Empowerment Narratives

A collection of exemplars illustrating empowerment of nurses and midwives

September 2003

DEPARTMENT OF HEALTH AND CHILDREN
AN ROINN SLÁINTE AGUS LEANAÍ

Prepared for the Empowerment of Nurses and Midwives Steering Group — An Agenda for Change

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Edited and Compiled by the
Centre for the Development of Nursing Policy and Practice
University of Leeds

For the Meaning of Empowerment Sub-group,
Empowerment of Nurses and Midwives
Steering Group — An Agenda for Change

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Preface

As we move forward into the twenty-first century there is no doubt that the contribution made by nurses and midwives in the provision of services, while recognised, should be reflected in their meaningful involvement and empowerment within those services. The growth of nurses and midwives into empowered well-informed professionals is a natural progression in the development of nursing and midwifery in Ireland, and an essential element in structuring a confident, effective health service.

The evolution of a professional practice has contributed to today's well-informed patients' expectations in regard to the delivery of our health services. Best practice is demanded in every aspect of their care. In order that nurses and midwives reach their full potential in service delivery it is essential that they are empowered to contribute to the decision-making process, thereby enhancing quality of life for patients.

The Report of the Commission on Nursing (1998) recognised and identified areas in which nursing and midwifery involvement needs strengthening if these professionals are to meet contemporary healthcare challenges.

Now, more than ever, the health system is dependent on the resourcefulness of nursing and midwifery. As the new millennium progresses, nurses and midwives themselves see the necessity to create and maintain a culture of partnership where the true contribution of nursing and midwifery care to the health of the nation is recognised. A key element of this recognition is the shared responsibility for the management and delivery of an effective health service.

Empowerment Narratives: A collection of exemplars illustrating empowerment of nurses and midwives demonstrates admirably how empowered people have greater control over achieving the goals of the organisation, and how they individually develop into confident and effective nurses and midwives.

This publication represents almost two years work by many nurses and midwives at all levels throughout the Irish healthcare system as well the members of the Meaning of Empowerment Sub-group of the Empowerment of Nurses and Midwives Steering Group – An Agenda for Change established by the Minister for Health and Children, Michéal Martin TD, in March 2000. I would like to formally thank everyone involved and in particular acknowledge the vision, enthusiasm, dedication and commitment of the sub-group members in regard to the empowerment agenda of nurses and midwives in this country.

Mary McCarthy
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Introduction

The Meaning of Empowerment Sub-group of the Empowerment of Nurses and Midwives Steering Group – An Agenda for Change solicited exemplars to illustrate the progress in empowering nurses and midwives through innovative and effective work. Kanter (1993) defines empowerment as work effectiveness; that is, an empowered individual is able to exercise control of the content and context of work in order to achieve the goals of the organisation. The exemplars received by the sub-group are illustrative of work effectiveness, and help to inform others about the context of work that enabled progress toward more confident and effective nurses and midwives.

The sub-group embarked on a process of identifying and highlighting good practice exemplars in terms of empowerment that were already in existence. Nursing practice co-ordinators were identified as a key group in this regard and two facilitated workshops were held with members of their national group. It soon became apparent that a wealth of examples already existed but few were documented from an Irish perspective. Hence it was considered important to make visible such innovations.

A working definition of empowerment and an instrument to collect the necessary data were drawn up as well as selection criteria for inclusion in this publication.

In October 2001 a call for submissions and a protocol for submission were sent to all directors of nursing/equivalent grades inviting submissions of nursing-led and midwifery-led innovations to illustrate empowered practice in the Irish health services. One hundred and sixty-three submissions were received and all of them demonstrated elements of empowerment. Ultimately it was agreed that forty-three would be published. These are representative of the divisions of the register of nurses, geographical spread and different age categories.

The next phase in the process was to evaluate all the submissions on the basis of their relevance to the criteria drawn up by the sub-group. The major criterion for selection was clarity of description; demonstrating that the action taken had a definite aim, clearly stated, and had resulted in well-defined outcomes that produced evidence/experience-based examples of empowerment.

The submissions included in this publication show clear evidence of co-operation between nurses, and in some cases between nurses and other health professionals, in planning and carrying out initiatives. Those selected had a clear purpose, were effective in executing plans and were successful in evaluating outcomes. The exemplars had implications for all team members, both in terms of job satisfaction and in personal development. Consideration was also given to terms used in the submissions. References to communication, collaboration, change, innovation, safety, co-operation, job satisfaction and quality were considered when scoring, as were allusions to assessment, support, patient-centered care, compliance and patient outcome.

Documents published by An Bord Altranais (2000) *Review of Scope of Practice for*

Nursing and Midwifery: Final Report and the Department of Health and Children (2001) *Quality and Fairness: A Health System For You* helped to provide an accurate focus on the final scrutiny and selection of relevant and effective interventions outlined in the submissions.

To ensure uniformity in approach the Centre for the Development of Nursing Policy and Practice, University of Leeds, was commissioned to edit and compile the empowerment exemplars using a narrative format. A wide range of practice was evident in the exemplars, but soon it became clear that empowerment was exercised through work in several important areas.

Empowerment of patients – empowerment of others involves the building of relationships of equity where both parties have the feeling of competence and ownership of the situation. It can feel risky to trust that others, who are perhaps ill, or not as knowledgeable as the professionals caring for them, can still decide for themselves and direct their care.

Staff development – knowledgeable people feel they have greater control over their work and their lives. This is clear from the rising tide of well-informed patients and the expectations they place on the health service. And it is equally evident from the hunger for development amongst nurses and midwives, and the resulting sense that they can improve care for the patients and their families.

Nurse-led services – nursing is evolving from a vocational pursuit to a professional practice. With professionalism comes the ability to work more independently to manage the care of patients requiring the particular skills and knowledge that nurses and midwives possess. Empowerment in these examples is expressed through taking the lead in patient services and delivering safe and effective care.

Practice development – the systematic and intentional improvement in care by the application of evidence and experience characterises practice development. Empowerment is exercised through the creation of systems that support best practice and the involvement and belief in the contribution of a wide range of people.

Clinical quality improvement – clinical quality improvement involves the confidence and skill to examine current practice, evaluate the process and outcomes, and change the way things are done. This can involve challenging common practice that no longer works, or sometimes changing what is convenient and comfortable because standards and expectations have moved on. Empowerment in these examples involves courage of convictions and skill to persuade and educate.

Research and investigation – research is the generation of knowledge through a systematic process of investigation and conceptualisation. Though often criticised as remote from the day-to-day challenges of clinical care, it is through research that nursing and midwifery can evidence their excellence. Participating in or applying research in the clinical setting empowers both the nurse and the patient.

Each exemplar is presented in two parts. The first part describes the intent of the project or story, extracts some of the learning, and comments on the empowerment embedded in the exemplar. The second part describes the project itself and provides the contact details of the project leader. It is hoped that this collection will give other nurses and midwives a resource of ideas and experiences that will inspire their efforts to empower themselves and their patients.

Patient and family empowerment

Self-medication programme

Older people returning home after a period in hospital often find it difficult to manage their prescribed medication. As many as one in every six older patients has problems adhering to drug regimes in the first few weeks following discharge. Most nurses have encountered cases where failure to adhere to prescribed medication has led to readmission. Studies demonstrate that patients' drug compliance can be increased by self-medication in hospital.

This self-medication programme, using evidence-based practice, gives patients the chance to get used to taking their medication safely and correctly before leaving hospital. Nurses have the opportunity to assess the patients' skill and to educate them at the same time.

By handing over control of medications the nurse empowers the patient in a very important way. Confidence and capability grow. In order to empower patients the nurse must feel empowered him/herself. In undertaking and succeeding with this innovation in patient care, the nurse treats the patient as a partner, capable of autonomy and responsible decision-making, rather than as a passive recipient of care.

Thus one of the lessons of empowerment is that empowering others is not about transferring existing power. Rather it is about generating power, for patients and nurses, through mobilising resources and rallying support.

Project outline

A programme of self-medication, whereby patients are responsible for taking their own prescribed drugs while in hospital, was piloted in a 'Care of the Elderly Rehabilitation Unit'. A self-medication protocol was devised and nurses and pharmacists were offered support in educating the patient.

While still in the early stages the positive impact of the project on patient independence, confidence, autonomy and perceived quality of life was evident to the multidisciplinary team.

Expected long-term outcomes include patients having a greater understanding of their medications. This together with a greater degree of flexibility in timing will lead to an increase in drug compliance. Patients taking responsibility for their own health will foster independence, autonomy, confidence and self-esteem. It is expected that nursing time will be transferred from drug administration to patient education. The discharge process is expected to be smoother.

Patients on the self-medication programme are monitored throughout the process, within the context of their overall plan of care. Patients complete a pre and post self-medication audit form assessing their knowledge of their drug regime. Results are compared.

Following the initial pilot the self-medication programme is expected to be adopted as part of the general rehabilitative care of the elderly. In time self-medication will be adopted in other suitable clinical areas throughout the hospital.

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Individualised pain management

Pain management in general hospitals is often ineffective due to the blanket way in which pain is treated. Treatment regimes are standardised, with drugs administered at set times. Patients experiencing pain often have difficulty in being 'heard' in the absence of an acceptable pain assessment tool. This is especially true when pain recurs before the expected four-hour duration of the effect of an analgesic.

This project sought to individualise the assessment and treatment of patients' pain. The development of a pain diary and pain intensity chart recognises that pain is subjective and that individual assessment is mandatory. It allows for the patient's experience of pain to be validated and accepted. This empowers patients to become partners in care and empowers nurses to develop individualised care.

Empowerment in this project is evidenced by a group of nurses exercising control and impacting on the context and content of work. This core group, acting on a recognised need, worked with and supported nursing staff to change ways of working. Some reluctance displayed by medical colleagues was overcome through good communication, feedback and influencing skills.

Project outline

Recurring concerns among staff in relation to pain management on a general ward led to the establishment of a nursing pain-management team. This team sought to develop an individualised, holistic approach to the assessment and treatment of each patient's experience of pain.

A suitable pain scale was selected following a review of the literature and current best practice. A numerical pain intensity chart represented by a graph, combined with a pain diary which recorded interventions, was chosen. Relevant nursing staff were offered education and training in the use of the pain scale prior to piloting it in two areas. Guidelines for use of the scale were drawn up.

The pilot implementation provided positive feedback from both patients and staff. A few adjustments were made to the layout of the pain intensity chart prior to its introduction to all areas of the hospital.

The use of the pain scale has resulted in increased recognition by staff of pain as a subjective and unique experience. More effective individualised pain management has resulted in a reduction of pain and more effective communication between patients and the multidisciplinary team.

The use and value of the diary and pain intensity chart was evaluated using patient and staff questionnaires together with staff interviews.

CONTACT

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Last days

The death of a patient in care is a very difficult and emotive issue for most nurses. In the extended care setting, where the relationship between the patient and the nurse is more established and more intimate, preparation for death is very important. Talking about and preparing for death with patients and families requires special skills and support for nurses.

In a nursing development unit nurses examine all aspects of their care, seeking continuous improvement. This project resulted from nurses recognising that preparation for death is part of holistic care for the patient in the extended care setting. The patient's physical, emotional and spiritual needs are addressed in a way that protects dignity and personal choice. The appointment of a resource nurse to provide advice, support and direction ensures that difficult emotional issues are dealt with.

The empowerment in this project is evident in the nurses' recognition of the need to work with patients and families in this most intimate phase of their lives. The nurses empowered themselves and the patients and developed a true partnership of care. Success in this initiative has encouraged the nurses involved to address other aspects of care.

Project outline

Nursing staff in an extended care unit recognised that when a patient has reached the end stages of his/her life, there is a change in the care the patient requires, and preparation for the pending bereavement must be addressed.

The physical well-being and control of symptoms are attended to by members of the nursing team. A key person is appointed to facilitate patient/family communication and aid emotional support.

A resource nurse is identified to offer advice, direction and support to all staff. The spiritual needs of the patient are addressed. Patients are introduced to the chaplain of their choice. Preferences for prayers, hymns and music are discussed and recorded. Family members are offered the opportunity to assist in aspects of care. An information leaflet on practicalities/arrangements required after death has been produced for family members.

Following the death of a patient the emotional and spiritual needs of the remaining patients and staff are attended to through prayer and reflection time. This allows a natural grieving period and remembrance of those who died. Staff involved with the patient prior to and during death are offered reflection time to talk about the experience.

The bereaved family members are contacted some time after death and are offered condolences and further advice and support if required.

The outcome of this initiative has facilitated individualised care around death and dying. Better communication with patients helps to allay fears, answer questions, encourage expression of choices, reminiscences, sharing and ultimately friendship and a fuller knowledge of the patient. Families have reported benefits including feeling supported, comforted and helped in allaying fears.

This project was evaluated through a questionnaire audit of staff before the changes and again six months following introduction of the changes. Staff discussions were ongoing during the implementation of changes. Feedback from families is informal through phone contact following bereavement.

Nurses feeling empowered from this initiative are currently examining others areas of practice for improvement and nurse-led initiatives.

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Patient anticoagulation advice

Lack of appropriate patient information can lead to many problems for patient care. Patients can have difficulty complying with medication regimes and behaviour modification. This can in turn lead to frequent re-admissions, pressure on bed resources and waste of treatment resources.

