

The PARTNERS Programme Summary Evaluation Report



PARTNERS

Participatory Action Research To develop Nursing Electronic health Records

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Foreword

The focus of this project is inter- agency communication. This report evaluates how formal terminology underpinned by health informatics standards can assist health care providers to communicate patient centred information across traditional service boundaries more efficiently and effectively. It provides evidence on how nurses work between different environments across different settings. The tool devised for shared care by the project team may serve as a starting point for those individuals who are engaged in the development of discharge or transfer of patient centric care documentation e.g. the newly established clinical directorates. The participants in this project who are primarily nurses recognise that formal communication processes involving interagency communication between the primary care, continuing care and acute care sectors is currently dependent on informal communication processes such as the telephone or fax machine. The process of approaching formal communication using health informatics standards and adopting formalised concepts and terms facilitates shared meaning between health care parties which the group maintain could enhance existing inter agency communication. In the longer term such initiatives may directly impact upon patient safety. This summary report offers a brief overview of an evaluation of phase one of a pilot study programme entitled PARTNERS. The word PARTNERS is an acronym for Participatory Action Research To develop Nursing Electronic RecordS. The PARTNERS project identified two key objectives, firstly to educate and train nurses in health informatics, specifically in relation to a health informatics standard developed internationally to guide nursing records development on nursing diagnosis and interventions (ISO 18104). Secondly, to identify formalised concepts and reference terminologies for future inclusion in nursing documentation practices. The identified set of concepts and terms in this report, whilst crude, may inform future interagency communication on discharge planning or transfer of care, not only for nurses but also other members of the multidisciplinary team. To demonstrate these objectives in action a purpose built assessment form using a set of design restrictions in the form of an archetype was devised. The archetype is designed in accordance with a health informatics standard entitled EHRcom (EN13606) and is defined as follows *“an agreed, formal and interoperable specification of the data and their inter-relationships that must or may be*

logically persisted within an electronic health record for documenting a particular clinical observation, evaluation, instruction or action” (Kalra 2004).

These two objectives were made possible by liaising with the Dublin Institute of Technology on a research programme entitled EHRland. The EHRland project supported by the Health Information and Quality Authority (HIQA) is a research programme which is testing the health informatics standard EN13606. The standard EN13606 is the European standard for the electronic health care record. The PARTNERS group defined the requirements, concepts and terms for the archetype and the EHRland group designed the archetype and created a database for use for the duration of the pilot study.

The information presented in this evaluation will draw from both of the PARTNERS and EHRland projects. This is made possible as the author is the Principal Investigator of the PARTNERS project and is a member of the EHRland project team. Whilst the focus of the project was the development of an archetype to enhance interagency communication the EHRland group also devised a prototype information system to collect and store patient centred outcomes as defined by Almost et al (2003). The PARTNERS group were keen to collect patient data which could minimally present patient centred outcomes, and involve the patient in the decision making processes relating to their care. For example did the patients like the idea of having access to and keeping their own record? Because of the size and resources associated with the project, the project team opted to complete a small pilot study and evaluate the overall effectiveness on a group of over 65 year olds and on those practitioners who sought to pilot the tool (practitioners n = 14, Cases n = 16 Settings = 6). Initial thoughts suggested that this evaluation would focus on whether the PARTNERS assessment form was effective or indeed ineffective, simply stated putting into practice the 3 W’s which are if the prototype archetype/s (assessment form) *worked* for *whom* and under *what* circumstances. Over time it became apparent that the evaluation required a more inclusive focus. This evaluation therefore focuses on exploring both the mechanisms (processes) and outcomes relating to the assessment form and also seeks to identify those mechanisms which will impact on the overall sustainability of such practice development initiatives in the future. In this way the PARTNERS group can offer the reader an honest account of the lessons learnt by practitioners, patients and the evaluator’s overall experience.

Executive Summary

Words reflect and collectively create meaning between people, and more often than not are associated with a view within a particular context and time. Words form the basis of a language which has the capacity to evolve and change thus altering the actual meaning of the vocabulary. The workflow of the role of nursing could be described as peripatetic; nurses often practice in several different settings which can span service boundaries. Often whilst performing nursing interventions their practice is interrupted due to unplanned events and information is often recorded retrospectively. Future health care systems will need to be able to address such events and from a quality and safety perspective facilitate capturing the language of nursing to reflect the local patient context detail and time. It is therefore important that nurses in Ireland initiate the process of adopting formalised concepts and terms whilst documenting shared patient care across service boundaries. This is of particular relevance to the profession of nursing as health care leaders focus more intently on measuring cost efficiency, and based on these results, redesign existing processes to be more effective, particularly from the patient perspective. In the summer of 2009 a national principles based framework was established to create clinical directorates within Ireland. The primary purpose of creating clinical directorates is to achieve the best clinical outcome and experience for patients with the best available resources (O'Shea, 2009, p.107). Such developments would suggest that objective data is increasingly becoming the yardstick to inform newly integrated programmes of care, enlighten clinical judgment and decision making and allocate already scant resources to care pathways. Within this particular report a care pathway could be described as locally agreed, multidisciplinary practice based on guidelines and evidence for a specific client group, it forms part of the clinical record documents the care given, and facilitates the evaluation of outcomes for continuous quality improvement Middleton and Roberts (2000).

