



PACE Pilot Project
Planning Person Centred Nursing Care
Evaluation Report
July 2016

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1.0 Introduction

- 1.1 Since 2009, under the commission of the Chief Nursing Officer for Northern Ireland, NIPEC has been taking forward a project, Chaired by Mr Alan Corry-Finn, Executive Director of Nursing, Western Health and Social Care Trust, the aim of which is to improve the standard of nurse record keeping practice in the region.
- 1.2 The purpose of recording nursing care is to evidence decision making and clinical judgements while supporting delivery and continuity of care, subsequently improving communication between healthcare professionals and the identification of risks to the person accessing the service. Nurses are required from a regulatory and employer perspective to provide evidence of their contribution, professional judgement and interventions in care delivered. Standards of this practice have been reviewed as part of public inquiries and reports.
- 1.3 Northern Ireland (NI) Public Inquiries during 2010 – 2015 recognised inaccurate record keeping practice as a particular failing of service provision¹. The recording of nursing care can be related to all the themes identified and is also as a specific theme. General issues demonstrated included: non-adherence to Nursing and Midwifery Council (NMC) guidance and standards in relation to nurse record keeping; the need for improvement in communication in record keeping and nursing handovers; issues of falling standards in documentation and communication, legibility of records being of particular concern. Specifically, the Regulation and Quality Improvement Authority (RQIA) identified inconsistencies in recording care in a number of reviews, such as inadequate evidence of assessment, planning, evaluation and monitoring of patients²’ needs, consequently a lack of demonstration of the delivery of safe and effective care. The NI Ombudsman’s Annual Report (2015)³ highlighted the point that poor record keeping practice could potentially have a negative impact upon delivered care.
- 1.4 It is recognised that the complexities of nursing necessitate a framework to capture the contribution and impact of the profession. Models of nursing date back to the 1960’s with Virginia Henderson’s based on 14 nursing activities⁴. In more recent years the desire to move away from ‘medical models’ and focus on the unique contribution of the nurse, saw the development of models such as Roper, Logan and Tierney’s Activities of Daily Living⁵, which remains the main assessment model for nursing care in Northern Ireland.

¹ Northern Ireland Practice and Education Council for Nursing and Midwifery. (2015). *Systematic Review of Northern Ireland Public Inquiries and Reports*. Belfast, NIPEC.

² In this report the term ‘patient’ is used interchangeably with ‘person’ and should be understood as defining the person receiving care in the clinical environment, including children for relevant wards.

³ *Annual Report of the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints*. (2015). Available for download at: <https://nipso.org.uk/site/wp-content/uploads/2016/02/AOCC-Ombudsmans-report-2014-15.pdf>

⁴ Murphy, F., Williams, A. and Pridmore, J.A. (2010). Nursing models and contemporary nursing 1: their development, uses and limitations. *Nursing Times*. 106, 23. 18-20.

⁵ Roper, N., Logan, W. and Tierney, A. (1990) *The Elements of Nursing*. Edinburgh. Churchill.

2.0 Background

- 2.1 The development of the way forward to improve the quality of care planning within the nursing profession in Northern Ireland began January 2014 (For a description of relevant action see **Appendix One**, page 24).
- 2.2 The product of this process was the 'PACE' framework which is used in conjunction with the activities of daily living incorporating relevant risk assessments. During this time the Northern Health and Social Care Trust (NHSCT) took an alternative approach to recording nurse care planning.
- 2.3 Evidencing a person's plan of care with the assistance of the PACE framework was first piloted September 2015, through a small scale pilot in four Health and Social Care (HSC) Trusts. There were two evaluation methods: the NIPEC Online Audit Tool (NOAT) and a focus group with those staff members who had been using the framework. The results were extremely positive, with NOAT demonstrating a significant improvement in care planning practice of 39.5%. The focus groups revealed that nurses were highly motivated to change their current practice of recording care plans to the new method. They also reported increased ownership, professionalism and autonomy.
- 2.4 The PACE framework enabled a nursing record that clearly evidenced person-centred assessed needs with an associated plan of care, updated on each shift. It was demonstrated that this required the nurse to utilise critical thinking skills in order to produce concise, factual and accurate records that led to contemporaneous evaluation of the prescribed care.
- 2.5 The findings of the pilot were presented to the Executive Directors of Nursing in November 2015 and agreement achieved to support a wider testing of the framework in three wards in each of the four Trusts, including a children's care setting in one Trust. A requisite from the pilot was that a facilitator at Trust level would be available in any future work to support the nursing staff. During January 2016, a small resource was made available via NIPEC to fund a part time facilitator for 12 weeks of the pilot in each HSC trust. This funding was also offered to the NHSCT, to enable parallel development and evaluation of their approach, to support learning.

3.0 Aim

- 3.1 The aim of the pilot was to further test the structure, format and utility of the PACE framework across four HSC Trusts in Northern Ireland and to test the opportunity for learning with the approach used in the NHSCT.

4.0 Methodology Overview

- 4.1 The PACE pilot was led and co-ordinated by NIPEC, in collaboration with participating HSC Trusts. The methodology was designed to support consistency of approach, aid learning and development in the use of PACE and identify the need for production of appropriate resources.
- 4.2 A consistency workshop was held for champions and facilitators within the pilot wards, 19th January 2016. The purpose of the workshop was to:
 - present feedback from previous pilot, September 2015

- offer further training in the use of PACE
- provide an understanding of the facilitators role
- review a balanced scorecard for evaluation to allow feedback from staff
- identify the requirements for constituent parts of a resource pack
- agree a time line for the pilot, February 2016 – April 2016 (**Appendix Two**, page 25).

4.3 It was elicited during the pilot in September 2015 that clinical staff had a desire to be involved in developing examples of how to use PACE, as they felt it was imperative these were relevant to their area of practice. To that end, a second meeting was convened before the commencement of the pilot, 28th January 2016, to assist the formulation of worked examples with frontline staff in the care settings that were included in the pilot. A resource pack was also presented at this session; a list of the contents can be found at **Appendix Three**, page 26.

4.4 The pilot took place during the weeks of 1st February 2016 – 11th April 2016. During the 12 weeks, three evaluative cycles were examined. Cycle one also facilitated training at ward level in NOAT and PACE. Traditional care plan records were evaluated in cycle one with records documented using the PACE framework being evaluated in cycle two and three. Cycle two began at week four and cycle three at week eight. The pilot wards were comprised of seven that had participated in the previous small scale pilot in September 2015 and five that had not. One of the wards had continued to use the PACE framework from September and another was using a similar approach. It was agreed that these wards would remain in the pilot as it would yield evidence on sustainability of this method of recording nursing care. One ward was a newly constituted ward which obviously had no previous model in operation of recording nursing care.

4.5 Regular facilitators meetings were co-ordinated and directed by NIPEC, throughout the pilot and post pilot phase. The purpose of these meetings was to provide a consistent approach to problem solving and support. It also provided the opportunity to appraise the evaluation methods and role of the facilitator. All five HSC trusts were invited to these meetings.

4.6 The evaluation methods were:

- Use of the care planning section of NOAT
- Time in Motion (TIM)
- Observations of practice
- Patient survey
- Focus groups

4.7 Patient survey, TIM and observations of practice were additional methods to those used in the first pilot and agreed with the Steering Group of the Recording care Project, taking into account the feedback received from clinical staff at the two pre-pilot days in January 2016.

4.8 *NOAT*

NOAT was designed to measure the standard of nurse record keeping in an adult acute setting including traditional care planning using the nursing process and Roper, Logan

and Tierney model. It was agreed from the outset, that with some guidance, the care planning section could be used across the adult and children's wards. The resource pack therefore provided guidance on using the audit tool to measure the standards of recording planned nursing care in the PACE format to enhance the reliability of the results. It was recommended that two people, trained in the use of NOAT, carried out the audit.

4.9 *Time in Motion (TIM)*

TIM studies were suggested by the Recording Care Steering Group members as a helpful data set to understand a range of issues including: time required to implement a change of practice; time spent recording care with the patient both before the change of practice and after; and time spent on other record keeping practices. TIM records were produced in the format of a coloured columned table. The columns measured units of 10 minutes of time relating to record keeping practice such as: nursing assessment, nursing care planning, nursing evaluation, bed end recording and communications with relatives, carers or members of the multidisciplinary team. It was a requirement that an indication was given when any of these elements of practice were carried out with the patient. This was completed by one nurse for the entirety of his/her shift.

