s collaboration, inclusiveness, and participation approach to promote a culture of respect in the workplace, to acknowledge and appreciate the contribution of each individual, and to explore how diverse cultural backgrounds added value to work carried out.\(^2,3\)

Getting to know you:
Team building exercises explored the rich multicultural backgrounds of the nursing staff. A map of the world with coloured national flags of the staff members’ various countries of origin made it evident that we truly were a league of nations on the Rehabilitation Unit. Some staff discovered that other families, or their friends, came from the same country. We even discovered that one staff member came from the same town as the legendary Mahatma Ghandi. Following this, all nursing and allied health staff were invited to a multicultural food day and staff eagerly participated by bringing favourite dishes from their country of origin. All staff enjoyed sampling the many different kinds of food and relating stories about their national pastimes. This created a relaxed environment that encouraged participation, enhanced collaboration, and the building of positive relationships. In exploring the theme of diversity at Calvary within both our patient population and our own staff, we have embraced a unique and important element in our practice — our strength lies in our understanding, appreciation, and celebration of cultural diversity.

Values realised in practice:
We adopted the EOC program principles of collaboration, participation and inclusion which aligned with Calvary’s own core values of Hospitality, Healing, Respect and Stewardship. Guided by EOC program facilitators, and using the NSW Health Ways of Working in Nursing (WOW) resources, we created a list of shared values to which all nursing staff had the opportunity to make their contribution. Values such as respect, honesty, trust and integrity formed the basic tenet of our work practice. Acceptance of these values gave nursing staff the confidence and fortitude to engage in critical reflection and dialogue. The team integrated these values into a Mission Statement as a commitment to continuing to strive for excellence in the delivery of high quality care.\(^2,3,4\)
Identifying issues and collaborative action planning:

An interesting and inspiring outcome of the values clarification, WOW agreement, and the establishment of the mission statement, is the progressive engagement of staff as the meaning of the EOC program became more tangible. Meeting attendance is voluntary and yet more than 90% of nursing staff having participated! Opportunity for critical analysis and reflection from ward observations was both empowering and enjoyable. The dynamic engagement of all staff, who were keen to contribute their ideas, knowledge and expertise on ward practices, led to the sharing of insights and anecdotal evidence. This was an indication of the unrealised potential of the teams’ cultural and cognitive diversity and intelligence. Several recurring themes from the ward observations were displayed in the ward and staff were invited to make comment with their impressions/thoughts/ideas on the displayed themes. Given the opportunity to make comment in a trusting, supportive and positive environment, staff actively engaged in having their say and it was very enlightening to see how solution driven some of the staff were—it was a very positive and interactive experience. The results showed that many staff had been engaged in personal reflective practice without an opportunity or motivation to share their opinions or views. A previously untapped resource had now been discovered.2

Sustaining change through engagement:

The EOC program provides nurses with a framework to examine patient care using transformational Practice Development (PD) and is enabling a person-centred approach to become embedded in our workplace practices.3,5 Outcomes such as, regular attendance at EOC meetings, staff engagement in, and sharing of, reflective practice has become the norm. Offering solutions, instead of grievances, has become commonplace with staff bringing their ideas and expertise to EOC meetings. These meetings have become a congenial opportunity for nursing staff to reflect on, and to discuss, all aspects of ward practice as well as being a forum for collaboration, team building and cohesiveness. A number of staff have stated that the involvement of NUMs and senior staff in EOC meetings endorses the value of staff input, expertise and experience and is a motivating factor for participation in the reflective process. It became evident over time that staff had been quietly sharing the same ideas around practice development issues, however, these only came to the fore when the opportunity arose for positive engagement in a supportive environment. The adoption of the EOC program into the Calvary Health Care workplace is the beginning of a journey of self-reflection and discovery for nurses. The application and implementation of the program complements nursing practice by enabling staff to take ownership and to be self-directed and autonomous in their actions which leads to self-empowerment and professional growth.5

Vision for the future at Calvary:

Nursing staff have recognised the need for culture change and the need to challenge assumptions around routine practice in healthcare delivery. They have identified that healthcare delivery practice should be as dynamic as the health care needs of our patient population and that the complex health needs of older populations requires care that recognises, and is sensitive to, both cultural and
individual healthcare requirements. Several staff have been proactive in attending EOC program meetings and PD education independently which, together with the proposed strategy to have 40% of staff receive education on clinical leadership and management of cultural change, will underpin the success of our aspirations. The vision for Calvary is that nurses will take the leadership role, that they will be informed by patient feedback, professional experience and insight, and, as a result, will continue to hone their work practices so that healthcare delivery is more about the individual needs of the patient rather than simply conforming to conventional and traditional modes of care.¹

References:
The Implementation of Clinical Bedside Handover using the principles of Practice Development

Sarah Parkinson, on behalf of the Clinical Bedside Handover Working Party, Hornsby Ku-ring-gai Hospital, Northern Sydney LHD

Acknowledgements: Virginia Armour, Michael Peregrina, Cheryl Finch, Fiona Bruce, June Paynter, Sharon Minton, Jo Sillery, Jay Halkhoree, Leonie Hillard, Debbie Skinner, Trish Butler, Annie Koay, Geraldine Gilroy, Janice Clark, Belinda Thompson, Melinda Simpson.

Background
Recommendations from the Special Commission of Inquiry – Acute Care Services in NSW Public Hospitals (Garling Report) led to the NSW Health PD 2009-060 Clinical Handover Standard Key Principles. The Hornsby Ku-ring-gai Hospital (HKH) commitment to maintaining effective nursing/midwifery clinical handover aligns with this PD and recognised that directives for change would be best implemented through a consultative process across the hospital. This would allow for critical discussion and debate to identify how the changes could best be incorporated within each unit of the hospital.

The Clinical Handover Working Party was established to progress the implementation of nursing/midwifery bedside clinical handover within the medical, surgical, maternity, pediatrics and critical care inpatient services at HKH. The overall aim of the working party was, and continues to be, to implement a support structure that enables nursing/midwifery staff to provide consistent, clear and relevant handover information leading to improved clinical safety. All working party members fed information back to their units and worked collaboratively to identify an implementation strategy, to develop educational power-point presentations, and to evaluate the processes.

Method
Collaborative processes across all clinical units were used to identify individual unit needs for adoption of the bedside handover principles. Twelve (12) units participated in the implementation and evaluation process ranging from Emergency and Operating Theatres to acute care units, and Maternity and Paediatrics.

An education strategy was agreed to and endorsed. This included the development of standardised power-point presentations for the facility discussing the implementation strategy, the new process for clinical handover, and tools to support these in each unit. The education strategy included examples of how the bedside handover was to be incorporated in each unit, as well as an opportunity for staff to engage in question and answer sessions, critical discussion, and action planning.

Each working party member met with staff from their respective units to identify how the bedside handover could be adopted into their handover process within their existing individual workplace context and culture. This process meets both the EOC and IPSE program principles for the introduction of change.

Communication of the implementation process included notices in a weekly newsletter, the Monday Memo, and memos to the Nursing and Midwifery Unit Managers (NMUM) advising of the education and the implementation plan. The evaluation process included both quantitative and qualitative data collection and interpretation.
Nursing/Midwifery Unit Managers of participating units were invited to complete a pre- and post-implementation survey. There were nine (9) responses to the pre- survey and six (6) to the post-survey.

Overall, responses showed a progression towards a standardised handover procedure incorporating a bedside component aimed at visualising and including the patient as well as greater usage of patient charts to be better informed about the patient’s current health status. There was a significant increase in positive responses by N/MUM in the post-implementation survey.

Nursing and Midwifery staff pre and post survey
March and July 2011
The pre-survey was posted out to all participating wards/units prior to the implementation on the 1st March 2011. The post- survey was distributed in July 2011 to all participating units. The Quality Department coordinated the dissemination and collation of data. The pre- and post- surveys were distributed to the twelve (12) participating units with responses received from ten (10) of these units.

Key outcomes of the survey showed that there has been an increase in the inclusion of a bedside component to the nursing/midwifery clinical handover procedure and a slight increase in staff conception that the standardised handover process provides the opportunity to relay and prioritise key clinical information for patient care. The surveys reflected a positive response that, since the introduction of the bedside handover procedure, staff have gained a better understanding of the meaning and function of the nursing/midwifery clinical handover process. However, patient and carer inclusion in the handover process remains limited. Also of note was a decline in staff responses in the post-survey to the question of whether clinical handover is a valued and essential part of daily work practice or not.

The surveys also provided opportunity for staff to comment on specific aspects of the process, including transfer of responsibility and accountability, impact on care, positive aspects of the process, and how the process could be improved. These additional comments provide insight into how to further support and enhance the clinical handover process. The following are examples of the comments received:

“Get more information about patients conditions and medications that improves my nursing care”
“… can reduce the errors from the previous shift”
“… makes all staff more accountable… patients feel like they have more ownership in their care.”
“… improved my handover skills by referring to more relevant information.”
“… made me more aware of the importance of a complete handover.”
“… introduction immediately to the patient.”
“… quickens handover process.”
“The visual checking of patients and charts.”
“Safety, efficiency, peace of mind, all staff know all the patients”

Comments were also made about the benefits of a standardised process and the use of ISBAR.

Clinical Handover Observation Audits
July/August 2011
Observations of Clinical Handover were conducted across all the participating units and three handover periods, including the observation of the transfer of patients to and from operating theatres, and the emergency department. There were two observers per handover. Observers recorded their observation notes on a tool that was developed by the Quality Department in collaboration with the working party. A total of fifteen (15) observer data sheets were submitted.
Key observations included:

**Duration of handover**—The key objective was to implement processes that allowed for a timely handover whilst meeting assessment needs for the patient. The average time for handover is 20-30 mins.

**Clearly Identified Team Leader**—This was recognised as an important aspect to support the handover process and to allow for processes that kept the team leader informed.

**Primary Carer providing handover**—This allowed for firsthand information to be provided. However, variables in staff availability at standard handover time due to short shifts and priorities of care to another patient highlighted that collaborative care/team nursing models change the concept of ‘primary carer.’

**Bedside component to handover**—As a key recommendation to improve communication of patient care and observation of the patients’ current health status, this was a primary component to be observed. Results revealed that 28 of the 47 occasions observed the handover included a bedside component.

It is recommended that further education, and a review on each ward, will enable staff to understand the significance of the bedside component and suitable strategies to improve the application of this practice.

**Use of ISBAR (Identify patient, current Situation, Background, Assessment, Referral/Recommendations)**—The audits show some significant areas of inconsistency with the use of ISBAR and information included in the handover process, particularly with the identification and introductions to the patient.

**Provision of background information**—This was significant with long length of stay units where staff were familiar with a patients’ history and the more relevant information for handover was considered to be the current situation and discharge planning.

**Use of Patient notes to inform handover**—The use of clinical notes during the audit period showed reasonable consistency, with occasional exceptions.

**The road ahead**

The continued vigilance in the support of the nursing/midwifery clinical bedside handover procedure is essential to promote staff understanding of the key principles of an effective handover process.

The following actions are to be implemented to ensure the principles of effective bedside clinical handover are embedded into the Hornsby Ku-ring-gai culture:

- Continue and to renew support for recognition of the value of the nursing/midwifery clinical handover procedure.
- Provide further education to support consistency in the handover process across all transfers of care to encourage:
  - The use of ISBAR,
  - The inclusion of the patient and/or carer where appropriate,
  - The adaptation of the key principles of handover to meet individual ward environments.
- Review the handover of transferred patients to ensure consistency of the information provided.
- Build a culture that values the clinical handover procedure and promotes conversation between shifts and supports the use of questions for clarification during the handover process.
- Revisit individual units to focus on implementation of the principles of the handover procedure with particular consideration for the length of time for a handover process to be completed.

