Recording Care: Transformation Funding

Transforming Nursing and Midwifery Data

Project Plan

Revised June 2019

Contents

STRATEGIC CONTEXT

1.1 The Recording Care Project, which has consistently been chaired by an Executive Director of Nursing, began in 2011. Over the past 7 years, the Project has coordinated the spread of improvement methodologies, guidance and resources for record keeping practice for nursing and midwifery within adult hospital based care, children's hospital based care and learning disabilities care settings in Health and Social Care (HSC) Trusts, Northern Ireland.

1.2 The underpinning messages of *Delivering Together*[1] such as:

- Moving towards a model of care focused on provision of services close to home
- Concentrating specialised procedures on a smaller number of sites
- Increasing emphasis on prediction, prevention and health promotion rather than 'reactive' care
- Providing a structure for better citizen engagement
- Investing in and building capacity within existing health and social care networks
- Investing in eHealth to support improved self-management, care at home and use of information

have identified a continuing need for the nursing and midwifery workforce to continue to develop and adapt to new knowledge.

1.4 In addition, it has been recognised that the professions need to engage more fully in the use of digital solutions to improve efficiency and reduce bureaucracy and duplication. In the past, there has been a clear expectation by the Minister for Health, Department of Health, that nurses and midwives should be supported to have appropriate time to care for patients by reducing bureaucracy whilst continuing to identify, develop and adopt new ways of working which maximise and demonstrate the contribution to patient care and delivery of successful outcomes[2].

1.5 The link between the provision of safe, effective, person centred care delivery and accurate record keeping practice has been the subject of many public inquiries over the last 10 years in Northern Ireland[3][4] and is recognised across the nursing and midwifery professions as a key objective to be taken forward to

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[1] Department of Health. (2016). *Health and Wellbeing 2026: Delivering Together*. Belfast, DoH.

[2] http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-nov-2012/news-dhssps-281112-minister-poots-reassures.htm

[3] Northern Ireland Practice and Education Council for Nursing and Midwifery. (2010). *Systematic Review of Northern Ireland Public Inquiries and Reports*. Belfast, NIPEC. Themes arising from recommendations include incomplete records, information not recorded on admission, discharge and during an episode of care, and lack of evidence of patient and carer engagement.

[4] O'Hara, J. Q.C. (2018). The Inquiry into Hyponatraemia-related Deaths. Available for download at: http://www.ihrdni.org/index-1.htm

underpin practice within the developing healthcare economy within Northern Ireland.

1.6 Change across the HSC requires nurses to have the knowledge, skills and attitudes to seek out and manage information using the technology available[5] to them including the need to maximise the nursing contribution to e-Health. With the ever improving accessibility and availability of information there is a need for health care professionals to manage information to review and assess the quality of care and to use this to plan effectively on an individual and population basis, including consideration of how patients and their carer's are best supported to use information effectively to make decisions about their care. This has been identified in *Delivering Together*[6] through the intention to develop a patient portal, commencing in 2017 with the development of a portal for dementia care.

2.0 TRANSFORMING NURSING AND MDIWIFERY DATA

2.1 Northern Ireland is continuing to progress the procurement of a digital health and care system to include electronic clinical noting, amongst other elements through the Encompass program of work. It has been recognised that the important role of nursing's data must be considered, when electronic patient record systems are developed in health care organisations[7]. It is therefore of significance, that in moving forward with transformational work relating to nursing and midwifery data capture, the Steering Group of Recording Care continues to contribute to this emerging agenda in Northern Ireland. In addition, it is important for nurses and midwives to explore the use of internationally validated nursing informatics systems, such as the International Classification for Nursing Practice (ICNP®)[8].

2.2 Currently the policy position for Northern Ireland is to advance toward a health system founded on principles of co-production[9], underpinned by the transition of people moving from being passive recipients to partners in care and services. At the heart of this move is the care planning process and care plan[10].

2.3 The importance of person-centred approaches and the need to obtain the views of users and carers as part of assessment and care planning has also been highlighted in multiple regional reviews and public inquiries in Northern Ireland.