4.10 *Observations of practice*

Facilitators carried out observations of practice using the same record for TIM. Following discussion at the first workshop 19th January 2016, it was deemed that a four hour period would be the most appropriate span of time to complete the observation of practice, for a minimum of three times in each cycle.

4.11 *Patient survey*

A separate patient survey, consisting of five questions, was designed for both adult and children's care settings devised from current patient surveys in use in the HSC Trusts. Following an initial pilot of the forms, the questions were refined to enhance readability. It was also recognised during cycle one that patients did not have a clear understanding of the questions, therefore following a meeting with the facilitators, written explanation was generated and given to the patients with the survey. To aid measurement of the reliability of data the last question asked if the patient had any help to complete the questionnaire. The web-based tool Survey Monkey was utilised to ease the recording and communication of results from the facilitators.

4.12 *Focus groups*

Focus Groups were convened following the completion of the pilot and had representation from all participating HSC Trusts. The style was identical to the small scale pilot in September 2015, whereby feedback was facilitated through open discussion with ward champions and facilitators exploring:

- What worked well
- What didn't work well
- The experience of implementing change – barriers and enablers
- What future support might be required for a wider roll out

- 4.13 It was acknowledged that due to pressures currently facing front line colleagues it was difficult to release staff; therefore facilitators collected views by means of a comment sheet on each pilot ward to widen the opportunity to feedback.
- 4.14 The NHSCT were offered all evaluation tools and support assistance from NIPEC. Staff implementing their methodology intend to present a separate evaluative report.
- 4.15 The raw data from all the evaluation methods was sent by each facilitator to NIPEC for analysis and will be presented in the next section of this report.

5.0 Results

5.1 NOAT

Figure 1, below, presents the average scores for all 12 wards in the four Trusts in the three cycles.

At completion there was 20% improvement for all wards, in the standard of nurses' recording care planning practice. Cycle one includes three wards that used the PACE framework at baseline.

Figure 1: Average Scores Four HSC Trusts

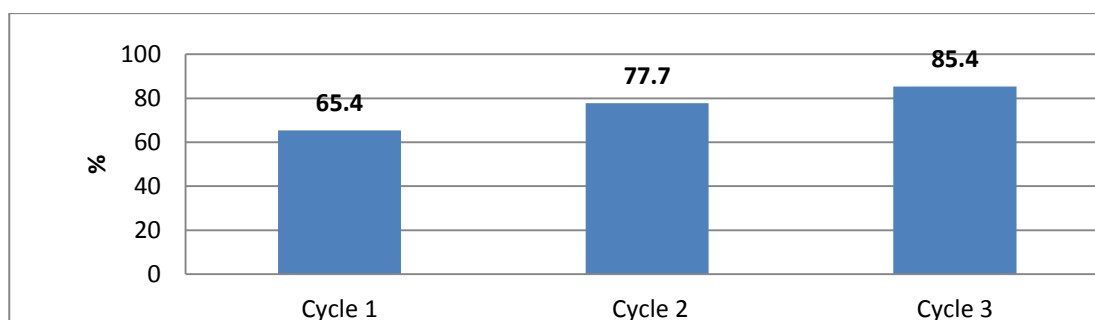


Figure 2, below, displays the results for the children's ward in all three cycles.

The children's ward involved demonstrated an improvement of 17% in the care planning section. It is worthy of note, however, that the NOAT audit tool requires significant interpretation for use in children's setting.

Figure 2: Children's Ward Scores

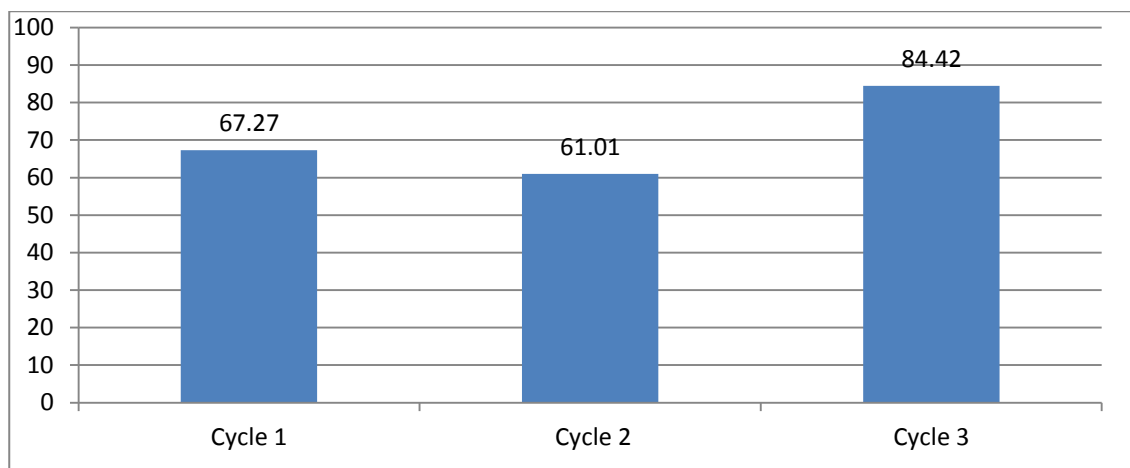


Figure 3 below presents the results for individual wards using PACE, across the three cycles of the pilot: baseline, midway and completion.

The range for scores was: baseline 27.3% – 98.9%, midway 37.2%- 98.7% and completion 63.4% - 95.4%. Two wards did not complete some of the audits, notably Wards F and G.

Ward B scores declined by 6.3% in cycle two compared with baseline but this recovered by cycle 3, with an improvement of 17.1% when comparing alongside baseline.

Comparing cycle three with baseline, two wards C and G noted a regression of 4.6% in one and 8.0% in the other.

There was a decrease in scores in cycle three compared with cycle two in four wards, D, E, H and I. This was appeared to be more significant in two wards, H being 6.3% and E was 14.3%.

Three wards, for a range of reasons, used PACE from the outset of the pilot: B, D and F. The baseline audit demonstrated higher scores, averaging 14.7% greater compared to the rest of the participating wards. These scores were not maintained, in fact declining 6.3% by cycle three, in two out of the three wards, B and D. Ward F could not be measured as no data was submitted for cycle two and cycle three.

D was a new ward that had not used traditional methods within the ward base, using PACE framework upon opening and coinciding with the beginning of the pilot.

Figure 3: Scores from 12 wards across three cycles

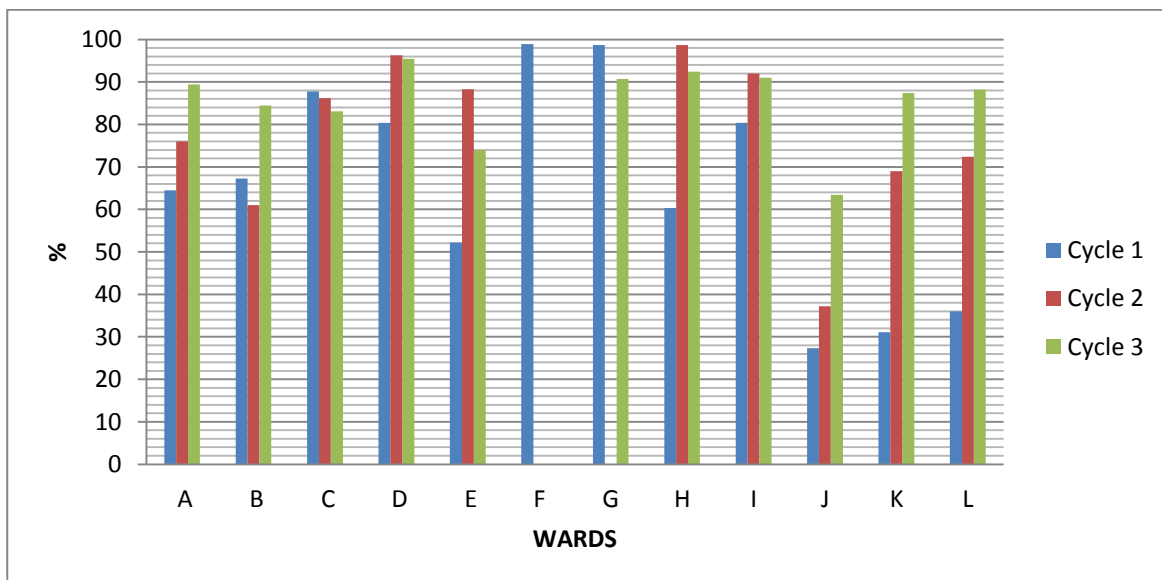


Figure 4, below shows the results for the seven wards that had participated in the pilot in September 2015. Two of these wards had continued to use a form of PACE, the other five wards, reverting to their original methods of planning care.