**Process Outcomes:**

This process encouraged the application of the principles of Practice Development and gave staff being impacted by the change the opportunity to be included in decisions about how it is to be implemented within their specific context. The overall process produced a cultural shift related not only to change in clinical handover practices, but also to a greater understanding of the value of the individual’s point of view in the principles of Practice Development, as well as in collaborative decision making for the introduction of change.
Person-centred outcomes are the anticipated result of using a person-centred approach to care (Manley, McCormack & Wilson, 2008). The relationship between nurses and allied health teams working in a rehabilitation/stroke unit requires an environment that is supportive of shared decision making and collaboration. This paper will discuss the approach used to establish values for a rehabilitation/stroke team and how this contributed to the staff having critical conversations about patient care.

The Rehabilitation/Stroke Unit is a 24 bed, regional inpatient unit comprising of a team of nurses, physiotherapists, occupational therapists, speech pathologists, social workers, dieticians and doctors. A series of sessions were arranged in which team members identified and clarified their team values, explored the meaning of those values and established a values statement that contributed to this team discussing issues of importance relating to caring for rehabilitation patients. By enabling ownership of the process of establishing unit values, creating standards and engaging the team members to generate benchmarks for practice, they were supported to have critical discussions about practices on the unit.

Initially staff identified their personal values around clinical care and then collaborated with an aim to prioritising the values for the unit. In a series of values sessions, groups were formed that narrowed down the broad list of values to three core values. The following statements were completed and discussed by each group ‘we believe (value) is important because we need…’ and ‘in our unit (value) would look like…’. Using a voting process a number of values statement options were displayed on the unit notice board (see picture below).

The next stage of the exercise was for the staff members to vote, a gold coloured star was used for this purpose with the statement that best reflected the philosophy of the rehabilitation team being identified. As a result, a values statement was then created as follows:

Values Statement:

In the Rehabilitation / Stroke Unit we aim for excellence in care for our patients and each other.

We achieve this through effective teamwork.

Our Team Values are:-

- Collaboration- working together always
- Communication- open, honest, respectful
- Consultation- respecting the roles and knowledge of others
- Conflict resolution- resolving issues in a fair and timely manner. and
- Caring- with compassion for every individual

When these health care professionals were provided with opportunities to discuss their beliefs around values and to express how those values could look in their unit, constructive and positive dialogue resulted. Enabling staff members to collaborate on prioritising the values for their unit assisted them to create a mutually agreed standard of care in their work environment. For example one nurse discussed the importance of effective communication between the team members to enable a high standard of care to be delivered to
the patients. The reflective process, facilitated in
the session provided a method for using language
to raise awareness of the lived experiences of staff
in the unit and share observations in order to gain
insight into people’s practices and expectations.

As staff practice in a multidisciplinary team,
they have the opportunity to witness other
disciplines practice standards. Team members
need opportunities to develop skills in having
conversations that challenge the way care is
delivered and create work environments that
appreciate the value of speaking up. For this unit
the journey now commences and each discipline
has a daily opportunity to witness practice standards
and to reflect on the unit’s values. The collaborative
processes used in this phase of the Essentials of
Care program are potentially generally applicable,
and beneficial, to other health care Units.

References:
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Walk in my Shoes – Essential of Care – Communication

Janice Calwell, EOC Facilitator Paediatric Unit Wollongong Hospital in cooperation with the Nursing Staff on both the Paediatric Unit and Emergency Paediatrics at Wollongong Hospital, Illawarra Shoalhaven LHD

Introduction:
It was time to revisit one of the more challenging issues that was raised during our team's initial exploration of what an ideal paediatric unit would look like. An issue was raised around interdepartmental communication. It was acknowledged that effective communication involves arriving at a shared understanding of a situation and that ineffective communication could compromise patient safety.

Aim:
To identify the issues and concerns that existed within the paediatric unit and the paediatric emergency department about communication patterns. The majority of communication was by phone and was after hours.

Method:
Focus group discussion:—What were the paediatric nursing teams concerns?
- Why do we get a phone call at 1500 hours with five admissions?
- We are only given partial information and, upon arrival, the child can be for isolation or is sicker than in the information provided.
- We get three different phone calls from three different people within half an hour.
- Their attitude is rude.
- They don’t understand our requirements and needs.
- We are busy and we can’t help if the child is breaching in ED.
- They don’t believe us when we inform them that we have no isolation beds.
- Asthmatic treatment in ED is a real concern.
- The nurses who transfer the child cannot give an accurate handover because they do not know the child.

What were the emergency nurses concerns?
- Always a delay finding the in charge of shift.
- Being told that the staff is at tea and is therefore unable to accept an admission.
- Nursing staff not being able to give a time for the transfer.
- Asking too many questions when we are busy.
- Their attitude on the phone is rude.
- Upon arrival the staff ignore you, or just point to a bed.
- No one wanting to take handover.
- No one is returning phone calls when they said they would.
- Some days they are always busy and cannot find a bed, and we are under a lot of pressure to get the children to the ward quickly.

The focus group also suggested that a management or leadership group be made aware of the concerns of both teams as they thought that this would give them more resources to facilitate change. The concerns from both teams were discussed with the Clinical Nurse Specialist, Clinical Nurse Consultant, Nursing Unit Manager, Clinical Nurse Educator, and Paediatric Clinical Nurse Practice Review Committee.

Process:
Several focus groups, involving the Paediatric Department Nurses group, were conducted and the concerns of both groups were presented. Suggestions for solutions/processes that would
improve communication and safe and timely transfer of patients were sought from the respective groups. Ideas that were tabled were:

- In charge of the paediatric unit is to wear a phone at all times on after hour shifts.
- In charge of the shift on the paediatric unit attends a bedside handover in emergency department prior to coming on to the ward.
- There are to be no transfers between 1400—1600 hours to the paediatric unit.
- In charge of the paediatric unit is to view all children requiring increased observation (hourly or less observation) prior to transfer.
- Only paediatric nursing staff to book beds in order to reduce the number of phone calls, and therefore staff looking after the patients transfer the correct and current information.
- The person who knows the child is to transfer the child.

The leadership group suggested that a three months secondment could be trialled where volunteers swapped positions within the departments.

After further discussion with the leadership group the two areas that were considered for trial were the secondment of nursing staff, and the In Charge of Paediatric Unit to attend the Emergency Department for a face-to-face bedside handover prior to coming to handover at the paediatric unit.

The question was asked by the facilitator, “Which solution do we have control over?”

Solution 1:—It was hoped that these processes would:

- Enhance communication so that both individual and teams had access to adequate and timely information necessary to perform their roles effectively and appropriately,
- Foster positive communication face-to-face,
- Provide information on which children may require admission on the next shift,
- Provide accurate, face-to-face information on the children who are to be admitted to the ward,
- Assist with staff allocation for the children’s ward,
- Allow the ED paediatric staff to know who is in charge of shift in the children’s ward, and
- Facilitate all staff getting to know the person on the end of the phone.

Solution 2:—The CNC Paediatric Emergency and Clinical Nurse Educator Paediatrics presented a proposal for an interchange of nursing staff between the two departments on a three months’ timeframe. The aim of the secondment was to:

- Increase the awareness of both units specialist skills,
- Increase in paediatric skills for all nursing staff,
- Increased understanding of policies and procedures in both units,
- Increase collaboration between the two nursing teams,
- Create familiarity between the two teams, and
- Know the person on the end of the phone, and have walked in their shoes.

Results of the Trial:

Solution 1:

The nurse in charge of the shift on the paediatric unit attends a bedside handover in the emergency department prior to coming on to the ward at 1330 hours each day. After a four months trial of this process, the nursing staff involved in the process on both units were surveyed.

Survey Questions:

Question 1—There are fewer phone calls from the emergency department about admissions between 1500—1600 hours. **Agree: 9 out of 11.**

Question 2—There is an improvement in information received about children who are to be admitted on pm shifts as the in charge see the children, and talk with the nursing staff looking after the child, in the ED. **Agree: 7 out of 11.**

Question 3—The process assists with the allocation of beds for admission and the speed of transfer between departments. **Agree: 8 out of 11.**

Question 4—The process assists with the allocation of nursing staff on pm shift knowing the admissions from the ED. **Agree: 9 out of 11.**
**Question 5**—This process fosters positive communication between the nursing staff in both departments.  
**Agreed: 10 out of 11.**

Great idea, fosters better relationship

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**Emergency Department responses to new process:**

- We now know who is in charge,
- Sometimes doesn’t happen,
- It’s nice to get to know the staff,
- It’s great to share information about the children’s care,
- A walk-around handover is good so that we all know what’s happening, and
- We now know if the ward is busy or not.

**Solution 2:**

The aim of the secondment between the departments, the process, and the timeframe were publicised, and volunteers were ready to commit to the program. Unfortunately, the secondment of nursing staff, although supported by the nursing staff in both departments, could not be implemented. It is hoped that this will be revisited in the near future.

Over the last few months several nursing staff from the paediatric unit have been allocated to the emergency department pediatrics unit for shifts due to sick leave or staffing issues in the pediatrics emergency department. This has enlightened the staff as to the working conditions within this department and it is hoped that this will foster better relationships.

This project will be revisited in the near future.

**Conclusion:**

In health care, effective communication involves arriving at a shared understanding of a situation and, in some instances, a shared course of action. Although we only looked at two solutions, the overall impact has been to improve the ways we work and the way we communicate with each other.
Medical respiratory ward – patient focussed care

ASHLEY HOWLEY, RN, MEDICAL RESPIRATORY WARD AND THE EOC PROJECT TEAM
YVONNE STOLK, HEATHER JIMENEZ & FLOR GONZAGA, SHELLHARBOUR HOSPITAL, SOUTH EASTERN SYDNEY LHD

Shellharbour Hospital Medical Respiratory Ward has been involved in the implementation of the Essentials of Care (EOC) program since 2010. During this time there have been many changes and improvements in response to the initial observations of care.

One of the key strategies recently undertaken involved reviewing the ward routine in the morning because it was observed that staff members were being interrupted during pill rounds in order to take patients to the toilet or to assist them with getting ready for breakfast. The initial observations indicated that the constant interruptions to the morning routine had the potential to lead to medication errors and also affected the performance of the staff and how they related to the patients. The EOC program team met and discussed the observation information and focus groups were then held to identify appropriate strategies for addressing this issue.

It was determined that the morning routine was not conducive to a patient-centred approach and that there was a mismatch with the patients’ and nurses’ morning routine. In the morning, the nurses were trying to hand out medications, which needed to be administered by 8:00am, while patients were in the process of trying to get ready for breakfast. As some of these patients required repositioning or toileting, they were calling the nursing staff for assistance.

It was decided that a review of the current routine would take place to ensure that the focus was attending to patients trying to prepare for breakfast. Once the patient’s needs were attended to, then the morning routine could commence with minimal or no interruptions.

The process was piloted on the morning shift with very positive feedback from both the patients and the staff and further discussions with staff determined that the patient-centred approach could be implemented for all shifts and so now all the staff members do a round together to check on the patients’ needs prior to any other tasks commencing. This new work practice also ensures that the patients are assessed, and their needs are attended to, at the commencement of the shift, leading to a more effective patient handover procedure as well as to decreased interruptions once the nursing staff had commenced their routines.

