

The PARTNERS Programme

An Evaluation Report - Appendices



PARTNERS

Participatory Action Research To develop Nursing Electronic health Records

The PARTNERS Programme is funded by the National Council of Nursing and Midwifery and the Health Information and Quality Authority EHRIland Research Programme

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ISBN 1872327877.

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Appendix 1

Scales Used in Patient Centred Outcomes

Examples of Scales used in patient centred outcomes presented in this document are

a) Dependency Scales

Dependence Framework Scale

1= Dependent never

2= Dependent minimal

3= Dependent partial

4= Dependent extensive

5 = Dependent complete

b) Independent Framework Scale

1= Independent never

2= Independent minimal

3= Independent partial

4= Independent extensive

5= Independent complete

c) Symptom Management Scale

Symptom scale ranging from

None

Low

Moderate

High

Extreme

d) Pain as a symptom scales include

Frequency

Intensity

Duration

Appendix 2
PARTNERS Assessment Form Version 1

PARTNERS Assessment Tool

This tool is designed for use with patients who are over 65 and who require nursing care in both the acute primary care and continuing care sector. The purpose of this PARTNER assessment tool is to collect standardised information on patient centred outcomes on a single patient. This assessment document is for use on discharge or transfer of care across and between agencies. It is not for use as part of the care plan. Its primary function is to assess patient health status periodically and to inform interagency communication across and between services.

This pack is the first phase of a feasibility study which is scheduled to be undertaken from June to November 2009. The form is to be completed on admission and discharge or transfer to and from services by nurses who are caring for this patient. In the event the patient is a resident in a long term care facility, the assessment form can be completed monthly or as often as the nurse and patient think is appropriate to capture changes in patient health status.

The services involved in the piloting of this form are services x y and z . The document is a patient held record however; it is the research team who are responsible for the inputting of the data and the overall management of the record keeping and **not** the patient.

If you have any queries in regard to this form please contact Pamela Henry on **7005698** or mobile **087 0634783** for further information.

What is in the patient held pack?

This is the main assessment document in the patient pack, printed on **white** paper.

The instructions on how to use the tool are printed on **blue** paper.

Additional supporting documentation is also included for different services such as the intervention scales for the population health information tool (PHIT), used by the public health nurses. These are printed on **yellow** paper, not all of the documents may be relevant to your individual service.

PARTNER ASSESSMENT RECORD V.2

1. Source of referral service detail

For repeat assessments fill out source of referral on the interagency summary sheet at the back of the form

Name of Service/ Ward _____

Source of Referral Acute 1 ☐ Acute 2 ☐ Com RGN ☐ PHN ☐ DCT ☐ GeriAOPD ☐ LTC ☐ GP ☐

Assessment type **A**= 1st Assessment **B**= Return in/ repeat assessment **C**= Change in Status **D**= D/C **E**= T/F out **F**=Routine Quarterly

2. Personal Detail

Name First _____ Last _____ **Gender** Male ____ Female ____ **Allergies** Y ☐ N ☐ Specify _____

Ethnicity – How would you describe yourself? _____ **Language spoken at home** _____

Date of Birth

--	--	--	--	--	--	--	--

D D M M Y Y Y Y

PPSN

--	--	--	--	--	--	--	--

Address _____

Next of Kin Detail

Name _____ Contact _____ Relationship _____

3. Health Findings (only complete elements if required for service provision or relevant for the patient care)

Height (in cm) _____ Weight(in kg) _____ Temp (C) _____ Pulse BPM _____ Respiratory Rate _____

Infection rate status/ or risk for N ☐ Y ☐ If Y specify MRSA ☐ C. Diff ☐ NLV ☐ Other specify _____

4. Service Related Data (for completion by community services linking to Population Health Information Tool)

Medical Diagnosis Code Number 1-16 (see yellow pages) GP Detail _____

Date of last assessment see summary sheet Local Health Centre Code 1-6 DED

Referral Code 1-14 PHIT code list Future Scheduled Appointments _____

5. Patient Need Detail

What is patients expressed greatest need? _____

Health care services ability to address need? _____

Comment _____

Satisfaction level of
care is
1= at expected level
2 =at a high level
3= at a low level

Date							
Assessment Type							
Satisfaction Rate							

6. Social circumstances impacting on self care

Assessment type **A**= 1st Assessment **B**= Return in/ repeat assessment **C**= Change in Status **D**= D/ **E**= T/F out **F**=Routine Quarterly

Select & Insert code number in table from left menu

Issues with facilities within the patients home are
1= None
2= Simple
3= Complex

Measurement Date	010109								
Bath facilities	1								
Toilet	2								
Hot water	1								
Living areas	2								
Steps, stairs	1								
Cooking & safety	2								
Heating & safety	3								

Select and Insert code number in table from left menu

Existing supports that are used
1= Daily
2= Weekly
3= Monthly
4= Yearly
5 = Refused
6= None

PHN	3								
Home care support	1								
Meals on Wheels	1								
Family	1								
Friends and neighbours	2								
Voluntary organisations	6								
Social Club	6								
Day care centre	6								
GP	3								
Consultant	3								
Day Hospital									

7. Self care - Psychological Ability for the following terms is

MMSE Insert Score =

Geriatric Depression Scale

The psychological ability for the following terms is
 1= At the expected level
 2= Enhanced from previous level & ability
 3= Impaired from previous level & ability

Insert assessment type in the column below

A= 1stAssessment **B=** Return in/ repeat assessment **C=** Change in Status **D=** D/ **E=** T/F out **F=**Routine Quarterly

Assessment Type	A								
Measurement Date	010109								
Insert Code Number for psychological ability in table below on each assessment									
Thought & cognition	1								
Decision making	3								
Level of motivation	3								
Memory	3								
Communication	3								
Comprehension	1								

The anxiety level relating to this patient is
 1= At the expected level
 2= Low
 3= Moderate
 4= High

Anxiety level is	2								
------------------	---	--	--	--	--	--	--	--	--

8. Self Care Sensory

1= Hearing noprob
 2= Hard of hearing
 3= Deafened
 4= Deaf
 5 = None
 6= Partial
 7= Total
 1 = Seeing noprob
 2 = Sight impaired
 3 = Blind
 If blind are they
 registered blind
 Yes No

Assessment type in the column below A= 1stAssessment B= Return in/ repeat assessment C= Change in Status D= D/ E= T/F out F=Routine Quarterly									
Assessment type	A								
Measurement Date	010109								
Insert Code Number for sensory ability in table below on each assessment									
Sensory percept – hearing	1								
Extent is	5								
Sensory percept- seeing	1								
Extent is	1								
Aids used please comment									

9. Functional status

Use dependency
 framework the
 functional status is
 1= Dependent never
 2= Dependent minimal
 3= Dependent partial
 4 =Dependent extensive
 5 =Dependent complete

Insert assessment type in the column below A= 1stAssessment B= Return in/ repeat assessment C= Change in Status D= D/ E= T/F out F=Routine Quarterly									
Assessment type	A								
Measurement Date	010109								
Insert Code Number for functional status ability in table below on each assessment									
Ability to perform hygiene	3								
Ability to Dress	2								
Ability to Groom oneself	2								
Ability to Bath	3								
Ability to Mobilise	2								
Ability to Walk	2								
Ability to Transfer chair /bed	2								
Ability to Walk in room	2								
Ability to Walk in corridor	2								
Ability to climb steps/stairs	3								
Ability to Toilet self	3								
Ability to Feed self	3								

10 Symptom Management A= 1 Assessment B= Return in/ repeat assessment C= Change in Status D= D/ E= T/F out F=Routine Quarterly											
Assessment type	A										
Measurement Date	010109										
Insert code for Fall in table below on Falls 1= Never 2= Rarely 3= Often 4= Risk for fall is high 5 Risk for fall is low											
Falls	2										
Risk for Falls is	5										
Insert code for Pressure ulcer / skin integrity PU 1= PU Stage 1 2= PU Stage 2 3= PU Stage 3 4 = PU Stage 4 5= None 6= At risk											
Pressure Ulcer / Skin Integrity	6										
Insert code for continence below 1= None 2= Partial 3= Total I = Intermittent C= Continuous											
Incontinence is	2										
Incontinence (Int or Cont)	I										
Insert codes for Constipation 1= None 2= Actual if actual 3= Partial 4 = Total											
Constipation (problems with)	2										
Extent of Constipation	3										
Insert code for nutrition below 1= Nutrition in normality state 2= Abnormal state If abnormal then refer to dietary assessmt											
Nutrition	1										
Fluid balance is 1= Normal state 2 Abnormal if 2 then select from following list 3 = Deficit in fluid volume 4= Excess fluid volume 4= Fluid and electrolyte imbalance 5= Fluid retention											
Fluid Balance	1										
Abnormal status is	---										
Insert code for breath/days 1= Dyspnoea none 2= Functional Dyspnoea low 3= Functional Dyspnoea high 4 =Resting Dyspnoea											
Breathing / Dyspnoea	3										
Insert code for Weakness and Fatigue 1= Fatigue none 2= Fatigue low 3= Fatigue Moderate 4= Fatigue high 5= Fatigue extreme											
Weakness / Fatigue	3										
Insert code for Nausea below 1= None 2= Low 3= Moderate 4= High 5 = Extreme											
Nausea	1										

Pain frequency is

1= Never

2= Sometimes

3= Often

If 2 or 3 Pain Intensity is

4 = Low

5= Moderate

6 = Extreme

Duration of pain is

7 = Intermittent

8 = Continuous

Insert three sets of codes for Pain Frequency and Intensity

A= 1 Assessment **B=** Return in/ repeat assessment **C=** Change in Status **D=** D/ **E=** T/F out **F=**Routine Quarterly

Assessment type	A							
Measurement Date	010109							
Pain frequency is	2							
Pain intensity is	4							
Duration is	7							

Visual Analogue Scale here or in the pack to use with patient**No Pain****Worst Pain Possible****1****10****11/ 12. Medical devices****Use dependency****framework the****functional status is**