In this project the transfusion surveillance officer observed a number of problems relating to anticoagulate patients taking warfarin. These problems included frequent elevated International Normalized Ratios (INR), an increase in admissions to A&E, a high incidence in the use of fresh frozen plasma, waste of cross-matched blood due to cancelled elective surgery, pressure on bed resources and increases in 'waiting lists'. These problems were deemed to arise in part from a lack of patient education in relation to warfarin treatment. A programme of education was designed, consultations took place and the programme was implemented.

A patient information leaflet was designed and produced and each patient was offered an education session with the nurse specialist.

Eight months of feedback from the programme is very positive. Patients have a better understanding of their treatment and compliance has increased.

Once again recognition by nurses of a gap in care which was resulting in a number of problems led to a new service development. Empowering patients with information to enable them to become partners in care led to many improvements.

By adopting a systems approach to the problem the transfusion surveillance nurse has effected change in many areas and improvement in service to the patient. Like many empowerment initiatives one solution reveals many more areas for exploration. This nurse has identified potential areas for research.

Project outline

The transfusion surveillance officer in a general hospital with an average of twenty newly warfarinsed patients per month identified a series of problems relating to patients on warfarin treatment.

These problems included increased INR's in many patients presenting at the A&E department with haematuria, epistaxis, injuries from falls and other traumas. There was a costly waste of cross-matched blood – a scarce resource. This resulted from the cancellation of elective surgery due to warfarin mismanagement. Such cancellations caused stress to patients and families, problems with bed management and further lengthening of the 'waiting list'.

The nurse recognised the lack of structured patient information on warfarin management as a major contributor to these problems. She decided to develop a patient education programme to address this issue. The programme was developed in conjunction with the setting up of a new information technology system for anticoagulation treatment, 'Dawn A.C. – Anticoagulation System'. This system is designed to streamline appointments and to provide comprehensive patient details, treatment and appointment planners. Each patient is now given a 'Yellow Book' clearly stating the appointment date, INR reading, date of next visit and containing a comments column.

PATIENT EDUCATION

A patient education programme was designed to give both written and verbal information. A patient information leaflet 'Patient Anticoagulation Advice' was designed and printed. This patient friendly leaflet gives information on

- warfarin and it's function
- the necessity to have frequent blood tests
- regulation of dosage according to blood INR
- INR readings
- tablet strength linked to colour coding
- duration of therapy.

Patient education also included an individual patient session with the specialist nurse. This session was designed following consultation with the haemoviglience nurse, OPD nurse manager, information technology personnel and the consultant haemotologist. Patients who are prescribed warfarin are referred to the nurse specialist so that the education session can take place prior to discharge. The specialist nurse has full access to patient information including medical/social history prior to the consultation.

OUTCOMES

After eight months of the programme there are fewer emergency admissions that require warfarin referral. There is a noted reduction in cancellations of elective surgery due to warfarin mismanagement. Patients have a better understanding of warfarin treatment.

EVALUATION

Feedback from patients and staff is encouraging and care delivery is improved.

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Coping with a brain tumour

In today's healthcare environment patients and families expect to be fully informed about all aspects of their illness and treatment. Access to relevant easy to understand information is a necessary part of care. Availability of accurate, timely and relevant information empowers patients and nurses to work together for the best quality care. Internet information is often American or English in origin, so there remains a need for Irish-based information that is easily understood.

In this neuroscience department nurses identified a gap in 'Irish' information available to patients with a brain tumour. The idea for an Irish-based information guide for patients and families was conceived. With nurses taking the lead from the conception of the idea through to implementation 'Coping with a Brain Tumour – a guide for patients and families' was produced.

The empowerment in this initiative is evident with nurses seeing the opportunity to improve patient care and demonstrating the leadership and courage to see the project through to completion.

Project outline

Nurses working in a neuroscience department identified a gap in the availability of information for patients with a brain tumour. Information booklets available were American or English in origin. A need for Irish-based information in written form was identified by nurses. A decision to compile an information booklet was made. A steering group was established and work undertaken.

Drafts were written and circulated for evaluative comment in relation to content, layout and relevance to patients. Groups consulted included patients and families, nurses within the department, consultant neurosurgeons, NCHD, Irish Cancer Society, Brain Tumour Support Group and lay people.

The final document is a concise, comprehensive Irish-based booklet with information on all aspects surrounding brain tumours for patients and their families. The booklet is a 28-page colour printed document.

The booklet has not been formally evaluated since publication. Informal feedback however is very positive and the booklet is seen as of great benefit to patients and their families.

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Staff development

Intervention skills training for alcohol and substance abuse for managers and supervisors

Substance misuse/dependency can be one of the most self-defeating problems that an individual may experience. The impact on the workplace of untreated substance misuse results in severe social and economic problems. Many managers and supervisors find it difficult to deal with such problems in the workplace other than through the organisation's disciplinary procedure.

A group of nurses working in addiction using reflective practice through case studies noticed the emergence of non-standardised practices of referral by employers in Co Donegal to the health services for employees with alcohol related problems. Recognising that the employers did not have the skills necessary to address this issue appropriately in the workplace they saw the opportunity to develop a training programme in intervention skills for alcohol and substance misuse in the workplace. This specialist programme has been availed of by over 100 managers and supervisors.

Nurses used their expert and specialist knowledge and skills to respond to the changing needs of clients. These nurses have empowered employers to provide early intervention for a serious problem and have developed health education in the workplace. They have been further empowered to broaden their scope of practice to offer consultancy in substance misuse protocol and policy development in the workplace. Nurses undertaking an empowerment initiative often feel further empowered to develop new areas of practice.

Not content with developing a training programme the nurses undertook a rigorous research evaluation, examining the factors that influence effectiveness of training.

Project outline

As part of ongoing case and practice review a group of nurses working in addiction recognised the emergence of non-standardised practices of referral by employers to health board services for employees with alcohol related work performance problems. It was evident that managers, in organisations without an employee assistance programme, generally dealt with substance misuse problems through the organisation's disciplinary procedure.

A two-day programme to assist managers and supervisors to deal in a timely and appropriate manner with substance misuse was developed and offered locally. This programme encompasses

- facts on alcohol and substance use, misuse and dependency.
- basic communication skills of listening and empathy
- intervention skills – interviewing employees whose work performance deteriorates as a result of the way they use alcohol.

OUTCOME

To date over 100 managers and supervisors in Co Donegal have attended the training. This has resulted in an increase in early intervention for substance misuse problems in the workplace. Written guidelines on workplace intervention for alcohol and substance misuse have been compiled. The training programme is an income generating initiative.

The nurses working on this programme have broadened their scope of practice to offer consultancy for protocol and policy development for alcohol and substance misuse in the workplace.

EVALUATION

The evaluation of the programme provided an opportunity for nurses involved to conduct research to examine factors that influence the effectiveness of training.

The evaluation design employed the use of reaction level evaluation questionnaires, observations, unsolicited and solicited feedback, a diary and focus groups/semi- structured interviews. A triangulation of methods was employed to validate the outcomes.

CONTACT

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Shoulder dystocia

Shoulder dystocia is a rare but serious obstetric complication that can result in significant neonatal and maternity morbidity and costly litigation. All maternity units should have an updated policy on and a systematic approach to the management of shoulder dystocia. Midwives and obstetricians should have regular training to ensure they work together in the event of an emergency.

In this project the labour ward manager identified a lack of uniformity in, and no regular training for, the management of shoulder dystocia. Lack of systematic management of this condition constitutes a serious risk management issue for any organisation.

Feeling empowered from knowledge gained at a study day and by the fact that she could predict a better outcome of care for mothers and infants this manager set about developing a workshop to train midwives and medical staff. Although run on a multidisciplinary basis this initiative was midwife led. The need for training was identified by the midwife, the workshop was developed by the midwife and the midwives still act as a resource to the medical profession and outside agencies.

If an empowerment initiative is dependent on one person for continuation it often will not survive. In this case, with the encouragement of the instigator, more midwives were trained to take over the initiative. In this way the empowerment has spread to other midwives and quality care is ensured.

Project outline

In 1999 a labour ward manager identified a lack of uniformity in the management of shoulder dystocia. There were no guidelines and no regular practice drills to prepare staff for this obstetric emergency.

Having reviewed the literature, gained knowledge from a study day and obtained senior management support the midwife together with a medical registrar developed a workshop to include theory and practice. Workshops and drills are ongoing.

OUTCOMES

The following outcomes have been observed.

- There is a systematic, updated, evidence-based approach to the management of shoulder dystocia.
- Shoulder dystocia is anticipated.
- Midwives are confident in the management of shoulder dystocia – having the relevant knowledge and skills.
- Teamwork is enhanced.
- Clinical risk management records reveal best practice in the management of shoulder dystocia.

EVALUATION

The project is evaluated through staff evaluation of workshops and the effect on practice through clinical incident reports on shoulder dystocia.

CONTACT

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In-service education on service planning

Service planning as part of the annual business cycle of all organisations has until recently remained the preserve of business managers in the healthcare sector. With the implementation of decentralised management, front-line managers have had to embrace service planning. The involvement of front-line managers in service planning is critical to the overall business planning of any organisation. In this way managers have input into the strategic and operational development of their units.

Service planning has generally met with resistance from front-line nurse mangers, many of whom found the concepts and language of business difficult to understand. For many their initial involvement was undertaken without much training or coaching, and with little or no feedback. As a result, service planning became a chore rather than an opportunity.

Change managers have long understood that lack of knowledge about a subject can result in resistance to undertaking new work. Providing knowledge and training relevant to new work will reduce resistance and encourage participation in new work. In this project a divisional nurse manager recognised the need for training for nurse managers in service planning. The programme has been run on five occasions and feedback is proving positive.

The empowerment in this project is evident in the process of a middle nurse manager identifying a training need within nurse management and working with the current nursing structure to have the need met.

Project outline

A need for training in service planning for clinical nurse managers (CNM2 and CNM3) was identified. The manager who identified this need set about putting in place an education programme on service planning for this group.

With the assistance of a mentor a process of consultation was set up. All relevant groups, including the management group and the nursing practice development unit were consulted. CNM2s were surveyed for their perceived training needs in relation to service planning. A literature review and discussion with the director of nursing and development were undertaken prior to a programme being developed. The programme was then run via the nursing practice development unit.

The outcome for nurse managers was development in all of the core management competencies as identified in the Nursing Management Competency Framework.

The project was evaluated as part of a management development training programme. Participants are also surveyed via questionnaire on completion of the programme.

CONTACT

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Preceptor programme for newly-registered staff nurses

The transition from student nurse to autonomous practitioner is a major developmental phase for all nurses. The success of this transition impacts on the quality of patient care, the competence and confidence of the nurse and ultimately on the retention of nurses within the health services. The transition requires assistance and support from more senior staff to ensure development (*From Novice to Expert*, Benner 1984). This support should ideally be offered in a structured format as of right to every newly- qualified nurse.

Preceptorship is widely recognised as assisting and supporting newly qualified personnel in the adaptation to a new role (Morton-Cooper 1993:102). The preceptor model of education was originated in America and Canada to aid the socialisation of college educated graduate nurses into the bureaucratic environment that is hospital life. The UKCC in the United Kingdom has since 1993 made it mandatory for all newly-qualified registered nurses to be provided with preceptor support. Within nursing a preceptor is identified as a first-level nurse, midwife or health visitor who has agreed to work in partnership with a newly-qualified registered practitioner.

This project set out to design, implement and evaluate a preceptorship programme in an Irish hospital where no such programme existed. An action research approach was adopted. Action research is described as a spiral process involving a number of stages including identifying an issue or problem area, developing a plan of action, implementing the plan, evaluating its effects and applying this knowledge to the original research problem (Coates and Chambers 1990; Elliot 1991). It is particularly useful when implementing change.

The empowerment in this project involved a nurse developing, implementing and evaluating in a structured way a much needed development in nurse education. The leadership given elicited a high level of support and commitment from all staff and managers involved.

Designed to empower and develop newly-qualified staff nurses the programme also empowered those who worked as preceptors. Reflection on practice resulted in changed perspectives and professional behaviour and affirmed many in their clinical skills.

Project 1 outline

An action research project was set up with the aim of introducing a preceptorship programme to a hospital where no formal support mechanism existed for newly- qualified nurses. The five month programme was piloted initially.

The programme was run in two phases. Phase 1 involved assessment and planning over a one-month period. Phase 2, over four months, included implementation and continuous evaluation of the programme.

The assessment process involved weekly meetings with newly-registered nurses to ascertain their professional developmental needs and to introduce the preceptorship programme. Specific areas for development were identified through questionnaires. Pain management and the role of the nurse in cardiac arrest were the two areas most highlighted. Preceptors were recruited during phase 1. Nominees were furnished with literature and details of the programme. Each preceptor was contacted individually to explain the programme and provide an opportunity for questions.

A major component of phase 1 was the development of core competencies for junior-level staff. Draft competencies developed from the literature review were circulated to ward managers. Comments and feedback were incorporated into core competencies. The competencies were then used as part of a 'Preceptor Journal'. This journal allowed for documentation of issues raised during the process.

During phase 2, the preceptor and preceptee were required to work together a minimum of two shifts per week and to meet every two weeks to discuss learning and identify developmental needs. The competencies were used as a framework by which progress was measured. The project co-ordinator monitored progress of each team. At monthly meeting of all participants progress was discussed and evaluated.
A programme of weekly one-hour sessions for preceptors and a series of clinically focused sessions for preceptees were also provided.

During this pilot phase the commitment and support shown by all staff and managers for the programme was excellent. This support ensured a positive outcome for the programme. The time commitment for meetings posed some difficulties.

The programme was evaluated in an ongoing way and involved all participants. It was deemed worth all the work and effort. The findings have been reported on and the programme is to be run again.