A survey was carried out one month after the implementation of the new routine to ascertain if its introduction had been beneficial, and if any changes could be made to refine it. Staff members were asked eight questions relating to the impact that the implementation of the new routine had had on their work. The first seven questions were Yes/No answers with the eighth being an open ended question, asking the staff, “How has this improvement assisted you in your work?” This gave the staff the opportunity to provide feedback and suggestions on how the new routine could be further improved.

The response rate to the survey was 60% and analysis of the results indicated that:

- 75% of the respondents felt that the redesign of the routine assisted them in their role,
- 70% felt that the implementation of the routine and team approach had reduced interruptions while trying to carry out their routine,
- 65% felt more supported in their daily tasks,
- 65% felt that there were better manual handling practices with the implementation of the team approach,
- 65% felt that patients were more satisfied with the care which is provided and felt that they were able to provide a more focussed and holistic approach to the patients care needs, and
50% of staff felt that patients were using call buzzers less because there was a more coordinated approach to addressing their personal care needs.

In response to the eighth question, asking, “How has this improvement assisted you in your work?” staff provided some positive feedback. Some of the responses received are shown below:

“I feel it gets me more organised for the day when each staff member helps each other, and then I am able to assist patients more promptly when required”

“I don’t have to stop when I am doing my medications to take patients to the toilet, and I have a better understanding of my roles and responsibility as a nurse”

“Heavy loads are shared better”

“It has given me more time to feed patients and fill in paperwork and things which proved difficult prior to the redesign”

“Having two people improves manual handling … it’s team work and I like it”

“… It allows me to identify patient care needs with my team member and provides a better routine to my day”

The feedback was discussed with staff and there were comments and suggestions made about how the process could be further improved. Further meetings with staff will be held to refine the process as we move towards a patient-centred approach in the way we carry out patient care.

The Medical respiratory ward at Shellharbour Hospital has been involved in the implementation of the EOC program for two years. During this time the program has gained momentum as a result of the staff members experiencing positive effects from the strategies they have implemented and the realisation that it provides them with the opportunity to address and to solve issues in a productive and effective manner.

Survey Results – Team Work and redesigning routines

1. Do you think that the redesign of the routine has assisted in your role?

2. Do you think the implementation of the team approach has reduced interruptions to attend to patient care needs?

3. Do you feel more supported in your daily tasks?
4. Do you feel that there are better manual handling practices?

- Yes: 65%
- No: 35%

5. Do you feel that the patients are more satisfied with the care which is provided?

- Yes: 65%
- No: 35%

6. Do you feel that you are able to provide a more focussed and holistic approach?

- Yes: 60%
- No: 40%

7. Do you feel that there are less patients buzzing

- Yes: 50%
- No: 50%
Creating a better workplace in a Cancer Care Unit

Background and Introduction:

The Tweed Cancer Care Unit provides medical oncology and haematology treatment services including chemotherapy, immunotherapy, biotherapy, supportive therapy, and palliative care for adults and children. The unit is a ‘day only’ unit and consists of four consulting rooms, two treating beds and 10 treating recliner chairs.

In cancer care, patients need a lot of care and that care often extends beyond the patient because a cancer diagnosis affects all those around as well as close to, the patient. As nurses, every day we are also affected by our patient’s situations. Often the best care comes from the caring relationships that grow from getting to know and understanding our patients as they come back on a day-to-day, week-to-week, or month-to-month basis. This continual provision of care to others can, at times, come at the cost of not adequately caring for ourselves. The notion of ‘caring’ appealed to this team of caring professionals and made it easier for us to engage the staff in the EOC program implementation process.

One of the first questions that we asked of the EOC program was, “Could implementation of the EOC program help us, the staff, to improve the working environment for ourselves?”

The challenges presented by the provision of the ever-growing service, and the recent extension of the unit through the introduction of the haematology service, posed many issues to the delivery of the multi-disciplinary care that is provided by all staff members. Key to the multi-disciplinary continuum of care is effective coordination (Siggins & Miller, 2008). Some changes to our work practices were needed to improve the delivery of patient care. The opportunity for staff to engage in evaluating and improving their own work practices, and to have ownership of those improvements, was appealing.

In a claims, concerns and issues activity, some staff stated that, “EOC was a positive thing and an opportunity to observe and discuss practice that we can improve; an opportunity to implement change and get agreement...” though allocating in-service time for staff to participate in the EOC program activities would be a real challenge.

Values clarification is the starting point for cultural change in the workplace, (Manley 2002 cited RCN Workplace resources for practice development) so a values clarification activity was used to develop a common set of values for our unit. The staff members reflected on their roles and were asked what they believed to be the purpose of their role. Responses were captured on flip chart paper and later themed. Several short, facilitated discussions, with small groups, were held in relation to how values and beliefs influence behaviour, and how our agreed values can be put into practice. The collaborative approach encouraged the staff to continue their EOC program journey. They liked the opportunity to collaborate and it was viewed positively in terms of developing the team. The staff also stated that they had never had the opportunity to explore their values and beliefs and that they enjoyed the inclusive and participatory approach. They were very proud of the final values statement and felt a sense of ownership.

The assessment phase was challenging and complex. The data collection training was undertaken in short sessions with the onsite EOC program coordinator and a return-to-work nurse assisting with the observations of care and the patient interviews whilst the two internal facilitators completed the clinical audits. At times, the observations were limited to 30 minutes as it was too great an impact on the unit for a staff member to be away for an hour at a time. Peak activity periods were chosen for observation and a timetable was developed and...
displayed. In total, five hours of observations were undertaken. A key focus was the clinical handover. Some of the initial interest and momentum was lost throughout this period of data collection and we used the clarification of our values process to regain interest. Patients’ stories were also beneficial in re-engaging staff interest. One nurse wrote that it was, “Nice to hear good feedback and a good place to start when considering improvements.”

Through the engagement with the EOC program, the staff identified the limitations and challenges to effectively undertaking handover before each day’s activities. This handover is essential to the transfer of information, accountability, responsibility, and coordination of patient care, (NSW Health, 2009). Staff agreed that an effective handover procedure would improve patient-centred care and outcomes. Through this process it was also identified that there were limits to existing handover practices. Through the synthesis, analysis, and critical discussion of the results of the clinical audits, observations of care information, and claims, concerns and issues activities, the practice of handover was found to be inconsistent, with no uniformity, no regular staff attendance, and to suffer from multiple interruptions.

Clinical audits and observation of care indicated that documentation was not always contemporaneous and at times did not reflect the actual care that was provided.

Positive aspects of handover observed were the use of appropriate and respectful language, good use of the electronic patient notes known as MOSAIQ, and the involvement of patients when they arrived for their treatment.

The observation of care data showed several inconsistencies in handover and staff did not appear to follow any set procedure. Handover did not always commence on time, and there were numerous avoidable interruptions.

Claims, Concerns and Issues Activity:
A claims, concerns and issues activity was conducted in relation to the unit’s handover process and its effectiveness at the beginning of the shift. Individuals were asked to write down their claims and concerns regarding handover and provide them to the larger group for further discussion. Responses were displayed on flipchart paper in the units’ meeting room, which allowed staff to add to the discussion at any time. Enabling questions were used to create discussion and to identify strategies to improve handover processes. Critical questions were formulated from the claims and concerns and appropriate actions identified.

Group discussion/working party:
A group discussion was held in the cancer unit to analyse the data and a specific handover action plan was developed. The handover process was identified as a priority for action as handover within this ‘day only’ unit occurs before patients arrive for their treatment. Discussions also included the purpose of handover, the essential information to be handed over, and the most appropriate area within the unit to undertake handover.

The staff members were keen to participate in patient care improvement activities and found
the utilisation of practice development tools and principles to be an effective approach to evaluate clinical practice and to explore methods to improve our ways of working together.

Outcomes:

Currently, handover commences at 8am sharp in the large common room. All staff are now participating and actively engaging in the handover process. The team leader conducts the handover using both MOSAIQ interactively with the daily allocation sheets. Handover involves systematically running through the day’s activities, consistently, uniformly, regularly, and without interruption as was recently observed. The NSW Health handover guidelines will be adapted to meet the needs of the outpatient Cancer Care Unit.

As part of the continued EOC program implementation process, evaluation of the actions implemented will be attended to as indicated in our action plan. In a recent ‘claims, concerns, and issues’ activity, the Cancer Care Unit team identified the need to change the procedural reference from ‘handover’ to, possibly, ‘patient review’ to better reflect their work practices. Further improvements to the handover process have been raised and these will be explored.

Where to from here:

As a result of a recent ‘claims, concerns and issues’ activity facilitated by the EOC program Coordinator and the State EOC Facilitator, staff reflected on their experiences of being involved in the EOC process and on what they have accomplished and what their concerns/barriers/inhibitors are. Once again, the flipchart was utilised to record the responses. Some of the claims related to clinical practice improvements, however, many others were about practice development outcomes.

The staff highlighted the following:

- The team is now more cohesive,
- Staff relationships have improved,
- The environment is friendlier,
- There is engagement and involvement in discussions with all staff,
- There is self-awareness and better understanding of both unit and team needs,
- There are more learning opportunities,
- There is now involvement in the decision making process,
- There is a feeling of empowerment,
- Staff have the ability to be responsive and plan patient care based on skill mix and patient need,
- Staff are inspired to change when they see the benefits, and
- An opportunity exists for staff to influence practice more broadly.

There were fewer concerns raised than claims and the following were some of those conveyed:

- Involving, and giving feedback to, other disciplines and stakeholders,
- EOC program is viewed as a temporary project,
- Evaluation skills and process,
- Loss of momentum,
- Ongoing commitment,
- Effective use of time,
- Using evidence to support practice change and
- There are no strategies for communicating EOC activities on a regular basis within the unit.

A poster has been developed highlighting the unit’s EOC program implementation journey with the handover process to facilitate communication concerns.
Conclusion:
Through the continued support and involvement of the entire Cancer Care Unit’s team, we will endeavour to work together to promote a positive cultural change, and we will be working with the values mutually identified as important to all those of the Tweed Cancer Care Unit. We will continue to utilise the Practice Development principles of inclusiveness, participation, and collaboration to explore ways of improving both our clinical practice and our work environment.

Acknowledgements
The committed staff from The Tweed Cancer Care Unit.
Lily Fenech EOC Coordinator Northern NSW LHD.

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RCN Workplace resources for practice development (2007), Royal College of Nursing Institute.
In late 2009 I entered into Essentials of Care (EOC) program as a novice facilitator. The EOC environment was very blurry to me. Its concept and methodology were very interesting and yet so different from our usual way of working. The staff raised a lot of questions and there were doubts, misunderstandings, and complaints that lasted for quite some time.

Time was an essential element in the preparation of the staff. It took almost half a year to introduce EOC to all staff members—hearing their values and concerns, collecting their opinions, and involving them in discussions. Through these processes, we started to reflect on our own work practices, to understand more about each other’s differences, and to respect different opinions. As a result, we developed a group culture that took ownership of the program.

Our first step was to prepare for the program. To do this we recruited seven observers who conducted observations over our nine domains of responsibility. Thanks to the supportive external and internal observers, the program started to take shape.

As is the case in most journeys, we experienced challenges and interruptions that sometimes felt like thunderstorms that were so pressing, we felt as if we were crashing and hoped to escape. The impact of the EOC program implementation was not immediately apparent and it seemed to wear on the patience of efficiency-seeking staff. Some felt that the program was not working, and that it was just time consuming. Examples of failure were readily identified and this resulted in some staff becoming disinterested and disengaged from the program. Discouraging words spread, and at times we were on the verge of giving up.