Five of the seven wards showed rising average scores of 26.1% when comparing baseline with cycle three. Of the remaining two, F did not complete results for cycle three and C regressed by 4.6%.

The average score for the baseline was 67.3%, compared with cycle two, 81% and cycle three, 85.5%. The latter two cycles were based on six results as ward F did not present scores.

The greatest improvement noted was 56.2%, by ward K.

Figure 4: Previous PACE Pilot September 2015 Participants

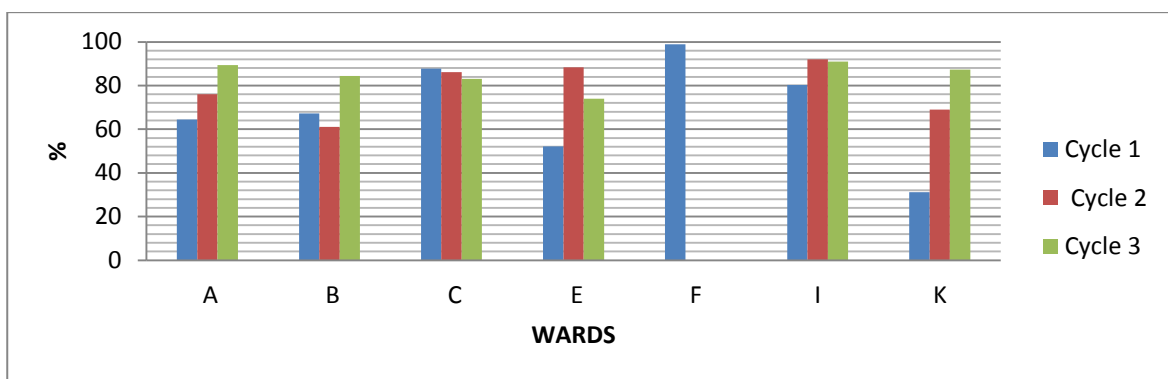
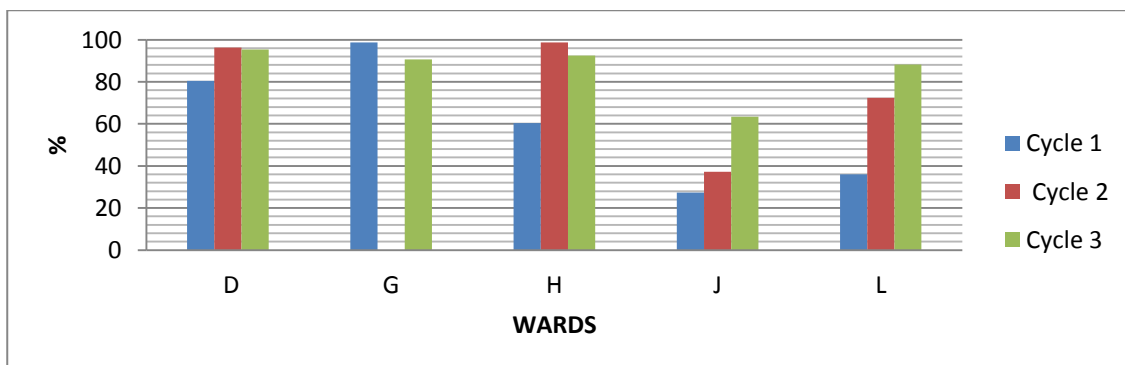


Figure 5, below, demonstrates the five wards that had not previously participated in the practice initiative.

With the exception of ward G, all wards demonstrated increased scores when comparing baseline with cycle three, averaging at 33.8%. Ward G regressed 8.0%; however the baseline score in this case was 98.7%.

The average score was: baseline, 60.3%, compared with cycle two, 84.3%, and cycle three, 90.7%. Cycle two is the average of four wards as G did not submit results.

Figure 5: Wards New to Using PACE



5.2 *TIME IN MOTION, including OBSERVATION OF PRACTICE by facilitators.*

The purpose of the TIM was to evaluate the amount of time nurses were spending with the patient recording care before and after the PACE framework was implemented. TIM charts were completed by the facilitators for three out of the four Trusts and submitted for analysing to NIPEC. All Trusts offered data completed by the nursing staff.

There was evidence of variation in the results when comparing data from nursing staff with facilitators' data. There were significant differences in three wards in particular, pertaining to record keeping practice relevant to nursing assessment, care planning and evaluation. The figures relating to bed end recording broadly correlated. The final section, communication, did not always correlate; this was apparent across all Trusts.

From facilitators' figures in cycle two in all four HSC Trusts, there was an increase of 59.4% in the amount of time nurses devoted to recording nursing assessment, care planning and evaluation in the presence of the patient, compared with the baseline.

From the same figures and considering Trusts on an individual basis, one displayed an average increase by cycle three of 55%, and another 49% in the time that was spent with the patient recording care compromised of nursing assessment, care planning and evaluation. In one ward, by cycle three, nursing assessment and planning care was carried out entirely in the presence of the patient.

Bed end charts were completed with the patient, most wards averaging 100% in all cycles, reflected by facilitators and nurses. Although the average was high across all cycles, a 2.2% increase in the time the nurse spent with the patient recording bed end charts was reflected across all wards.

In relation to the communication section the nursing staff data showed evidence of a rise of 65.2% in the amount of time spent with the patient, when comparing baseline with cycle three, across all Trusts.

Data from nursing staff demonstrated that time spent planning nursing care increased from a maximum of 40 minutes per 12 hour shift in cycle one to a maximum of 60 minutes per 12 hour shift in cycle two. Documentation of evaluation also increased from a maximum 50 minutes per 12 hour shift in cycle one, to a maximum 150 minutes per 12 hour shift in cycle two.

5.3 *PATIENT SURVEY*

This section presents the results from the patient survey questionnaires across the four Trusts. The question presented in **Figure 6**, page 12, was aimed at determining whether or not the person was involved in his/her care and treatment decisions. There was a notable rise of 23% of people answering 'yes' in cycle three compared with the baseline, across all Trusts.

During the last cycle there were no answers attributed to 'never'.

In **Figure 7**, page 12, results are presented relating to a question posed to determine whether or not the person perceived that the nurse took recognition of his/her preferences. Those answering 'always' increased by 35% from baseline compared to cycle three. In cycle two, 81% answered 'always'.

Figure 6: Question: Did you feel the nurse involved you in decisions about your care?