1= Dependent never

2= Dependent minimal

3= Dependent partial

4 = Dependent extensive

5 = Dependent complete

Assessment type	A								
Measurement Date	010109								
Insulin regime (ability to use)	1								
Oxygen (ability to use)	1								
Personal Alarms (ability to use)	1								
Bed (ability to manage)	2								
Pill boxes (ability to use)	2								
Inhalers /Nebuliser (ability to use)	2								
Frames (ability to use)									
Wheelchair (ability to use)									

13. Health Education / Readiness for discharge from acute care and home care domain

A= 1st Assessment B= Return in/ repeat assessment C= Change in Status D= D/ E= T/F out F=Routine Quarterly

1= Independent never
2= Independent minimal
3 = Independent partial
4 = Independent extensive
5= Independent complete

Assessment type	A						
Measurement Date							
Knowledge of medications currently taking	2						
Understand the purpose of the medication	2						
Ability to take medications as prescribed	2						
Understanding why you experience some change in your body symptoms related to your illness	1						
Recognition of changes in your body (symptoms) related to your illness	3						
Knowledge of what to do things or activities to control these changes	2						
Ability to carry out the treatments or activities that you have been taught	3						
Ability to do things or activities to look after yourself and maintain your health	2						
Ability to perform regular activities , such as bathing shopping preparing meals visiting friends	2						
Ability to adjust your regular activities when you experience body changes (symptoms) related to illness	3						
Knowledge of whom to contact to get help in carrying out your daily activities	2						
Knowledge of who to contact in case of medical emergency	2						

ADL / EA Risk is
 1= Low
 2= High
 3 = At the same level
 PHIT Intervention
 0= see scale
 1= see scale
 2= see scale
 3= see scale

A= 1 st Assessment B= Return in/ repeat assessment C= Change in Status D= D/ E= T/F out F=Routine Quarterly								
Measurement date								
ADL status is	3							
EA risk is	1							
PHT/ MMH Intervention level	2							

Summary Sheet of Assessment Schedule (Sheets to be placed in front of the patient record pack)

PLEASE COMPLETE INTERAGENCY COMMUNICATION TOOL SUMMARY SHEET AT THE BACK OF THIS PACK

Variation Sheet / Comment Sheet (sheet to be added to the back of the patient record pack)

Date	
Comment	
Signature	

Date	
Comment	
Signature	

Date	
Comment	
Signature	

Patient Family Comment Sheet with instructions for health care agencies

Date	
Comment	
Signature	

Date	
Comment	
Signature	

Date	
Comment	
Signature	

Medication List

Medication	Dose	Frequency	Comment

Glossary of terms within the assessment tool

ADL	Activities of daily living
AL	Assessment level is
Acute	Acute care services
BPM	Beats per minute
C	Centigrade
CIT	Community Interventions Team
C. Diff	Clostridium Difficult
CM	Centimetres
Comm Reg	Community Registered Nursing Service
DCT	District Care Team
DED	District Electoral Division – a code use by public health nurses
GDS	Geriatric Depression Scale
Geri Ass OPD	Geriatric Assessment Out Patients
Kg	Kilograms
LTC	Long Term Care Facility
MRSA	Methicillin-resistant Staphylococcus aureus
MMSE	Mini Mental State Examination
NLV	Norwalk-Like Virus
PHN	Public Health Nursing Services

Appendix 3

Full Transcripts from Services with

Context Mechanism & Outcome (CMO) Models

3.2.1 Population Health / Generalist View 03/11/2009

Researcher

On review of this particular model in terms of a more generalised practice approach what do you think are the key concepts that need to be included in the model to reflect the reality for the acute continuing and primary care sectors?

Respondent 1

What do you mean by role is it each individual agencies role or the domain role in the process of health care provision?

Researcher

Yes it is I guess it can be either or both the role of the nurse can be made more evident by the development of archetypes designed by nurses for inclusion in EHR.

Respondent 2

And are they sustainable then as they can evolve over time?

Researcher

Yes as they are based on a strong architectural model they can be amended over time.

Respondent 2

Health and social need is a good example considering some of the cases that we have been discussing over the past few days.

Respondent 1

Health and social need comes to mind for me as we are both currently involved in public health nursing groups and the group that I am involved with is in regard to the elderly.

One of the first things that people start discussing in this group when it comes to patients is the problems that the patients have. But our mandate in public health goes further than that. For example we hold a register for all individuals over 65 and part of the role we perform is to inform them of their rights and their entitlements. That never really goes away as you spend a great deal of time doing that and referring them on to other agencies as appropriate. This forms the basis for older adult care younger people can use the

Internet etc. but elderly clients don't have such resources. Sitting down with them in they're own home and advising them on what they're entitlements are or helping them make decisions is a key part of the role. I suppose I would call it advocacy helping to keep them well.

Researcher

Is it advocacy then does this need to be in the model as a mechanism?

Respondent 1 and 2

Yes it does.

Respondent 1

They don't always have a network of friends or relatives or they don't always have the insight to work it out for themselves. But people are forgetting about this now, it's all about how many clients have you got that need care packages.

Respondent 2

It's now about numbers on the books rather than about service provision. We are both involved in steering committees looking at the role of the public health nurses particularly in regard to their integration into the primary care team so this is being done at a national level to rebrand nursing in the community. Respondent 1 is involved in one group on older persons and I am involved in another more general group.

What I gather is that those individuals involved in the groups who are not from a public health nursing background are coming out defining patients needs based around a particular condition. For example they might say that the diabetes or cancer groups are doing a great job because their defining peoples needs around cancer. They are all labeling people with conditions as opposed to seeing them as a population which is dynamic. They then spoke about needing to have specialists coming out from the hospital to see this person in a capacity that would only care for one aspect of that person. So there was one very bright person there in the group who also noted that the groups are defining the community nurse as the public health nurse or the community RGN, but what about the community mental health nurse, you cannot leave out mental health issues for patients who may be suffering with a chronic condition such as the chronic renal failure patient.

Researcher

OK I understand but I am going to have to try and pin this down in to the model, to me what you're talking about here is the bio psycho social model of care rather than adopting a medical model approach is that broad enough to encompass what you're both saying here?

Respondent 2

In terms of words I kept hearing yesterday generic the generic community nurse or the generic public health nurse, but you know you would never hear anyone calling the doctor in the community the generic practitioner do you its a general practitioner isn't it? So what's wrong with the nurse being a generalist who specialises in generalist care or practice? Now maybe we need another word like holistic but words are a hard thing to label if I change the name of an object from one name to another it may not always mean the same thing to people.

Researcher

OK, it is interesting how labels can be used on certain concepts so we're not sure if this is the final label for the term but generalist is what I am hearing as a starting point is that correct and it would come under the larger concept of role?

Respondent 1 and 2

Yes that's right.

Respondent 1

Yes but the term is inclusive rather than exclusive.

It has to be including all care provision not just someone who is discharged from hospital for diabetes care.

Researcher

OK so do you see this linking into the bio psychosocial model?

Respondent 2

Yes but its part of the assessment process as a mechanism.

Respondent 1

But then where does health and social care need come into it they are important concepts also.

Pause and everyone looks at the draft model.

Researcher

I think the health and social care need as defined by bio psycho social assessment provides a generalist care approach which impacts upon discharge planning and admission to the acute services. Is that what you're saying?

Respondent 2

Yes

Respondent 1

As long as the concept of health and social need is defined as the World Health Organisation defines it.

Researcher

Yes we will put that in as a reference in a footnote but what about care is that the right word?

Respondent 1

What about replacing the word care with practice?

Respondent 2

OK

Researcher

OK so generalist is a type of role is that correct?

Respondent 1

I think this is really important as it will allow the generalist role to evolve whilst accommodating differing professionals to work in different roles with the different constraints that are currently upon us. We are not reducing our roles to fit into different boxes it's a broad enough term.

Researcher

Is there anything else?

Respondent 2

Do we need to think about patients in different groups, I am thinking here of patients coming in and out of different services the acute chronic and well. I am thinking about the client journey.

Respondent 1

Thinking about that I am delighted that we have the case finding on the model because this is something that is peculiar to us in public health as you won't find cases walking along the corridors of the hospitals.

Respondent 2

Geriatricians are very interested in this idea as they have these waiting lists they often get people coming into them who haven't been triaged except by a GP and who hasn't been in on their circumstances the way public health nurses or community nurses would have been. So I think that this is interesting.

Researcher

OK let's go back to case finding first is this linked to classification and time perhaps?

Respondent 2

Well I think it is but I would think that we have to start moving away from classifications relating to conditions or disease processes but instead on acuity or wellness.

Respondent 1

Yes I agree or for perhaps based on urgency of need.

Researcher

OK well then does the generalist care in some way tie in with this classification and is this classification in the population health information tool already?

Respondent 1

Yes well they are classified in the population health information tool as acute, stable, stable/ chronic etc.

Respondent 2

Yes it would be good if we could include these.

Researcher

OK so the generalist role is linked to the population health information tool monitoring case finding mechanism and generalist practice which can be used to define a generalist population classification which is not disease orientated but more based on client need as defined by a health status such as chronic stable and acute is that right?

Respondent 1

Yes health promotion, acute, chronic stable, and chronic progressive

Researcher

OK this is detailed but I think it needs to be. OK is there anything else?

Respondent 1

Yes these are all relating to the individual patient, but what about the community capacity or the environment. How is that going to fit into the model, whilst you're focusing on individual patients it's the environment that your operating in that also needs to be taken into account. This has to be of interest as well as it actually the community itself. You need to consider that the capacity or environment in one community might be better than in another environment. We need to think about the community environment and the social capital as well, there are huge supports in a hospital but this is often not the case in the community. Often with elderly people the longer that they are in hospital the more their ability to be independent is lost. Their self confidence to live on their own is gone and this needs to be built back up.

Researcher

You know I think this is really interesting when you think about it. In my 20 odd years in acute care I came from the perspective of attending to elderly patients needs as much as possible. But what I am hearing you say is that in the community it's all about promoting the individual to be as independent as possible in order to promote confidence especially if they are living alone. It's just a personal opinion but maybe this varying perspective is not as evident as it could be between the acute and primary care services. I think the drive towards independence for the older person is significant when they are in the community and perhaps one that I needed to be reminded of.