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[5] Health and Social Care Board (2016). *eHealth and Care Strategy for Northern Ireland*. Belfast, HSCB.
[6] Department of Health. (2016). *Health and Wellbeing 2026: Delivering Together*. Belfast, DoH.
[7] Hunt, E.C., Sproat, S.B., and Kitzimmer, R.R. (2004). *The Nursing Informatics Implementation Guide*. Health Informatics Series. New York, Springer.
[8] The ICNP® is a unified nursing language system. It is a compositional terminology for nursing practice that facilitates the development of and the cross-mapping among local terms and existing terminologies. There are three distinct domains to this system or 'elements': Nursing Phenomena (or nursing diagnoses), Nursing Actions, and Nursing Outcomes. For further information please go to: http://www.icn.ch/pillarsprograms/about-icnpr/
[9] Department of Health. (2016). *Health and Wellbeing 2026: Delivering Together*. Belfast, DoH.
[10] Philips, J. (2010). Care planning: more than meets the eye. *British Journal of Community Nursing*. 15,1

2.4 The product of a 'ground up' iterative process, the '***PACE' (Person-centred Assessment, Care planning and Evaluation) Framework*** is applied in certain clinical areas in conjunction with the activities of living, incorporating relevant risk assessments. The Chief Nursing Officer along with the Executive nurses from the range of statutory sector organisations within the province have determined that, the use of the PACE Framework will be extended across the region to support person-centred care planning practice.

2.5 The nursing and midwifery workforce is the largest professional workforce. Practitioners record vast amounts of data every day of their working lives. Most of this data is currently difficult to collate – paper, paper-lite and paperless systems not easily analysed for any purpose of scale. Data that cannot be standardized and named, cannot be identified appropriately, taught, financed or transform public policy.

2.6 Through the PACE programme of work it has been established that nursing and midwifery practitioners in Northern Ireland require significant assistance based in practice environments to adjust to and adopt organisational change of this magnitude.

2.7 Work nationally and internationally suggests that effective contribution and improvement in nursing and midwifery care and outcomes can be better managed through specific to care and service settings which is reported centrally and managed independently to inform transformation of services. The project will secure a regional approach to care planning which will be utilised in any future digital solution such as the Encompass programme of work. This work will identify information distinct to nursing and midwifery practice.

2.8 A further benefit will be secured in the future beyond the timescale of this project through opportunities to benchmark practice across Northern Ireland. Triangulation of coded data also allows opportunity for identifying areas of quality practice to enable learning for others. Benchmarking offers the opportunity to understand influencing factors on a range of workforce and quality activities, analysis of which will provide learning for improvement.

2.9 Fundamental to enabling this change is the development of nursing staff to support the 'cultural shift' in practice. This may include the future development of informatics competencies for nursing staff to support learning needs analysis and subsequent appropriate learning and development activities for this professional workforce[11].

3.0 PROJECT AIM AND OBJECTIVES

3.1 The aim of the Transforming Nursing and Midwifery Data (TNMD) Project is:

[11] Kinnunen, U.M. and Sorsa, K. (2011). Informatics competencies for nurses – requirements for practice and education of electronic nursing documentation and its utilization. *ACENDIO*, 26, Winter 2011, pp 5 – 7.

To support the transformation of practice and support the nursing and midwifery professions to lead and implement transformational change relating to data capture and preparedness for digital recording keeping.

3.2 The objectives of the project are to:

1. Extend the adoption of the regionally agreed PACE approach to nursing and midwifery care planning within HSC Trusts.
2. Support readiness for early digital adoption within nursing and midwifery practice.
3. Support transformation of practice and organisational culture
4. Ensure continued VFM with the public funding allocated to NIPEC

3.2 The objectives and intended outcomes for the Project are ambitious. Recognising this, the pace of progress will depend on the capacity of staff to support change in clinical areas.

3.2 It is planned that in the next two years the TNMD Project will:

Extend the adoption of the regionally agreed PACE approach to nursing and midwifery care planning within HSC Trusts.	**Year 0**	**Year 1**
Put in place a centrally co-ordinated resource in each of the HSC Trusts in Northern Ireland appropriate to the intended measurable targets. (November 2018, November 2019 - two tranches)	**Y**	**Y**
Develop a time framed schedule for phasing of cohorts of inpatient clinical areas within which the PACE Framework will be implemented (date for completion of inpatient areas September 2019).	**Y**	**Y**
Within each HSC Trust initiate quality improvement cycles in each cohort of clinical areas by (a) completing an audit of existing care planning processes (b) preparing nursing staff for the introduction of the PACE Framework (c) implementing and establishing the PACE framework (d) re-auditing practice with an aim of identifying further improvements. (e) Promoting the use of improvement science to maintain and embed quality approaches. Completion intended across all cohorts by March 2020.	**Y**	**Y**
Extend implementation of the PACE Framework to 1 team per locality per HSC Trust an agreed number of District Nursing Teams across HSC Trusts using the quality improvement methodology outlined at points a – e above (by March 2020).	**N**	**Y**
Implement the regional adult person-centred nursing assessment and plan of care record for hospital based care which is structured in a format to capture the PACE approach (by September 2019).	**Y**	**Y**

Support readiness for early digital adoption within nursing and midwifery practice.