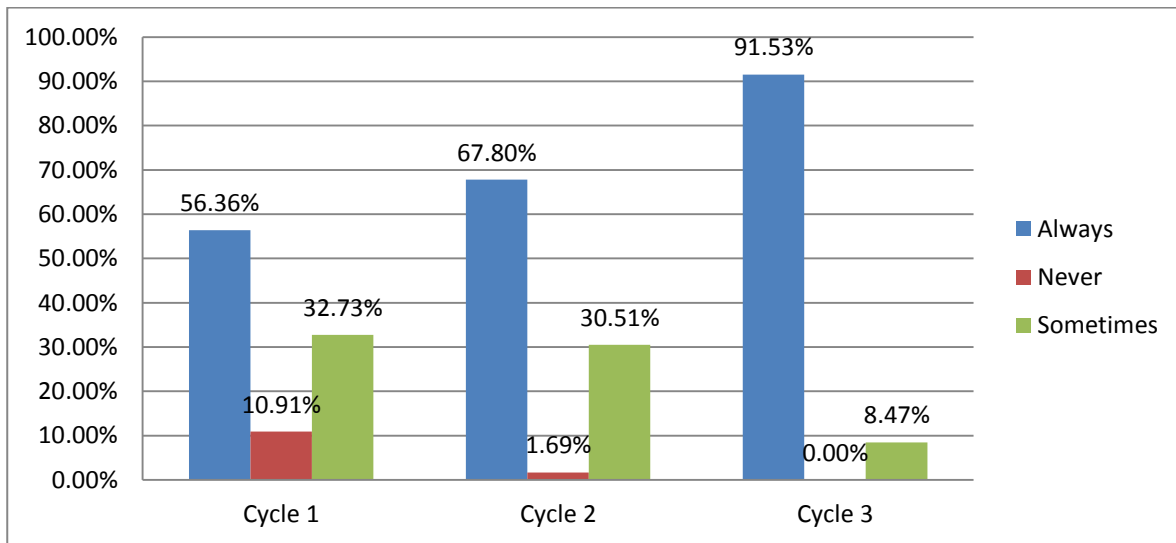
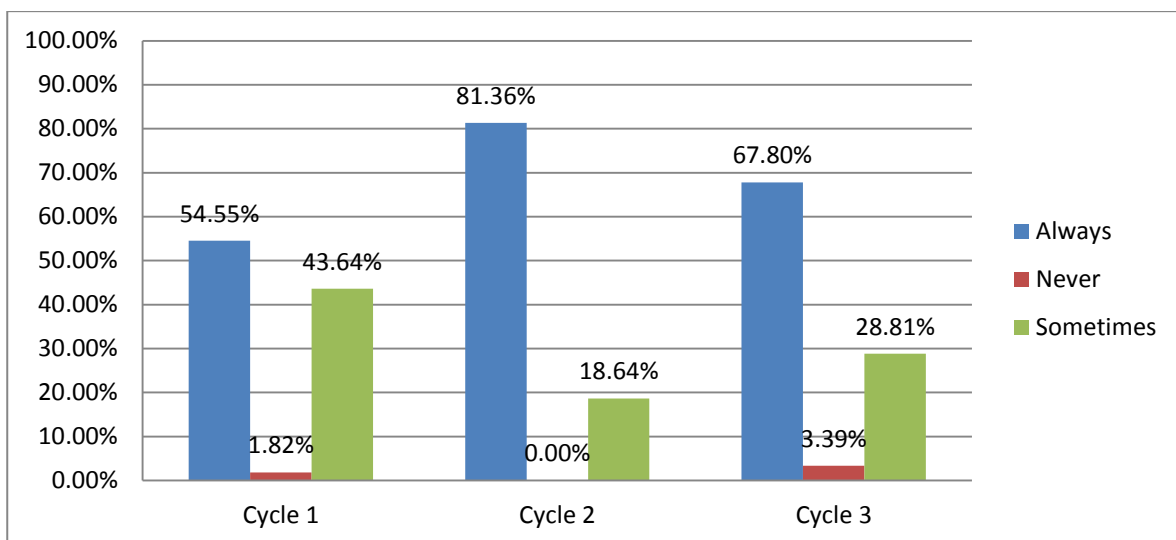


Figure 7: Question: Did you feel your wishes were taken into consideration?



The question presented in **Figure 8**, page 13, considers whether or not care was discussed at the bedside.

Cycle two revealed 64% of people answered 'always', however this declined in cycle three. There was a reduction in those answering 'never' in cycle three compared to baseline, nonetheless cycle two revealed the lowest scores across the three cycles.

Figure 8: Question: Did the nurse discuss your care with you every day at your bedside?

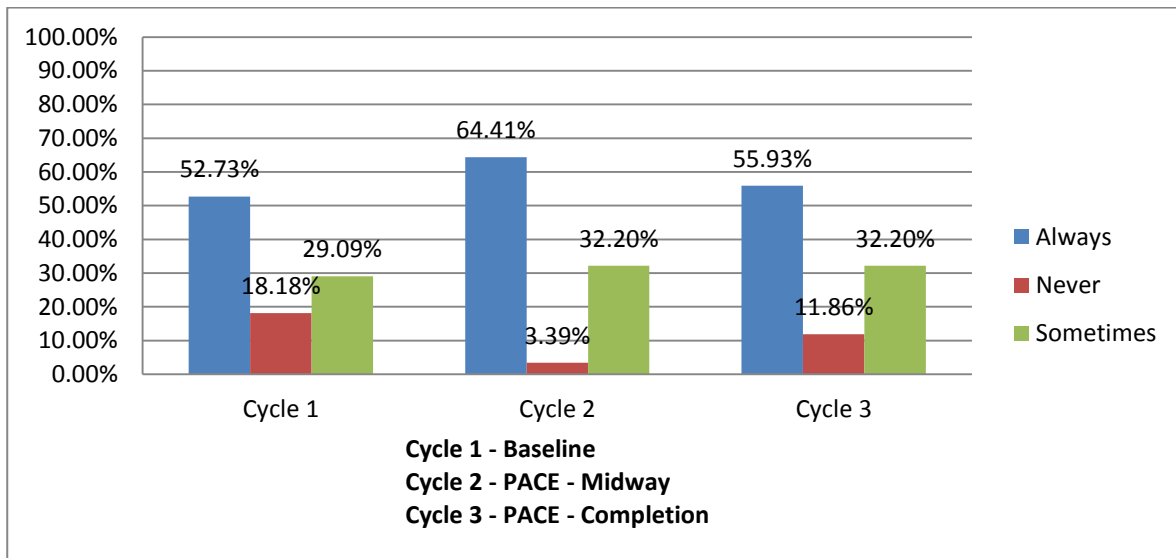


Figure 9, below, presents results relating to a question determining the person’s understanding of what was going to ‘happen’ to them whilst receiving nursing care. Cycle two demonstrated the highest scores, 94.92% answering ‘always’. Overall there was an increase in those answering ‘always’ in cycle three compared to in baseline. None of the people answered ‘never’ in both baseline and cycle two with only 1.69% in cycle three.

Figure 9: Question: Did the nurse explain what was happening in a way you could understand?

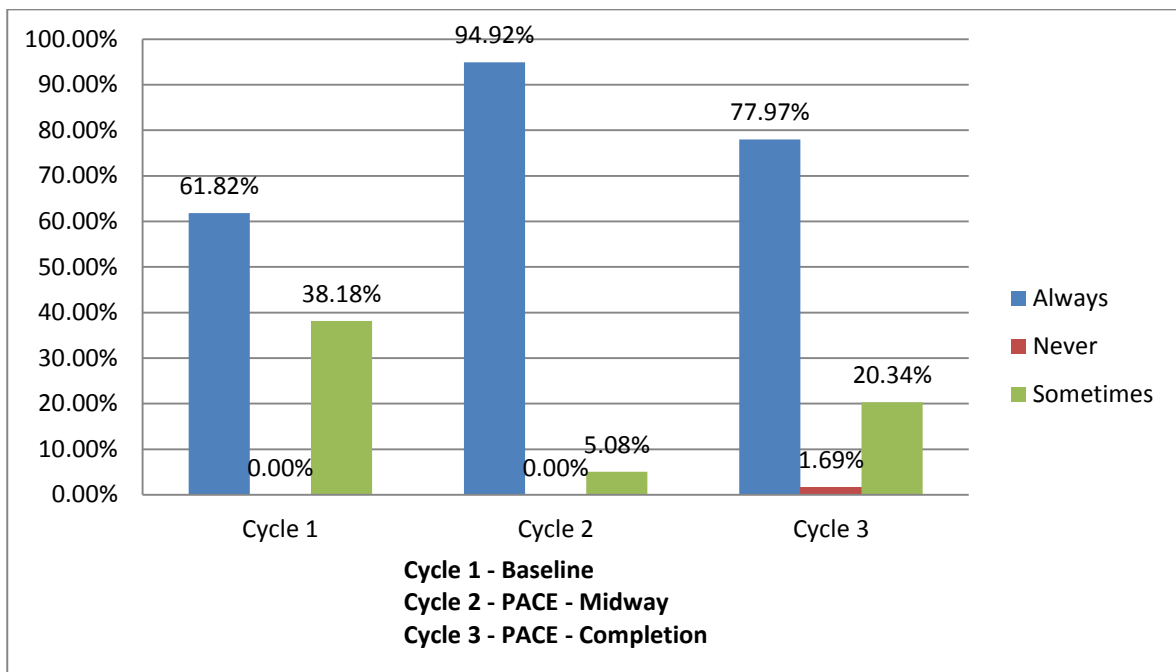
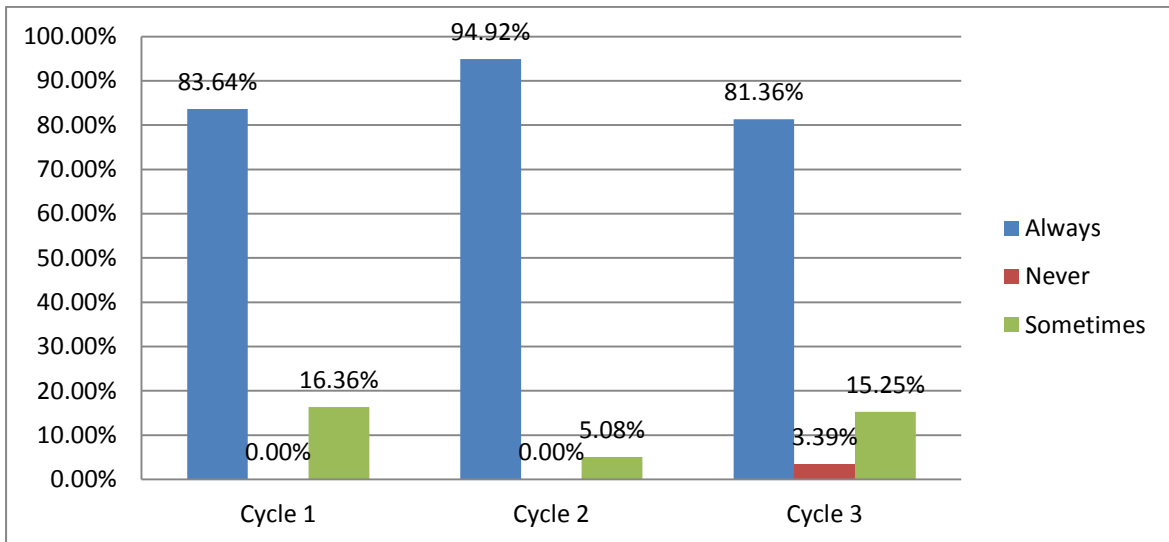