Respondent 2

I think continuing education could help you know the Swedish have interpreted the European Commission on Community Nursing Mandate for reform for Public Health and Community nursing as rotating all nurses working in Sweden to have experience in the community they didn't just do this with newly qualified or registered nurses but across the board with all nurses and they used learning technologies to support the process.

Researcher

OK that might be a useful paper to reference in this study can you send it on to me and I will include it.

Respondent 1

Community capacity is also key you can see that it involves a number of factors skill mix or available services in the community the environment social capacity itself and how dependent the person becomes when in hospital and is transferred home.

Researcher

Do you think that it might be useful to present this concept in a stratified view?

Respondent 1

Yes often the person needs to be de institutionalized to step back into their own role.

From day one of admission the person needs to have discharge planning initiated.

Researcher

So are you saying that in some way community capacity influences discharge planning?

Respondent 1

I think its cause and effect if you have good community and social capacity the client is usually discharged on time and they are not readmitted as quick. In terms of hospital admission and discharge it has a huge influence on the patient. Specifically in terms of the patients care, but this doesn't take into account the psychology because the patients and often their families have now invested in a different social group and the longer they are in hospital the harder this is. In some cases the nurses even become part of their social group. How that separation is negotiated from the acute service is important they need to be geared towards a positive approach to being at home and are ensure that the resources are in place and properly set up. The setting up process is very important.

Researcher

I think the acute services and public health nurses are making progress on this. They are starting to see that communication is a two way street. This is evident from some of the transcripts that I have been writing up

Respondent 1

And that is where this type of PARTNERS assessment tool is going to be useful.

Respondent 2

I also think community Partnership needs to be in there, what you think the clients in the community need and what they want is not always the same thing.

Researcher

Does this link in with health issues or health threads whatever the health issues are for that patient that arises in the assessment and these impacts on the health outcomes is this right?

Respondent 2

You want to find out what they think their problems are they may arrive in a clinic and your thinking that the big issue is that their INR is high but to them that's not what the issue is at all in fact they couldn't care less about their INR level.

Researcher

OK Partnership needs to link with community capacity and all of its associated themes. Do you think that the PARTNERS process has helped to trigger a better understanding of the need for health information standards, concepts and terms and the EHR? Do you think this should be in the model?

Respondent 1 and Respondent 2

Yes

Researcher

Anything else you think should be on the model?

Respondent 1

No that's about it.

Respondent 2

No that's it

Researcher

Thanks for your time today.

End of transcript.

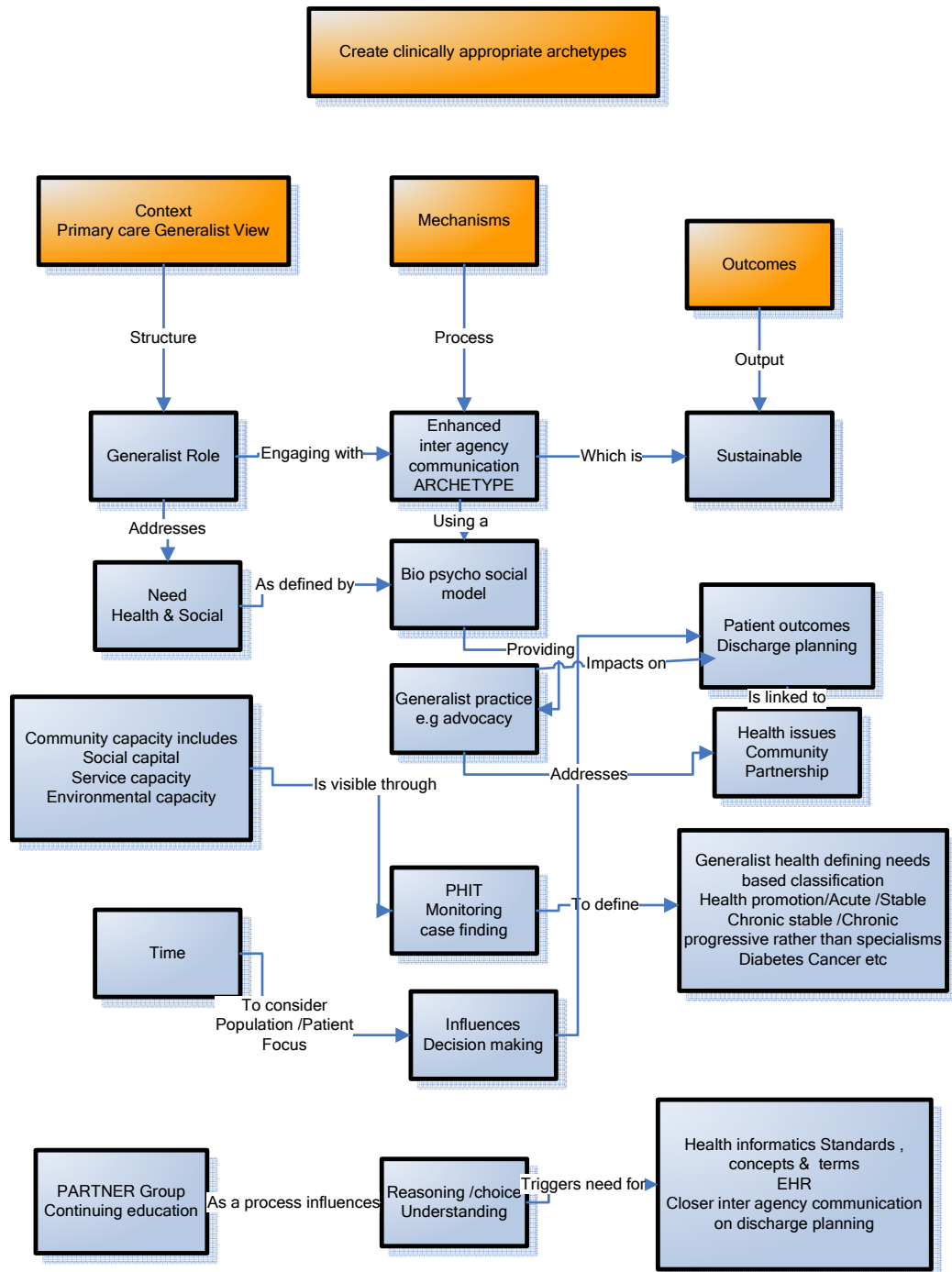


Figure 0-1 : Generalist population view

3.3.3 Primary care area 1 16/10/09

Researcher

What do you think are the key concepts that need to be included in the model to reflect the reality for the public health nurses?

Respondent 1

I suppose our role and time they're very important really because monitoring the time that you may spend with a patient that doesn't necessarily have an equitable measure.

Respondent 2

You can't measure them as such?

Researcher

That's interesting as this is coming up with the other researchers as well is it monitoring time?

Respondent 1

Yes.

Respondent 2

Something that you think may take a few minutes and when you arrive it may take an hour to sort out. You may go in for a wound dressing and you come out and they may need the occupational therapist and or the physiotherapist they need one or all of the other members of the multidisciplinary team. They may need something else in the house as well.

Respondent 1

Yes the dressing is no longer the only problem they have.

Researcher

OK, so it's only the thin end of the wedge in terms of their needs.

Respondent 3

Yes.

Researcher

So what kind of a label would we put on that its time but is there any particular way you would label it. Is it time to monitor?

Respondent 3

Time is not a great word for it.... its more of a combination.

Researcher

Is it a combination of time and role then?

Respondent 3

It's more time to the client and you don't want to give your self only 5 minutes because it could take you longer.

Researcher

OK that's a good point what I am going to try and do is work this up and then give it back to you so that it reflects your reality rather than mine.

Respondent 2

I would call it client centred care as opposed to time.

Respondent 3

Time is more when you're talking about a task.

Respondent 2

Time is where I have got to do something and it's only going to take me about 5 minutes.

Respondent 1

Where the reality is not like that.

Researcher

OK and you know that these concepts are to do with the context and not the mechanisms or outcomes yes? I think we should work our way through the rest of the model and then come back to this would that be ok?

All respondents – Agree by nodding.

Researcher

OK lets look at some of these associations in terms of autonomy flexibility is access to records also important to you or do you currently have adequate access?

Respondent 1

That would be very important to us as well as we wouldn't get access to any other records apart from what we have and the records may be from 1996 which is the last time that person was seen here and they could have had four or five admissions and discharges to the hospital and we would never know, we would not necessarily know.

Respondent 2

Like your often relying on GP information and they may not often have known the patient in the past, they may have moved on.

Respondent 1

There is actually no guaranteed link back to us to say as soon as they are coming out of hospital that we get information that they need this this and this.....(pause) sorry I forgot the only one is child health that's the only guarantee that we have up to date information but for the older person there is none.

Respondent 2

There is no particular place or service that is good or bad you couldn't say that any one particular place is brilliant for this they are all much the same.

Researcher

Ok what about right to perform are there any issues for you about this or do you have any other issues around right to perform in other words to be able to do things for the patient or are you pretty flexible in that area?

All respondents

Yes.

Researcher

OK let's have a look now at the mechanisms these are the concepts we have identified within this project that perhaps contribute to the outcomes. Can we look at them now for example what about the assessment tool do you think that this has assisted with the inter agency communication?

Respondent 1

I think that when this is accessible electronically as part of an electronic healthcare record people can access it anytime with their ID where as in the pilot if Joe Soap is holding on to it in a paper format then nobody can access it by themselves so it will hopefully work better and improve access in the long term.

Researcher

Yes having this tool in electronic format and accessible to all stakeholders is a long term objective for the project. The other thing I have down here is enhanced interagency communication which is also informal do you think that the project and the tool has impacted on that?

Respondent 1

Yes well for me that was very good I know I didn't get to all the meetings but meeting participant A from service A and participant B from service B although I knew them by name I didn't know them by face. This does make things a bit easier when you know each other face to face, and they understand your role as well because you can go to lots of meetings and can see that they don't know what the role of the public health nurse is. They just don't know exactly what your role is. And I am sure that that was the same for them to.

Respondent 4

Enters the room and the researcher gives her a quick overview of the model under review and explains the discussion to respondent 4 about time and role in the context of the programme. This opens the discussion on the concept of time again.