Now when we reflect, we realise how important it was to stay positive, to understand the frustrations, and to acknowledge staff efforts, value contributions, and celebrate achievements and to encourage everyone to continue on.

Today, for example, staff in Ward 3F:

- Willingly participate in activities,
- Are open and communicate in discussions,
- Attend meetings,
- Are interested in taking on roles,
- Support each other, and
- Have developed the capacity to adapt to changes and unforeseeable situations.

The EOC program showcase, held in June 2012, gave the team and me an opportunity to present a poster depicting the significant steps that we had taken along our journey. Most importantly, it highlights the values that the team embraced and that continue to assist us in moving forward with improving the care that we provide to our patients and, at the same time, build a team culture where effective and meaningful communication takes place.
Modern nursing was shaped by the early writings of Florence Nightingale. Her works, published in 1860, focused on caring for patients with every aspect of her nursing practice coming from a central core—the patient. Nursing duties were entirely patient-focused, from maintaining clean and pure airflow to ensuring that a patient is “not startled during sleep” (Nightingale, 1860). In recent times however, nursing has been accused of losing its way as it has developed as a profession with the patient as the essence of nursing slipping out of focus.

Implementation of The Essentials of Care program across NSW Health commenced in February 2008. In 2009, as a response to the Special Commission of Inquiry into Acute Care Services, the EOC program was recommended as a way to refocus on patient-centred care, and in late 2010, the implementation of the EOC program commenced at Liverpool Hospital Emergency Department. During this time, the department was experiencing an exceptionally busy period and was undergoing various internal changes. The EOC program facilitators encountered a number of barriers that impeded their effective engagement with nursing staff such as a limit of two facilitators, 12 hour shift rotations, and a busy work environment all of which contributed to difficulties in staff attending regular EOC program implementation meetings.

A change in approach was required and in mid 2011, a staff survey was conducted with the aim of identifying current staff workplace satisfaction levels in order to establish a baseline for future comparison. The survey was also intended to identify the key values and issues held by the general nursing population.

The Staff Survey Report, completed in 2011, summarised a total of 42 completed surveys that represented approximately 30% of the nursing staff. The initial quantitative results were refreshing as nurses agreed that they found their job “meaningful” and that they remained “satisfied” and “enthusiastic” even though they felt “busy” and that they “did not have enough time to deliver good care.”

During the qualitative analysis, a central theme was identified as being responsible for the preservation of the nurses’ satisfaction and enthusiasm—patient care. Patient care emerged as a major source of both satisfaction and concern for nurses who stated that they received satisfaction from “seeing really sick patients being treated and getting better.” The key ingredients to their satisfaction were “helping people and providing support... and making a difference in people’s lives.” They received the most satisfaction from “good outcomes... and positive patient and family comments.” Nurses, however, felt frustrated and unsatisfied when they were unable to deliver quality patient care, stating, “I sometimes feel unable to deliver the standard of care I would like,” highlighting “not enough time to form a relationship with the patient... and deliver good care” and being “too busy.” One nurse commented, “I’m a professional and find it extremely difficult when I cannot deliver the standard of care patients deserve.” Nurses also recognised various factors that contributed to their perceived inability to provide their desired level of care, such as “not enough time”, “not enough resources,” “not enough staff... skill mix... or doctors,” “heavy workload,” “poor teamwork,” and “poor communication.”

Such comments, provided by nursing staff, reflect the fact that patient care is at the heart of nursing
and that all nurses within the department are facing
the same challenges in their attempts to deliver
good quality patient care. This has provided a common
source for collaboration following the survey
results and, as a result, the implementation of the
EOC program has quickly progressed, gathering
momentum as nurses recognise the EOC program
as an ally, capable of empowering, influencing, and
changing the care that they deliver.

In 2012 the number of facilitators tripled and the
nurses completed their Values Poster.

This poster again highlights the fact that patient care
is the essence of what the nurses value. Organised
into focus groups, the staff discussed what they
valued in nursing over numerous sessions, and
although they contributed various values, one single
theme consistently emerged—the delivery of safe,
quality, patient-centred care.

As participation and awareness increased, changes in
the culture of the department became noticeable—
nurses were able to openly discuss their claims and
concerns with their peers, and they had a voice
which they felt was not only acknowledged and
valued, but also heard.

In conclusion, the focus of the nurses appears
to be unwaveringly fixed upon the patient, even
when that focus occasionally becomes blurred or
obstructed. The nurses at Liverpool Emergency
Department recognise patient care as the essence of
their nursing practice and acknowledge its influence
by recognising the relationship between nurse and
patient satisfaction. They have come to embrace
the EOC program and recognise its potential for
empowerment, addressing issues, and facilitating
change. Nurses within the department concur
that even though many factors may negatively
influence patient care, they are continuing to work
towards safe, quality, patient-centred care, as they
enthusiastically progress into the assessment and
observation phases of the EOC program, eagerly
awaiting the opportunity for involvement in nursing
directed changes and quality improvement.

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Looney, R. (2011). Essentials of Care Survey Report: Liverpool Hospital,
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Nightingale, F. (1860). Notes on Nursing: What it is, and What it is not.
London: Harison.
We are full steam ahead on our Essentials of Care (EOC) program implementation journey in the Birth Unit at Blacktown hospital and have been involved now for about eighteen months.

I would like to commend every one of our staff members, who have joined the journey. Their openness and enthusiasm has meant that the women attending the Birth Unit, and their families, are part of a health services delivery process that really cares. We also say a big thank you for the support provided by Tracy Naidoo (EOC Coordinator) and our Midwifery Unit Manager (MUM) Julieanne Barratt.

As midwives, we all strive to provide women-centred care (which is one of our group values) and as a result of striving to achieve this and engaging in the assessment of our workplace, we have made the following changes to our practice:

- From our observations of care we identified that members of our multidisciplinary team would spend valuable time finding, loosing, and misplacing patient files, especially around the nurses’ station. As a result the patient notes are now clearly identified using coloured inserts placed into the files, with the room number clearly visible, for easy location and we can now find patient notes at a glance.

- Every birth room has been set up with equipment that remains in the room, so that midwives are able to stay with their patients.

- The birth space environment has been enhanced with the installation of CD players that provide relaxing music and excess equipment has been removed to encourage normal birth strategies.

- Clocks in the birth space have also been repositioned so that they are easily seen by the midwives. This limits the twisting by the midwife to check times; a practice which is very important when a baby is on the way.

- From our patient stories our women voiced that they felt uncomfortable in our assessment beds. We have therefore improved privacy for our women in the assessment beds by fixing bed curtains, alternating bed allocation and through team discussions on effective triage.

- To ensure the privacy of phone calls between...
the patient and the midwife, the ward clerk now transfers calls received at the nurses’ station to a portable phone. There can be up to 30 calls per shift and these calls previously occurred in a busy environment. Now we can conduct these conversations privately, and in a peaceful atmosphere.

- We now utilise our infant resuscitation trolleys in a different way to minimise distress for our patients and minimise the need for staff to move trolleys. We have set up two birth rooms as “complex care” environments with neonatal resuscitation equipment ready for use. Midwives now triage patients according to their care needs. For elective Caesarean Sections, we are using one resuscitation trolley for the entire list and replacing stock as required rather than having trolleys pushed back and forth to the operating theatre. To achieve this, there has had to be good communication, and liaison, with the wards persons, operating suite staff, and birth unit midwives.

- We are investigating ways of improving how we deal with our birth room waste.

- An evaluation of our progress, with as many of our team present as possible, will be conducted at the end of September, 2012. For this, we will redesign our patient satisfaction survey to include questions relating to the changes that we have made. The Birth Unit team are all looking forward to analysing our outcomes and improving more and more, little by little.
A journey along the yellow brick road—how can we use the principles of person-centredness to take us up to the Emerald Palace?

Debbie Huxstep, Nursing Unit Manager, Urliup Assessment and Rehabilitation Unit
Murwillumbah District Hospital, Northern NSW LHD

Urliup Assessment and Rehabilitation Unit (ARU) is part of the Murwillumbah District Hospital located in the Northern Rivers Area, which services the people of Northern New South Wales and the lower Gold Coast of Queensland. The unit provides comprehensive assessment, rehabilitation and day therapy, as well as rehabilitation programs for a wide range of conditions, to patients within these areas.

During the clinical leadership program the nursing team in the unit introduced dramatic changes relating to the development of nursing values, goals, objectives and philosophy. The response to these changes was extremely positive so the implementation of the Essentials of Care (EOC) program seemed like the next logical step. The macramé spider web represents the links between our values, goals, objectives and philosophy for improving patient care and our workplace environment.

In September 2009, two ward staff and the Nursing Unit Manager (NUM) attended the two day facilitation development workshop at Coffs Harbour. It was a little scary for all of us, not knowing what lay ahead, however, we viewed change as not necessarily all hard work and that it can also be fun. Our positive attitude towards change and facilitation development was the first important step to introducing the EOC program to our team.

At the facilitation workshop we learnt about a number of interesting theories and strategies to help us implement the EOC program processes and procedures. We also learnt a lot about each other on both a professional and personal level which enhanced our journey. One of the workshop activities was for us to do a creative representation of what we thought the EOC program was all about and the yellow brick road came to mind and the whole ‘Wizard of Oz’ theme was born. We were so encouraged by our own enthusiasm at the facilitator’s workshop that we decided to follow our own ‘yellow brick road.’

As a way of keeping everyone informed and up to date about our progress with the implementation of the EOC program, a dedicated noticeboard was set up in the Unit for all staff to read (including allied health, medical and support staff) which displays monthly updates, newsletters and traffic lights indicating progress. Positioned alongside our values (see photo), we often see staff, patients and visitors...
looking at the displayed information which is a great way to maintain interest and motivation. One nurse commented that seeing the values board prompted her to reflect on her own approach to clinical practice and patient care.

An EOC power point presentation was developed by the facilitators for staff to access at their convenience on the Unit computer desktop. This proved to be an effective way of communicating what the implementation of the EOC program is about and to engage the staff. Sharon Lesleighter, unit EOC program facilitator, wrote:

“EOC will involve some changes to nursing as we know it on our rehabilitation unit and to the care we provide. These changes will be ward based, all nurses will have a say, it is about nurses at the “coal face” being involved in the change. Instead of being told that we must change and being directed to change, EOC allows nurses to drive the change themselves by giving them a voice…..and it is about time!”

An exercise to explore generational groups enabled us to better understand our team and our strengths, as well as how to work with these strengths to enhance team effectiveness.

On completion of the Assessment Phase where a number of audits, observations and patient stories were carried out to gain a better understanding of care and the care environment in our Unit, a number of facilitated sessions were held to include all nursing staff. Participants, working in small groups, were invited to share their thoughts using processes that enabled everyone to contribute, about what we do well and what we could do better. We have made enormous progress in working through the identified issues and implementing change to our work practices—such as the introduction of bedside handover, safer medication practices, weekly nursing case review and rehabilitation nursing goal setting. Using a ‘claims, concerns and issues’ activity to engage with and to hear from all stakeholders, issues were further explored post implementation. This activity was very helpful in evaluating the nursing case review and goal setting and we gained a better understanding of what we were trying to achieve. We now have a systematic process where nursing goal setting is undertaken in partnership with the patient and discussed at the weekly multidisciplinary case conference. Currently, we are using PRAxIS to develop an evaluation of our nursing case review.