Project 2 outline

A preceptor programme was initiated in a large teaching hospital to facilitate the transition from student to staff nurse. The programme is based on a preceptor programme currently in place at Guy's and St Thomas's hospitals, London. This highlights how good practice can be adapted for use in different settings.

Preceptors were selected against set criteria and objectives for the programme were clearly established. The purpose of preceptorship is to support and facilitate the newly-employed nurse in meeting his/her development needs with regard to becoming familiar with the systems and processes used in this hospital and developing the skills needed to function as a member of the nursing team. Preceptors are required to assess nursing practice, provide feedback and identify development needs. Written records of the programme are maintained.

At the inception of the programme the development needs of preceptors were highlighted. This led to the establishment of a preceptor study day, co-ordinated by the clinical facilitator and the College of Nursing. Informal ward-based teaching on the preceptor tool was also offered. These initiatives have resulted in good working relationships between the clinical facilitator and link tutors and greater communication and understanding between staff nurses and clinical facilitators.

The preceptor programme has been adapted and amended to suit service needs since its introduction. Preceptors and preceptees are asked for feedback on the programme to facilitate monitoring.

PROJECT 1 CONTACT
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Research awareness course

The focus of nursing's unique body of knowledge includes the holistic response to health and illness as the nurse interacts with an ever-changing environment. A solid research base will provide evidence of the actions that are effective in promoting positive patient outcomes. Nurses must be competent in critical thinking and be empowered to question care and re-evaluate ritualistic practices. All nursing care today should be research-based or have a sound rationale.

Reluctance to embrace changes in professional practice can be attributed to a lack of confidence in the knowledge and skills that result from research. Many nurses view research as academic and difficult to understand.

To promote evidence-based practice leaders must demystify research and increase nurses' awareness.

This project sought to offer education to nurses on the basic concepts of research to facilitate the promotion of evidence-based practice.

Project outline

Nursing leaders in this general hospital recognised the need to educate staff in basic research concepts and processes. This was deemed necessary to facilitate nurses in coping with the demands of working in an ever-advancing nursing, academic and technological climate.

A research awareness course was developed and offered to nursing staff. The course, run over three half-days, covered awareness of research methods, examined the research process, looked at developing a research question and preparing a literature review. Data collection methods were highlighted and ethical issues surrounding nursing research were explored and their importance reinforced. Practical lessons on the use of the library, computerised databases and the internet were offered to enable participants access relevant literature. To assess learning participants were required to review literature and present the main findings and the implications for practice.

Participants in the programme have demonstrated an increase in research awareness. They are adept in the acquisition of literature and have a good understanding of how to critically evaluate literature. The training has offered nurses the skills required for many post-registration courses and enabled clinical nurse specialists to adapt to the research component of their roles. As more nurses undertake the training it is hoped to filter critical thinking and research awareness into the clinical setting and to promote the practice of research at ward level.

The training course has highlighted the need for more practice development staff, IT equipment and training support. An increase in library facilitates is also required.

CONTACT

NOREEN O'SULLIVAN
Mercy Hospital
Cork

Nurse-led services

Wound clinic

Continuity of care is recognised as essential to achieving optimum outcomes and as a component of quality care. Continuity of care has been achieved in ward care through the introduction of systems of care including primary nursing and team nursing. In emergency departments patients are transient and continuity of care is not a major issue. In many emergency departments however a wound dressing service is offered. Patients attending for repeat wound dressings are not always offered continuity of care. Offering continuity of care through a structured evidence-based approach will result in better outcomes. Continuity of care offers a holistic approach, provides opportunity for patient education and increases patient compliance.

In this project, nurses in an emergency department recognised how using their knowledge and expertise to develop a nurse-led wound-care service would develop a better quality of care for patients. In taking the initiative to develop such a service, nurses promoted an ethos of holism and family-centred care. Nurses were also empowered to develop independent decision-making and incorporate evidence-based practice into care. Empowerment also resulted in increased personal and professional satisfaction with greater ownership by nurses of nursing practice.

Project outline

In the emergency department of a large children's hospital nurses recognised the need to develop continuity of care for the patients attending for wound dressings. A significant number of children attend the emergency department with trauma-related wounds. Prior to 1998 the provision of wound care was unstructured, lacked uniformity and inhibited a more dedicated approach to providing wound care. Recognising this, nurses engaged in a consultation process with nursing staff within the department, the School of Nursing and the emergency department consultant with a view to establishing a nurse-led wound-care clinic.

The service is led by a senior emergency department nurse with extensive experience and training in tissue viability. All wounds are assessed using a generic wound-care assessment tool that was devised in the department. The wound is assessed for

- wound dimensions
- stage of wound healing
- presence of exudates, odour
- pain experienced
- signs of infection
- need for medical review.

This assessment forms the basis for an individualised wound-care plan. Dressing types and frequency are prescribed and outcomes are evaluated at each visit.

The purpose of the nurse-led clinic is to

- promote optimum benefit through consistent evidence-based care
- educate children, parents, staff and students
- audit attendance at the nurse-led service

The clinic provides a quality service to children and their families. Waiting times in the emergency department are reduced as a result of an individualised appointment system for wound care. The infection rate has been reduced by the use of a more co-ordinated approach to management of wounds. Continuity of care also provides a more reassuring environment for children and families. Familiarity with nursing staff allows a bond of trust to develop and has facilitated patient education.

CONTACT

JOAN MAYE - Staff Nurse
Emergency Department
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Bug-busting programme

The problem of head lice is a major public health issue in communities with large school-going populations. The problem appears to be ongoing and unstoppable. Many treatments are ineffective for several reasons. Parents and children do not want to talk about the issue. Children with head lice are often labelled and isolated by others. Due to the secret nature of the problem and the treatment many parents deal with head lice ineffectively.

Public health nurses (PHNs) identified a need to deal with head lice effectively. The problem was a long-standing one for children, parents, schools and PHNs. It appeared to be at the root of many school-related problems such as absenteeism and in some cases children had to be hospitalised due to secondary infection. The current health board policy was ineffective, distasteful and costly.

Looking for an alternative treatment which would be effective and acceptable the PHNs came across the 'bug-busting programme'. This had been effectively used in another community care area and in 1996 was the treatment of choice of the UK Department of Health.

The bug-busting programme is an educational programme about head lice detection and culminates in bug-busting days to stop the continuous cycle of head lice. The programme, involving several disciplines and agencies, is an intensive multi-pronged approach. It aims to 'out' an often hidden problem and to change lifetime habits.

Working closely with communities, public health nurses are ideally placed to identify community problems. Solutions to such problems require a community approach rather than an individual one. Identifying the problem and recognising that it is within their scope to offer solutions is an aspect of empowerment. Taking responsibility for their practice and exercising their authority the nurses were working as autonomous practitioners. The open educational approach of this programme has highlighted ways to address other health education/public health issues.

The lack of formal evaluation of the programme is a limiting factor and may inhibit its development and role out.

Project outline

The ‘bug-busting programme’ was identified by a group of public health nurses (PHNs) as an alternative to the current practice of treating the recurring problem of head lice in their community.

Head lice are a serious problem for children, parents and schools. Many school-related problems such as bullying and absenteeism are attributed to the problem of head lice.

Having investigated alternatives, the PHNs chose to pilot the bug-busting programme. Planning and preparation included costing of the programme compared to the cost of current treatments. Funding was sought and obtained and discussion with other disciplines – pharmacists, GPs and hospitals – took place. Local schools were informed of the programme and offered support and co-operation in adopting it.

The programme was launched at the beginning of a school term. PHNs showed a video and gave a talk to each class. The video was shown daily in the health centre. Parents were given the bug-busting kits following an instruction session. Intensive awareness-raising bug-busting days were announced. On these days homework was suspended and all children were encouraged to remind their parents to bug-bust. Bug-busting days also included poster competitions, and displays of art, song and dance were centred around the programme.

Working as a team, involving other disciplines, agencies and the community itself, the PHNs addressed a serious public health problem. The intensity of work during the programme required good co-ordination and teamwork. The programme was informally evaluated and appears to have been a success. It was not formally evaluated however, which may prove a difficulty in rolling out the programme.

CONTACT

PUBLIC HEALTH NURSES
Community Care Area 8
Northern Area Health Board
Dublin

Pre-admission screening clinic for day surgery patients

Technological developments in medical care have led to an increase in day surgery in recent years. Day surgery results in a greater utilisation of resources, with a greater number of patients receiving services and better bed-utilisation.

Pre-operative screening is important for all patients undergoing surgery. Inadequate screening can lead to cancellation of surgery on the day. Some patients have to be admitted overnight to allow for screening and investigations prior to what could be day surgery. This was recognised as a waste of valuable resources.

In this project a nurse manager recognised the importance of pre-operative preparation for the patient. It was recognised that physical and psychological preparation could enhance post–operative outcomes for patients and their families. A reduction in cancellation of surgery led to better bed-utilisation.

A clinic was established based on the recognition that nurses had the organisational and clinical skills to provide pre-operative preparation and screening.

Being empowered to develop a new service within her area of influence led to the lead nurse being involved in the development of a service-planning video in which the pre-operative screening clinic was featured. A case of ‘success breeding success’.

Project outline

Nurses working in day surgery identified the need for adequate pre-operative screening for patients undergoing day surgery.

A pre-screening clinic was established by nurses to ensure that all day surgery patients were prepared both physically and psychologically.

At this clinic all necessary pre-operative investigations are carried out. The patients are given the opportunity to discuss the surgery and ask relevant questions. This helps reduce anxiety. Patients are then allocated admission and discharge times and given all discharge information.

Patients are now adequately prepared and have all relevant information, which helps them to plan and prepare for surgery. This allows for greater patient involvement and autonomy in delivering their care. The risk of cancellation of surgery is reduced when patients are adequately informed and prepared.

The project is evaluated through patient questionnaire.

Following the success of the pre-screening clinic the lead nurse was involved in the development of a service-planning video that incorporated the development of the pre-operative screening clinic.

CONTACT

EDEL KIRWAN
Clinical Nurse Manager 2
Our Lady of Lourdes Hospital
Drogheda, Co Louth

Activities nurse

The importance of structured activities for mental health patients in an acute psychiatric unit has long been realised. Many patients with mental health problems have difficulty in integrating with others and in developing hobbies or interests. Staff working with such patients, whilst recognising the need for such activities, can have difficulty in incorporating them into daily care.

The purpose of clinical audit is to highlight areas of good practice and identify areas for improvement. The value of audit can be measured by the developments in patient care as a result of recommendations.

In this project an integrated client and staff audit of admission procedures to an acute psychiatric unit identified patient loneliness and boredom as issues to be addressed. The audit recommended the development of structured activities and recreation to enhance the rehabilitation process and promote positive mental health.

A full time, supernumerary, staff nurse position was created to develop an activities programme. The nurse, in consultation with staff and patients, developed a structured programme of activities both on and off the unit.

This project highlights how, when an opportunity is presented, the creativity and enthusiasm of nurses can develop a high quality, relevant service which enhances patient outcomes. Despite the limitation imposed through having no dedicated space and difficulty accessing money, the programme has proved very successful.

In developing a new service the process provided both personal and professional growth for the nurse involved.

Project outline

Following a recommendation from a clinical audit of admission procedures in an acute psychiatric unit the post of activities nurse was created. The post holder was to develop structured activities to address the boredom and loneliness of patients. This post is full time and supernumerary.

In consultation with patients and staff a programme of activities both on and off the unit was developed. The programme is based on enjoyable, achievable, relevant activities appropriate to individual and group needs. Individual exercise programmes, group games, group crosswords and social outings are included.

Patient participation is voluntary. The programme is expected to enhance patient care, reduce stress levels and relieve boredom for patients. Patients are introduced to new activities and experiences. The programme provides staff with the opportunity to introduce health promotion information.

Staff have also reported a reduction in stress levels.

The project is evaluated from both a staff and patient perspective. Formal group discussions, informal feedback, observation and attendance levels all show a positive impact.

The programme has resulted in networking with community groups and other health board areas.

CONTACT

MR M LENNON
Assistant Chief Nursing Officer
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Lead Nurse Lynn McDonnell PRN

Community substance abuse service

Alcohol and drug related problems in patients admitted to psychiatric hospitals are a major drain on hospital resources. Repeated admissions, longer length of stay and poor patient outcomes were resulting from a medical model of care. This model of care persisted in one acute psychiatric unit until a group of nurses took an interest in developing a more holistic model of care. The first step involved several meetings with medical staff to highlight the serious issue and to negotiate the implementation of a more suitable programme.

A pilot programme was established and demonstrated positive outcomes. As a result out-patient services were developed. This service allows for follow-up of patients on discharge and has resulted in a reduction of almost 50% of bed occupancy days. The service continues to evolve and expand to meet patient needs. This process of development is enhanced through continuous evaluation and reflective practice. Developing a specific focus through a specialist service helps the long-term viability of the service.

The project was initially established in 1998, which shows that nursing innovation and empowerment is not a new concept. Factors which enhance empowerment can be 'naturally occurring', such as an individual's interest, personality and confidence. If these intrinsic factors are supported by extrinsic factors, such as evidence-based practice and supportive nursing management, empowerment is facilitated.

Nurses currently working on this project recognise that empowerment means different things to different people. Enhancing empowerment requires a commitment to continuously evaluate practice and develop reflective practice. An evaluative approach requires courage and openness to ask for feedback and to change practice on foot of this.