Respondent 1

It could take you half a day to organise that particular patient you need to come back to the office and set up the relative services it could take up to an afternoon to organise the relevant services.

Researcher

Would you say then that it's dealing with the patient in their context?

All respondents

Yes, yes that would be it.

Researcher

OK well then maybe that's what's missing from the context element of the model the patient in context?

Respondent 1

The patient in the context of their home versus the patient in the context of the hospital is totally different and that's what we need to capture.

Researcher

I am thinking that an association may be influences for example patient in context influences the care package.

Respondent 1

Yes.

Respondent 4

I think it's the care process as well as the care package its how you get from A to B with the patient.

Researcher

OK is it influences the care process.

Respondent 4

I think its feeds into the care process.

Researcher

OK that's good that we have tied that down, now let's look at the rest of the model looking at the outcomes for example how would you define quality?

Respondent 1

The quality part I suppose well part of it would be getting to the client as soon as possible and that is a big thing with poor communication.

Respondent 4

It's the transition process.

Respondent 1

Yes if you can get to see them as soon as possible that brings alot less stress on the patients often they are on their own at home alone.

Respondent 4

A planned discharge.

Respondent 1

A planned discharge leaves less for the client to worry about. You then have as much information as possible that you can take out to the patient and they don't feel as stressed because they don't always remember all the information.

Respondent 3

They are unclear a lot of them.

Respondent 1

Yes they are unclear and if you can visit them saying that you heard that they were in hospital and you had this particular problem and this particular treatment it's better.

Respondent 3

Yes they are not repeating a lot of information back to you or asking you did you not get my letter from the hospital.

Respondent 4

Or they will say did nobody tell you what happened?

Respondent 1

They get flustered and this is an issue that I would identify with quality.

Respondent 4

There are cases that you don't get a phone call or a letter about and this then ties in with the time issue of setting up the relevant services. I have had patients who I don't get a phone call or letter about and 10 days later the client or their family is ringing up the centre asking when are you coming to do the dressing?

Researcher

OK so is this directly related to the concept of patient in context and discharge planning then?

All respondents

Yes.

Researcher

So what happens to the letter or the phone call then does it not come is that it?

Respondent 1

Exactly we got a letter today or was it a fax and the patient came home last Sunday and he sat at home all week waiting for us to call.

Researcher

OK can we talk a little about health issues that you can think of that are prevalent in your service and which are relevant to this programme.

Respondent 4

There are plenty to choose from such as chronic ulcers, exercise.

Respondent 1

Nutrition and smoking.

Respondent 3

Smoking, illiteracy, and living with chronic illness.

Respondent 4

Social Isolation, this is a big issue.

Researcher

OK that's fine anything else you want to comment on?

All respondents 0

No that's about it really.

Researcher

Thanks for your time then.

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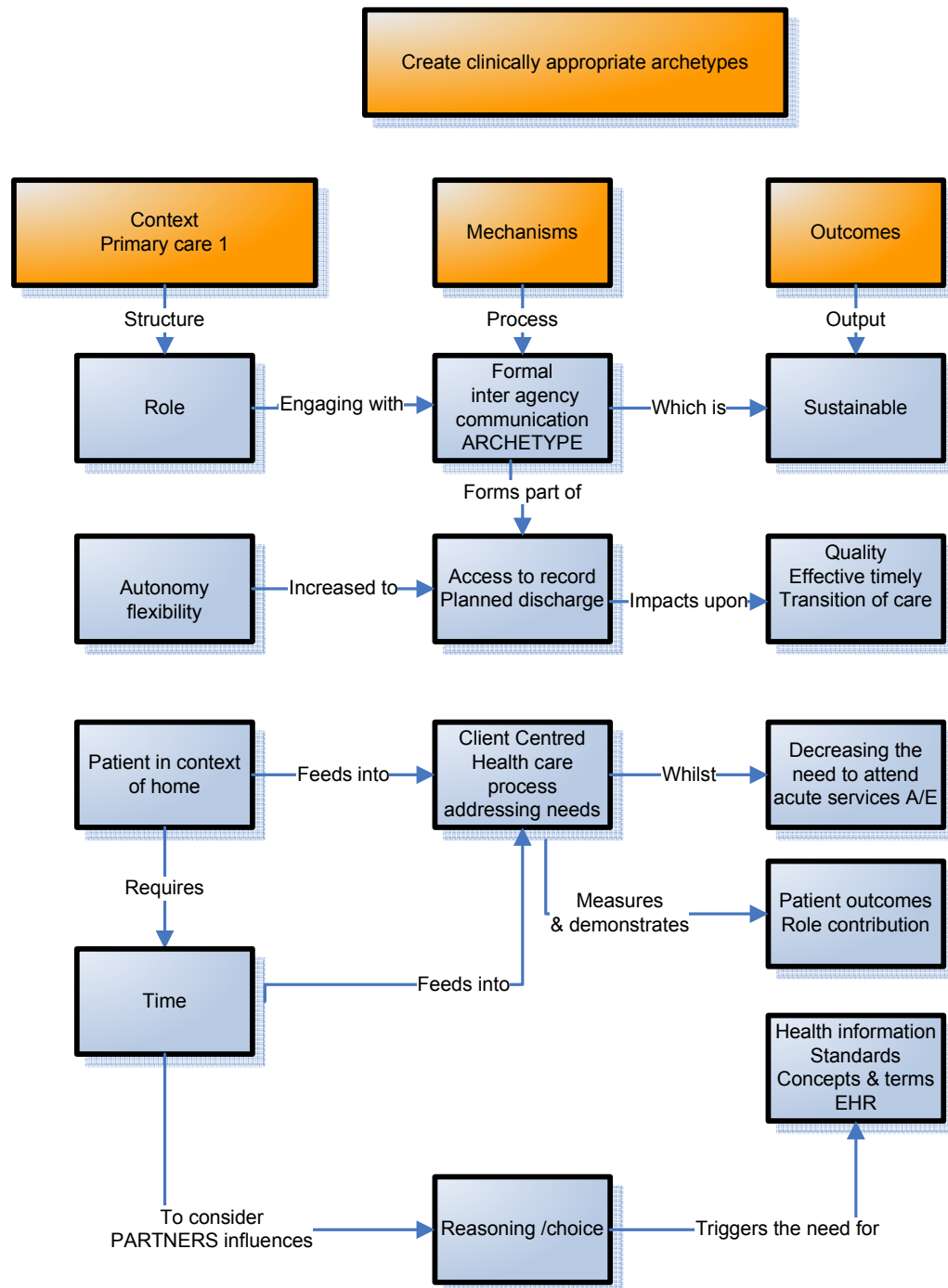


Figure 0-2 : Primary care area 1

3.2.3 Primary care area 2 21/10/09

Researcher

We are going to consider PARTNERS as a process as well as the tool can you look over this model and tell me what you think of the concepts identified do they in any way relate to your reality here in the primary care area 2 ?

Respondent 1 and 2 review the model

Researcher

What do you think of the process of PARTNERS what we have been doing over the past 18months do you think it's important?

Respondent 1

Yes I do I knew nothing about it beforehand.

Respondent 2

Absolutely it is important as we are now moving towards using a universal language and that's very important for the development of electronic health care records and standardising nursing information. The tool captures the health status of the client in a clearer format i.e. hospital to CRT and CRT to PHN and Population Health Tool.

Therefore outcomes from interventions can be measured periodically

Researcher

What do you think about the access to records interagency communication?

Respondent 1

To a degree we have access but we still have a huge problem trying to gain access to information about appointments or results and alot of our patients are orthopaedic and we have difficulty finding out what happens to them in the fracture clinic and what they have been told. If they have form of cognitive impairment they are not able to relate back to us accurately on what has been discussed and arranged. You then have a situation where we or the physiotherapy are trying to contact the fracture clinic you are talking about a great deal of time that is taken up with this activity. We have huge problems there.

Researcher

So this is time consuming and there could be some potential to improve there?

Respondent 1

Absolutely yes its time a huge amount of time.

Respondent 2

It's also about changes in client status that's difficult to capture from a client status perspective. An assessment completed in the hospital which is captured on the day but by the time it's translated back out in the community very often there's a lot of change by then. The time that the patient will take to get to the general practitioner for the change of medication and also for the patient understanding of medication is often problematic. Unless its really explained to them they feel there on the same medication all the time when in fact they're not, and I feel a tool like this will capture any change and that would be very valuable. I suppose that if I was to look at a patient outcome as a result of an attendance at an appointment that I can actually see the facts in the record. I am not just listening to the patient and their own perception of what happened during the encounter. I am also then not spending time trying to trace a nurse who was on duty at this time that this patient attended the outpatients often by this time the chart is gone (back to medical records) buried and it won't be retrieved until the next time. But with this particular tool you have it there and then to me its factual its not's someone's thoughts based loosely around what they heard. It makes its possible to measure client outcomes over a period of time e.g. change of medications and what impact it has made on the clients condition or the ability of client to self care medications or outlines deficits that they may have. Also it captures the ability of the client in regard to functional status.

Researcher

What about the concept of health issues?

Respondent 2

It's back to medication again this is a big issue for us I know its highly documented being sent back in to A/E for medication mismanagement. This mainly includes clients who have complex health issues i.e. those who are chronically ill.

Researcher

Are they often over medicated?

Respondent 1

The drugs were administered to them in the hospital and they don't understand their new regime, when they come home they go back down to what they were taking before they were admitted. This is partly because they're the ones (the medications) that they recognise we have this problem constantly.

Researcher

OK let me see if I understand this they come out with a set of drugs

Respondent 1

No they don't, they come out with a piece of paper which has to go back to their general practitioner and its not even a prescription to them because its a hospital prescription which they then have to bring to their general practitioner to get it put on to the medical card prescription then that goes to the chemist and they get their drugs from the chemist. But alot of the time they don't recognise the new drugs they will go back to the ones that they got in March, even though they were in hospital since then. You will constantly find that they have gone back to their drugs that they have at home and they were taking and they are not taking these new ones at all. And sometime they think they have enough tablets to keep them going and they don't.