To engage staff in various activities we introduced the ‘contract of co-operation’ concept (see diagram 1) where staff nominated their level of involvement. Following discussion about each level; participate, cooperate or support, the concept map was placed on the notice board to enable staff to self-nominate.

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followed when implementing the EOC program, which in itself is part of the challenge. As a manager,... knowing when to lead and not manage and vice versa proved to be one of the most difficult aspects for me to deal with”, Debbie Huxstep (NUM).

To date, progress with the implementation of the EOC program has been slow and steady however, there is now more evidence of staff engagement and collaboration around clinical practice improvement activities. The changes that staff have noted are: ‘better teamwork’, ‘people are listening’, ‘there is continuity of care,’ and ‘I feel really supported.’ One staff member commented that she now looked forward to coming to work whilst another said that initially there was more interest in outcomes, such as the extra medication trolley that the ward was able to purchase, rather than engaging in critical discussions and a set, systematic process. As indicated previously, implementation of the EOC program has also impacted on the NUM whereby she has gained a better insight into her leadership style and has adopted appropriate changes using a transformational approach.

One elderly patient told in his story how, when he was first admitted to the ARU for long term rehabilitation, he was frightened and rebellious as he had a poor understanding of his proposed treatment and its possible outcome. He appreciated the time given by one of the nursing staff who sat with him and explained his condition and its management. This was a turning point for the patient and he no longer displayed rebellious behaviour. Staff acknowledged incremental improvements, such as standing without assistance, which gave him the necessary encouragement to continue to try harder.

Like Dorothy’s journey to the Emerald Palace in the ‘Wizard of Oz’ the implementation of the EOC program has been both positive and stormy at times. Even though it hasn’t happened as easily as just clicking our heels together three times, it is happening and although there is still some resistance to change we are progressing and achieving success with the majority of staff showing a willingness to participate.

On our EOC program implementation journey, we have all experienced growth, both professionally and personally, which can only have a positive impact for our patients. We have confidence in the team to continue to meet the demands of the challenge of change, and that we will make it over the rainbow to our own Emerald Palace by improving patient outcomes and promoting a positive unit culture.
Building Partnerships & Person – Centreddness in an Aged Care Rehabilitation & Assessment Unit

The implementation of the Essentials of Care (EOC) Program commenced in Aged Care Rehabilitation & Assessment Unit (ACRAU) a 17 bed unit at St Joseph’s Hospital in November 2011.

There have been noticeable changes in the unit since the implementation of EOC both visually & ergonomically. The physical layout of the unit has changed with an EOC room being created. The EOC room is extremely cozy and a lounge was procured to make it comfortable for nursing staff and other team members, EOC information has been placed on the walls. It was decided to make this space a dual purpose space and so nursing staff lockers have been moved into the room so as to receive daily inspiration.

The culture in ACARU has improved since the commencement of the EOC program. The EOC program concepts were new to staff and, since commencing, staff have begun to flourish within the unit due to the formation of new ideas, improved collaborative processes, the emerging of a pro-active culture and the willingness to try new ways of working together. These changes are being achieved through transformational Practice Development (tPD).

Staff discussions about the value of communication has enabled the team to critically reflect on the effectiveness of the units’ current communication strategies. The nursing team have openly discussed issues which they felt were causing concern and could be improved upon. This enabled open discussion and sharing about the communication processes surrounding admission, discharge, handover, reporting care, multidisciplinary communication and negotiating care/patient interaction. The nursing team stated that they would benefit from clearer communication processes with the multidisciplinary team and that this would enhance patient care. The team clearly noted two separate issues where communication processes could be improved upon and which would benefit both patients and care givers, and promote more congenial relationships between the members of the multi-disciplinary team.

Multidisciplinary Team Communication:

It was identified that improved communication between the members of the multidisciplinary team about when patients attended therapy outside of the unit would be most beneficial. Further collaboration with members of the physiotherapy department resulted in an appointment planner being devised and the Physiotherapy Head of Department developing a communication sign that is to be placed on each patient’s bed board and indicates the time of the physiotherapy session. This sign assists nurses and others in understanding the patients routine around therapy sessions ensuring that patients are ready and sitting by their beds in time for therapy sessions to commence. The physiotherapy session planner adheres to the hospital infection control guidelines; it is laminated and therefore can be cleaned and staff...
can write the bed number with a marker making it environmentally friendly as it is re-usable.

From a person-centred approach it has enabled nurses to plan patient care more centred on the individual patient’s needs. It’s use has also resulted in an improvement in the professional intra-disciplinary team members relationships.

Patient Locator

The second communication concern identified overlapped with the Preventing Risk and Promoting Safety Domain - there was no formal process of identifying the whereabouts of patients when they were not on the unit. The Nursing Team felt that all multidisciplinary team members, including nurses were currently working within their own silos and that a more person-centred approach, based on interdisciplinary collaboration, would result in better patient outcomes.

The Nursing team with the EOC program facilitator discussed the issue with the Clinical Nurse Educator and devised the concept of a ‘Patient Locator’ which could be placed next to the elevators. The Nursing team discussed the issue and the patient locator concept with one of the physiotherapists and the physiotherapy team created and designed the Patient Locator tool in its user friendly format and in compliance with infection control standards. The Patient Locator is placed on the wall next to the elevators and lists all the patient beds. When patients leave the unit to receive therapy or leave with a relative or friend a card is placed next to their name on the locator stating where they have gone.

The Patient Locator is a Person-Centred tool appreciated by patients’ relatives and friends when they visit because, if the patient is not on the ward, they are able to see where their loved one is and who they are with. Nurses are finding that all the members of the multi-disciplinary team find the patient locator useful and everyone discusses it in positive terms.

Conclusion:

When staff members were asked about what the EOC program meant to them, the consensus opinion was that, as a team, the ACARU staff are more adaptable, open to new ideas and are reflecting and critically thinking about ways to improve patient care holistically.

Their comments sum up their impression of the implementation of the EOC Program:

“It includes everything, both the care for the patient and the staff. It has bought to the fore the caring culture on our ward” Josefina Rigor, Endorsed Enrolled Nurse

“Working with the multi-disciplinary team together to collaboratively improve patient outcomes and expedite their recovery; it is really rewarding to see our patients improving” Julita Padua, Endorsed Enrolled Nurse.
Unlocking the potential for person-centred approaches within clinical teams

Introduction

Hunter New England Local Health District (HNELHD) covers an area of over 130,000 square kilometers with 15,000 staff across 67 facilities. At the conclusion of 2011, HNELHD had introduced the Essentials of Care (EOC) Program to 106 clinical teams. We were keen to explore the progress achieved by these teams at the completion of each of the EOC program phases as a number of reports indicated slow progress or disengagement from the process and the intent was to discover ways to further support implementation. To remain consistent with the Practice Development methodology underpinning the EOC program the implementation project utilised a person-centred approach with the aim of developing an implementation framework that would support clinical teams in all areas of the HNELHD and identify and quantify the level of support required to implement the EOC program.

Data Collection

A transformational Practice Development (tPD) approach was used in order to remain consistent with the EOC program principles. Key stakeholders were invited to actively contribute by way of manager surveys and facilitator feedback to highlight their experiences of what enabled and what inhibited their team’s progression with the implementation of the EOC program. Rural teams were also included because of the potential for differences in availability of resources and support unique to their location. Two sets of data were collected from HNELHD and State reports, manager surveys and facilitator feedback. The first data set included HNELHD teams that remained in the preparation stage for the implementation of the EOC Program and represented a wide range of clinical specialties from a number of locations. The second data set was collected from two rural teams that were actively implementing the EOC program.

Results

From the first set of Manager Surveys:

The surveys were anonymous and open-ended questioning was utilised. Ten manager’s surveys were completed and returned with the following positive themes:

- The implementation of the EOC program is a worthwhile process;
- The EOC CNC/Coordinator role is the most useful resource available to teams;
- Values clarification and exploration is a positive and useful activity to undertake.
- Themes identified as inhibiting the progress of the implementation process included:
- The inability to release staff for meetings and training due to financial and workload issues;
- The lack of implementation champions in clinical areas;
- Competing priorities and programs.

**From the second set of Manager Surveys:**

The themes from the second set of manager's surveys were almost identical to the first set, with the exception of an additional positive theme highlighting the enthusiasm of facilitators.

**Facilitator Feedback:**

The following two graphs depict the themes arising from the first facilitator feedback data:

### Helpful for establishing EOC

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<tr>
<th>Facilitator support</th>
<th>Management support</th>
<th>Quarantined time for EOC</th>
<th>Make EOC non-optional</th>
<th>Support for outcomes</th>
<th>Access to examples of outcomes</th>
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### What has hindered your units progress in EOC?

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<th>Staff attitudes</th>
<th>No Management support</th>
<th>Facilitation skills</th>
<th>Lack of time</th>
<th>EOC not priority</th>
<th>Busy unit</th>
<th>Change issues</th>
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The themes from both sets of facilitator feedback data were almost identical and were similar to the results obtained from the manager’s surveys and this provided necessary validation. The survey results and feedback led to the identification of five (5) core elements which are fundamental in supporting the implementation of the EOC program. The data also revealed the inter-related nature of the core elements.

The five (5) core elements considered vital for the successful implementation of the EOC program and which comprise the major component of the implementation framework are:

1. Staff attitudes;
2. Management support and leadership;
3. Facilitator skill development;
4. The EOC CNC/ Coordinator role; and
5. The priority of the implementation of the EOC program.

Two (2) key messages were also evident and these are:

1. The importance of leadership by the manager,
2. The lack of previous exposure by staff to tPD methodology.

Essentials of Care Implementation Framework

The intent of the implementation framework is for clinical teams to explore and effectively introduce the core elements to their individual clinical settings, and to develop strategies relevant to their context. Therefore, tools and resources are included to assist teams to undertake this. The final version of the implementation framework included feedback from a broad range of stakeholders (see acknowledgements).

Sustainability and Evaluation

Stakeholder engagement, an integral part of tPD methodology, was utilised in all stages of the development of the implementation framework. An early draft of the framework was assessed at John Hunter Hospital and was considered transferable to the larger tertiary hospital. As part of the review process, the framework includes a questionnaire relating to its appropriateness and relevance for the key stakeholders to complete. The implementation framework will be a living document with sustainability being fostered by the endorsement of key leaders in all areas of the HNELHD. The project document is available in hard copy and electronically from the EOC program webpage located on the local Intranet ‘myLink’ site. The deliberate collection of data from a diverse range of practice specialities.
from several HNELHD sites has resulted in the implementation framework being broadly applicable to clinical teams and contexts in the HNELHD. Positive feedback on a presentation about the project at the Statewide EOC program Showcase in Sydney in June, 2012 was evidenced by the number of requests for copies of the Framework from state wide EOC implementation leaders and managers.

**Conclusion**

Recognition of the need for change within the NSW Ministry of Health, as evidenced by the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, endorses the need for the implementation of the Essentials of Care program. The Essentials of Care program itself enables and empowers clinical teams to address their specific environmental and clinical issues as well as implementing new initiatives and directives as they are received with the aim of improving patient care outcomes. The Framework has been developed to assist teams to implement the Essentials of Care Program in the context of their own clinical setting by identifying and quantifying the support required to successfully integrate person-centred approaches within the clinical setting.

**Acknowledgements**

The authors would like to thank the rural managers and facilitators who completed the surveys and shared their stories, past and current members of the HNELHD EOC Team, HNELHD Director of Nursing & Midwifery Services, Former NSW CNMO Debra Thoms, and NaMO EOC Team for their feedback and encouragement towards the completion of the Framework Document.