The task of educating, training, and implementing formal language within nursing documentation has and will continue to be a complex process (Hoy et al, 2008).

In addition, the anecdotal evidence within Ireland suggests that integrated programmes of care will be difficult to effectively deliver without first laying a strong foundation stone in the form of education and training (O'Shea, 2009).

Education therefore must be viewed as an integral part of the transformational programme for change. In particular educational programmes which support electronic healthcare record development will need to include an introduction to the process of labeling and adopting formalised language in patient care records. One example of a repository to access formalised reference language relating to the profession of nursing is the International Classification of Nursing Practice. Further information is available from the following website <http://icnp.clinicaltemplates.org/info/v2/>. It is important to state that this perspective is not solely related to nursing but extends to the entire multidisciplinary team. The profession of nursing as the largest stakeholder group involved in the co-ordination of care however will be required to engage as a priority (O'Shea, 2009). To do less may have serious ramifications for nurse resourcing and patient safety in future health care service provision (Aiken 2002, Aiken et al 2002, MacNeela et al 2006 Needleman et al 2002). A first step in delivering an archetype and collecting data to review the nursing contribution to patient care is to create a system in the form of a simple database and basic user interface application. Key principles guiding this development are that the system is clinically pragmatic, reflects the reality of nursing practice, captures patient centred outcomes, whilst including the preferred formal language and terms that are relevant and used frequently by the profession (Hannah et al, 2009). By "cross checking" or mapping the language of nursing into the existing formal reference terminologies objective data can be identified for inclusion in future EHR. Some authors advise that establishing a database can be a complex and indeed lengthy process and should not be entered into lightly (Hegyvary, 1991; Jones, 1993) and this is represented well in the following quote from Pringle and Doran (2003).

In order for databases that house information relevant to nursing to be established for a region or a health care system, there must be consensus among nurses as to a) what inputs processes and outcomes to include, b) how to define and measure them and c) agreement on the timing of their measurement recording and abstraction

Pringle and Doran, 2003 p. 8

System developers engaged in database development must therefore understand as a priority that such systems cannot and do not operate in isolation. Nurse researchers interested in developing such databases which will support information systems must

recognise that such systems will inform part of a larger enterprise wide development centred on the patient journey through the continuum of healthcare –namely the Electronic Healthcare Record (EHR). For this reason the project identified in this evaluation has been designed in accordance with key European health information standards namely ISO 18104, the reference terminology for nursing diagnosis and interventions, and EN 13606 the European standard for the Electronic Healthcare Record (ISO: 2003, EN: 2008).

The format of this summary report is as follows: part one, PARTNERS as a vehicle for change offers a brief summary of the motivations for this particular project and the theory under investigation. Part 2 describes the evaluation methods adopted and briefly outlines evaluation principles as defined by Pawson and Tilley in their book *Realistic Evaluation* (Pawson and Tilley, 1997). Part 3 of the summary report presents only the quantitative statistical findings of the report completed by a member of the PARTNERS group Ms Mary Sharp lecturer in Health Informatics in Trinity College Dublin. In the main evaluation report and the associated appendices the qualitative data is presented. However as this summary report was prepared for online publication the qualitative data which contains patient sensitive data has been omitted from this summary report. Part 4 offers a summary of the original full evaluation report and Part 5 offers a brief conclusion. Key requirements emanating from this study is the need for nurses, from the acute, primary and continuing care sector to access information on current, future and past health and social care initiatives undertaken with their patients by multidisciplinary teams. There is an urgent need for nurses to have access to medication regimes particularly post transfer from and to different health service providers, and also to have access to what transpires to patients during outpatient activity. The nurses who engaged within this study view the development and implementation of archetypes as a positive experience. The patients involved in this study liked the idea of having access to and holding their own record and in some cases articulated their interest in being involved in similar projects in the future. The bond of trust that was evident between the patients and nurses was tangible and the significance and vulnerability of this bond should not be underestimated particularly as we move forward within the health reform programme. Key recommendations from this evaluation are presented in the following section.