Respondent 2

And very often with the elderly it's about the way that they have been given their tablets. I have seen them with the tablets in their pockets and popping their tablets saying oh yes I will take it now. It's very easy to overdose or for certain drugs to go over the brain blood barrier and next of all it's resulting in outcomes such as falls and then you're into a totally different health status of medication mismanagement.

Researcher

So the health issues from your perspective are medication management and the whole journey across the services? Is the therapeutic self care tool in the form written by Sidani and Doran is that catching some or all or some of this

Respondent 1 and Respondent 2.

Yes yes it is

Respondent 2

And very often when they're in the hospital everything happens 8 hrly, twice a day or whatever, but how does that translate out to the community for somebody. What is someone's day is often somebody else's night, especially with the elderly who have problems with social isolation and living on their own loneliness is a huge problem out there and that opens up a whole plethora of other problems for them.

Researcher

OK what else is on this model that you want to consider?

Respondent 1

Well in terms of the patient model (pause), the very fact that were dealing with over 60's we shouldn't expect a huge improvement in patient outcomes. I guess for this set of clients the base line is that they can self care at primary care level that they're not going in for acute care cause that would be a huge improvement.

Researcher

So is that how you would define quality then?

Respondent 2

Yes I suppose so the ability to self care is enhanced is how we define quality in this particular patient model. Also to consider the clients satisfaction with the care given.

Researcher

OK then what about this tool we have been building.

Respondent 1

In terms of the tool I think the model reflects the reality that we are trying to improve the quality of patient care. I don't think it gets in the way but its not tried and tested enough for example in this record from acute care area 2 its a bit confusing in the way that they have completed it the social structure i.e. that the needs for the bathroom facilities for this individual are complex. How do they know that as they have not been in the person's home?

Researcher

OK this is a good point we need to build into the tool something like a perceived need based on the information that has been given to the nurse by the patient or the family in the acute service. After which on transfer and subsequent assessment by the community

nursing group in this case the CRT it can then become actual or discounted based on the nurses judgement.

Respondent 1

Yes but I also think the tool is good for narrowing down the focus to the individual needs. The tool has the ability to transfer hand held client information across the services that is in the primary and secondary care which results in a seamless journey for the client. The assessment tool has the ability to measure client outcomes over time it makes the outcome more visible.

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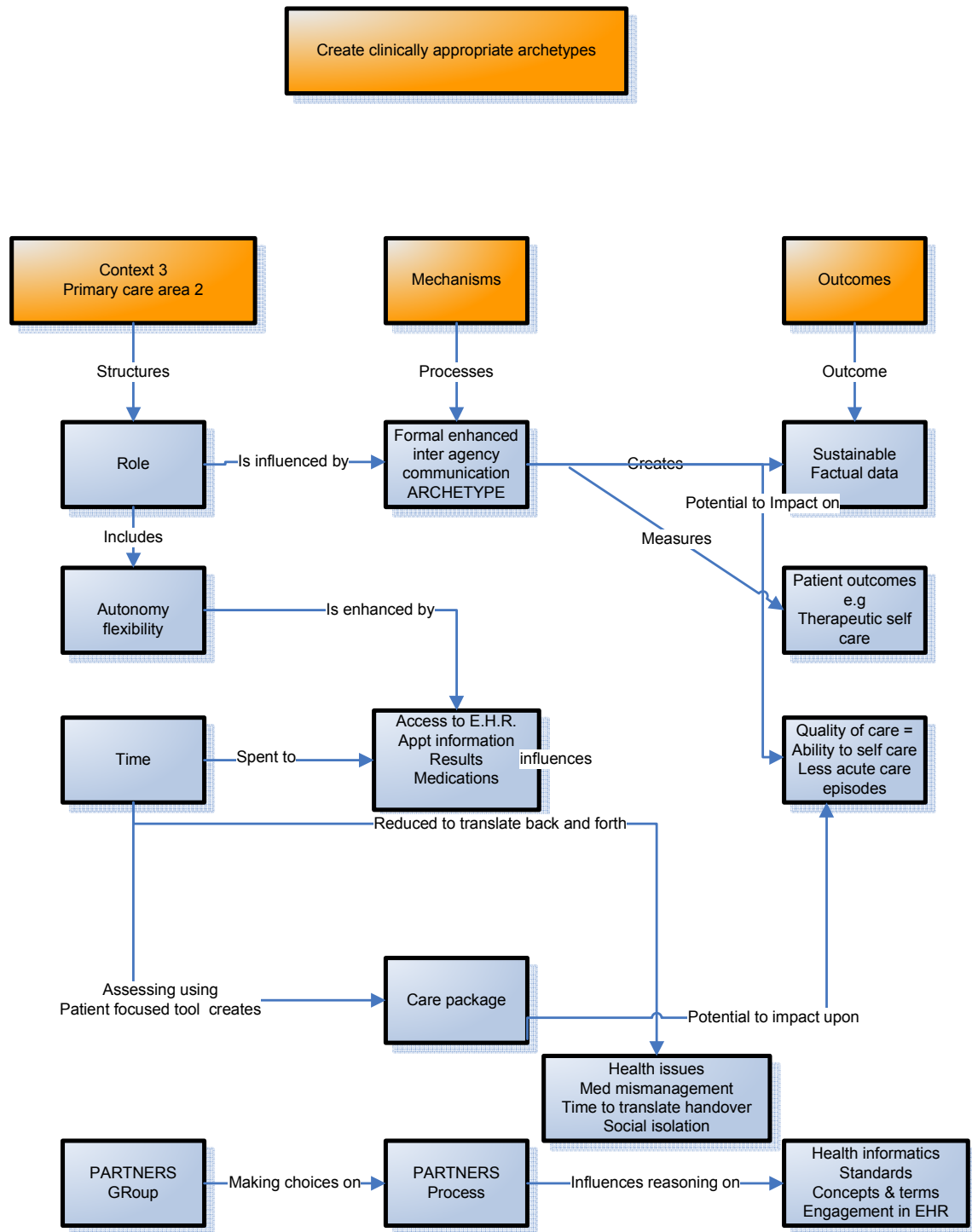


Figure 0-3 : Primary care area 2

3.2.4 Continuing Care Area 1 15/10/09

Researcher

Looking at this particular model what do you think are the key concepts that need to be included in the model to reflect the reality for the continuing care area 1?

Respondent 1

I guess Role is important recognising each of the nurse's particular roles and how they work within it for example the role of the public health nurse or us here in continuing care.

Researcher

OK in terms of the tool are there any concepts on this model that you think are realistic or not realistic for that matter?

Respondent 1

What I would be looking at is the mechanisms getting the information across the different agencies and not relying on the patients to remember to tell them that they had documents. So the role of the person knows that once its in place and that they have been to place A and now they are going to place B that they can now see what happened in A and then they can move on and manage this patient and document the care before they move on to place C. So it's not the responsibility of the patient to deliver the information back

Researcher

So you have got that continuity across the services for all the practitioners involved in the patients care?

Respondent 1

Yes

Researcher

Is there anything else about the model?

Respondent 1

No I think its right you can see time is it the time that they take to fill it in or they complete it after they do their own assessment what do you mean by time ?

Researcher

Well I put time in here in relation to having time to have a patient focus. As one of the key points I see from an observation point of view at least what I think is that documentation is a process that has to be completed just get it out of the way and I notice that with the PARTNERS assessment tool you really need to home in on this one particular patient for example asking the patient what is your greatest need. This is not a question that is always asked.

Respondent 1

Yes but I think even when your filling out the documents even when your filling out any document you have got to step away from looking at that this process as a time consuming exercise or that its just a document your looking at the patients need your actually doing their care and its part of looking after them . To me the time if it's taking too much time or that there worried about the time that it's taking.....

Researcher

That the nurse thinks its taking too much time?

Respondent 1

Yes

Researcher

I think its interesting as time is a concept that keeps coming back up some of the groups have issues with time to access information rather than complete an assessment.

Respondent 1

I think time can be seen as two different entities *time consuming* and *time for patient* they are both different issues that relate to the time concept. So are we saying that once this type of tool is in place then that some of these time consuming practices trying to access information this will be gone?

Researcher

I hope so; at least we shouldn't have to waste so much time looking for information.

Respondent 1

Great...(pause).. to me every time I see time I think of introducing something new in practice and you see individuals saying oh its going to take time and we haven't any time

to spare so its almost programmed into you that time has a different meaning altogether to different people.

Researcher

Yes the other groups have expressed alot of issues with time to access the information.

Respondent 1

And that's where if you had the example of a patient going and coming say from acute care area 2 to here and on to the community and perhaps back into us that you would see that.

Researcher

Yes the flow isn't there yet we have had some issues with gaining access to some of the services one of our key issues was also to develop clinically appropriate tools I think we have made a good start what do you think?

Respondent 1

Yes the whole concept is now out there and straight away I can now see the benefits and especially with the elderly it's just.... (pause) And these are the problems with cognitive impairment and even without the cognitive impairment they can benefit. The whole idea of hospital can be very daunting and they forget so much. This is also because of the stress around attending a hospital and it's afterwards when they go home they think oh I should have told the nurse this and I should have done that. So from that point of view that you're going to be linking backwards and forewords with different people it's really going to be better.

Researcher

Is there anything else there on the model that you want to change or comment on?

Respondent 1

Yes you see the way you're talking about reducing the visits to A/E?

I would change that to decrease the need for rather than the number of visits cause we don't want them to think we don't want them to come in to A/E. That's what that looks like or what its telling me. So if its down on the model of because of all of this work and the continued communication with all of the different agencies the care is better the quality of care is better and in the long term then there is a decrease in the need for A/E

and hospitalisation rather than decrease the number of visits as that's hitting me saying we don't want you here

Researcher

That's a very good point and I will make a note to change this on the model. You mentioned quality there how do you define quality for your patients?

I am asking all the groups this as I think it's a word that is over used and sometimes has different meaning for different groups of people.