Figure 10, below, presents responses to a question which focused on the perception of the person as to whether or not, in his/her opinion the care 'helped'.

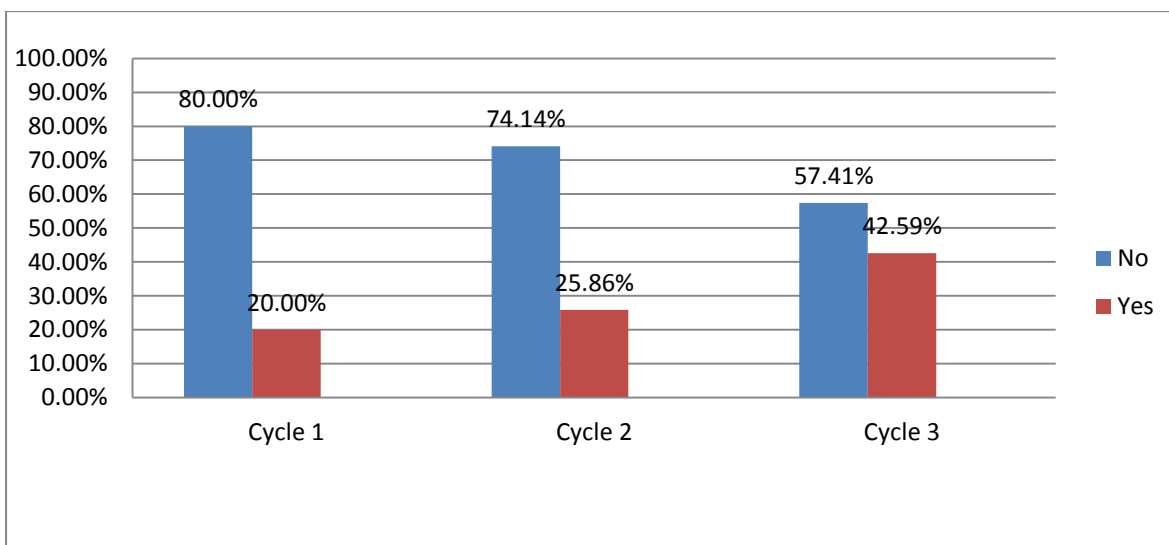
There was a slight reduction of 3% in people answering 'always' in cycle three compared to baseline. Notably, cycle two revealed the highest score of 94.92% answering 'always'. None of the people answered 'never' in both baseline and cycle two with only 3.39% in cycle three.

Figure 10: Question: Did the care you received help you?



The results presented below in **Figure 11** related to a question asked to determine whether or not a person had received assistance to complete the survey. There was variation across the Trusts and cycles for those patients that received help to complete the survey. Cycle three demonstrated the highest amount of patients receiving help to complete questionnaire.

Figure 11: Question: Did someone help you to complete this survey?



5.4 FOCUS GROUPS AND STAFF FEEDBACK

The results from these exercises will be presented in the following three subcategories:

- What worked well/what didn't work well
- Enablers/Barriers to change in practice
- Future support

Results from the focus group meeting will be presented in terms an exploration of themes and feedback received. Broadly speaking, similar themes were uncovered for what first two subcategories, with the addition of the themes of patient involvement, knowledge and skills and training in response to barriers and enablers to the change in practice.

Impact of Change

Staff felt that previous exposure to the PACE framework in the small scale pilot in September 2015 had provided a good understanding of the need to change the way nurse care planning was recorded. The fact that staff acknowledged that current practice was falling below accepted standards was a great motivator to change practice. This acknowledgement was seen to be a powerful enabler by the group, recognising nonetheless that changing practice was a 'stressful' process, particularly under current pressures.

It was elicited from the group that in a minority of wards there was a lack of engagement from ward leadership. Those attending the focus group felt that staff attitudes at all levels could potentially be a barrier if negative. Nurses believed that in today's climate, change fatigue was a significant obstacle. If change was enforced staff felt it could increase resistance due to fear of the unknown, lack of ownership and feelings of not being involved, all of which were recognised as detrimental to practice development.

PACE framework

The benefits of the framework were reported as: structure found to be helpful, simple to use, provided a level of standardisation, less repetition contributing to care plans being up-to-date for each shift and clear increase in involvement of the patient. PACE was also viewed to assist nurses to focus on care that was delivered, based on the person's needs and clearly evidencing outcomes.

The PACE framework did not work so well if it was used in isolation of the Activities of Daily Living. Generally within the group there was a feeling of confusion in the components of assessment and care planning ('A' and 'C') which were cited as causing repetition and overlapping. Some nurses felt that PACE would flow better if 'A' and 'C' were together. It is worth noting that some staff in the children's wards did not share this view.

A possible barrier was expressed as the subjective nature of the framework as it could cause difficulties when recording care for a person who lacked capacity, for example an individual with dementia.

Recording care with the person

Some nurses felt that contemporaneous record keeping was now automatic as a result of using PACE and they were able to spend more time at the person's bedside.

Others expressed that it was difficult to get the chance to document at the bedside and the fact other patients could over hear could potentially compromise privacy. There was also the issue of frequent interruptions whilst in the patient's bay.

Person Centeredness

There was a sense that PACE facilitated an increase in both patient and nurse satisfaction; nurses expressed the view that they got to know people and their families much better and vice versa. It appeared that the individual was more involved in his/her care and the nurses knew what was important to him/her which consequently led to a feeling of being enabled to treat the person holistically and not simply as one with a medical condition. It was reported that this method of recording nursing care planning appeared to facilitate the empowering of people.

Communication

Staff had noted an increase in communication and interaction with the person, consequently leading to people reporting more opportunities to speak with nurses. Practitioners reported that they enjoyed the challenges of critical thinking, giving greater consideration to the purpose and value of their records. The group had the view that the framework demonstrated a more visible record of the nursing contribution and made their records more 'meaningful'. In addition, a clear care journey for the person was demonstrated. Staff appreciated the fact that it gave greater understanding of the person to have a positive impact on handovers.

Time

This particular theme had significantly more comments relating to what didn't work well. Nurses felt having time to read the PACE training examples was particularly challenging due to demands placed upon them in current clinical environments.

In the absence of care plans, the PACE framework requires nurses to document a plan of care as near to the start of the shift as possible which staff reported they found challenging, as traditionally this was completed at the end of a shift. Staff also described difficulty in recording care before 10am as there were many demands on their time, especially in the first couple of hours of their shift. There was a belief, however, that this new method of recording care allowed nurses to spend more time with the person.