**References:**


When it comes to measuring care, many people believe more numbers are better. However, an epidemic of measures in health care including the number of incidents, complaints, and errors may be more reflective of a workplace culture or system problems. Weiss and Wagner (2000) argue that performance measurement in healthcare is still in the ‘experimental stage’ of development and its use as an evaluation tool requires a degree of caution. This paper aims to present findings that focused on actively managing the change process using retrospective and real time audit data.

Audit data was used as a tool to identify patient care issues and the nurses approach to clinical handover in a regional general medical unit. Clinical handover is common practice in health care however, considerable uncertainty remains about the actual processes used by nurses when handing over patient care. Nurses vigilance in detecting patient errors before they occur have been acknowledged however, the implications of an erroneous handover procedure can result in medications being missed or incorrectly administered, omissions or delays in treatment, and failure to address patient safety risks. Healthcare professionals are accountable and responsible for the provision of an effective handover of patient care (Jorm, White, & Kaneen, 2009).

Over a period of three months, audit data was collected which focused on patients’ vital signs, falls risk, intravenous lines, and wounds. The aim was to evaluate the completeness of nursing care plans and the clinical handover tool. Over 100 patients’ charts were randomly audited. The results showed that:

- On average 85% of nursing care plans were updated daily,
- Observation frequency was recorded 93% of the time, however, observations were actually taken on average 82% of the time,
- Falls risk were charted in 94% of charts assessed, however, falls risk strategies were recorded only 58% of the time. A falls risk sign placed over the bed occurred on average 80% of the time for patients at risk, and a falls sticker on bedside charts occurred 69% of the time,
- Intravenous access was recorded 86% of the time, however, the date of intravenous insertion, and dressing change due occurred on average only 66% of the time,
- Evidence of a wound was recorded 74% of the time, however, a wound chart was evident in only 53% of charts,
- Limited evidence (5%) of a signature that handover had occurred was evident, and the Adult Patient Assessment Tool was completed on average 69% of the time.

These findings provided a baseline of information for planning further interventions to promote patient safety on this unit.

In addition to the chart audits, Essentials of Care facilitators conducted two real time handover audits where an internal and external observer shadowed two clinical handovers. Measurement outcomes included the number of interruptions to handover, the number of questions required by the next shift to clarify issues, and whether opportunities to teach staff were incorporated into the process.

Working in a person-centred way requires developed interpersonal skills (McCormack & McCance, 2006). Communication skills were also observed during the handover procedure, for example, how the staff interacted with the patient, the precision of the language used to share information, and the attentiveness of staff receiving handover. Importantly, the clinical judgement of staff was observed to identify if patient instability was
acknowledged, and whether handover was reprioritised due to the need for more immediate interventions. Feedback on the audit results were provided to staff for the purpose of celebrating the positives, exploring adjustments to the handover process, and to challenge staff to find workable solutions for the identified issues. Those issues included, respect for the nurse handing over, the appropriateness of patient selection for bedside handover, and collaborative processes during handover.

Combining observed performance and quantitative data within the same review helped guide the staff to challenge the notion of using numbers only as the measure of the quality of care. The insights gained from the different perspectives that the data provided allowed staff to explore the findings to a deeper level, and to provide relevance to this aspect of clinical care that would lead staff to relate their performance to patient outcomes.

References:
All aboard the EOC bus

Karen Anderson, CNS, Di Goldie, Nursing Unit Manager
Maree Froogley, CNE-ICU, Lismore Base Hospital, Northern NSW LHD

The Essentials of Care (EOC) program was introduced in Lismore Base Hospital in 2010. The hospital is a regional referral, level 5 base hospital within the Northern New South Wales Health District providing care to over 23,700 patients per year. It has a combined Intensive Care, Coronary Care, and High Dependency Unit with 13 beds and 58 nursing staff. 4 beds are allocated for ventilated patients and 4 are for coronary care patients.

A staff workplace culture survey was developed and conducted in Lismore Base Hospital's Intensive Care Unit in 2009 yielding a 67% response rate. The survey information raised some issues relating to the way we worked and provided the staff with an opportunity to voice their opinions. As a team we implemented changes on a small scale without fully exploring the issues and necessary actions to be taken. Following the survey feedback, many of the staff asked if we could repeat the survey. It was agreed to repeat the survey in a couple of years. This was around the same time that the EOC program was being introduced to our local health district. We realised that the EOC program had better tools to assist us in addressing our units' issues in a collective way. We discovered it uses the Practice Development principles of inclusiveness, participation and collaboration, but most importantly, it was about team ownership.

The staff engaged in critical reflection and discussion to gain insight about the way we work, as many of us believed we had a good team, we all got along, and the outcomes for our patients were good. But how did we really know this to be the case? Were we biased and out of touch with reality and, was this a belief held by everyone? How could we make changes to improve team engagement? It was important for us to experience a feeling of well-being and job satisfaction. The staff's well-being and patient care were important issues for us to address. When staff enjoy their work and are satisfied with their job it reinforces their sense of affective commitment towards their team and the organisation, (Meyer & Allen, 1991).

By implementing the EOC program, with its underlying practice development principles, we engaged all of the team in exploring how we could work collaboratively to improve care delivery and our care environment. This was achieved by multiple, co-facilitated sessions for the staff to focus on why we come to work. We shared our individual thoughts and what we value as nurses. We explored what we do well and what we could improve. We worked as a team using person-centred approaches and we liked that we would have ownership of the care improvement initiatives. To achieve this we decided to work from a common belief. A bus symbolising staff participation was chosen to engage the ICU team and the double decker bus is large enough to carry all the staff that chooses to jump on board. The journey began with the team exploring their shared values and developing our units' vision statement. This gave everyone a voice to help build a mutual ground that we all accepted and would strive to achieve.

So the bus ride begins......

1. The first step in the process was for the ICU team facilitators to participate in facilitation skill development training and gain an understanding of the EOC program. We had to learn and to work through our own preconceived ideas and...
assumptions, particularly about how we picture the unit moving forward. As facilitators, we had to be flexible in our approach, we knew we had to step back, throw the keys to the team and let them drive the bus rather than enforcing engagement. We asked all staff to join us on the bus. We bought some smiley stickers and asked staff to place their name on one of the smiley faces and then place it on the bus displayed on the allocated EOC program notice board. As not all individuals were ready to engage, everyone was given the opportunity to join, or not join, the bus ride. The size of the stickers varied as did the smiles, some had huge smiles and some had what appeared to be a smirk. In time, most staff connected with the bus and some of those that were the least ready to participate had some of the biggest smiles. Those that chose to be actively engaged placed their smiley face up the front of the bus whilst those that were unsure of their level of participation placed themselves in the back of the bus.

2. Due to the large number of staff (58) in the unit, and the nature of a rotating roster, we thought our biggest issue would be to ensure that all staff had an opportunity to participate. Our biggest challenge was—how were we to engage and encourage participation of the entire unit’s staff with their diverse personalities and backgrounds?

At the facilitator skill development workshop we participated in reflective activities on values and various themes were identified. This creative and inclusive activity was the key to help steer the ICU team to the development of our vision statement. Initially many staff thought (some still do) it was all a bit touchy/feely, but in the end, when it was all pieced together, people expressed how it was actually a good process to experience. It was noted that the staff with the most exposure to the sessions were the loudest advocates of the process and of the final vision statement.

So we refocused the team on why we were here. The following challenging questions were used to encourage critical reflection and discussion—“Why did I become a nurse?” “What do I believe my role is in this unit?” “How can I achieve my role/purpose in this unit?”

This challenged people to think about the reason they came to work. We had many laughs throughout the process. One notable male nurses’ response was:

“I wanted to work in a profession where you were respected by the community. Save lives or ensure a peaceful death. Meet lots of girls.”

3. More than four weeks was allocated to gather individual’s responses on paper. Messages were left for some staff, unable to be part of the discussion, on their lockers to allow them the chance to be involved and they then left their responses in envelopes on the clinical nurse educator’s desk. The responses to each question were typed (for de-identification) and presented back to the staff who then worked, in small groups, and in allocated education time, to allow the staff to select common words or themes from the responses. Initially the word ‘competent’ was selected to refer to the ICU team, however, several months went by whilst staff continued reflecting on the meaning of the word and it was replaced by several others until eventually the word ‘experienced’ was agreed to. The team felt it was important to get the wording right. One group suggested that two vision statements were required, one relating to the service we provide for patients and their families and the other relating to the staff. Finalising the vision statement was lengthy but worthwhile as it enabled participation and encouraged ownership.

4. Several vision statements were developed by many different groups, each with a different approach, but essentially all had the same focus. The draft statements were displayed on the white board for comment and voting occurred for the preferred statement. A facilitated discussion was undertaken to agree on where our final shared vision statement was to be displayed.

5. Our tea room is already a busy area for education but it is a place that all staff visit, so it was chosen as the perfect place for our EOC program notice board to display the draft value statements. The traffic light communication system (one element of the Studer program) was utilised as it fitted nicely with the EOC program principles and is an effective way to keep staff informed about EOC activities. The green light indicates what we
have put in place, the yellow light indicates what we are currently working on, and the red light indicates what is at a standstill.

6. Our vision statement is visible to every person who enters our unit, is on the cover of our relative handbook, and is displayed on our computer monitors when they are in standby mode.

The staff are very proud of their achievement and the final statement. ‘Respect’ was the word that all staff agreed reflected how we work together. For us it means respecting each others abilities and skills, being mindful of peoples’ thoughts and feelings, and valuing individual input.

7. The vision statement was the final stop at the first destination!

So our bus ride continues….

8. We are now at the stage of progressing to the implementation phase. From the patient stories, clinical audits, observations of care and other relevant unit data, 25 themes were identified for actioning. In a facilitated session the themes were prioritised, numbered, displayed and discussed. The staff were encouraged to express their ideas and concerns. They were motivated, excited and keen to participate in patient care improvement initiatives and willingly agreed to address several themes by working in small groups. A self-nominated process was used for action planning. The staff were asked to pick a theme to be actioned and one that they found interesting and would like to be involved in. To our amazement we now have several working parties addressing 16 of the 25 actions. 3 of these are now research projects. Some of these focus on patient care improvement, some on the team, and others on our work environment. This may seem like a large number of working parties, however, the staff felt empowered and were keen to actively participate. Several of the staff approached the lead internal facilitator seeking an opportunity to be involved. Using a person-centred approach has transformed some individuals. Manley and McCormack (2003) suggest that ‘transformation is required in order to create effective, sustainable cultures that are person-centred and evidence driven.’

There is increased accountability as each group is currently developing their own working party action plan. Groups are supported by internal facilitators, CNC, CNE and NUM. Working parties are supported to develop individual practice development skills and knowledge, to enhance their ability to lead change processes, and to engage others in shared decision making. Additional skills required, such as goal setting, literature searches, and reviews of evidence based practice are also developing.

Some challenges have been encountered with the large number of working parties with some
reporting difficulty in finding the time to meet due to different shifts and rosters. Keeping the team members motivated has also proven to be tough at times. Likewise, the lead facilitator has stated that supporting and enabling others ‘without taking over’ can be quite challenging.

Various individual groups are allocated a set time during the monthly unit meeting to report on EOC activities. Notes from the meeting are then made available to all staff. This strategy has been an effective way to communicate EOC information to the large number of staff within the unit. Individual working parties reporting helps the team to maintain interest and motivation and validates their participation in EOC.