It is also recognised that empowerment is a process, not necessarily an end product. Nurses working in this substance abuse service have been empowered through negotiating the service from a disease-oriented approach to a broader public health approach. They recognise that no one person or profession has absolute knowledge, that it is a case of *both/and* rather than *either/or* – working in collaboration to develop patient services.

Project outline

During the 1980s it became increasingly apparent that the number of admissions to an acute psychiatric service of persons with a substance abuse problem was increasing. A nursing survey of patient admissions highlighted the number of bed days occupied by patients with alcohol related problems. Meeting to discuss the issue nurses recognised that the strictly medical model of care – detoxification and lengthy in-patient stays – was inappropriate. The result was repeated re-admissions to the hospital.

Nurses undertook to convince medical staff of the serious problem and to elicit support and co-operation in implementing a suitable treatment programme. Several meetings took place after which a pilot programme was set up. During this pilot in-patients were offered two weeks of substance abuse counselling.

The evaluation highlighted that the two-week period was insufficient and that patients required follow-up for six to eight weeks after discharge. Length of inpatient stay was reduced considerably. The need for additional staff training was identified.

A community-based substance abuse counselling service was established. Four years later a retrospective study comparing length of stay pre and post substance abuse counselling showed a 50% reduction.

The service is continuously evaluated using a variety of means including patient and staff surveys, monitoring readmission rates and length of stay of in-patients. The staff engage in reflective practice both as individuals and as a group.

The service has survived many staff changes and has continued to develop over the years. The development of a philosophy unique to the service and adoption of a patient-centred treatment model have contributed to the success.

CONTACT

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Breastfeeding hospital initiative

Breastfeeding has long been recognised as the best method of infant feeding. The benefits to infant health and well-being are recognised. Health gain from breastfeeding lasts into adulthood. Benefits to feeding mothers are also recognised.

Despite all the evidence, breastfeeding rates in Ireland remain very low. A *National Breastfeeding Policy for Ireland* (DOH 1994) set out targets and policies to promote and increase the rate of breastfeeding. Most health boards subsequently developed complementary strategies. Both local and national strategies have failed to have significant impact on breastfeeding rates. Societal and cultural norms favour formula feeding.

Policies and strategies remain as aspirations until someone undertakes to promote and implement them. In the Mid-Western Health Board the local breastfeeding strategy allowed for the appointment of a breastfeeding specialist to promote breastfeeding. This post is now at clinical midwife specialist level.

The current post holder saw the opportunity to take the local strategy further and aim for accreditation with UNICEF/WHO through the 'Breastfeeding Hospital Initiative'.

Again, we see empowerment coming from a personal interest and commitment to promoting quality care for patients. This, combined with management support (through the creation of a specialist post), allows for real change to take place. Despite a first unsuccessful external assessment, the project continues and the aim of accreditation remains real. Empowerment initiatives require that we are open to feedback and take corrective action to achieve improvements. The real success is in the journey rather than just the destination.

Project outline

The Mid-Western Health Board Breastfeeding Strategy was launched in 1999. The 'breastfeeding midwife' appointment aimed to implement the strategy. The next logical step was to seek accreditation through the UNICEF/WHO Breastfeeding Hospital Initiative. This project was launched in late 2000.

Policies based on national and local strategies were introduced. The regional breastfeeding policy was displayed on all wards. A breastfeeding management training programme for all staff was introduced. This aimed to update knowledge and attitudes to breastfeeding.

A booklet on breastfeeding is now provided to all women at the booking clinic. The input on breastfeeding at antenatal clinics has been increased. The ad hoc approach to documenting infant feeding practices while in hospital has been replaced with a standard procedure to facilitate accurate recording. A network of community-based breastfeeding support groups has been established to support mothers following discharge.

An environment conducive to breastfeeding has been promoted within the hospital. Equipment and rooms are available for breastfeeding mothers – whether patients or staff. Paid lactation breaks for breastfeeding staff are also allowed. All information promoting formula feeds has been removed from display.

It was hoped to achieve a 'certificate of commitment' within one year and full accreditation after a further two years. The hospital was not successful at the first assessment but efforts are continuing.

Evaluation and monitoring of infant feeding practices are continuing. The training for midwives is ongoing.

The project has generated a lot of interest and support locally and nationally that has been very encouraging. Difficulties encountered included balancing work on the initiative, teaching and a full clinical case-load.

CONTACT

MARGARET O'LEARY
Clinical Midwife Specialist
Regional Maternity Hospital
Limerick

Domino and hospital outreach home birth service

Pregnancy and childbirth are normal physiological events and the majority of births are low risk. In Ireland, since the 1960s, the vast majority of births have occurred in maternity hospitals with a predominately medical model of care. Midwifery skills and knowledge are under-utilised in this model of care.

Demand for alternative models of care has been growing from both expectant mothers and midwives. Many expectant mothers today want a more holistic model of care, with continuity throughout pregnancy, labour, birth and the postnatal period.

A group of midwives saw an opportunity to develop alternative models of care following the publication of *A Plan for Women's Health* (1997) and the work of the expert committee on home births that followed. The National Maternity Hospital submitted a proposal to the Department of Health to provide a pilot scheme for DOMINO (Domiciliary In and Out) and home births.

A team of eight midwives with a designated team leader started the pilot scheme, which was funded by the ERHA. Using their full range of midwifery skills the team offer holistic maternity care to mothers fulfilling the eligibility criteria. The service is offered within a geographical area.

The team has accepted full responsibility, authority and accountability, within guidelines, for the midwife-led service. It has developed guidelines and protocols, recruits clients and provides a full 24-hour service with continuity of care.

Empowerment in this project came from recognising one's skill and knowledge and seeking opportunities to utilise these to the full. Constantly seeking to improve services through feedback, audit and research facilitates ongoing personal and professional development and ensures best quality care and service. The positive outcome of the service demonstrates how empowered staff offering quality service in turn empower users of the service.

Project outline

A comprehensive midwifery-led service for home births and DOMINO births was set up in response to the expert committee's report on home births. The pilot was funded by the ERHA for two-and-a-half years. An independent evaluation was commissioned by the ERHA to complement the ongoing evaluation by the midwives.

Eight experienced community midwives with a designated team leader run the service which offers 24 hour maternity care to a defined group of women in a defined geographical area. This service offers alternatives to the traditional hospital-based service. All the midwives involved had additional training and reskilling.

The scheme offers low intervention births in a home from home environment, in the hospital with early discharge 6-12 hours following delivery. All women have a daily visit by a team member for 6-10 days postnatal. Women choosing home births have home-based antenatal care. Antenatal care for DOMINO births is offered in outpatients or satellite clinics. The team also run antenatal classes for women and their partners.

The midwives developed the guidelines and protocols for midwifery care. They recruit clients and offer holistic care in collaboration with the clients and their families. Women with low-risk pregnancies and with no significant medical history are offered the service. The team take full responsibility for duty rostering to ensure continuity of care. The care delivered is planned and modified according to need. Standards of care are monitored and improved through audit and research.

In a two-year period there were 240 deliveries in the scheme – 24 home births and 210 DOMINO births. The outcomes as evaluated by the midwives have been very positive in relation to neonatal well-being and breastfeeding rates.

All 240 babies were live births and all were well at the six-week neonatal check-up. A total of 82% of mothers initiated breastfeeding with a 78.5% maintenance at six weeks. This compares to a national initiation rate of 30%. Client satisfaction with the service was significantly more favourable than that with hospital care, 93% satisfaction compared with 43%. The cost comparison also proved favourable. Births in the midwife-led scheme averaged €1,413 compared to €2,820 for hospital births.

The independent evaluation reported later.

The only factor hindering the scheme is the geographical limitation. Not all women who wish to avail of the service can do so.

CONTACT

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Team Leader
Community Midwifery Team
National Maternity Hospital, Holles Street, Dublin 2

Community-based parentcraft

Antenatal education has been found to have a positive impact on intra- partum and post-partum care and early parenting. Antenatal education is offered by maternity hospitals and units to all mothers.

Despite the proven benefits, uptake of antenatal education is often very low. Hospital-based classes are often very large with partners only allowed for certain sessions. The distance to the hospital can cause difficulty for some, with added problems in cities of traffic and parking.

Recognising a gap in this area a group of public health nurses developed a community-based antenatal education programme for expectant mothers and their partners. The programme is offered in local health centres.

Empowerment in this project is through nurses identifying a client need and recognising that they had the knowledge and skills to initiate a new service. Through the provision of community-based antenatal education expectant parents who might otherwise not have availed of classes now have the opportunity to prepare for a safe delivery and the transition to successful parenthood. The sharing of knowledge by nurses in turn empowered clients.

Project outline

Public health nurses with their unique role in primary care are ideally placed to identify health needs in the community they serve. A group in north Dublin recognised that for many expectant parents existing antenatal education classes were not easily accessible. For many the time and distance involved in attending hospital-based classes proved difficult. Dublin maternity hospitals are city-based and this causes both traffic and parking problems. Given the large attendance at such classes many fathers were not permitted to attend all sessions.

Due to these difficulties many expectant parents were effectively denied access to this important service. Public health nurses with the knowledge and skills set up community-based antenatal education. Courses of six sessions covering all aspects of pregnancy, delivery and early parenthood are now offered at a number of health centres.

Uptake rates are good with many expectant parents availing of classes. Most attendees are first-time parents. Classes are evaluated through client questionnaires, with classes adjusted to meet need. From these classes the nurses now recognise that a shorter, refresher course could be offered to multiparous mothers.

The main limiting factor in this project is the lack of access to delivery suites to familiarise parents prior to delivery.

CONTACT

PUBLIC HEALTH NURSES
Community Care Area 8
Northern Area Health Board
Dublin

Acute community day hospital and homecare service

Changes in care and treatment for patients with mental illness have resulted in shorter in-patient stays and an increased emphasis on community care. In recent years in-patient beds have been reduced and resources diverted to community-based services. The challenge to staff working with such patients has been to develop a community orientation to care and treatment of patients and support for their families in promoting health.

A new acute community day hospital was set up by a psychiatric hospital following the closure of an in-patient ward. The purpose-built structure and new service was established in 1999. The nursing team was involved in the design and furnishing of the unit as well as planning and developing the nursing practice and input.

This project shows evidence of strongly empowered leadership empowering the nursing team to participate in decision-making and action within the unit where there is an equitable distribution of power.

Good leadership is evident through regular staff meetings where all staff have the opportunity to assess, plan and evaluate the service. The focus of the team is on problem-solving and decision-making. This requires that staff are clear in their responsibilities and level of authority. Staff appraisal is also in operation in this unit.

The empowerment of the nursing team has resulted in good morale and increased job satisfaction. The empowered team can initiate and develop many innovations. This also facilitates empowerment of patients, families and colleagues to accomplish their goals.

Project outline

Crannóg is an acute community day hospital and home care service for mentally ill patients. It provides a therapeutic environment for people who are acutely ill and supports their families to provide an alternative to hospital admission. The philosophy of care is to provide a service that encourages patients to identify and develop their own resources. Patients are actively involved with nursing staff in setting their own objectives, enabling them to take responsibility for their own mental health and to regain control of their lives. It is expected that community support and service will result in hospital admissions being reduced and length of stay shortened.

The service offers

- 12-hour cover 365 days a year
- weekend cover for community services
- structured group therapy five days a week, informal at weekend
- alcohol detoxification service
- outpatient Clozapine therapy monitoring
- home care service
- supervision of medication
- multidisciplinary patient reviews
- liaison with rehabilitation services and day centres.

The service is evaluated through continuous patient assessment and staff reviews. The service evolves and develops through these reviews.

The service is somewhat a victim of its own success. Increased patient numbers, while staffing levels remain the same, is hindering any future developments at present.

CONTACT

ANN BUGGY CNM2
Crannóg Day Hospital
St Vincent's Hospital
Fairview, Dublin 3

Home-based treatment team (HBTT)

There is much talk in healthcare about the need to develop holistic, patient-centred care, yet many practices continue to militate against this. Changing traditional practice requires courage to face the 'brutal truth', risk-taking to try new ways and openness to evaluation and comment.

In this project the 'brutal truth' was faced in the outcome of research on psychiatric services to patients in Monaghan. Serious deficits were highlighted where there was reliance on a medical model of care. Treatment focused on psychopathology signs and symptoms and ignored underlying social and interpersonal stresses. Professionals worked in isolation from each other. This resulted in high levels of certification of patients and high re-admission rates.

As a result of this research a change of orientation was initiated. A home-based treatment team was set up as an integral part of the community mental health team.

The HBTT was nurse-led. Four nurses formed a team with designated team leader. The team was allocated responsibility and the commensurate level of authority to plan and develop the service.

In accepting the responsibility and authority the nursing team overcame its initial anxiety of moving from a protective hospital environment to working autonomously. The team members used their expert knowledge and skills to develop a bio-psychosocial model of care. The enhanced motivation has resulted in better professional communication and a sense of value that ultimately led to up-skilling and a sharing of skills. Increased job satisfaction results from offering a client-centred and family-centred approach to care.

Change and growth was enabled and facilitated by the vision and conviction of the team leader in regard to the way forward. This made it easier to motivate, support and empower other team members.

Project outline

Research (1995) into psychiatric service provision for patients in Monaghan highlighted serious deficits. This resulted in 1998 in the establishment of a home-based treatment team (HBTT) as an integral part of the community mental health care team.

The nurse-led service aims to provide a quick, responsive service with intensive ongoing support to people and their families experiencing a mental health crisis. Such a service in the home environment offers choice to service users and reduces the need for hospital admission. The service offers

- mobile seven days per week service from 9 am to 9 pm
- an easily accessible and rapid response to referrals
- joint medical and nursing assessment
- development of a care plan taking into account the needs of client and family
- education of both client and family about the illness and expected outcomes.

