POSTER ABSTRACT

Development and Implementation of Person-Centred Nursing Documentation

17th International Conference on Integrated Care, Dublin, 08-10 May 2017

Susan Daly

HSE South, Ireland

Introduction: Irvine et al (2006) assert structured documentation can improve resident care by limiting vague narrative style entries. Nevertheless, in practice the personal and individual aspects of care can only be recorded through a person-centred approach to care planning (Broderick & Coffey 2012, Butterworth 2012, Prideaux 2011). Nurses are therefore challenged to balance the factual, non-speculative principles of good record keeping with a person-centred approach to writing that acknowledges the residents perspective (Butterworth 2012).

Short description of change implement: The Kerry Community Hospitals/ Nursing Units undertook a planned, gradual and inclusive process of change that involved the redesign of structured nursing documentation into a nursing care record that facilitated the creation of individualised contemporaneous person-centred care plans.

Aim and theory of change: This project aimed to improve the nursing documentation (assessment, care plan and evaluation) used throughout the 6 Kerry Community Hospitals/ Nursing Units as a step towards providing testament to the person-centred care being delivered. The Lewins (1951) force–field analysis change model has been utilised to support successful change.

Step 1: Unfreezing (2016)
- stakeholders are made aware of the need to change
- project team created to steer the innovation
- Multi-disciplinary team involved
- New document created
- External review

Step 2: Moving (2016/2017)
- Experimenting with new ideas – additional projects initiated
- Collaborative consultative process
- Internal and external education for RGNs on creating individualised person-centred care plans
- Resource folders created
- Phased introduction of new document
Step 3: Refreezing (2017)
Reinforcing and integrating the change
Motivation (effective communication & continuing education)
Audit & Review - Evaluating the effectiveness of the new documentation in practice

**Targeted population and stakeholders:** Nurses, Clinical Nurse Managers, Directors of Nursing, Area Manager

**Timeline:** 12 months to create and pilot the documentation and 12 months to implement in all sites

**Highlights:** (innovation, impact and outcomes) Successful implementation of a new style of nursing documentation that supports a comprehensive biopsychosocial assessment using validated evidence-based tools, which support and guide the development of contemporaneous person-centred care plans

Residents involvement evident in the care planning and evaluation process

Positive feedback from HIQA inspector

Introduction of
- ISBAR record for contacting the doctor
- PINCH ME Assessment
- AVPU Assessment

**Comments and sustainability:** Regular auditing and evaluation to insure continued success and ensure necessary modifications are addressed.

**Comments and transferability:**
Implementation throughout the 6 Kerry Community Hospitals/Nursing Units
Creation of 318 person-centred care records
176 nurses (including nurse managers) engaged in the change
Transferable to other designated centres for older adults

**References:**
Keywords: contemporaneous; person-centred; care plans