The EOC process has enabled us to improve our workplace culture as demonstrated by the enthusiasm and keenness of staff to be engaged in patient care improvement initiatives. The staff see the value in the changes we are making and are motivated to continue to improve our service.

References:


Acknowledgement: All staff from ICU/HDU/CC
Witnessing a Team’s Transformational Journey

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The Essentials of Care (EOC) Program was first introduced in 2009 when I was the Clinical Nurse Educator for the unit. As the external facilitator I was interested to find out what this program could offer the team in terms of professional development and better patient care delivery.

The staff came from a variety of culturally and linguistically diverse backgrounds and included a large number of junior staff within the team. My main aim as the facilitator was to help the team gain a unique perspective of their role as health providers and the link between their role and the changing organisation. The EOC program coordinator assisted in the implementation process by explaining the EOC framework to the staff in easy to understand steps.

By mid 2010, the team was having robust, proactive conversations, based on real, clinical incidents, that brought meaning and purpose to the team by valuing their clinical expertise and working together to collaboratively achieve a common purpose and the team progressively became more comfortable with purposeful, objective debate.

The team have established their values and have since put those values into daily practice. By thinking outside the box, and by asking questions, they were able to identify those areas in their workplace that required change in order to improve patient care and teamwork. As a result of these discussions, all of the staff were involved in the creation of a set of ‘Staff Allocation Guidelines & Principles’ to assist team leaders, and the manager, in the appropriate allocation of staff and the challenges of patient acuity—under any circumstances during any given day or shift.

The next step is the development of a ‘Team Model for the General Medical ward’ that will be based on the team’s value statement, which will describe how each team member will support the team leader, collaborate and assist each other, and discuss issues directly with the team leader, during the shift.

It is encouraging to see staff grow professionally and work in a collaborative way to implement meaningful improvements in patient care and build an effective workplace culture and, as a result, the team can now identify and talk about their ‘challenging areas’ as they continue to explore further ideas about making changes. As a facilitator, I find this outcome renews my enthusiasm and commitment to working with teams.

The team has become more independent so my role as an external facilitator is changing. The internal facilitator is working closely with the team whilst I assist as requested or when moving through to the next phase.

The implementation of the EOC program needs time for people to understand and embrace the methodology and person-centred approach that underpins the EOC framework. Realising the achievement of goals and investigating and adopting new and sustainable ways of working also require time.

The key principles of practice development, collaboration, participation and inclusiveness have encouraged the team to engage and grow. This has occurred in a structured supportive environment where the team’s input was fundamental, welcomed, and facilitated.

The General Medical team’s implementation journey continues and they are becoming an empowered group of professionals who have a transformational approach to their work.

References:
Nepean Hospital Ward N1G is a 20 bed Acute Rehabilitation Unit within the Nepean Blue Mountains Local Health District. The Hospital is located at the base of the Blue Mountains in Penrith, NSW, Australia. Penrith lies on the Nepean River and is one of the fastest growing areas in Sydney.

Our Unit has been involved in the Essentials of Care program (EOC) since 2010. This has allowed our team to gain insight into the domains of EOC and as a result we have become empowered as a team to understand that “yes we can fix it!” In establishing our shared values we believed in the vision of improving patient care and optimising rehabilitation opportunities both psychologically and physiologically for our patients.

Our EOC sessions rapidly became a popular time for our staff as we explored ideas for what we would like to change in our unit, using fun activities such as Claims Concerns and Issues and Circle of Concern/Circle of influence. Using these activities allowed us to feel safe and encouraged to put our ideas forward. The EOC facilitators constantly encouraged us to think outside the square and closely reflect on our current practice.

We identified an area of the ward no longer utilised which could be turned into a dining room for our patients; this was adjacent to a courtyard which we also wanted to gain access for our patients. We were fearful if we did not utilise the four bedded area once used for interim chemotherapy patients we would lose the ability to access this space. Also previous access to the courtyard had been denied and staff felt dissatisfied with the current feeding regime for their patients. Staff identified whilst patients were eating at the bedside their self independence was not encouraged as staff witnessed families feeding patients rather than the patients rehabilitating and feeding themselves. The environment at the bedside discouraged the patients from eating and many wanted to stay in bed to eat meals and many had a loss of appetite. In EOC meetings we discussed how important it was for us to create this space into a dining room and how it reflected our values in encouraging our patients to achieve their maximum goal for optimum levels of independence.

We began by carrying out a risk analysis concerning the security of opening the doors to the garden area, and then we developed guidelines surrounding times...
of the day when access to the courtyard is permitted allowing the safety concerns of the patients to be addressed. By raising awareness through discussions with the team, we gained collaboration and a team agreement of the importance for creating this space for our patients. We voiced our ideas to management highlighting the importance of this dining room and courtyard garden access for our patients to allow our patients to interact and optimise their rehabilitation. With the support of our NUM we were successful in our request and turned the space into a dining room at the same time gaining access to the courtyard from the dining room.

Initially the patient’s mindset was difficult to change in coming to the dining room for meals at lunch time, but with positive encouragement, perseverance and education about rehabilitation some patients lead the way for others. Staffing allocations were adjusted by the NUM to ensure supervision & support in the dining room was adequate during lunch. Family and friends were encouraged to use the outdoor gardens whilst visiting to provide some normality and privacy. In a small section of the dining room is a mini library and quiet corner to allow patients to sit, read and listen to the radio outside their room. Wii therapy by the Occupational Therapist is used for patients who wish to do a little extra. This was initiated by nursing staff and now allied health and medical staffs have embraced this new initiative. It has increased patient’s socialisation and allowed patients to become more confident with their own self-management.

We have gained support from staff consultants and our Allied Health team members on the importance of encouraging our patients to attend the dining room for meals. A collaborative decision between nursing staff, medical consultants and allied health team members, agreed any patients who do not go to the dining room will be referred to the social worker. The importance of this is to increase socialisation for our patients, it is identified many patients feel uncomfortable or afraid to socialise due to their disability. An opportunity to discuss this with the social worker provides a safe space for the patients to discuss how they are feeling, which also provides opportunities for us to meet some of their emotional and psychological needs. Further to the development of creating our dining room space, on admission each patient receives a weekly individualised schedule which includes the dining room meal times, physio appointment times and other rehabilitation activities. This is to reinforce to the patient and their family/friends the importance of going to the dining area for their lunch as part of their rehabilitation process.

We have now commenced the evaluation phase of the EOC process; this has begun with identifying how many patients attend the dining room for meals. We will shortly be undertaking patient stories which aim to explore the patients experience in having their meals in the dining room. It is important we also provide opportunities for the staff to reflect on their experiences, we therefore aim to hold some critical reflection sessions for staff to share their thoughts on what the dining room mean to them and their patients.

The Essentials of Care program has provided us with so many opportunities to share our ideas and we feel empowered to make change. Seeing our ideas come to fruition has created a buzz and excitement about the many possibilities we can create. We presented our “Yes we can fix it” poster at the EOC state-wide showcase in 2012, receiving a special mention from the Minister Jillian Skinner.

We also received an award of acknowledgement in the Nepean Blue Mountains Local Health District 2012 quality awards. These opportunities to celebrate our success allow us to share our initiative and highlight the wonderful team in the rehab unit.
Our learning's with Essentials of Care: Slow and Steady wins the Race

J. ROBERTSON, NUM, J. CAFAGNA, CLINICAL COORDINATOR
A. GALVIN, EEN, SURGICAL WARD, BELMONT HOSPITAL, HUNTER NEW ENGLAND LHD

The Surgical Ward at Belmont Hospital became involved in the Essentials of Care (EOC) program earlier this year, primarily to address issues with our clinical care. We wanted to improve patient outcomes by improving the quality of care delivery, adapt to changes arising from “Between the Flags,” and increase compliance with bedside Clinical Handover.

In a previous role as Nursing Unit Manager (NUM) of a Coronary Care Unit I had been involved in the EOC program during 2008-2010. This unit was chosen as a pilot site for the program due to long standing issues with staff members who were entrenched in their work practices and who expressed an inability to adapt to change and it was felt that this attitude was not viable in a changing health environment. When we began implementing the EOC program, we were very “gung ho” in our approach and the staff wasn’t really given the choice to participate and the implementation process seemed to be “busy”, time consuming and uncomfortable. The staff, however, persevered and identified many aspects of clinical care that they felt required improvement and a long and laborious action plan was developed. On reflection, it was too much for a small unit to accomplish and, although some worthwhile change was achieved, staff members quickly lost interest. Achievements included a reduction in medication errors, incidents involving falls, and negotiating the introduction of transition RNs to CCU, which resulted in our becoming involved in the Cardiology RN2 program for improving the skill set of the nurses being rotated through the unit. These achievements led to a marked improvement in staff morale.

The lessons learned from the CCU experience were to avoid setting an unrealistic number of goals and objectives, and to ensure the majority of staff members are engaged and motivated to change. This requires an approach that is collaborative, inclusive, and participatory.

Initially, there was much resistance and reluctance by staff in the Surgical Ward to participate. Eventually two staff members volunteered to be our internal facilitators with the NUM supporting them in this role. Fortunately, both of these staff members were well respected by the team and would act as change champions.

In order to make the implementation of the EOC program work for us in the Surgical unit, we decided, as a team, to work on one project at a time using the principles of the EOC program, which enabled us to do things in a way that matched our context and purpose. We engaged the help of our Essentials of Care Coordinator to guide us and keep us on track. Her relaxed approach was reassuring to us—she took the fear factor away—and we found her to be a valuable resource.

In consultation with staff we agreed to start with the bedside clinical handover procedure and we chose this for a number of reasons, namely:

- To ensure that patients are involved in their own delivery of care,
- To enable patients to communicate with us and to ask questions regarding their care so that they have a better understanding,
- To increase accountability in relation to care being delivered as planned, e.g. medications administered, IVs infusing as prescribed, pain...
issues addressed, and observations appropriately attended and responded to, and

- To introduce ourselves at the commencement of each shift.

We invited input from team members through a series of meetings, brainstorming sessions, and strategies to enable any staff member, who may feel inhibited in this setting, to contribute by posting their comments on a notice board placed in the ward. Some great ideas came forward and it was a pleasure to be part of a team that worked well together.

We decided to develop a checklist in order to ensure that all aspects of patient care are discussed. At first this was quite a foreign concept to the staff but it is now becoming embedded into the work culture of our ward. The major concern for the staff members who were resistant to the idea was patient privacy. This was considered to be a valid issue, so we decided to survey our patients and listen to their stories to better understand how they felt about this.

The majority of patients have stated that they feel safe, are reassured that the staff know what is happening to them, and that they are included in their own delivery of care. They also enjoy being introduced to the next staff member caring for them. Issues or conditions of patients that may be private or embarrassing to them are discussed at the work station prior to going to the bedside and this eliminates the need for disclosing information that may be confidential or upsetting for the patient at the bedside.

It was also identified through SAGO (Standard Adult General Observation) chart audits that we were consistently not performing to the standard of compliance required. By adding this to our handover checklist, within a month we had achieved the required compliance standard. At this point in time, we are still at the evaluation stage and fine tuning the checklist.

Our challenges are to ensure that the revised bedside clinical handover procedure is occurring on the weekend when the regular “drivers” of the process are not present. Patient rounding has revealed that, at times, staff members are not attending the bedside, and so at the moment this issue is also being examined by consulting with staff to determine the reasons that prevent this from occurring and working through them.