Respondent 1

Quality is giving the best I can give to an extent that the patient can expect or that you would expect to get back yourself. We all here about *care* that maybe isn't to a high quality and well you look at the events of the care and then wonder what would you have done differently. Quality for someone who has lost the ability to perhaps function independently can still have meaning quality of life for example maintaining a base it's doing the best that you can for that person within their own personal parameters

Researcher

OK (Pause) can we talk a little now about PARTNERS as a process do you think the work that we have been doing the process of what we have done do you think it may trigger any shift in your or other practitioners reasoning?

Respondent 1

I think people need to see how it is going to work and if they can see how it works and that it will work then it will influence reasoning. Because it's like anything new if they don't see it then they will all say oh that's not going to work. But if they can see it in practice working and we can demonstrate how this is going to work from one person on to the next person etc explaining and demonstrating how this works is half the battle its seeing- oh its not too bad and that is manageable rather than oh that's double Dutch. I'd never be able to manage that or take that on. Being able to see is important although it probably depends on what type of learner you are as well. But the tool is only a matter of passing on what we did here passing it down the line and then the whole continuity of care continues or the cycle of care continues for the patient.

Researcher

That's fine is there any health issues that you think are important from the continuing care perspective that need to be included?

Respondent 1

The biggest health issue by far that takes elderly people into A/E is falls.

This is an issue that affects every single one of them; the number of falls for elderly patients attending A/E across the country is not coming down. I know they're studying this currently in St James. You might have people with COPD, CVA's and cardiac problems or whatever, but falls are the biggest thing. Even falls within the hospital patients fall when in hospital and everyone says why did they fall were you not looking after them? But with the elderly it's something that we need to include in considering care plans. There is this whole issue around falls.

Researcher

Well we have it captured in the C.Hobic Terms included in symptom management risk for falls is high low etc but are you saying you think it needs to be specified in the model as well?

Respondent 1

I think that right across the boards you may have patients with cardiac problems or other health problems and there may not be uniformity with the patients but the one common issue that they all face is falls and it impacts seriously on their health when they do. It could be labelled as a frailty risk related health issue.

Researcher

So is it the mechanism of the fall do you think fall needs to be included as a mechanism?

Respondent 1

I am not sure it's just a serious health issue.

Researcher

OK is there anything else about the model?

Respondent 1

No that's about it.

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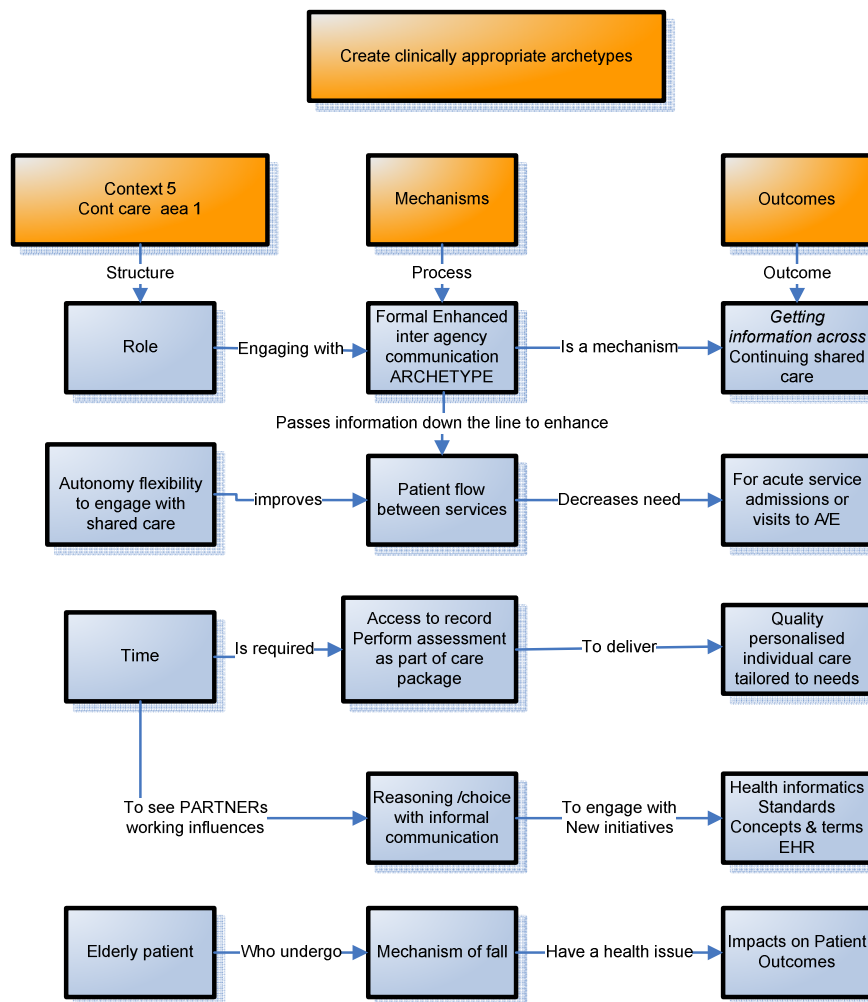


Figure 0-4 : Continuing care area 1

3.2.5 Continuing care area 2 02/11/09

Researcher

Looking at this particular model what do you think are the key concepts that need to be included in the model to reflect the reality for the continuing care area 2?

Respondent 1

Well definitely role is important we have defined our role within the day care centre. Since we started this initiative our numbers have risen there are more people coming into day care, and there is an increased demand for day care. This is impacting upon what we are doing with our clients and also helping us define our role more clearly as the clients have particular needs. The role is very different for a day care nurse as opposed to RGN's who are working in residential care or public health nurses. The clients coming into us have medical and social needs and also psychiatric needs. Our client group has a very broad base. When we took over this centre initially the majority of our referrals were from psyche of old age but now its about 50% medical and 50% psyche. Its better I think as the psychiatric patients see other people coming in perhaps having had some physical disability and in a wheelchair but still despite their disability taking part in the activities. This tends to motivate the psychiatric patients to become more involved in activities and also the two groups tend to support each other which facilitate greater group cohesion.

Researcher

So what you're saying in effect is that the mix of medical and psychiatric patients is good? OK is there anything else that stands out for you on this particular model in relation to continuing care area 2?

Respondent 1

I suppose flexibility and autonomy is important to be able to extend our roles to the clients needs. One of the reasons we can do this is that our Director of Nursing is open to this idea and is allowing us to develop our roles based on the client's specific needs. For example the hearing clinic or falls prevention programme and foot care are good

examples of new programmes that we are introducing here in continuing care area 2. We are also now doing eye care we organise all the clinics and fill out all the referral forms.

Researcher

What about access to information?

Respondent 1

Definitely access to information this is an issue for us we are like detectives here sometimes trying to find out what is happening with the clients it is very difficult to source information. A key resource to find out about client detail is the families; they are a great source of information. It is rare that we would get a full medical history to view before patients are referred to us. Unless there is a direct referral from the Mater and even then it's often patchy with gaps and we need to fill in the gaps by getting back on to public health nurse or the family or the service that referred them. We also get back on to the GP's also but sometimes you don't get a reply and you have to ring them 3 times to get the information. At this stage I have often had to move on to other patients needs but I do find in some circumstances we can get good feedback. For example we did an exercise programme here and we got a 95% response for information from the GP's which was brilliant.

Researcher

OK what else on the model do you think is missing or relevant and reflects your reality here in continuing care area 2?

Respondent 1

Well time is relevant the context of time is important in day care we have set time only have the clients with us from about 10.30 to about 3.30pm and its only in that particular time frame that you can do your activities with them or to focus on their needs. Sometimes the day can just run away on you if something goes wrong because there is only two of us here its difficult to do all the activities. It varies really you don't know what is going to come through the door. You may have someone who has fallen at home and hasn't bothered to go into accident and emergency. So your day may be planned to do a health promotion session with the clients however the day may be scuttled as someone arrives in who has sustained a fall or has done some type of damage to

themselves. They may refuse to go to accident and emergency and you need to contact the relatives and the time just runs away on you.

Researcher

OK so what about inter agency communication do you think the PARTNERS tool would assist in communication between continuing care area 2 and the agencies that you're dealing with?

Respondent 1

Definitely yes the PARTNERS tool can develop with us in day care; it's only in the last few years that the concept of day centers is becoming more evident so our documentation is evolving. There is very little written about the role of day centers and their impact on clients. The last study that I read was done by the national association of older people of Ireland who did a big study that was done in 2000. A key finding in this study was that nurse led services were effective in day care. If this tool could be developed to include some of our activities we could monitor patient outcomes.

Researcher

So do you see this feeding into the overall quality of care for the patient?

Respondent 1

I think it does records like this would help us look over clients progress over time and you can see how they are progressing and what their needs are , there is a large section on medications and I think that is particularly useful.

Researcher

OK another concept that we trying to identify is health issues or health threads is there any particular health issues or health threads that are frequently arising here in continuing care area 2?

Respondent 1

I think there needs to be more information in it to collect data on emotional social and psychological support. Alot of our time is dealing with this and also dealing with relatives on the phone and in person sometimes they will ring us and we can be up to an hour on the phone talking to them.

Researcher

What kind of things are you talking to them about?

Respondent 1

Well you might have somebody sick at home who cannot attend day care, I will need to contact the public health nurse to call in and review these individuals at home. A lot of our clients live alone.

Researcher

Listening to you I think the client needs to be in the context, this model is about developing electronic records and the patient doesn't sit with all of the service models that I have been developing but your focus on the client is very unique I think.

Respondent 1

Yes I agree the patient or client needs to be in the context, but you know calling them clients doesn't even seem right these are people who are with us for years, we get to know them very well and they are never discharged.

We take a personal interest in each and every one of them we try to do all the activities and assess their ability sometimes they don't tell us that they have had incidents happen to them such as a fall at home. What we tend to do is assess them during planned activities during the day and monitor things like their mobility. We also try and keep them focused on what they enjoy doing gardening pottery etc and we try as best we can to improve their health state or to prevent them from deteriorating.

Researcher

OK that's fine is there anything else you want to comment on in relation to the model.