The provision of this service has resulted in a significant reduction in hospital admissions and length of stay. A decrease in re-admissions has resulted in a reduction of the 'revolving door syndrome'. Communication between primary and secondary care services has improved, leading to earlier interventions. Overall the model of care has changed from medical to bio-psychosocial.

Evaluation of the service has resulted in significant developments. GPs views of the service were positive and as a result of their comments GPs are informed of the commencement and completion of treatment by the HBTT. Relatives and clients views were sought through focus groups. A support group run by ex-clients has since been formed.

The success of the HBTT has required the employment of two extra nurses

CONTACT

MICKIE McKENNA
Monaghan Home-Based Treatment Team
North Eastern Health Board

Community-based counselling initiative

Psychotherapy and counselling are an integral and very important part of treatment for patients/clients with emotional and psychological illnesses. The disciplines of counselling and psychotherapy developed initially outside the health services and were for a time treated with suspicion by the medical profession. Many clients requiring counselling or therapy availed of the services through voluntary organisations or private practitioners.

Many nurses are attracted to work in the area of counselling and therapy and have undertaken training and practice in addition to their routine working. In this project a community mental health nurse with extensive training and experience in counselling and psychotherapy saw an opportunity to develop a new service for clients in the community. The service has developed and expanded and now includes a residential unit which is run as a charitable trust. The development of this service shows how quality and relevant services can be run by the creative use of voluntary and statutory services.

The leader of this project had empowered himself through extensive training and skills development. He had a vision of how his knowledge and experience could benefit patients in the community. With a supportive manager he was able to turn his vision into reality and develop a new service. Through the creative implementation of his vision nurses have been empowered to move into areas of practice that previously were not considered part of their role.

Project Outline

Working with a voluntary organisation to provide counselling and psychotherapy to people in the community, a community mental health nurse (CMHN) recognised how his knowledge and skills could be used to develop a new service in the statutory sector. The CMHN had trained extensively and is an accredited counsellor and therapist. Utilising his skills and experience and with the support of his manager he set up a stress and biofeedback clinic in Meath community care area. This service provided counselling and therapy for post-traumatic stress, particularly in relation to child sexual abuse, war and conflict, and trauma associated with violence. Going on to train in critical incident debriefing he is also working as part of a team that provides this service to staff in the North Eastern Health Board.

When counselling in the community was initiated in 1987 it was a relatively new concept and was treated with suspicion by many medical practitioners. With support from a senior nurse manager a number of other nurses have trained in various models of counselling and therapy in order to continue the community service.

In 1997 the nurse leader set up a charitable trust, which opened a twenty-six bedded residential centre to provide therapy and training for people affected by trauma and stress. The centre works with victims of the Omagh bombing, the Rape Crisis Centre, inner-city substance abuse rehabilitation groups, men's groups etc.

Statutory and voluntary services are working together to provide a much needed counselling and therapy service.

CONTACT

MARTIN DUFFY
Community Mental Health Services
St Bridget's/St Davinett's
North Eastern Health Board

Practice development

Prevention, early identification and management of postnatal depression

Although pregnancy and childbirth are considered natural physiological events, approximately one in ten mothers suffers from postnatal depression. Until relatively recently little attention was paid to this debilitating condition. Many women suffered in silence, having difficulty talking about their illness. Community services have not adequately addressed this illness.

Public health nurses, at the front line of primary healthcare, are ideally placed to detect and manage, with other professionals, postnatal depression.

A group of PHNs, having identified the need for a postnatal depression service, took the initiative to source information and training to facilitate setting up a new service. They sought support from other disciplines in establishing the service.

Once the need was identified the PHNs empowered themselves with information and training to meet the needs of the clients and community they served. The project was established as a pilot with the audit mechanism built in from the beginning. This demonstrates accountability whereby decisions are evaluated and future actions are directed.

The project highlights the capacity of multidisciplinary working to develop a new service and meet the needs of a client group. Nurses are ideally placed to identify needs and take a lead in service developments.

Project outline

A group of public health nurses in the Midland Health Board identified the need for a postnatal depression (PND) service for the mothers they served.

Four PHNs undertook a two-day research-based training in prevention and routine screening of PND using the Edinburgh Postnatal Depression Scale (EPDS). The training was based on the experiences of a Health and Social Services Trust in Northern Ireland.

Following the training a multidisciplinary team comprising a specialist in public health medicine, a consultant psychiatrist, a director of community nursing, an audit facilitator and the four PHNs was established. The team established protocols for the service and audit criteria using an adaptation of the model from the Health and Social Services Trust.

A retrospective study was carried out on all mothers who had given birth in a given six-month period. One year after birth these mothers were asked about any history of postnatal depression, diagnosis, treatment and support received. The results of this audit are not detailed. The information obtained will be used to assess and inform standards and evaluate the effectiveness of the service being offered.

While the study was ongoing the service also commenced. Mothers are assessed using the EPDS. This self-assessment uses a simple point-rating scale. A score greater than twelve indicates the likelihood of a low mood and the need for further assessment two weeks later.

The EPDS is carried out between 10 and 12 weeks postnatally or earlier if indicated by the protocol. The assessment is carried out in the home or clinic setting. If a woman scores a second rating greater than twelve, permission is sought to inform her GP. Four 'listening visits' are offered using non-directive counselling. Visits last one hour, with no more than forty minutes counselling.

The EPDS is an assessment tool and should not be used to replace clinical judgement. Women with high scores should have the opportunity to discuss the issue and be involved in decision-making about further action.

The pilot study is complete and being audited. It is hoped to train further public health nurses in the use of the programme. This will lead to sharing of expertise and enhance co-operative working across disciplines within the service.

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Introduction of team-nursing to a general medical ward

Nursing care should be delivered in a holistic way and with a patient-centred approach. The nursing system adopted in a ward situation should facilitate individualised care.

In many hospital and ward situations nursing care has traditionally been delivered in a task-allocation mode. Task allocation occurs where patient care is perceived as being a series of distinct tasks, which are best accomplished by nurses completing the same task for each patient. The fragmentation of nursing work and the absence of continuity results in many different staff providing care to any one patient. This is a mechanistic approach to care delivery where task completion and maintenance of ward routine takes precedence over the needs of individual patients (*Journal of Advanced Nursing* 1998, 27). Task allocation, characterised by the absence of an identified principle caregiver for individual patients, results in 'professional distance' between nurses and patients (Menzies 1966).

Nurses working in a task-allocation system have little opportunity for growth and development because overall responsibility for care, external ward communications and instrumental decision-making is firmly vested in the ward manger.

Team-nursing is one system of nursing that facilitates individualised patient care and allows for decentralised decision-making by the front-line caregivers. Team nursing emphasises humanistic values and responds to the needs of patients and staff whereby a small team of nurses, led by one nurse, assumes responsibility, authority and accountability for the nursing care of a group of patients for the duration of their stay in hospital. Continuity of care and greater flexibility of care-giving results in quality care for the patients and their families. Members of the nursing team are the main point of contact for patients and their families.

Nurses working in a team-nursing system need clearly defined responsibility, authority and accountability. This allows for decentralised decision-making with reduced vertical control and increased horizontal communication at operational level. Working in such an environment allows for growth and development and is empowering for nurses.

Leaders of nursing teams accept responsibility for managing patient care and team members. Team leaders co-ordinate the work of their team and share responsibility with the ward manger for patient care and external communications. Devolved responsibility for patient care frees ward mangers from day-to-day operational matters and allows more time for managerial aspects of their role.

In this project an empowered ward manager responded to the identified needs of her staff for a change to the existing care delivery system. Providing visible leadership facilitated change and presented an opportunity for growth and development of staff.

Project outline

In a general medical ward where nursing care was delivered through task-allocation a number of staff nurses identified problems. Staff felt frustrated with limited responsibility, authority and accountability. Empowerment of staff was not facilitated. The ward manager reviewed the literature on nursing-care delivery systems. The findings were presented to staff and, following discussion and consultation, agreement was reached to develop team-nursing.

Implementing this change was made easier with a group of nurses willing to embrace change and accept greater autonomy. Nurses were part of the planning, implementation and evaluation of the change. Difficulties to be overcome included getting the right skill mix for each team and ensuring that team leaders had the skills to lead and manage a team. The leaders needed to involve all members in planning implementing and evaluating care and avoid the risk of returning to task-allocation within the team. All team members needed to commit to this new way of working and accept the increased responsibility, authority and accountability, and to take responsibility for their own development.

Since implementation, greater continuity of care is provided and patients have a key nursing contact. Communication with patients and families has improved. Nurses identified that they felt empowered, with increased job satisfaction and job expansion. Team-working allows for all skills of staff to be utilised and provides greater support for staff. It provides a safe learning environment for the less-experienced staff, with all staff allocated a role within the team. The team leader's role gives greater responsibility and learning opportunity.

The project was evaluated both internally and externally to ensure reliability and validity of information.

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Nurse-led health promotion

The WHO defines health promotion as 'the process of enabling people to increase control over their health'. Providing a holistic service necessitates that all healthcare providers provide health promotion to patients and clients. Nurses are ideally placed to provide health promotion in both an informal, ad hoc and formal way.

Despite the national health promotion strategy (2000-2005) which advocates a holistic approach to health gain, most health promotion continues to be provided in an ad hoc way and is dependent on the commitment and interest of individuals. The financing of the health services remains orientated towards the curative sector. When pressure on resources occurs, investment in health promotion is often the first casualty.

In this project a staff nurse working in the mental health sector developed a personal interest in improving the health awareness and status of both clients and staff. Addressing the strategic aims and objectives of the health promotion strategy in relation to population groups, settings and topics she sought to develop promotion/education initiatives using a holistic approach. Increasing the health awareness of staff as part of the initiative was a positive approach that had personal benefits and also ensured their increased involvement with patients and clients.

The lead nurse established a multi-disciplinary team to co-ordinate and implement the initiatives. The continued support of senior management is a motivating factor for all involved. All team members are committed to a holistic approach to health gain, and sense of achievement is a driving force both on a personal level and within the group. The team set goals which were specific, realistic, achievable, timely, and measurable. The acknowledged achievement of goals was empowering for members to continue with further initiatives.

Confident in their approach the team submitted a poster presentation at the national health promotion conference. Feedback from this was enthusiastic and further motivated the team. The team leader undertook further education in the theory and principles of health promotion that helped attain quality using evidence-based practice.

The lead nurse in this project had a vision to develop a new initiative. With the visible support of senior management and working as part of a team she was empowered to bring the vision to fruition. Involvement of all team members and setting realistic goals enabled the continuation of the project. Evidence of achievement through evaluation of initiatives was a powerful energiser for all involved and allowed them to showcase their project at a national conference.

Project outline

A staff nurse in a mental health setting had a personal interest in improving the health awareness and status of both clients and staff. This was in line with the health promotion strategy (2000-2005).

A nurse-led multidisciplinary team was established to co-ordinate and collaborate with hospital and community-based staff to plan, implement, and evaluate health promotion projects. Team members included senior management, administration, nursing and housekeeping staff. Initiatives undertaken included

- a 'Staff Health Awareness Day' which identified staff whose health was at risk from undetected conditions, e.g. hypertension, diabetes, high cholesterol or excessive stress. This project raised staff morale and sense of well-being.
- World Heart Day, with participation by staff and clients
- 'Slí na Sláinte' on site, used by staff and clients
- smoking cessation support with a nurse/counsellor on site to anyone wishing to quit
- publication of a newsletter.

The work of the team was supported by the existing resources of the occupational health department, CPR and manual handling trainers, dietician and diabetic nurse specialist, critical incident and stress management teams. A grant of £500 was received from the Health Promotion Unit.

Evaluation of initiatives was ongoing. Process evaluation looked at appropriateness, cost-effectiveness and target audience. Impact evaluation looked at the short-term impact of the project. Evaluation tools included observation, structured and non-structured interviews, self-completed questionnaires, level of participation, records and general comments.

Long-term impact will also be evaluated.

Outcomes to date include raised awareness among staff that enables them to initiate client-focused programmes within their own departments.

Since commencement of the project management has applied to join the European Task Force on Health Promotion in the Psychiatric Services.

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Advanced neonatal midwife practitioners

Sick newborn infants require specialist medical and nursing care. Continuity of care is very important to ensure positive outcomes for infants and their families. Neonatal units in major maternity hospitals offer training in neonatal intensive care nursing to higher diploma level to provide for this care. Until recently however specialist nursing knowledge above this level was not available.

The Rotunda Hospital identified a need to develop specialist nursing knowledge to advanced practitioner level. The role of advanced neonatal practitioner (ANNP) was developed and initiated to provide holistic care of infants and their families as part of the multidisciplinary team. The major strength of the role should be that it is derived from practice and sustained by practice (University of Southampton, 2000).

In the absence of suitable preparatory education for the role at the time the post was initiated the hospital supported two candidates to undertake the ENB A19/BSc (Hons) Neonatal Studies at the University of Southampton. The ANNPs have limited delegated authority to make independent, autonomous decisions in clinical practice. The care provided is guided by established hospital policies and procedures.

Visible management support facilitated the expansion of midwifery practice and empowered two staff members to undertake and develop the role. As a consequence of empowering two staff members to work at an advanced level a collaborative and participatory approach to care has increased self-esteem and confidence amongst midwives and nurses in the neonatal unit. This is 'empowerment as a process of enabling power transfer from one person to another or one group to another' (Rodwell 1996).