Year 0	Year 1
N	Y
N	Y
N	Y

Identify common data sets of nursing and midwifery practice language that should be coded within digital records. (March 2020).

Identify potential reporting and future improvement opportunities that underpin evidence for practice development and service improvement from the data set. (March 2020).

Work with stakeholders to ensure close alignment to areas such as: coded data capture e.g. SNOMED-CT and if appropriate other nursing languages; links to the Encompass programme of work and clinical/ nurse coding terminologies for future reference (to March 2020).

Support transformation of practice and organisational culture

Year 0	Year 1
Y	Y

Develop a team of practice transformation facilitators to drive the cultural and organisational change required to embed the person-centred approach (March 2020).

Ensure continued VFM with the public funding allocated to NIPEC

Year 0	Year 1
Y	Y

The project will not exceed the current revenue allocation as per the business case.

4.0 PROJECT STRUCTURE

4.1 The Project will continue to be governed by the Steering Group retaining governance and accountability responsibility and have one Working Group charged with overseeing the outcomes of the Project. A summary of current Steering Group membership can be found at **Appendix A, page 8** of this document, along with current Terms of Reference at **Appendix B, page 9**. The Steering Group are at liberty to consider their membership at any time in relation to seeking representation from other organisations to support the work.

4.2 The membership and Terms of Reference for the Working Group can be found at **Appendix C, page 10** of this document.

4.3 It may also be necessary to engage a number of Expert Reference Groups (ERGs) across care settings to inform Project processes and assist in the achievement objectives. The Working Group will oversee and manage the constitution of these groups appropriately.

5.0 METHODOLOGY

5.1 This section of the project plan is to be agreed via separate briefing papers, due to the resource implications on an ongoing basis for each objective. A

proposed timeline for the objectives, identified at para. 3.2 of this document (Gantt chart **Appendix D**, **page 10**) will be kept under review, due to the nature of the work and the prior learning of the challenge of changing practice in current service environments.

6.0 RISK ASSESSMENT

6.1 The findings of the Professional Officers working across all of the phases of the Recording Care Project (20011 – 2018) were that staff required support to enable change in practice and sustain that change. The role of the Professional Officer within each Trust was and remains critical to facilitating a level of expertise in the area of record keeping practice. Ward staff often contacted the Officers to ask for help in a particular area of record keeping practice. The Officers also provided support in the coordination of audit dates and submission of scores to wards that were experiencing high levels of activity. There are a number of risks, therefore, associated with removal of any funding for this area of work and reliance on existing resources to facilitate change.

i. Staff working within existing challenges of service reform and modernisation will have competing priorities and therefore it is likely that change may not be sustained or further implemented.

ii. The standard of record keeping practice will decline, as evidenced by decreasing audit scores.

iii. Other clinical settings may not be progressed in a timely manner to improvement and audit methodologies.

iv. Assurance to Trust Board regarding the standard of nurse record keeping will not be supported effectively.

v. Inequalities in relation to nurse record keeping practice will exist across clinical settings within Trusts.

vi. Practice which has been identified as requiring improvement will not be addressed in the same robust manner with supported learning and development.

vii. Trust organisations will have, therefore, failed to act on practice identified for improvement.

viii. There may be difficulty in re-engaging staff in future work around record keeping to support improvement

xi. The summative effect on safe, effective person centred care will be a reduction in quality and increased risk of incident due to a poor standard of nurse record keeping practice.

6.2 In addition, there are a number of potential risks associated with the proceeding of the project namely:

a) lack of engagement from individuals in participant organisations with:

- the development of a spread plan across the five HSC Trusts to further roll out the PACE approach to care planning in Northern Ireland

b) Lack of available IT infrastructure in participant organisations to support learning and audit.

c) Lack of engagement from relevant networks at Trust level to support the spread of the work of the project.

d) Unsuccessful completion within the time frames, due to service pressures and challenges.

6.3 NIPEC will put processes in place that should mitigate against and minimise risks in relation to lack of engagement and completion to time. Other areas of risk will be drawn to the attention of the Steering and Working Groups if and when they arise.

7.0 PROJECT SCREENING

7.1 A risk and equality screening has been completed on this project document and can be found at **Appendix D: pages 12 -13**.

8.0 EVALUATION

8.1 The Project will be evaluated on an ongoing basis, evidenced through the audit trail provided by notes of meetings of the Steering Group and Working Group. NIPEC will be responsible for the achievement of the objectives of the project, in partnership with the five HSC Trusts and where appropriate the Independent and Voluntary sector.