Respondent 1

No that's about it

Researcher

Thanks for all your help on this

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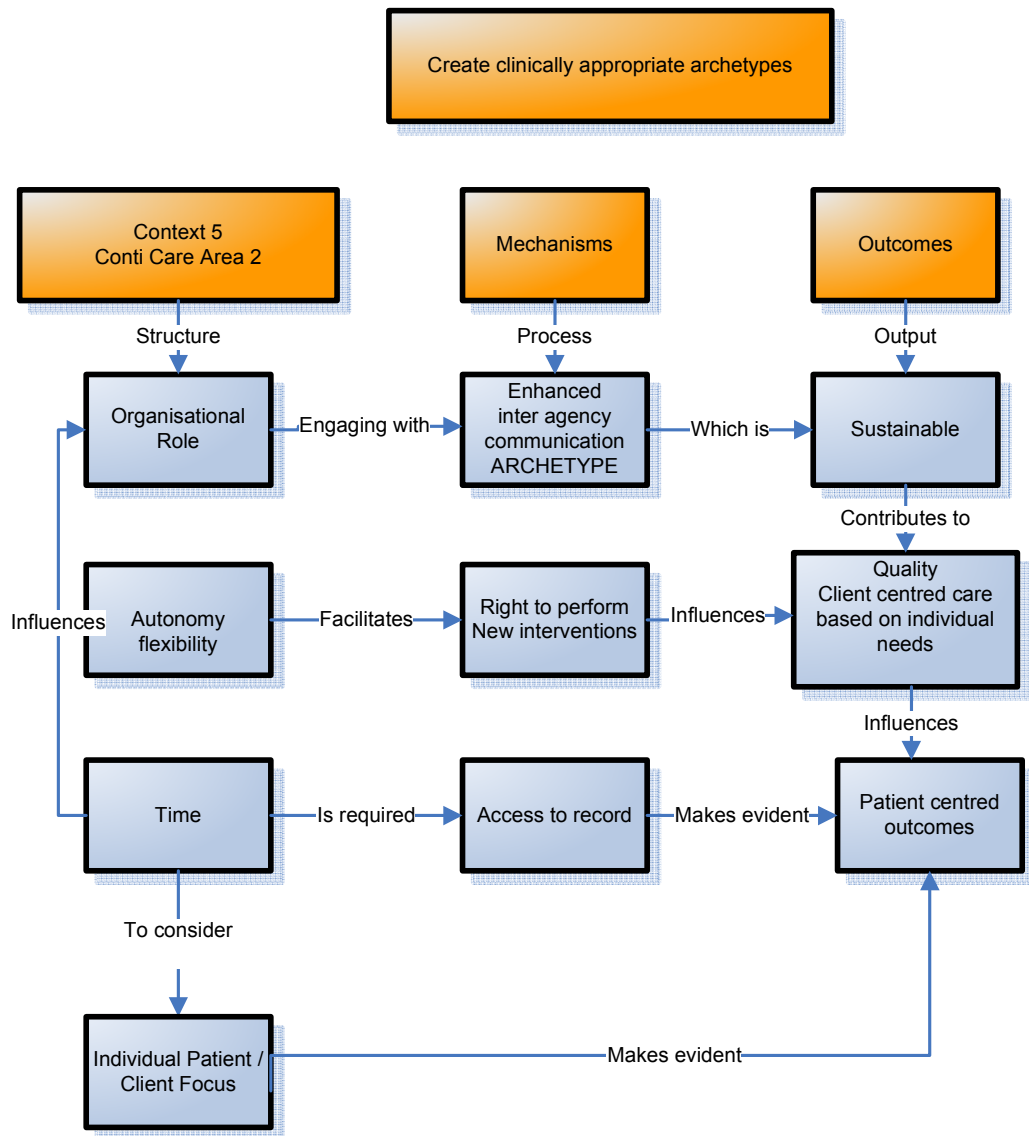


Figure 0-5 : Continuing care area 2

3.2.6 Acute service 1 21/10/2009

Researcher

What do you think are the key concepts that need to be included in the model to reflect the reality for acute service 1?

Respondent 1

Advancing our role since last year to advanced practice I suppose. Our role is changing we are now taking on acutely ill patients.

Respondent 2

We have started taking patients who require Intra venous therapy, intra venous anti-biotics and some who require INRs. We are dealing with patients with pulmonary embolus.... this is pretty serious; also we take on above knee deep vein thrombosis. Those who are discharged into the care of us we give the Innohep and some of them just get their loading dose from us.

Respondent 1

We are also doing a lot of patient education.

Respondent 2

Some of our cases are quite complex. Recently I had a case and he was spiking really high temperatures you know I have worked in Accident and emergency (A/E) and if I was taking care of this patient in A/E I would have put him into high dependency unit. It is a very different environment you know working in the person's home you can't call a colleague or shout for a doctor. In this particular case we repeatedly called in to see the client again and again. It was three times a day we had to call on this man as it was a very complicated case. Basically he was a young man in his forties who had lost his wife and had young children he was very ill. But alot of the cases we are dealing with are complex, there are very few simple cases really. Lines going and perhaps becoming infected over the course of the treatment it's just a multitude of tasks to be doing.

Researcher Are you saying that the types of clients that are coming home are now more complex than perhaps they were last year is there a shift in your role then?

Respondent 2

Oh there is a complete shift.

Respondent 1

We are kind of creating a hospital in the home which is filling a gap.

Respondent 2

But its what I would call the right hospital in the home when we started in this job initially we were thinking that we were like a hospital in the home but then the hospital in the home (organisation) was set up and my thinking at the time was that they were very specific tailored to the task but what we are doing is holistic and we have much of the same issues as the other public health nurses for example with medications or for example sending patients back to their general practitioners who hasn't had an update yet. We had one patient recently who went to a number of pharmacies picked up her prescription with the same medications I don't know how she did it but then she overdosed and when we got to her she was comatose.

Researcher

Medication management has been raised as an issue for another PARTNER group is it then an issue for you?

Respondent 1 and respondent 2

Yes, yes it is.

Researcher

Is there anything else about the model that you would like to comment on or needs to be changed to fit with the reality of the community interventions team?

Respondent 1 and respondent 2

No not really that's about it.

End of transcript.

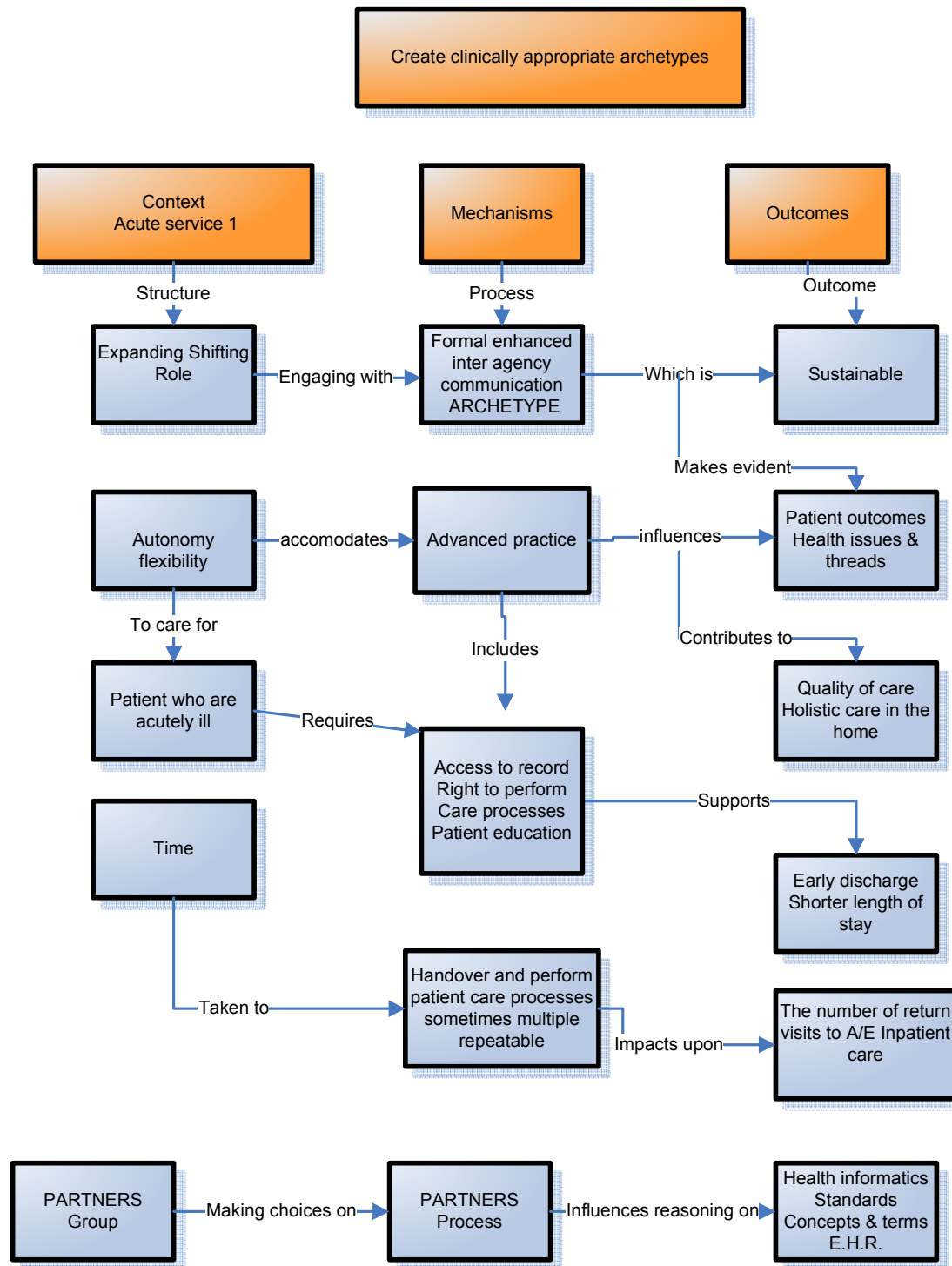


Figure 0-6 : Acute service 1

3.2.7 Acute care 2 30-10-2009

Researcher

What do you think are the key concepts that need to be included in the model to reflect the reality for acute service 2? Are the information needs the same as they would be for the community services do you think?