This innovation has commenced an empowerment process which is still developing. Chavasse (1992) asserts that empowerment is concerned with valuing others. In developing this role the recipients of care, the sick neonates, are valued through the development of consistent quality care. Nurses who chose to remain in clinical practice are also valued by the opportunity to develop knowledge and skills to advanced level.
Midwife colleagues throughout the hospital have an increased realisation of the value of nursing knowledge and experience in its own right and the contribution this can make to holistic care.

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Project outline

The Rotunda Hospital as a major provider of neonatal care recognised a need to develop specialist advanced midwifery knowledge in the care of the neonate. In the absence of suitable preparatory education two midwives were sponsored to undertake specialist training at the University of Southampton. The role of Advanced Neonatal Nurse Practitioner (ANNP) was established.

The role (ANNP) was developed and initiated to provide holistic care of infants and their families as part of the multidisciplinary team. The major strength of the role should be that it is derived from practice and sustained by practice (University of Southampton, 2000).

The ANNPs, using specialist clinical and theoretical knowledge, take a leading role in initiating and subsequently managing care of the sick neonate. They attend high risk deliveries to provide emergency management of the asphyxiated and/or premature infant. They work with parents to identify their learning needs and to empower them to take an active role in the care of their infant.

The ANNPs act as a resource in clinical practice and continuing education for pre-registered and direct access midwives and students of the Higher Diploma in Neonatal Intensive Care Nursing. They are involved in the education of junior medical staff – including participation in and facilitation of the neonatal resuscitation programme and the STABLE programme.

As leaders the ANNPs act as role models for staff. They lead on research-based and quality practice and participate in outcome-based evaluation of clinical care. They are involved in the evaluation of the clinical environment and advise on developments ensuring cost-effective use of resources.

The effectiveness of the role is evaluated against goals and objectives preset with senior nurse management and the consultant neonatologist.

Although initiated as an advanced practitioner role neither candidate holds a master's degree. The roles cannot be fully accreditated or implemented until this requirement of the National Council for the Professional Development of Nursing and Midwifery 2001 is achieved. Maintaining competency and developing skills is proving difficult meanwhile. Due to the shortage of skilled nursing staff the ANNPs devote 50% of their time to this role and the remaining time as CNM2

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Establishment of a nursing development unit

Nursing Development Units (NDUs) first evolved in the UK in the early 1990s as 'test beds' for pioneering practice developments.

The concept of practice development was pioneered in the UK by Pearson (1983) who developed nurse-led initiatives at Burford Community Hospital. Within this unit nurses became responsible for the admission, care management and discharge of patients, using discretion to call upon doctors when necessary (Hamer and Totterdell 1999). In 1989 Wright took the concept further and emphasised team building and staff development as an integral part of practice development. These initiatives set a precedent within nursing and healthcare, and with them came a realisation that nurses were not only well placed to lead initiatives but were competent to do so. The concept of practice development supported the notion that change must begin with the largest group closest to the point of service. If change can happen here it is deemed to be able to happen anywhere in the system (Porter O'Grady and Krueger-Wilson 1995).

Today many care units from the primary, secondary and tertiary care settings and the independent sectors have achieved accreditation with third-level institutions in Ireland or the UK. Accreditation is achieved when a care unit meets the criteria set out by the accrediting body. Specific criteria may vary between accrediting bodies but the main focus of NDUs is on the development and evaluation of research-based quality care led by nurses. Clinical leadership and ongoing staff development are important aspects of NDUs. Management and organisational support are essential for the development and maintenance of NDUs but decision-making authority must be devolved to ward/unit level. Links to third-level education systems are important for the development of practice, research and staff. Developments and evaluated initiatives must be disseminated.

With devolved authority nurses are empowered to develop practice within an NDU. Implementing new practices using research evidence these nurses enhance professional practice and improve quality of care. Through dissemination of developments and practice the NDU acts as a reference point for other wards and departments and nurses are empowered to influence others in practice development. The formal recognition of excellent practice through accreditation further empowers all staff involved.

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Project outline

In 1995 the Phoenix Unit of St Mary's Hospital, Dublin, entered negotiations with the Department of Nursing, University College Dublin, to develop a nursing development unit. The process involved meeting criteria set by the university and the Eastern Regional Health Authority.

As an NDU the Phoenix Unit aims to promote excellence in the delivery of nursing care. This is achieved through the implementation of evidence-based practices, which are continuously evaluated for effectiveness and efficiency. The unit is recognised as an area for innovation and creativity, utilising dynamic approaches to care to achieve the highest quality care. The focus of care is, ultimately, client satisfaction. The ethos and philosophy of the unit is firmly focused on partnership with care provided to meet individual needs.

The emphasis in the unit is not only on patient outcomes but also on the empowerment of the nursing team. All members of the team are supported in their ongoing development. Such development is integral to the success of the NDU. Nurses take responsibility for approaches to care and the development of nurse-led activities. The process of engaging in team building, developing new initiatives, promoting feedback and the achievement of set objectives facilitated the development of individuals.

The outcomes of accreditation as an NDU are multifaceted. Improvements in quality of care and patient outcomes are evident and continue to develop. Nursing staff have a sense of achievement through personal and professional development, achievement of goals and targets and awarding of accreditation. Staff morale has increased, with each member of staff valued for her/his unique contribution to the team. Members of the nursing team disseminate good practice through lectures and talks to other organisations.

After the initial accreditation the unit had to continue its development and quality ethos to achieve re-accreditation. This it did in 2001. The success and development of the unit is shared equally by all involved in the process.

The unit received good managerial support for the journey to accreditation. Support was also offered by the accrediting body, UCD. With managerial support the unit has managed to survive the chronic shortage of nurses in the health services.

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Clinical-quality improvement

Midwifery documentation project

The documentation of nursing and midwifery care is an important aspect of nursing/midwifery practice. Documentation should record accurately the nursing/midwifery assessment, care given and evaluation of that care. Accurate documentation facilitates patient focused care and continuity of care. Advancements in clinical care require that documentation be developed to reflect changes in practice.

Changing documentation to record practice can be difficult. Many nurses and midwives are comfortable and familiar with existing forms and do not see the necessity to change. Resistance to change requires the intervention of good leadership and management skills.

Change management requires creating and communicating a vision, identifying and staying close to the resistance, consulting widely, providing education and training and rewarding accomplishments.

In this project midwives had a vision for how care should be delivered in a small maternity unit. They identified the need for a midwifery documentation package that would support a research-based approach to woman-focused care. In a small unit where the midwives rotate through antenatal, labour ward, nursery and postnatal care in any one shift, continuity of care was difficult to achieve. Task orientation took precedence over holistic care leading to duplication of work, information and record keeping. The vision was to move to a model of care where the mother and her infant were cared for as a single unit with continuity of care, improved communication and better use of time by midwives.

The midwives in this project saw themselves as responsible for the quality of care and took the initiative to create the model best suited to their unit to deliver such care. They had the courage to question and review current practice. Implementing the change successfully demonstrated empowerment by the leader which in turn empowered the followers to engage with the change.

Project outline

In this small maternity unit midwives identified the need to move from task orientated care to a more holistic model which was mother and infant centred. The existing systems with staff rotating throughout the unit in any one shift and poor documentation supported this way of working.

Looking to change their way of working the midwives were allocated the resources to finance an 0.5 wholetime equivalent project midwife for one year. The project commenced with an audit of existing documentation. This was done by sample checking and a questionnaire to all midwives. A literature review of models of care was conducted. Samples of documentation from other units, with the pros and cons of each, were obtained.
A template to support a new way of working was designed and widely consulted on.

Education workshops to educate all midwives on the new way of working and use of documentation were provided. A pilot was then conducted using the draft documentation. Following the evaluation, amendments were made and the final documentation produced. To facilitate correct use a pocket-size user guide was produced. The documentation continues to be subject to ongoing random audits and a formal annual audit.

The project was supported by management who met with the project midwife every forthnight to review progress. IT support was available. External support was obtained through a nurse consultant.

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Integrated clinical audit in mental health services

Most professionals working in health care aspire to deliver a quality service. While it is believed that a particular standard of care is adhered to and that care is delivered through particular frameworks and processes, a comprehensive review of such activities is often not carried out.

Audit of practice provides the feedback necessary to implement change and develop quality services. It provides evidence of the efficiency and effectiveness of care and validates the work of the care givers.

In today's healthcare environment with huge demands on resources it is important to demonstrate that care and services are of the highest quality with measurable outcomes and efficient use of resources.

To implement an audit process requires courage, openness and a questioning attitude. Staff need to be supported in the process through education and training, adequate resources and a developmental approach by management. Evaluating care and service empowers staff to ask questions of itself and to take action on the outcomes. Taking ownership of the audit process affirms quality practice and allows staff to lead on service developments.

Government policy has supported the implementation of audit process. In 1989 the Commission on Health Funding stated that there was a need for qualitative review of services. This view was supported by *Shaping a Healthier Future* in which quality service was seen as the hallmark of healthcare. This project was supported by *Guidelines on Good Practice and Quality Assurance in Mental Health Services* which advocated evaluation of services in relation to quality, efficiency and effectiveness on an annual basis.

All initiatives and changes in practice require good leadership. This project was led by the clinical nurse quality facilitator who was assigned to co-ordinate and implement the process. Nurses initiated, co-ordinated and implemented the project in collaboration with other disciplines. The positive outcome of the process has resulted in similar such initiatives being implemented in other parts of the country. The learning from the project is being disseminated by those involved.

Staff involved have been empowered by the process, the affirmation of work well done and the recognition that their practice is based on internationally recognised standards of good care.

Project outline

Following a discussion between a member of nursing staff and the director of nursing the seeds of clinical audit were sown in the Louth/Meath mental health services. A nurse was allocated to head up the project in collaboration with nursing staff and other disciplines.

An integrated clinical audit group was established. An audit plan was developed and implemented using the Newcastle Clinical Audit Toolkit: Mental Health. During 1999 and 2000 the admission and assessment practices of both facilities in the service were audited. The aim was to assess current practice relating to admission and assessment and identify if key implicit standards were being adhered to. The audit tools included examination of admission policy and the information booklet, observation of facilities, asking patients and/or relatives about their experience, talking with key workers, and examination of medical and nursing notes relating to the first seventy-two hours following admission. Patient consent was sought.

The audit report highlighted adherence to implicit standards which are supported by current management structures. These implicit standards have now been developed into explicit standards using the RCN *Dynamic Standard Setting System* of structure, process and outcome. Following the identification of high quality care, staff sought a mechanism to further validate and build upon good practice. The European Foundation for Quality Management Model/Q-Mark validation process has been applied to the department of psychiatry, Navan, as part of overall quality improvements in the area. Further audits have been conducted – a repeat audit in one area and a comparative audit between the two facilities.

Feedback from staff and patients involved in the process has been positive as have the comments of the mental health inspectorate. Staff have since been involved in disseminating information on the process to other areas interested in developing quality systems.

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Proposal for the future and business plan

Service planning is an important function of all healthcare managers today. All service developments must be supported by proposals including costings in the annual service plan of an organisation.

For many professionals service and business planning required a new set of skills and a new way of working.

In this project the proposals for the future and the business plan are the result of five years of quality improvement work. In response to Ireland's first national health strategy *Shaping a Healthier Future* (1994) a group of nurses in St Joseph's Hospital, Clonmel, established a quality circle. With support from all professionals and managers this nurse-led group addressed areas of service delivery through all disciplines.

Building on the success of this group after three years the quality circle broadened to become multidisciplinary and adopt a multidisciplinary approach to quality improvements.

The work of the group facilitated open and reflective practice, flexibility, adaptability and willingness to change.

Empowerment in this project is evident from the commitment first of the nursing group and then of the multidisciplinary group to question, evaluate and change practice. All members availed of education and training – much provided locally. Some members have pursued further education in quality management.

Empowered by extensive experience in quality improvements the group recognise that quality is a process not a destination. Building on their achievements the quality improvement group is now looking to move forward and facilitate its organisation to achieve national accreditation. The business plan in this project presents a realistic and achievable way forward to this goal.

Quality that is led by practitioners involved in practice has a greater chance of success and of making lasting change. The drive for national organisational accreditation has in most organisations come from senior management; in this hospital the functional empowered multidisciplinary group has taken the lead which augers well for success.

Project Outline

A multidisciplinary quality improvement group in St Joseph's Hospital, Clonmel, has developed a five-year plan for its organisation to achieve national organisational accreditation. The plan is detailed and contains costings to achieve the goal in a realistic, achievable and measurable manner.

The development of the plan is the culmination of six years of quality improvement work in the organisation. In 1996, with outside facilitation, a group of nurses established a quality circle. Nurse-led, with support from other professions and managers it commenced quality improvements. Many areas of practice were evaluated and developed.

Building on the success of this nursing group a multidisciplinary group was established in 1999. Nursing input remained very strong in this group. Ongoing accessible education and training for staff is a feature of the quality culture in the organisation. The group worked well to manage change in practice and to introduce changes in an acceptable way.

The work of the group in promoting quality care has improved patient care, reduced risks, significantly reduced costs and reduced patient anxiety. Standards of care have been set for many areas of care. All the standards are audited internally and externally by independent auditors. The initiatives were published by the Irish Society for Quality in Healthcare.

The 'bottom-up' approach to national organisational accreditation is unusual. Because of the very evident commitment of staff to quality improvements and the established culture of clinical audit, accreditation should be achievable in the timeframe set out. A detailed plan to achieve accreditation is laid out with costings for dedicated staff, education, and training and support facilities.