Where the group expressed difficulties with contemporaneous record keeping, there was a view that staff to patient ratio was a contributory factor.

Lack of time to change behaviours and learn this new approach to recording care was perceived by the group as a possible obstacle to changing record keeping practice. Whilst the group expressed concern about the increased volume of documentation, it felt this initial fear would reduce as their confidence in using the framework increased.

Approach

In the September 2015 pilot only two patients were selected in each ward, whereas the 2016 pilot involved a full complement of patients in each ward. The staff felt that patient turnover was a factor in the speed of introduction, the higher the turnover the more gradual introduction was required.

Having a laminated card as an aid memoire was thought to be useful, as was having a laminated A4 prompt of PACE/Activities of Daily Living (ADL) frameworks in the patients notes. It was recognised that there was a need for staff to access up-to-date standard practice protocols and procedures to facilitate best practice, in addition to the use of PACE.

Nurses felt that they needed to be supported by facilitators and champions at a local level. They also thought it was imperative that managers not only supported this process but were motivated towards this practice improvement. Nurses reported difficulty in transferring critical thinking into written records. Language caused confusion e.g. terms that had the same meaning – evaluation record/progress report/continuation sheet. Constructive feedback to frontline staff was therefore deemed crucial to enable change of practice in recording care. Consequently, staff from wards that had not identified a champion and had not availed of the local facilitator found the pilot challenging.

Finally, the spread of change was perceived to be more challenging compared with the previous pilot where only two records were tested.

Training

The group attached a real importance to having protected time for champions to train and support staff. Nurses themselves would also require time to engage and implement the change in practice. Champions and facilitators were considered to be pivotal to this practice initiative specifically relating to training and development of staff.

Resources

Nurses felt very strongly that in order to successfully implement and sustain recording care, using the PACE framework the appropriate resources needed to be allocated.

Other

The staff felt there was more work required on guidance when using PACE with patients who lacked capacity.

Bank staff, particularly, experienced challenges as they were not using this method of recording care in all care settings that they worked.

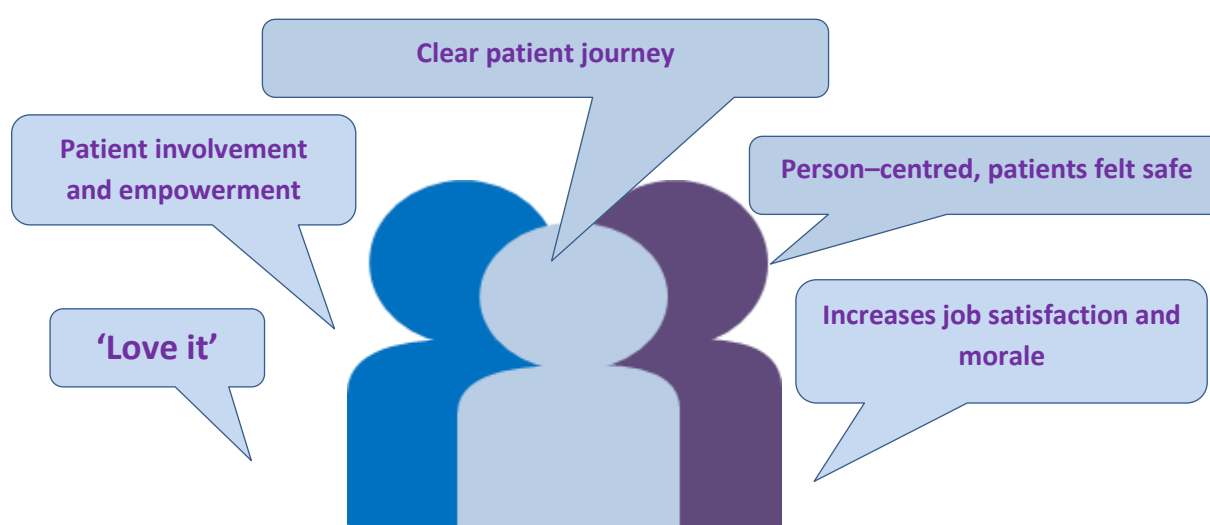
Interestingly, it was reported that there was not only an increase in compliments but patients were more aware of nurses' names. There was a sense this new practice initiative could cause additional stress among staff nonetheless the group conveyed an overall increase in morale among nurses, with greater job satisfaction noted by ward sisters/charge nurses within their teams.

Nurses expressed a belief that this method of recording nursing care plans increased professionalism, feelings of empowerment and increased levels of professional confidence.

The group felt that as nurses moved away from recording care in the style of the medical model, they developed critical thinking skills which demonstrated a clear account of the nurse's contribution in the records.

There was experience of increased autonomy and a great sense of teamwork as they worked together to compare interpretations of the framework. Such camaraderie was considered to be very helpful to assist staff working at different paces and those out of their 'comfort zone'. It was reported as making a particular difference on night duty.

Finally, it was thought to promote reflective practice, a skill at the heart of revalidation.



5.5 FUTURE SUPPORT

A period of time was set aside at the focus group to consider what, in the opinion of the participants, support would be helpful to facilitate prospective implementation of the PACE framework.

A feeling of isolation was expressed by participants, with three pilot wards taking part in each Trust which was a comparatively small number within each organisation. It was believed, effective organisational communication was required to raise awareness at all levels and disciplines to potentially reduce such feelings. In addition, sharing achievements and celebrating success from the pilot were deemed especially important to support and empower staff.

Participants felt it would be necessary to set up a working group to look at examples and emphasised the need for a strengthening of the guidance on the PACE framework in the resource pack.

Staff considered training in evaluation methods such as NOAT was as important as training in the PACE framework. The group felt that formal training of staff and champions including night staff was essential. There was also a need to ensure all staff attended awareness sessions on PACE framework including bank staff, with a longer lead

in time viewed as helpful to facilitate training on the new method of recording care planning.

It was felt that champions needed protected time to enable them to successfully carry out their role through supporting staff, engaging in audits and leading ward teams to effectively action plan. The development of action plans was viewed as being an integral part of the implementation taken forward by the whole ward team and not just a few individuals.

Participants expressed the belief that engagement with higher education establishments would be helpful to raise awareness with pre-registered nurses.

Greater collaboration was highlighted with cross site peer audit being suggested. To advance this practice initiative, consideration should be given to a full time project lead at local level as well as regionally. Finally, the group highlighted that a sustainability plan was required, as there was great motivation to change the practice of recording planned nursing care but this alone was not enough to embed it in practice.

5.6 *EVALUATION FROM THE FACILITATORS*

The facilitators were and continue to be a very important communication link to front line staff regarding the progress, outcomes and future plans for the PACE framework, as well as the invaluable support reported by staff in terms of training and understanding. An evaluation from the perspective of the facilitators was not part of the original methodology, however it was deemed helpful in order to capture the value of the role and pilot methods. Consideration was also given to the value and practical use of the evaluation tools. Information was captured via a small group discussion with the facilitators collectively, in a similar format to that used for the staff workshop.

It was apparent having such support in each of the Trusts with a working knowledge of the PACE framework allowed for staff preparation, enhanced staff engagement and provided motivation for staff with competing daily demands. Nonetheless the short lead in time impacted on the ability of the facilitators to provide adequate training. Facilitators felt it was helpful to reflect and learn from the past, in particular, the nursing process, where the perception was that this model had not been strategically implemented and possibly consequently had contributed to a legacy of poor standards in record keeping practices. Current pressures and the fact that the pilot occurred during the Easter holidays had a reported impact on the availability of staff to train.

The facilitators' presence at ward level was deemed to reduce the pressure to travel off-site for training; however securing time to provide training or review progress still proved challenging, reduced staffing levels cited as an influencing factor. The facilitators expressed a view that the regular regional facilitator meetings, held by NIPEC, were extremely beneficial. These meetings also supported the creation of a sustainability plan until future direction of travel is confirmed.

Champions were felt to be crucial to the change process, their consistent presence providing vital support to the nursing staff. The facilitators expressed a view that early identification and training of ward champions prior to the pilot was a significant factor for success in order to give adequate preparation time.

A summary of the elements required for future support not previously included within the staff feedback includes:

- Writing skills for nurses would be beneficial in terms of training provision focusing on factual and concise record keeping practice
- Resources such as, trolley with wheels, would be helpful to facilitate recording care at the patient's bed side.