9.0 COMMUNICATION AND DISSEMINATION

9.1 Communication and consultation will be ongoing throughout the project, using various mechanisms such as email, teleconferencing facilities and face-to-face meetings. The NIPEC website will update pages online, according to the progress of the project.

9.2 Approved notes of the Steering Group and Working Group meetings will be circulated to respective group members.

9.3 Dissemination of the Final Report of the project phase will be the responsibility of NIPEC.

10.0 CONCLUSION

10.1 This Project Document sets out proposals for the TNMD Project for consideration by the Recording Care Steering Group.

10.2 Further information can be obtained from Angela Reed, Senior Professional Officer, NIPEC: angela.reed@nipec.hscni.net

APPENDIX A

MEMBERSHIP – RECORDING CARE STEERING GROUP

Organisation	Representative
SEHSCT	Nicki Patterson, Executive Director of Nursing (Chair)
SHSCT	Grace Hamilton, Interim Assistant Director of Nursing (Nursing Governance Lead)
NHSCT	Suzanne Pullins, Deputy Director of Nursing (Nursing Governance Lead)
SEHSCT	Linda Kelly, Assistant Director of Nursing (Nursing Governance Lead)
WHSCT	Donna Keenan, Assistant Director of Nursing (Nursing Governance Lead)
BHSCT	Irene Thompson, Deputy Director Nursing (Nursing Governance Lead)
RQIA	By email update as per CE RQIA.
PHA	Claire Büchner, Nurse Consultant.
DoH	Patrick Gallagher, Nursing Officer
RCN	Linzi McIlroy, Senior Professional Development Officer
RCM	Deirdre Gill, WHSCT
Higher Education Institutions	Susan Carlisle, Nurse Lecturer, QUB
Clinical Education Centre	Siobhan Murphy, Assistant Head, CEC.
NIPEC	Lisa Houlihan, Council Member
NIPEC	Angela Reed (Lead Officer)

Administrative Support: Lukasz Karpinski, Programme Administrator

APPENDIX B: TERMS OF REFERENCE: STEERING GROUP

The aim of the work of the Recording Care Project is to facilitate improvements in person-centred record keeping practices for nurses and midwives underpinned by a robust evidence base to support safe, effective person centred care and service delivery for the population of Northern Ireland.

1. PURPOSE OF THE GROUP

The Steering Group of the Recording Care Project defines regional objectives for work related to the record keeping practices of nurses and midwives. The group directs work to the Working Group, which is responsible for producing outcomes and making recommendations for approval at Steering group. It informs the Chief Nursing Officer through the Chair of the group, of achievements, ongoing work and concerns/ challenges. The Steering Group also reviews information in relation to HSC Trust/ Organisation work relating to nursing or midwifery records, for overlap and duplication. It may, on occasion, provide advice and guidance to related project groups.

2. MEMBERSHIP OF GROUP

Expertise in record keeping practice should be drawn from HSC and education organisations at a strategic level. If a member is unavailable, he/she should nominate an appropriate member of staff to attend on his/her behalf, providing the relevant required information in advance for the alternate member to attend and participate appropriately.

3. QUORUM

Quorate membership is 50% of the total membership number.

4. FREQUENCY OF MEETINGS

Four times a year.

5. RECORD OF MEETINGS

NIPEC staff are responsible for agenda setting, record keeping and circulation of relevant papers in collaboration with the Chair of the Group.

6. ACCOUNTABILITY OF THE WORKING GROUP

The Steering Group is accountable through the Chair to the Steering Group of the Chief Nursing Officer (CNO). In addition, NIPEC, as project coordinators is also accountable through the Chief Executive to the CNO.

7. ROLE AND RESPONSIBILITIES

- Determination of a regional Project Plan and Project Objectives, with associated timeframes.
- Contribute to the achievement of the Project plan
- Direct work appropriately to the Working Group to take forward

- Undertake on-going monitoring of the project plan against the planned activity and timescales and agree remedial actions arising
- Participate in respectful, open debate
- Participate in shared learning across organisations
- Welcome and provide constructive challenge
- Manage information related to the project responsibly, ensuring confidentiality when required
- Provide progress reports to the CNO
- Provide advice to other regional groups as required

APPENDIX C: MEMBERSHIP AND TERMS OF REFERENCE: WORKING GROUP

MEMBERSHIP

Organisation	Representative
SEHSCT	Linda Kelly, Assistant Director of Nursing (Co-Chair)
NHSCT	Suzanne Pullins, Deputy Director of Nursing (Co-Chair)
WHSCT	Penny Moore
WHSCT	Mary McCullagh
SHSCT	Dawn Mackin
NHSCT	Holly Hamilton
NHSCT	Naomi Baldwin
SEHSCT	Jane Patterson
SEHSCT	Ruth Marks
BHSCT	Jaqueline Rafferty
BHSCT	Lynn Wightman
Higher Education Institutions	Susan Carlisle Anne-Marie Tunney Donna Gallagher
Clinical Education Centre	Deirdre Cunningham
NIPEC	Gillian McKee, Professional Officer