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Beaumont Hospital Foreign Language Tool

Communication is one of the most essential aspects of care. The ability to communicate effectively with patients is fundamental to the delivery of nursing care. Effective communication facilitates understanding and co-operation between the patient and the nurse. Reducing the fear and anxiety associated with surgery and unfamiliar surroundings facilitates recovery.

Ireland, until recently a monocultural society, did not have to address the real communication issues of multicultural societies. In the space of a few short years there has been a significant increase in the number of non-English-speaking persons living in the country. The healthcare system like many other systems was not prepared for this dramatic change. Nurses now have difficulty communicating with many of their patients.

One nurse, recognising this pattern, identified a need for a tool that would aid communication with non-English-speaking patients. On his own initiative he undertook to develop the Beaumont Hospital Foreign Language Tool (BHFLT). The most commonly used phrases, questions and answers used in recovery nursing were translated into fifteen different languages. Using this tool nurses in recovery, post-operative and neurosurgical wards can now communicate more effectively with patients.

Recognising a need this nurse was empowered to undertake the project. Despite the time commitment and the need to develop computer skills he succeeded. If the transfer of knowledge and skills is a requirement of empowerment this nurse has achieved his goal. Many nurses and other healthcare workers can now provide better quality care using the BHFLT.

Recognition of achievement is also an important factor in empowerment. The BHFLT has been short-listed for the European Language Label Award by the Linguistics Institute of Ireland.

Project Outline

A staff nurse working as a recovery room nurse identified a difficulty in communicating with many of his patients. This was due to the increasing number of non-English-speaking patients. In a few short years the numbers of non-English-speaking people living and working in Ireland has increased dramatically.

Healthcare workers who also interact with many people with little or no English have had little or no preparation or training for this. Communication with patients has proved difficult.

This staff nurse decided to address this problem within a nursing specialty. He selected phrases and words most commonly used in recovery and translated them into different foreign languages. Greetings, statements, questions and answers most commonly used in the recovery room, post-operative ward and neurosurgical ward were translated.

There is no requirement for the user to learn the languages because the translations are written phonetically with the user reading the words as they would English. Nurses and other healthcare workers can now communicate with patients in up to fifteen different languages. Nurses using the Beaumont Hospital Foreign Language Tool (BHFLT) have found it very beneficial. Patient comfort and confidence in the carers has increased as has nurses' job satisfaction. Creating a more culturally diverse care environment has met an identified need.

The translations were developed with people fluent in both English and their own language. The Linguistics Institute of Ireland has evaluated the project and shortlisted it for the European Language Label Award.

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Right patient, right drug, right time

Administration of medicines is an ongoing and integral part of nurses' work. Correct administration and patient compliance with prescribed medication is an essential component of medical care. Drug errors related to either prescription or administration do occur, with repercussions for the patient, the doctor, the nurse and the organisation. Drug errors are related to either prescription or administration.

Developing a questioning attitude to and reviewing practice is essential for quality service and professional development. Accountable practitioners must evaluate their practice to test effectiveness and to direct future efforts. Accountability tends to be underdeveloped in nursing practice, with many nurses claiming lack of time or skill.

In this project a major component of nursing practice, drug administration, was audited. The purpose was to elicit the level of drug errors and to make recommendations for improvement.

The involvement and commitment of staff to such an audit is essential. This requires strong leadership, which was evident in this project. Staff willingly took part in the audit and made recommendations for change which were acted upon. Having a voice to impact on change and development is empowering for staff and leads to greater acceptance of new ways of working. Staff are further empowered to question other areas of practice when change in one area is experienced as a learning opportunity.

In this project significant changes were made to a nursing practice, which led to positive outcomes for patients and staff.

Project Outline

The Mercy Hospital, Cork, undertook a hospital-wide survey to audit current practice in the administration of medicines. The purpose was to review practice and make recommendations for improved practice in order to minimise the risk of drug errors. Research suggests that drug errors are common in hospital settings and relate to prescription or administration.

The audit was conducted by a researcher who accompanied registered nursing staff in a ward drug round to observe procedure and to actively participate in the administration of medications. Prescription sheets were examined during the medication round and nurses were asked for recommendations regarding administration based on their clinical experience.

The results showed that in some incidents nurses were using their own discretion to decipher badly-prescribed medication orders, deciding what medication patients fasting for surgery should take and indicating the times for administration of drugs on the prescription sheet. Drugs were also left on lockers when patients were absent. 'Missed' drugs were recorded but little importance was attached to the fact that a dose of prescribed medication had been omitted. Prescription sheets were not fully completed, with details incomplete or illegible.

Nurses recommended that drugs should be prescribed and identified by their generic names. Drug administration times should be more patient-friendly, with the 6 am drug round discontinued.

The findings from this hospital reflected findings from UK and US literature.

Based on the findings, a new drug prescription format was drawn up with explicit instructions for the prescribing doctor and administrating nurse. Drug times were aligned to mealtimes. A database of registered nurses' signatures and corresponding initials was created. These changes were then piloted with the approval of the drugs and therapeutics committee.

Six months after the revised protocol was introduced throughout the hospital a full audit was conducted. This looked at prescribing practices, administrating procedure and prescriber and administrator satisfaction. To date no major flaws or problems are evident with the revised prescription sheet. Nursing staff have expressed overall satisfaction with the changes.

Nursing staff now demonstrate heightened awareness of their responsibility in drug administration. 'Missed' drugs are now routinely followed up. Prescribing doctors are called back if illegibility or ambiguity in reading prescriptions is experienced. If the situation is not resolved a potential incident form is completed. Drug administration aligned to meal times has increased patient awareness of the importance of taking medications and has improved compliance.

The issue of single-nurse administration was also addressed and the policy revised. Rather than a standard policy that all registered nurses should administer drugs alone it is now expected that the nurse and her clinical nurse manager will decide together on the nurse's competence. The revised protocol is addressed at induction and in-service training.

The involvement of relevant staff in the audit process, and seeking and acting on their recommendations, meant that the protocol and its implementation had a smooth passage in clinical practice.

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Mouth care survey

Reviewing clinical practice is an essential component of professional practice. To undertake audit and review, nurses must be supported through education and training and with organisational backing. Where audit and evaluation are seen as a developmental opportunity, nurses' involvement is increased.

In this project nurses' involvement was elicited and supported through a unit quality circle. Here nurses could develop a questioning attitude to their practice which in turn led to improvements in practice.

Empowered to voice concerns nurses collaborated to plan the survey of mouth care practice. They were supported in their efforts by the close working relationship between the nursing practice development unit and clinical staff. The audit tool used in this project was easy to use and provided results and recommendations in a short space of time.

Having experienced one completed audit facilitated by the nursing practice development unit it is hoped that clinical staff will take greater ownership in future audits, enhancing the process of empowerment.

Project Outline

At a Medical Unit Quality Circle clinical nurses expressed concern regarding the standard of oral hygiene in clinical areas. Oral care is a vital component of holistic patient care and is necessary to provide for the overall well-being of individuals (Bowsher et al 1999). Poor oral care can lead to poor nutrition and hygiene, oral infections resulting in systemic infections and oral discomfort and pain, difficulties in communication and reduced emotional and psychological well-being.

Because of the concerns raised a decision to review current practice was made. The driving objectives for the audit were to review clinical practice in oral hygiene, to revise current nursing guidelines on oral care and to introduce the QUASAR package.

The audit was planned using the QUASAR System – Quality Assurance Surveys and Reports. QUASAR is a complete quality management system that provides a swift and efficient audit process. This simple to implement tool gives easily understood results and identifies areas for improvement. Achievement targets can be set at the push of a button. Nurses can then devise action plans and set review dates.

This survey of mouth care involved twenty-five patients in four medical wards. The results showed that only 3% of patients had their mouth care assessed on admission. The frequency of mouth care given was not documented and there was inappropriate use of mouth care tools. Solutions used were discarded after single use in only 22% of cases. There was 100% compliance with the requirement for hand-washing before and after giving mouth care.

An action plan highlighting areas for improvement was drawn up, with a commitment to re-audit in three months. The current nursing guidelines and policy were reviewed.

The results of the re-audit are not available at this time.

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Deliberate self-harm liaison nurse

Suicide is a major health problem in most developed countries today. Death by suicide is a major cause of death in the young adult male population. The causes of suicide are recognised as multifaceted and complex. Strategies to reduce the incidence of suicide must be multifaceted and encompass many strands.

The National Task Force on Suicide (1998) as well as looking at causes of suicide and making recommendations to reduce the incidence also made recommendations for the treatment of para-suicide. It determined that '...every case of para-suicide be examined by the liaison psychiatric team and that each team nominate a healthcare professional to oversee the future management of these individuals...' In reponse to this the North Eastern Health Board is piloting this psychiatric nurse-led service.

Developing a new service or way of working with patients is challenging in a multidisciplinary setting. Lack of understanding of a new role by internal and external agencies and uncertainty in establishing boundaries for the work requires the nurse involved to be empowered. The nurse must have the ability to understand and work with resistance to change and to promote nursing theories and practice.

Empowerment in this case came from a personal recognition of what it means to be empowered, with support from manager and the Commission of Nursing. Working as part of a multidisciplinary team and with access to clinical supervision was important. The ability to seek support and accept feedback was necessary for personal development. Having the authority to develop personal practice in line with national and international good practice facilitated the development of a needs-led service.

In this project the empowered nurse was able to work in an empowered way with patients on the margins to develop a partnership of care and to re-establish hope in their lives. This innovative approach is challenging to all involved in traditional models of care.

Project Outline

In May 2001 the North Eastern Health Board commenced a Deliberate Self-harm Liaison Nursing Service based at the Louth County Hospital. The liaison nurse aims to see all patients who have attempted suicide or who have self-harmed. This client group is often not amenable to healthcare and many lose contact with services on discharge.

The new nursing service is respectful of the person's actions and has moved from a single session question and answer assessment to a series of conversations. This approach has been identified as more beneficial to patients and concentrates on strengths, coping strategies, past successes and collaboration to work towards a preferred future with adequate support from family and friends.

The liaison nurse links in with the patient's GP and any other healthcare professionals involved. She provides support and information to other disciplines working in this field.

The service is to be evaluated using a randomised control trial of the impact of interventions used. Clinical evaluation is ongoing using validated assessment tools, and admission and out-patient attendance data is recorded. Anecdotal information suggests that clients who have access to the service report high levels of satisfaction with their treatment.

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Developing and piloting a hospital falls risk assessment to identify patients at risk

Falls by patients in hospital have serious consequences. For the patient a fall often results in a serious medical condition unrelated to the original hospital admission. Patient injury results in increased length of stay which adds increased costs and puts pressure on already tight waiting lists.

Patient falls in hospital are often seen as single, unrelated accidents. Serious attempts to identify factors contributing to falls are not often undertaken. The literature suggests that if the contributing factors can be identified and action taken the number of falls could be reduced.

In this project the lead nurse together with other ward-based nurses undertook a two-year retrospective study of falls in their organisation. This revealed that most falls were a combination of intrinsic (host) and extrinsic (environmental) factors.

Having identified a problem this group of nurses took the initiative to address it. As nurses working in the clinical area and possessing a wide variety of knowledge they were ideally placed to put in place the appropriate processes to reduce falls.

Using the quality improvement cycle of describing, implementing, and measuring they designed a falls risk assessment tool.

Empowerment in this project was evident by the group identifying the common goal of striving to achieve best practice and working in a developmental way to take action. The group used information and feedback from the clinical area and a 'no blame' culture to reassess and refine the tool until it was satisfactory to all using it.

As with many empowerment initiatives individuals and groups achieve their main objective. In addition to this there are often unintended positive outcomes which further enhance the process. In this case the group increased its awareness of the extent and predisposing factors causing falls in hospital. It also developed skills of managing a project, data analysis, report writing and presenting to colleagues and senior mangers. The establishing of a task force required the development of team skills including defining terms of reference, objectives and managing group dynamics and teamwork.

The group identified the fact of involvement in a nurse-led initiative, using recent research and linking the work closely to clinical practice, as empowering.

Project Outline

Concerns by a group of nurses about the number and consequences of falls by in-patients led to an innovation in two phases.

Phase one consisted of a retrospective review of the incidence of in-patient falls over a two-year period and an analysis of patient falls within the hospital over a twelve-month period. This data was used to identify both intrinsic and extrinsic factors contributing to increased risk of falls. An extensive review of literature was also undertaken.

In phase two a falls prevention task force was established. A falls risk assessment tool was designed. The initial draft was piloted on four wards for two weeks. The tool was then reviewed and revised and re-piloted. It was again revised and reviewed. All revisions were informed by discussion and feedback from ward staff. The final risk assessment tool was implemented throughout the hospital.

The outcome of the implementation of the assessment tool was an increased awareness by staff of the risk to patients of falls while in hospital. Nurses became more proactive in the risk management of patient falls. There was a reduction in the number of falls. It is also hoped the development of the tool will assist in the accreditation process.

An audit of hospital falls one year after full implementation of the assessment tool was undertaken.

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The development of an assessment tool for the measurement of post-operative pain in infants

Historically, it was thought that neonates did not feel pain, but in the last decade it has been clearly demonstrated that infants are capable of perceiving pain. Because infants cannot report pain, nurses are dependent on observation and assessment of physiological and behavioural signs.

A number of different pain scoring systems have been developed internationally. Having researched and evaluated several tools, it was decided to trial the CRIES tool in the hospital. This tool had already been well received by medical professionals working with infants in other centres and had demonstrated high reliability for assessing post-operative pain in infants.