6.0 Discussion

- 6.1 This discussion intends to present an overview of the results section, including some of the information which was obtained through Trust staff throughout the pilot project. It is accepted that the evaluation methodology was not a research based methodology, and therefore the discussion is presented to outline data gathered, reflecting opinion and anecdotal evidence with some explanatory information alongside scores.
- 6.2 The results demonstrate a general steady increase from baseline to completion of cycle three in the care planning indicators scores, evidencing improvement in standards of record keeping practice when the PACE framework is used to document nursing care.
- 6.3 In some cases, ward scores declined in cycle two (example: **Figure 3**, page 9, Ward B) however, where the Trust facilitator and Professional Officer NIPEC worked closely with the ward to address the issues, the additional support appeared to contribute to an improvement in scores observed in cycle three. This demonstrates the value of the support and facilitation both regionally and organisationally. Indeed, the ward that demonstrated the most significant improvement (56.2%) had a motivated champion, keen to engage in change management.
- 6.4 Staffing issues were often cited as having an impact on the ability of the ward to change practice, however on some occasions falling audit scores could be attributed to other variables such as: insufficient support and resources for sustainability. Where wards experienced difficulties in completing audit cycles, staffing issues were cited as the main cause. It is accepted that service delivery is achieved in challenging contexts currently; this pilot study appears to make a clear link to a difficulty to make improvements in practice with reported reduced staffing levels.
- 6.5 This element may have been impacted by the fact that staff indicated that the change in practice led to an increased amount of time to document nursing care, as demonstrated by the TIM. The focus group members were not concerned about this increase in time to record at this stage of the change process however; they felt with time and practice this would no longer be an issue.
- 6.6 Using the PACE framework to document nursing care has the ability to situate nurses with the person receiving care more frequently, a fact which is supported by the TIM results. This evaluative method was generally more reliable when completed by the facilitator. From the facilitators' perspective it was difficult to complete the study accurately without being intrusive, and on occasion there was not enough activity to observe. Staff also felt it was confusing or concerning for other non-nursing staff members and patients. This may have accounted for the variation in results impacting on the reliability and validity of the tool.

- 6.7 Interestingly, nurses' ability to document at the bedside with the person could be inhibited by interruptions. During one observation of practice, a facilitator logged a period of two hours of interruptions in one afternoon. Remarkably, interruptions were observed as being interrupted. The majority of interruptions were by members of the multidisciplinary team and relatives, however, not patients. The ward sister on that particular ward demonstrated great leadership regarding bedside recording of care. It was noted by cycle three due to bed side recording there was an increase in compliments and anecdotal reports by patients that they knew the nurses names. From a discussion with the ward sister on a site visit, it was noted that there had been a problem in relation to recording care at the bedside prior to the introduction of PACE. Various methods to change this practice had been tried to no avail. PACE was cited as pivotal in changing this practice, all the nurses including bank staff documenting in the patients presence by the conclusion of the pilot.
- 6.8 Ward leadership was viewed as a crucial factor to the success of implementation of the PACE framework. Staff attending the focus group cited the ward sister or charge nurse as a significant enabler or in some cases barrier to the ability to effect change.
- 6.9 The positive impact of the nurses spending more time with people recording care was reinforced by the focus group data and staff feedback. During the time that PACE was used it was reported patients expressed a feeling of being 'safer' due to increased nurse presence. To summarise the patient survey, it appeared that patients felt more involved, their preferences being considered, recording care was at the bedside and they had a greater understanding of the prescribed nursing care when PACE was used, particularly in cycle two.
- 6.10 The nature of nursing care is incredibly complex therefore drawing rich data from patient's experiences presents a certain degree of challenge especially as they may not fully understand the components of nursing care. There certainly were increased responses in all questions to 'always' in cycle two. The facilitators had expressed a concern that patients had multiple surveys to complete within clinical areas currently; therefore this may have led to survey 'fatigue' by cycle three. It was also evident that a greater number of patients were assisted to complete the questionnaire in cycle two compared to the other cycles.
- 6.11 In terms of change management, change fatigue was cited as an obstacle by staff yet there was great motivation to switch to PACE, derived from the acknowledgement that traditional methods of care planning were not fit for purpose. The fact that traditional methods were simply not effective was reinforced by the low NOAT scores in cycle one/baseline audits.
- 6.12 There was a phenomenon observed where a number of wards achieved higher scores in cycle two than cycle three. On occasion this was mirrored in the patient surveys. A possible explanation for this effect may be a reduced ability to sustain change, an issue which should be explored in any future regional testing.
- 6.13 This appetite for improvement meant there was no feelings of enforced change expressed, staff being generally very receptive. The evaluation process, however, was considered to have placed extra pressure on an already very demanding care environment, particularly relating to the TIM carried out by the nursing staff. It is worth noting that the evaluation methods had been reviewed and amended following feedback from staff, via a workshop held prior to the pilot.

- 6.14 The improved standards have been referenced anecdotally as having infiltrated to other elements of care. The focus groups and staff feedback cited; increased patient safety, increased patient empowerment and overall positive patient experience contributing to their confidence in nursing care. This also had impacted upon nursing staff, with increased job satisfaction and staff morale.
- 6.15 It had been recognised from the development phase of PACE that there was a need for staff to access up-to-date standard practice protocols and procedures to facilitate best practice. The pilot was used as an opportunity to further explore the availability and access to standard practice protocols and procedures (**Appendix 4**, page 27). This element requires further development and is part of the recommendations of this report.
- 6.16 How care is organised impacts on the effectiveness of the PACE framework in practice. Reconfiguration of care systems was cited as helpful to promote the successful implementation of PACE into clinical practice. One ward had done precisely this; the practice indicator score from the care planning section of NOAT of 98.95% reinforces the possible benefits of reviewing care processes. Other areas reported challenges in the reorganisation of care processes. Additional to the consideration of the organisation of care processes was that of the physical environment (**Appendix 5**, page 28). An example of these changes was the purchase of trolleys to assist with recording care at the bedside, deemed to be a simple solution with a high level of impact to aid implementation.

7.0 Conclusions and Recommendations

- 7.1 The evaluation of this pilot demonstrates that the use of the PACE framework has the ability to evidence the nursing contribution to the journey of a person through a care episode.
- 7.2 PACE has been demonstrated anecdotally to influence more than just the written record, being of significant impact on safe, effective, person centred care.
- 7.3 Sustaining change continues to be a challenge in busy ward environments, requiring leadership, support and motivation of the ward teams.
- 7.4 Whilst the evaluation tools were not utilised in a robust research methodology, the evidence they have provided clearly demonstrates the strengths of the PACE framework and benefits of using it to evidence nursing care planning.
- 7.5 Factors such as ward leadership, staffing levels and change fatigue have the potential to impact on the practice improvement, however staff have demonstrated a commitment to change and articulated a desire to go forward, to continue to use the framework and learn from further implementation.
- 7.6 In terms of support and resources, it has been demonstrated that facilitation and regional support and oversight have been enabling factors in managing the change of practice. In any further implementation, it is acknowledged that examples for specific clinical areas of practice would be helpful to assist change management for staff.
- 7.7 Finally, further work to explore the reorganisation of care processes and access to up-to-date standard practice protocols and procedures to facilitate best practice is required.
- 7.8 The following recommendations are offered following completion of the PACE regional pilot:

- i. The PACE framework should be considered for further implementation and testing across more wards in each HSC Trust, taking into account the ideas raised by the focus groups regarding future support.
- ii. The PACE framework should be reviewed in light of evaluative data and support resources expanded to assist any further implementation.
- iii. A robust evaluation methodology should be agreed and implemented with the assistance of the Higher Education Institutions in Northern Ireland. The methodology should take into account the potential for sustainability of standards of nurse record keeping practice supported via the PACE framework.
- iv. Resourcing should be identified for a dedicated member of staff to support the wards implementing PACE in any future testing.
- v. A regional group should be convened to determine sources of evidence for inclusion in standards for nursing practice and recommendations for development and review of future standards.