Respondent 1

In terms of inter agency communication what we are highlighting here is that we don't always get the information coming in to the hospital and the other thing that has arisen recently at the discharge planning meeting and to be fair to our colleagues in public health nursing even though we have contact phone numbers there appears to be difficulty in contacting them. So what I am saying is that even if we have a phone number to contact the public health nurse they may be in a clinic or out in the community visiting patients. Now the public health nurses have mobile numbers and have sent in a list to the hospital which we now have but I am still attending meetings where individual group members in the acute service 2 are highlighting the overall difficulty with communication with the public health nurses.

Researcher

OK I understand then that inter agency communication is an issue for you as well particularly around getting the information in?

Respondent 1

Yes and there is a perception there that the acute services don't always need the patient information to come in , but they do and as they say themselves it would be nice to have this information at the time of assessment.

Researcher

OK so a key point for you also is access to records from the community setting. What about Role is this an important concept for you on the model?

Respondent 1 and Respondent 2

Yes

Researcher

In terms of autonomy and flexibility you have decided that you're going to discuss this draft model with the clinically focused nurses involved in the study, so is this maybe something that you will need to discuss with them?

Respondent 1

Yes that is correct.

Researcher

OK so getting information into the acute service 2 is so far a significant point for you in terms of this model?

Respondent 1

Yes they (the clinicians) don't always know if the patient is in contact with or known to the public health nurse, or if they are receiving care from the public health nurse. When they are in the A/E the patient may have cognitive problems and cannot always answer the questions that we are asking them.

Respondent 2

It's also important to know how the patient was before they came in to the A/E

Researcher

OK then in my mind that relates to access to record to know what the client's baseline actually is. Is that what you think?

Respondent 1

Yes it's about access to record

Respondent 2

It's also though about enhanced inter agency communication as communication is actually a two way street.

Researcher

OK so what you're saying is that the information flow needs to be a two way street?

Respondent 1

Yes and this is particularly important when your dealing with complex cases, the over 65s who require multi-disciplinary support. So one initiative that we are currently looking at is that the public health nurse is now included in the multidisciplinary meetings in the hospital to discuss this patients care. So the pubic health nurse is contacted to attend the

meetings from the outset. You look at the area the patient is from and you contact the relevant health centre and invite the public health nurse to attend all the meetings on this particular patient from the beginning of their episode of care.

Researcher

OK so you involve the public health nurse from the outset?

Respondent 1

Yes that's correct

Researcher

OK so this brings us on to the concept of time which is also on the model under context. This is a particularly interesting concept in terms of the model the groups all seem to have multiple notions of time as a concept. So what you're saying is to have time to engage with the public health nurse about the patient from the outset of the admission?

Respondent 2

Yes the key word here is early its early engagement.

Researcher

OK early engagement, so let's look at what else is relevant on the model what else is important to include on the model, can we consider quality as an outcome how would you define quality and how would it fit into the PARTNERS model?

Respondent 1

As a result of the improved communication you will have access to information which will enable better planning of the care to be carried out in a timely fashion, to create more patient centred care – it's their particular journey and the focus is on the individual patient. The focus is on the patient rather than the clinician and its allowing me as a clinician to focus solely on this particular patient. The result of this may lead to better outcomes for the patient or what the patient can see as a better outcome.

Respondent 2

I think quality is to get the best outcome for the patient bearing in mind the constraints that are there such as resources but it's to have the best outcome for a particular patient that they could have.

Researcher

Ok so are you saying the focus is shifting from a service orientation to a patient orientated approach.

Respondent 1

Yes it's tailored to the patient it may involve accommodating particular patient preferences for example dressing at a particular time or going to bed at a particular time but its individual to that particular patient.

Researcher

OK then if that's how you would consider the notion of quality should the patient be included as a concept in the context of the model, you may want to consider that as an option or is there anything else missing from this model that is important to your reality here in the Mater Hospital?

Respondent 1

I think a key point is getting the information out for example health link is a good example. We have had some discussions regarding the electronic discharge planning tool that is currently under development here and there is some interesting perspectives on how costly it may be to have a link from health link in the Mater to the community healthcare centre's in order to get the information out. If we could get the electronic summary to work with health link this would be good. In fact there is a lot of similarity between the PARTNERS assessment tool and the electronic summary, and if we could encompass this into an electronic summary and get that information out from here in the acute service 2 to the relevant community centers that would improve communication greatly.

Researcher

So the PARTNER archetype as a mechanism informs the electronic discharge summary process which impacts on your overall quality agenda. Is that right?

Respondent 1

Yes that's correct it informs the nursing assessment process which feeds into the electronic discharge summary.

Researcher

I suppose for me the PARTNERS archetype then complements existing nursing assessment processes whilst informing the discharge process is that how you would see it?

Respondent 1 and Respondent 2

Yes

Respondent 2

But I think we are still missing a concept here and that is that the outcomes need to feed back in if you have good outcomes then this data needs to feed back into your knowledge base at service level

Respondent 1

Yes I agree this is a very good point

Researcher

Are you saying some sort of link back to the context on knowledge governance perhaps?

Respondent 2

What I am saying is that if you have good outcomes for a patient that this should inform the care process of other patients with similar problems, this should all be a circle really.

Respondent 1

Yes what she is saying is that it should feed into our guidance and protocols framework so it shapes how we deliver our care in the first place.

Researcher

Ok let's see if we can fit this into the model here is it a concept in the context and what would you call it?

Respondent 2

It's your knowledge base that's what I would call it.

Researcher

Alright I will include this into the model.

Finally in terms of the model and PARTNERS as a process do you think that the educational and training material that we are building will influence people's reason or interest in concepts and terms health information standards or indeed the EHR?

Respondent 1

I think it will but I am conscious that I have been an active member in PARTNERS I am not sure what respondent 2 would think.

Respondent 2

Well I think that it does but I think it would very much depend on who you asked on whether they would agree with it or not. I think we do but I am not sure that everybody else would because that just not the way that they are thinking. It would depend very much on who you would ask as to whether they would agree with you or not.

Researcher

OK is there anything else that we need to consider on the model

Respondent 1 and Respondent 2

No that's about it , as we are both informatics nurses we will take the transcript back to the clinical staff and see if they wish to add or amend to it over the next week or so.

Researcher

Thanks for all your help with this.

End of transcript.

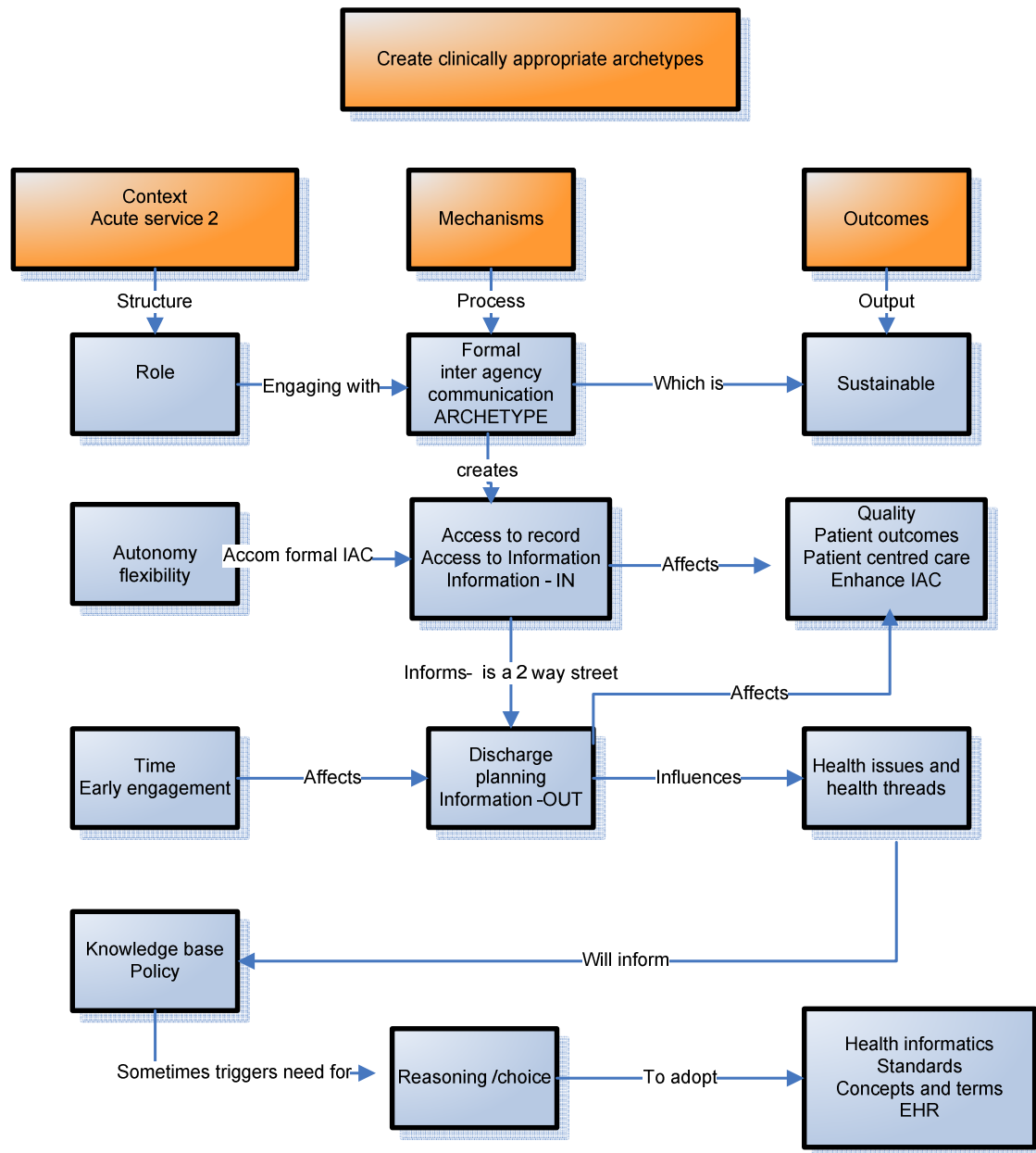


Figure 0-7 : Acute service 2

PARTNERS Participatory Action Research To develop Electronic ResourceS

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ISBN 1872327877.