Changing clinical practice, even when well supported with evidence and experience, takes skill. Healthcare professionals develop practice preferences and become skilled and comfortable with their choices. Because it is the nurse that spends most time with the patient and is best placed to see the signs that indicate pain in infants, the nurse has a responsibility to participate in improving practice in this area. Convincing others to implement a new way takes credibility, knowledge, and skills in communication, persuasion and empathy. Empowerment was exercised in this project by taking responsibility to lead the change, and to do it in a way that respected and included other professionals.

Project outline

Research findings over the last decade clearly suggest that infants do feel post-operative pain. The assessment and management of pain is a responsibility nurses share in caring for infants undergoing surgical procedures. Because infants cannot report pain, the nurse relies on the interpretation of physical and behavioural indicators.

Having investigated and reviewed a number of pain tools for infants, the CRIES pain scoring system was chosen for trial in the hospital. The purpose of the CRIES tool is to accurately measure infant pain responses using five parameters. These are Crying, Requiring oxygen, Increased vital signs, Expression and Sleepless. The maximum score is ten and a score of less than five represents that an infant is in pain.

The CRIES tool was introduced into the infant ward in February 2001 and apart from minor changes in the monitoring sheet it has been well received by staff. Some staff resisted using the tool at first, believing it would be time consuming. After the information sessions where nurses had a chance to really understand the tool and its benefits, there was no problem.

This nurse-led initiative has significantly helped nurses, particularly junior or inexperienced nurses, to accurately assess post-operative pain. The view of staff at this hospital has been much like that in other hospitals that have implemented the tool; that is the tool is easy to use, and seems to track pain and the effect of analgesics well. A formal evaluation has not yet been conducted but comments have been very positive.

CONTACT

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Guidelines for tracheostomy care

Nurses working with chronically disabled people are often caring for highly dependent patients, many of whom have tracheostomies. The responsibility for the daily management of patients with tracheostomies falls to the nurse. In order for these patients to receive high quality safe care, the nurses must be knowledgeable and confident, and must receive support, education and advice to keep their skills up.

Using the An Bord Altranais Scope of Practice Framework as a guide, clinical nursing guidelines were drawn up. Nurses now have a reliable, evidence-based standard to guide them in caring for these patients. Their fear of caring for the patients has been reduced, and several patients have been weaned off the tracheostomy or decannulated.

Nurses were empowered through taking ownership of an important aspect of patient care. They used a working group to carefully draft guidelines that incorporated patient care and were within the scope of practice framework. Nurses were then educated and given support to improve the quality of care provided. Nurses are now competent and knowledgeable in tracheostomy care, and with that competence comes confidence.

Project Outline

Prior to the development of guidelines for the care of patients with a tracheostomy, nurses felt unsure about providing the best evidence-based practice. Some nurses were reluctant to care for these patients, and felt afraid of giving inadequate care. Others were unclear about what could be undertaken within the An Bord Altranais Scope of Practice Framework.

A working group was set up to write clinical guidelines. It consulted with other hospital staff caring for highly dependent patients with tracheostomies. Working with the An Bord Altranais Scope of Practice Framework, the guidelines were drawn up. They included details relating to

- overview of tracheostomy care
- bedside equipment
- care of inner cannulas, stoma site and stoma ties
- suctioning via tracheostomy tubes
- humidification of inspired gas
- care of cuffed tracheostomy tubes
- care of fenestrated tracheostomy tubes
- decannulation
- dealing with emergencies
- resuscitation
- equipment list ensuring quality products are available.

Education sessions were provided by specialist nurses giving advice and developing skills in caring for patients. Examples of training included selecting the most appropriate tube, changing tubes and decannulation. Nurses have grown more skilled and confident as a result.

The effect of this new skill in managing tracheostomy care has had a positive result for the patients. Patients no longer have to be moved to another ward for the changing of tubes. The patients are also more confident in the nurses' skill and they are responding more positively to living with a tube. Some patients have also been successfully decannulated so they no longer need the tube.

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Blood transfusion record chart

The transfusion of blood and blood products is a highly-skilled nursing activity. It is in fact a transplantation of human tissue (live cells) from one person to another. Because of the potential for serious harm to patients as a result of blood transfusion *Serious Hazards of Transfusion* (1999) highlights the need for comprehensive monitoring of all blood use and patient response. Best practice in this area of care requires excellent observation and patient assessment, and rapid intervention if something goes wrong.

The need for a new blood transfusion record was identified as a way to help nurses to record complete and accurate information on transfusions. Empowerment in this example was enhanced by creating a record that supported and advanced transfusion practice. This was achieved through the support of the director of nursing and colleagues on various committees of the hospital. Medical staff were persuaded by the evidence presented and the early results following the pilot on a surgical ward. Other features of this experience that created empowerment were the consultation with colleagues, the introduction of evidence, and the desire to make nurses more capable of making good decisions in an emergency. Nurses feel they now have more control over the transfusion setting, thus promoting safe practice.

Project Outline

Best practice in blood and blood product use in patient care now requires a comprehensive recording of all aspects of practice. Nurses are intimately involved with the process because it is usually nurses who transfuse the materials, and assess for patient response. This is a particularly important role considering that blood transfusion is actually a transplantation of living cells from one person to another.

The Haemovigilance officer saw the need to create a new record of blood transfusions. The existing system made it difficult to know how many units had been given, and the history of compatibility. The new record on an A4 sheet has observations on one side of temperature, pulse and respirations and numbers of units received, and on the other the compatibility record. This allows nurses to easily determine how many units have been given and how many are yet to be transfused. The advantages are clarity, ease and traceability.

The transfusion record was developed with co-operation and advice from the director of nursing, the nurse practice development officer, the documentation committee, nursing colleagues and the risk manager. The new record was approved, and commended by the drug, therapeutics and transfusion committee. A pilot study was undertaken on the surgical ward and was very well received. The nurses felt that the record could be used effectively for review, audit, investigation and analysis of practice.

Evaluation has been conducted and the record has received overwhelming support.

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Adjusting medication administration times to promote patients' sleep

Sleep deprivation is a common problem for patients in hospital. Sleep deprivation has unpleasant effects for patients, including disorientation and delayed recovery. In many hospitals, medication administration routinely commences with the first round of the day at 6 am when the patients are woken for their tablets. By adjusting routine medication times to avoid the hours between 10 pm and 8 am, patients got more rest and the effectiveness of their medication was unaffected.

This innovation empowered both the nurses and patients. Patients were enabled to have a more 'normal' routine while in hospital and to waken spontaneously. Patients were given medications at times more closely resembling times they would take them at home, thereby making the transition to home easier.

Nurses were empowered by advocating on behalf of the patient, and working with colleagues to enhance practice. They effectively challenged an established, routinised practice using skills of planning, collaboration and negotiation. Supports were put in place in the form of new medication records and new prescribing practices by pharmacy. Though nurse-led, this innovation involved effective collaboration with doctors and pharmacists, nurses and committees of the hospital.

Project Outline

Sleep deprivation in hospital is a common experience. Noise, activity and routines of care can interfere with the rest needed to encourage recovery. In many healthcare settings, patients are awakened late at night or in the early morning for routine medications. This project involved the changing of standard medication times to avoid routine drug administration between the hours of 10 pm and 8 am.

A new prescription chart was devised that changed standard medication times and allowed for variation of medication times if needed. Nursing activities were scheduled every 90 to 100 minutes where possible at night to allow for a complete sleep cycle. This change was piloted on a female medical ward and some benefits were noted. Patients reported longer sleep times and feeling more rested. Nurses liked the new medication schedule because it served patient needs better. A planning group involving nurses was set up at ward level to identify and resolve problems locally.

This innovation was nurse-led and involved the co-operation of a wide range of professionals involved in the care of the patient. Patient care improved and nurses felt they were giving more patient-centred care.

An evaluation was conducted through the recording of sleep diaries and interviews with staff and patients. The results were very positive with tangible results of longer sleep periods reported by patients. Nurses felt they had the support of colleagues and management, and used their skills of communication and collaboration.

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Monitoring haemodialysis adequacy

Patients requiring haemodialysis are by their very nature complex. Many hours each week are spent receiving this life sustaining treatment, and it is the healthcare teams aim to ensure that effective dialysis takes place. European guidelines for haemodialysis adequacy have been established and serve as a useful benchmark for treatment effectiveness.

This haemodialysis team was aiming to achieve 100% compliance with haemodialysis adequacy, thus ensuring that patients are properly dialysed and that resources are properly used. Empowerment was demonstrated by nurses educated in renal nursing and having the competence, knowledge and skill to implement primary nursing, and to have an input into the dialysis prescription. This initiative required a commitment to skilled nursing care and co-operation among the multi-disciplinary team members. Nurses took the initiative to develop this monitoring process and to follow through with evaluation.

Project outline

This initiative was undertaken to ensure that the patients achieved the best result possible from haemodialysis treatment. A monitoring process was developed and a monitoring form drawn up to record the findings. Six factors were monitored: blood flow, urea levels, serum albumin, recirculation, venous pressure and URR. The primary nurse for each patient was consulted by the nurse carrying out the monitoring. The compliance levels were compared with the European guidelines for haemodialysis.

The monitoring process can now be used to continually evaluate the effectiveness of haemodialysis for the patient. Education of nurses not trained in renal care was necessary to ensure they understood the monitoring process. The primary nurse, who is trained in renal nursing, is able to be more involved in the haemodialysis prescription.

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Research and investigation

Alternative birth positions

Traditionally, women commonly gave birth in upright positions and this was considered normal in most societies. In the nineteenth century, the traditional child birth practices became subject to the medical model. Institutionalisation of child birth in the twentieth century allowed intervention and mechanisation in labour. As the medical model of care became the norm, the midwife-led model declined. Labour became 'managed' and women were confined to bed for all stages of labour.

This innovation aimed to educate pregnant women and midwives in alternative labour and birth positions. Antenatal preparation classes now include information on active birth and upright birth positions. Props are provided in the labour ward to encourage upright positions including birth balls, bean bags, wedges and floormats.

This midwife-led initiative was underpinned by research into the effects of various birth positions on the mother and infant. Midwives were empowered by developing skills and knowledge about alternative birth positions. They in turn were supported to empower patients through education and encouragement to choose the position they found most comfortable in labour.

Project outline

The past two centuries have seen the increasing medicalisation of child birth. This has resulted in women being confined to bed for labour as the norm. Research into the normal physiology of labour and birth suggests that more upright positions for labour and birth are beneficial. Women report less discomfort, less intolerable pain and less difficulty bearing down. They are more likely to have spontaneous birth, fewer perineal and vaginal tears, but may experience more labial tears. An upright position in labour enables women to develop confidence in their own ability to give birth and to use their judgement more naturally. When women are not restricted, they tend to favour upright positions and will often instictively squat, kneel, walk or go on hands and knees.

In antenatal classes women are now given information on active birth. They are encouraged to visit the labour ward and become familiar with the cushions, bean bags and other props to assist them in labour.

Midwives have attended workshops on active birth and developed skills and confidence in supporting women who choose this approach. The midwives then can empower the patients to take a more active role in their birth choices.

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Shared governance: executive summary of thesis

This paper describes an action research project undertaken to investigate if shared governance, whereby responsibility, authority and accountability are devolved to unit level, does empower staff.

Shared governance is a structure that supports the ethos of decentralised management and empowerment at unit level. Nurses are involved in making more decisions, and information is shared more fully.

Six months prior to the commencement of the research, meetings, brain storming sessions and team building exercises took place. A review of skill mix, cost effectiveness, self-rostering and re-engineering of working environments was carried out. Patient satisfaction was measured, and staff satisfaction was sampled using the occupational stress indicator.

During the three month study, participating staff completed diaries of activities and a qualitative questionnaire describing their experience.

The results of the study suggest that a decentralised approach did inspire changes. Staff nurses are more motivated to solve problems as they occur, to re-engineer work, to take ownership of their work and the working environment by stating clearly the obstacles to success and changes that are needed. There was a massive reduction in absenteeism, suggesting that staff are more intrinsically motivated and committed to their team.

The conclusion drawn from the patient survey would indicate that staff became more aware of patients' individual needs during the study period.

Overall, the study concluded that there are merits and costs associated with shared governance at a unit level, but that the model showed that with the right supports in place, shared governance shows promise as a strategy for retaining a committed workforce and improving patient care.

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Improving Traveller health status: the role of the nurse as co-ordinator

In 1989 for the first time ever the health needs of Travellers were profiled. The population structure resembles that of a developing nation characterised by high birth rates, high infant mortality and relatively few people surviving to old age. A study from 1995 found a low uptake of preventive health services and a high uptake of curavite services. Similar patterns exist for other nomadic communities.

A senior public health nurse was appointed in the Western Health Board with the specific remit of seeking ways to improve the quality of life and health of Travellers through working in partnership with them and others to improve access to services and to influence the formation of policy by the health board.

Several challenges are posed in working with Travellers:

- maintaining dialogue and establishing information networks
- increasing access by employing Travellers as primary health care workers
- shifting the balance from cure to prevention
- continually increasing their awareness and value for improved health.

The public health nurse also faces challenges in working with colleagues across the health service. These challenges include maintaining Traveller health as a priority on the agenda, and providing culturally appropriate services.

The main challenge in the role is the need to maintain effective relationships with Travellers, Traveller organisations, health service providers and others. In the words of the author ‘this is a demanding role but also one worth doing well’.

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