Timeline	Organisations	Action	Outcome
Jan 14	NIPEC	Description of process to progress Objective 8	Agreement regarding methodology for progression.
Mar 14	NIPEC	Care planning literature review commenced.	Review of literature challenging due to small number of papers – search widened.
Aug 14	WHSCT & SHSCT	Pilot studies and evaluation of 'goals of care' model for care planning.	No significant improvement noted. Key messages around barriers to improvement collated and mapped between both organisations.
Sept 14	NIPEC	Care planning literature review completed.	No new models of care planning uncovered – key principles for excellence identified.
Sept 14	NIPEC	Review of Process for progression of Objective 8.	Agreement to hold workshops October 14 to describe way forward.
Oct 14	NIPEC & HSC Trusts	Meeting of key individuals across HSCTs seeking to progress the care planning work stream.	Agreement of broad principles for care planning. Proposal to host care planning summit in January 2015.
Jan 15	NIPEC & HSC Trusts, other HSC orgs and HEIs	Hosting of care planning summit, Mossley Mill.	Consensus agreement of broad principles and some further elements of inclusion described for new model.
Feb 15	NIPEC, HSC Trusts and HEIs	Development of outline content for proposals paper for Steering Group.	Proposals paper described – completed by NIPEC. NHSCT describing separate way forward.
Mar 15	Recording Care Steering Group	Review of progress for Objective 8 via proposals paper.	Summary paper to EDoN/CNO meeting to seek permission to test.
April 15	CNO Executive Nurse meeting	Presentation of summary proposals paper.	Review, discussion and challenge regarding proposals. NHSCT describing separate way forward.
May 15	Recording Care Steering Group	Review of challenge from CNO meeting and methodology for NHSCT (NHSCT colleagues presented to Steering group).	Agreement to host further meetings with frontline staff to assist development of new approach.
May 15	SHSCT	Sharing of POEP model for care planning and SHSCT pilot test findings.	Agreement to review method as part of meetings with frontline staff.
June and July 15	NIPEC, HEIs & BHSCT, SEHSCT, SHSCT, WHSCT	Two meetings to discuss construction of a potential framework using all of findings so far including SHSCT approach.	Construction of early PACE model with prompt document.
Aug 15	NIPEC and 4 HSCTs	Consistency workshop – approach outlined and evaluation methods.	Training offered for 'champions' who would be using the new approach in practice. Evaluation methods outlined.
Aug/ Sept 15	BHSCT, SEHSCT, SHSCT, WHSCT	Pilot of PACE in 3 wards x 4 HSCTs and 2 patients.	A total of 24 records were carried out using the pilot methods and an audit of control and PACE nursing records carried out using NOAT.
Timeline	Organisations	Action	Outcome
Sept 15	NIPEC & 4 HSCTs	Evaluation workshop for pilot sites	Key messages described and overall intention to proceed with further testing. Minimal change to the framework – insertion of prompts only.
Oct 15	Recording Care Steering Group	Presentation and review of pilot results for consideration of further action.	Decision to present to CNO/EDoN meeting.
November 15	CNO Executive Nurse meeting	Presentation of summary progress paper and recommendations.	Decision to proceed with further pilot.

Clearly document if tradition/pace records on all evaluation data

Date	1/2/16	8/2	15/2	22/2	29/2	7/3	14/3	21/3	28/3	4/4	11/4	18/4	25/4
Activity	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13
Training in NOAT and PACE													
ALL Baseline Evaluation Data		TRADITIONAL CARE PLAN RECORDS PTSURVEY/TIM:OBS/NOAT											
Commence roll out of PACE													
Collect Patient Surveys (min 5)						PACE RECORDS PT SURVEY							
Collect TIM (5) / obs of practice 3x4hr						PACE RECORDS TIM/OBS							
Mid pilot audit end week 6 (5)							NOAT						
Continue roll out of PACE													
Collect Patient Surveys (min 5)										PACE RECORDS PT SURVEY			
Collect TIM (5) / obs of practice 3x4hr										PACE RECORDS TIM/OBS			
End of pilot audit (5)											NOAT		
Submit data for collation to NIPEC													
Focus Group Evaluation													

Week 2 – 3 is when Traditional care plan records are evaluated 8/2-15-/2

Week 4-11 is when PACE care plan records are evaluated 22/2-11/4

TYPE OF EVALUATION	Collected by	Number		
Patient survey	Facilitator	Minimum 5	A paper copy is given to the patient.	CHILDRENS https://www.surveymonkey.co.uk/r/CHILDRCP
				ADULT https://www.surveymonkey.co.uk/r/ADULTSRCP
			The facilitator inputs information from this to survey monkey	
TIM	Ward Staff	5	Nurse will record the amount of time they spend recording care during their shift. This could mean for more than one patient.	
TIM- Obs of practice	Facilitator	3	The facilitator will record on the TIM sheet (3 blocks of 4hours) the amount of time a nurse spends recording care. This could mean for more than one patient	
NOAT	Facilitator & staff trained in NOAT	5	This is completed by 2 people, facilitator and a member of staff on ward that is trained in using NOAT.	

Practical resources
Timeline for PACE regional Pilot February 2016 – April 2016
PACE prompt sheet Adult and Children
Working examples – Surgical/Medical/Children’s
Mapping of PACE to NOAT Care Planning and NMC CODE
Evaluation scorecard outline
Evaluation resources
TIM proforma
Patient survey Adult/Children’s
NOAT guidance with Care Planning section mapped to PACE
Balance scorecard for evaluation pace framework

**STANDARD PROCEDURES
COMPUTER ACCESS**

APPENDIX 4

TRUST A STANDARD PROCEDURES			
Ward	Resources available	Hard copy	Electronic
1	1.The Royal Marsden Hospital Manual of Clinical Nursing Procedures (7 th ED) 2.Core Care plans 3.Care pathways/end of bed charts 4.NICE Guidelines	Y y	y y
2	1.The Royal Marsden Hospital Manual of Clinical Nursing Procedures (7 th Edition) 2.Intranet/Internet 3.Trust policies & procedures 4. NICE Guidelines	y	y y y y
3	1.Manual of Children’s Nursing Practices (GOSH) 2.Internet/Intranet 3.Local policies/procedures 4.NICE Guidelines	y y	y y y y
COMPUTER ACCESS			
Ward	Type of computer/device	number	multiuser
1	Desk top computers	6	yes
2	Desk top computers	6	yes
3	Desk top computers	2	yes

TRUST B STANDARD PROCEDURES			
Ward	Resources available	Hard copy	Electronic
4	Royal Marsden Trust policies and procedures Local protocol and procedure manual PACE resource folder Care plan reference folder as trigger Pocket PACE reference cards	- X X X X X	X X - - - -
5	Online Royal Marsden nursing procedures Trust policies and procedures Care pathways PACE resource file	- X X X	X X X -

COMPUTER ACCESS			
Ward	Type of computer/device	number	multiuser
4	Desk top computers on main ward	2	Yes
	Portable computers	2	Yes
	I pad for sister only	1	No
5	PC on desk/wall	3	1 Yes 2 No
	Flo-cart	1	Yes

TRUST C STANDARD PROCEDURES			
Ward	Resources available	Hard copy	Electronic
6	Royal Marsden (9 th Ed)	Yes	Yes
7	Royal Marsden (9 th Ed)	Yes	Yes
8	Royal Marsden (9 th Ed)	Yes	Yes
COMPUTER ACCESS			
Ward	Type of computer/device	number	multiuser
6	PC	2	YES
7	PC	3	YES
8	PC	3	YES

WARD	DETAILS OF ORGANISATION OF CARE AND PHYSICAL ENVIRONMENT THAT HAD BEEN CHANGED
TRUST A	
1	Change of ward routine to facilitate the documentation of the nursing assessment and care planning early in the day. Documentation before wound dressing/discharge planning. Frequent evaluations throughout the day instead of one block of writing in the evening. Documentation moved to end of bed, use of notes trolley for nursing notes. Attempts at contemporaneous writing when ward acuity allows.
2	Encourage nurses to record care at the bedside where possible. Assessment, planning and recording of care to be carried out in the morning as soon as ward activity permits.
3	Staff to assess, plan and record care in early morning. Assessing, planning and evaluation to be carried out contemporaneously throughout the day.

WARD	DETAILS OF ORGANISATION OF CARE AND PHYSICAL ENVIRONMENT THAT HAD BEEN CHANGED
TRUST B	
1	Documenting at the bedside is common practice and staff are facilitated to do this with the use of trolleys, bed-end tables and bay-end tables
2	Two notes trolleys were purchased for the ward to facilitate the nurses documenting at the bedside.
3	The ward is naturally split into four areas and they currently have three trolleys. One notes trolley was purchased to facilitate all the nurses to document at the bedside.

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This document can be downloaded from
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