TERMS OF REFERENCE

1. PURPOSE OF THE GROUP

The Working Group supports the Steering group of the Recording Care Project through participation in and completion of smaller elements of the project to meet stated objectives. As such this Group is responsible for producing outcomes and making recommendations for approval at Steering group. Expertise in record keeping practice should be drawn from HSC and education organisations at an operational level.

2. MEMBERSHIP OF GROUP

If a member is unavailable, he/she should nominate an appropriate member of staff to attend on his/her behalf, providing the relevant required information in advance for the alternate member to attend and participate appropriately.

3. QUORUM

Quorate membership is 50% of the total membership number. Representation from three out of five Trusts is required for decision making within this quorate membership.

4. FREQUENCY OF MEETINGS

8 weekly

5. RECORD OF MEETINGS

NIPEC staff are responsible for agenda setting, record keeping and circulation of relevant papers in collaboration with the Chair of the Group, or where relevant the Deputy Chair.

6. ACCOUNTABILITY OF THE WORKING GROUP

The Working Group is accountable through the Chair to the Steering Group of the Recording Care Project.

7. ROLE AND RESPONSIBILITIES

- Directed by the Recording Care Steering Group Project Objectives, agree a rolling evidence-based action plan and associated timescales
- Contribute to the achievement of the action plan
- Undertake on-going monitoring of the action plan against the planned activity and timescales and agree remedial actions arising
- Participate in respectful, open debate
- Participate in shared learning across organisations
- Welcome and provide constructive challenge
- Manage information related to the project responsibly, ensuring confidentiality when required
- Contribute to progress reports to the Steering Group
- Provide advice to the Steering Group as required

8. REVIEW OF TERMS OF REFERENCE

Biennial.

Appendix D – Gantt Chart Project Timelines

Objective	Dec 18 - Mar 19	Apr - Jun 19	Jul - Sept 19	Oct - Dec 19	Jan - Mar 20
1. Centrally co-ordinated resource HSC Trusts					
2. Develop a time framed schedule PACE					
3. quality improvement cycles					
4. Extend PACE to 1 team per locality per HSC Trust DN Teams					
5. Implement Revised adult Document					
6. Identify common data sets of nursing and midwifery practice					

for digital coding					
7. Identify potential reporting and future improvement opportunities					
8. Close alignment to areas such as: coded data capture					
9. Develop a team of practice transformation facilitators					
10. project will not exceed the current revenue allocation as per business case					

Appendix E – Risk and Equality Screening

Area	Comments
Risk Management questions	
• Have any risks been identified? • What is the potential impact of these? • How can these be mitigated or have alternatives options been identified which would have a lower risk outcome? • Where negative impacts are unavoidable, has clarity been given to the business need that justifies them?	Resourcing, timescales and engagement Failure to complete project successfully, loss of credibility to individuals involved. Project management processes, terms of reference. Appropriate nominations to Project Groups. Appropriate governance processes in place. Not as yet, where negative impacts are emerging rather than potential, including those relative to lack of clarity for funding.
Equality and Human Rights questions	
• What is the likely impact on equality of opportunity for those affected by this policy for each of the Section 75 equality categories (minor/major/none)? • Are there opportunities to better promote equality of opportunity for people within the Section 75 equality categories? • To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group (minor/major/none)? • Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group? **NB –** please refer to NIPEC's Equality Screening Policy and Screening Templates to assist in considering equality and human rights	Process is underway to equality screen project plan and determine any implications from a human rights perspective.

Appendix E – Risk and Equality Screening Contd.

Privacy Impact Assessment (PIA) questions	
• Will the project use personal information and/or pose genuine risks to the privacy of the individual? • Will the project result in a change of law, the use of new and intrusive technology or the use of private or sensitive information, originally collected for a limited purpose, to be reused in a new and unexpected way?	No No
Personal and Public Involvement (PPI) questions	
• Has a requirement for PPI been identified, and if so, what level of PPI will be required for the project? **NB –** please refer to and use NIPEC's PPI Decision Tree/Algorithm to assist in considering PPI	To be determined through the project Groups and progressed at HSC Trust level.

Alternative Formats

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For further Information, please contact

NIPEC
Centre House
79 Chichester Street
BELFAST, BT1 4JE
Tel: 0300 300 0066

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