Another challenge is trying to engage all staff, to encourage participation and to not just rely on the facilitators to do most of the work. This is being discussed with all staff members during their annual Professional Development Review (PDR). Some staff members will always be reluctant to adapt to change, however, through supportive discussion, everyone is challenged to “agree and commit, disagree and commit or disagree and quit.” Our aim is to ensure that resistance to change does not get in the way of improvements and the great work already being achieved by some team members. Our priority is safe patient care and, as our work culture develops and change is embedded, we anticipate resistance to acquiesce.

So far, our experience with the EOC program this time has been positive, with the team members feeling that we are achieving what we set out to do, albeit slowly and surely, and are not encumbered with unrealistic timeframes. It certainly has been a different experience for me as the NUM, and has reinvigorated my approach to the quality improvement process. Consultation will soon begin on the next issue to be tackled.

Some of our Coronary Care team members
The Essentials of Care (EOC) program provides an avenue for caregivers to transform their working environment in order to achieve the common goal of improving care, satisfaction and outcomes. Midwives have found this ideology easy to take on board, giving them a methodology, an approach, to harness their passion. The EOC program is not a foreign world or concept, but rather a delicious means to enable their voices to be heard. A positive and natural relationship has been proven to exist between the EOC program principles and the midwifery philosophy, and this became evident when the midwifery staff from the Maternity Unit in Port Macquarie Base Hospital (PMBH) embarked upon the EOC program journey.

When the EOC program principles and pathways were introduced to the Maternity Unit midwives, an encouraging relationship began to form. Through the process of negotiation, different types of relationships have developed which are characterised by the level of involvement and commitment (Ramos, 1992, Morse 1991, cited in Stein-Parbury, 2009, p.36). The excitement that we felt as facilitators, following the workshops, was due to the fact that, as midwives, we believed that the EOC program was the gift we needed to harness our energies and ideas. The fit between the EOC program framework and what we, as midwives, see as fundamental to our practice, was simply perfect—it was the connection between practice development principles and the midwifery philosophy.

The implementation of the EOC program allowed the facilitators to reflect upon how the EOC principles complemented the midwifery philosophy. The International Confederation of Midwives states in their ‘Philosophy and Models of Midwifery Care’ that midwifery care combines both art and science, is holistic in nature and is grounded in an understanding of the social, emotional, cultural, spiritual, psychological and physical experiences of women, and is based upon the best available evidence. Pairman (2010), comments on midwifery practice as being about relationships, and that these relationships are the medium through which midwifery is practised, and take place in varying contexts and over varying periods of time. Our maternity unit is filled with a diverse collection of passionate, strong-willed, determined and independent midwives. However, the very independence that is a characteristic of midwives can result in fragmented teams. Driven by a passion to empower women and their families, midwives strive to provide a woman-centred experience for women and their families. The EOC program has the ability to harness this vast wealth of knowledge, skills, and passion to create a united team whose collective interests are for the women in their care.

Subsequent to the completion of the facilitator workshops, our enthusiasm and excitement for the EOC program followed us back to the maternity unit where we endeavoured to pass on our passion and commitment to our fellow midwives. A number of years prior to this time, our unit developed a set of midwifery team principles and a mission statement using the underpinning principles that the team members believed supported their work.
The first step in our EOC journey was to revisit our values, to check in and ensure these values still were still relevant. As we have several new staff, this was perfect timing and allowed another opportunity for collaboration. We plan to do this by writing all our current values on different sheets of butchers paper placed around our education room and to invite all staff to make comment, add changes, or to confirm. After two weeks we will collate the responses and once again ‘check in’ with staff.

This will be via email as well as the use of butcher’s paper notes. How we present our values will also be open to suggestion, with the hope that we can gather some inspiration about how this will ‘look’ and how we can continue to keep our values alive!

As part of International Midwives and Nurses week, we created a ‘Talent Tree, (pictured above) an idea that was simple yet incredibly powerful. The names of all staff, including midwives, doctors, clerks and cleaners, were written on individual pieces of cardboard, and then placed in a bag. Staff members were then invited to take a name and write at least one talent that the named person has. The response was amazing and the entire team participated—in fact, we all loved our tree so much that it is still in the Midwifery Unit Manager’s (MUM) office waiting for a permanent home! We are now immersed in the preparation phase!

The success of the preparation phase of the EOC program within the maternity unit at PMBH has endured due to the cohesive relationship between the methods in which midwives work and the EOC program pathway. The EOC program can provide both a united voice—one that promotes current best practice, that unites all members of the team, that is inclusive, person-centred, and has demonstrated the beginning of cultural changes within our team—as well as a vehicle for collaboration and moving towards our ability to live up to our values in a meaningful way.

Values, facilitation, empowerment, and philosophy of change are all complementary elements of both the principles of midwifery practice and of the EOC program. Due to the harmony that already exists between the midwifery philosophy and the practice development principles, together with the demonstrated enthusiasm of the midwives within the maternity unit, it is anticipated that the implementation of the EOC program will be successful.

We are also very aware that the very nature of what makes midwives open to the EOC program can also be our potential weakness. In other words, we can sometimes get lost in what we were doing, and at times we can be easily distracted by other projects or ideas, so our team of facilitators will meet regularly in an attempt to maintain the momentum, focus, and the ongoing energy of our team. We have two dedicated EOC program notice boards—one is located in the main corridor with general information of interest to our mothers and visitors, and the other is situated in our education room and has more detailed information and EOC program updates.

In June 2012, the facilitators of the EOC process within the Maternity Unit were accepted to present a poster at the State-wide Essentials of Care program Showcase held in Sydney. This was an exciting opportunity to share a piece of our passion regarding the EOC program and the practice of Midwifery. The poster was designed by the facilitators to graphically demonstrate the perfect fit between these two philosophies! As you can see from the poster, the design idea evolved to become a representation of how the EOC program philosophy feeds on the philosophies of midwifery practice. The water flowing from the watering can is the principles...
behind the EOC process, giving the nutrients needed to grow the tree that bears the fruit of our midwifery work—the families, the women and the babies. This tree is then rooted in midwifery concepts and models, with the central strengthening root being the values that were previously identified by our maternity team in PMBH. This was a wonderful opportunity and numerous NSW Health staff members were interested and inquisitive regarding how the EOC program principles work in a Maternity unit. The poster attracted interest from the audience and it even elicited remarks such as, “We need to get our maternity unit to see this, and how it does fit into midwifery practice.”

We are delighted that the enthusiasm for the EOC program has continued to grow and that another two facilitators have completed Workshop 1 both of whom are vital to the ongoing success of the program and to ensuring its sustainability.

No doubt the collection of data through observations will need to be creative in our Unit as it has, in fact, four individual and very different areas—an Antenatal/Postnatal ward, an Antenatal Clinic, a Birthing unit, and a Special Care Nursery. We are confident however, that the data collected will provide a wealth of information for us to draw on as we continue to strive and reflect on our work practices that provide an ever improving and evolving model of excellence in care to women. In closing, all we can say is—“Watch this space!”

References:
Clinical nurses often transition from a primarily clinical role into the role of an Essentials of Care program facilitator. The transition is recognised as a period of role adjustment and a need for critical reflection. While facilitation challenges have been acknowledged in practice development literature (Manley, McCormack & Wilson, 2008), there is renewed urgency to examine facilitator’s perceptions of the role because of concerns about facilitator retention and Essentials of Care program implementation. Facilitators are identified as a critical element of the Essentials of Care program as the program moves toward building capacity and sustainability. By the end of September 2011, the Nursing and Midwifery Office reported, 607 NSW Ministry of Health units had been engaged in the implementation of the Essentials of Care program (Nursing and Midwifery Office). This data has significant implications for health facilities because the point after facilitator training is often when the facilitator starts to assume a leader role for program implementation and thereby there is a need for ongoing support to practice newly acquired facilitation skills. Facilitator training is not without cost including the cost of orientation, travelling expenses, release time and ongoing support and development.

Although there are many published reports of the requirement for facilitation skills when influencing work practices (Hardy et al., 2011; Wilson, 2005; Taylor, 2006) the data source varies, ranging from critical dialogue to studies involving relatively limited sample sizes. Persistent themes that reportedly influence the facilitators experience are the need for additional knowledge, the requirement for critical reflection, support through mentoring or critical companionship, and the exposure to expert facilitators. (Manley et al., 2005; Taylor, 2006).

Based on my own personal facilitation experiences, I will present a brief overview of how I transitioned into the facilitator role. Initially, after attending the Essentials of Care program Workshop One, I felt unclear and less confident of my ability to communicate the program objectives to others. In addition, I was unsure of my ability to learn about a ‘new’ program, and I was anxious about how much the effort involved would add to my existing workload. In discussion with other facilitators, I found that they had also experienced similar feelings. However, over time, through ongoing reading of various resources, incorporating facilitation practice into my ‘usual work’, exploring workplace challenges using Practice Development tools, ongoing attendance at facilitation development opportunities, and reflection on facilitation experiences all progressively developed my ability to engage with the program.

Prior to engaging in the Essentials of Care program, I had worked relatively autonomously and to access the support mechanisms provided to me as a facilitator was a foreign concept. Over time, the role of the co-ordinators and the program development team became clearer to me and the role modelling, facilitation styles, and shared learning opportunities were pivotal in my personal development. My eyes were opened to the possibility of reinventing the way I worked and engaged with people.

During the development of my facilitator skills, I was attempting to influence and change my work practices through education, policy development, point of care training, and research. However, due to a relatively limited insight into the difficulties of the change process, and a general inability to acknowledge the workplace cultures in which the change was occurring, it always felt like ‘hard work.’ As my expertise in facilitation skills progresses, I am becoming more mindful of the fundamental drivers
of change—in particular, the notion that ‘the first person you must change is yourself!’

More convincingly it has been the clinical units that I have witnessed embrace the practice development methodology and the person-centred framework that underpins the Essentials of Care program that have helped me relate to the gains that can be realised. For example, I have witnessed patients who were involved in the handover of their care informing the next nursing shift of an upcoming investigation or a medication change. Also, Nursing Unit Managers are co-facilitating critical discussions with staff where clinical issues are addressed. The commitment and engagement inherent in this process is the foundation upon which a much more effective clinical care delivery outcome is being realised.

Facilitators have a key role in the successful implementation of the Essentials of Care program and their transition into this role requires constant consistent learning, support and personal development. Closer partnerships with the Essentials of Care program support teams, which includes co-ordinators and program developers, can assist facilitators to integrate Practice Development concepts throughout the implementation of the program and which, importantly, closes the gap between the technical and the transformational processes, and provides ongoing opportunities for significant person-centred outcomes.

References:
“I have noticed the emergence of more leaders within our team. The program has gained momentum creating a happy environment in which we work together as a team. We have had multiple sessions on how we work together as a team. We have had multiple sessions on how we work together as a team, what does it look like? What does it feel like? This raised real awareness.”

Essentials of Care facilitator Angelo Fatato, E3H, Napean Hospital

“I am please to support the Essentials of Care program and encourage the wards/units to continue to strive towards a culture of sustainable practice change where critical reflection, effective feedback, open questioning and working with values is part and parcel of who we are as a health care profession.”

Richard Chrystal, ADNM, Western Sydney Local Health District

“That through perseverance and staying focussed on engaging staff brings results.”

Attendee at 2012 Essentials of Care Showcase key learning

“How hearing stories reminds staff that there is more to a patient then recording numbers and monitoring equipment, that there is actually a person in there.”

“How hearing patient stories helped me to remind me of my commitment towards my job and to enhance my values and beliefs as I relate to my patients.”

Quotes from article “Patient Stories as a tool for Reflection to enhance Person-Centred Care” Prince of Wales Hospital