Key Recommendations

1. The International Standards Organisation (ISO) 18104 Nursing Diagnosis and Interventions standard¹ meets the requirements for nursing documentation in the acute primary and continuing care sector and nursing leaders may wish to consider this standard in future practice development initiatives within Ireland.
2. The introduction of scales (rather than tick boxes) in nursing documentation practices using outcome data sets such as C.HOBIC assist in making evident change or maintenance of patient outcomes status during assessment over sequential time intervals.
3. Integrated care programmes will require an educational and training budget and will require local management for effective implementation. Nurses who participated in the study but who were not members of the PARTNERS group tended to focus solely on practice interventions with their clients. This is perhaps best described as a task orientated service delivery of care. This particular focus hampers the individual nurse's ability to have dedicated mental time to engage with, reason through or indeed understand the implications of appropriate data collection for use across traditional service boundaries.
4. The evidence base suggests that patient outcomes collection should adopt a theory led model approach. From a health informatics standards perspective this theory led model should include strong linkage with an evolving information model underpinned by health information standards such as EN13606. It is anticipated that the context mechanism and outcome configurations identified in this study may offer a useful resource to inform future research work in this area.
5. Patients involved in this study liked the idea of having access to and contributing to their own health record. This is a feature that will need to be considered further in future EHR development.

¹ At the time of writing this report ISO 18104 is under review the new title for this standard is Categorical Structures for Representation of Nursing Diagnosis and Nursing Actions in Terminological Systems

6. Models designed for future patient outcome data collection will need to include an element for social care particularly in regard to social circumstances impacting on self care ability and education in relation to medication management.
7. The degree of reform needed is significant and should not be underestimated. This evaluation encountered nurses who are already practicing in a dynamic environment with existing fiscal constraints; one could perhaps describe these practitioners as “battle weary”. The project team would therefore suggest that the local leaders who possess skills and tacit knowledge of what will work under particular circumstances need to be nurtured and given the appropriate support as and where necessary.

1. PARTNERS as a Vehicle for Change

The current environment in which Irish health care professionals operate within could be described as complex, dynamic and often pressured. This may in part contribute to the limited enthusiasm that nurses possess to adopt and implement formal reference terminologies into existing documentation practices. It is however only in completing such methods that the profession of nursing can assist in making evident the impact of nursing care, and identify key concepts and terms for consideration in future EHR development within Ireland. This report evaluates a programme jointly funded by the National Council of Nursing and Midwifery and the Health Information and Quality Authority EHRLand research programme. The programme entitled PARTNERS is an acronym for Participatory Action Research To develop Nursing Electronic Records.

An overview of the PARTNERS group and their work is available to view at www.PARTNERSCT.com. This reports main preoccupation is to focus on the evaluation of PARTNERS programme over the past two years. Briefly the report views information from four perspectives, namely the participant's perspective (the patient), the practitioner's perspective (the nurse), the policy maker's perspective and the author's perspective. By drawing information and opinions about the programme from these four sources this evaluation will endeavour to demonstrate the local operational processes of nurses to define contextual and information requirements across different settings. This approach the author would maintain can present to the reader a practical overview of what works for whom and under what circumstances. The theory defined by the PARTNERS group for evaluating the programme is *Do archetypes have the capacity to support the creation and analysis of high quality data that can be shown statistically to be responsive to healthcare interventions across different settings and in different environments?*

2. The Evaluation Process

The term *Realistic Evaluation* initially identified by Pawson and Tilley has been promoted extensively in social research programmes since its publication in 1997 (Dickenson, 2008). The central thesis of this particular evaluation approach is that social programmes do not operate in isolation; they therefore must be evaluated across the spectrum of contexts in which they would wish to operate. Pawson and Tilley (1997) suggest that programmes comprise of context mechanisms and outcomes and the best approach to evaluating social programmes is to identify the theory associated with the programme, and then to test whether this theory works, or does not work under different circumstances with different people in different contexts. In order to complete a realistic evaluation it is therefore necessary to evaluate the theory using a stratified approach for each group of participants involved in the programme, for example population versus specialists, client need versus task related interventions. They describe the research process as follows: *What are the mechanisms for change triggered by a programme and how do they counteract the existing social processes? It is not the programmes that work but the programmes ability to break into existing chains of resources and reasoning in specific contexts* (Pawson and Tilley 1997, p.15). From an ontological perspective Pawson and Tilley argue that a post-empiricist view is required as this approach focuses on a process of explanation, and is therefore not a technique which is solely driven by method and measurement. Research programmes which are practice orientated can often offer a more extensive role for theory or the generation of theory. By adopting a realist approach to the programme which informs the research method one is not completing research solely for the benefit of science, but rather a research method to inform the thinking of policy makers, practitioners, programme participants and the public in general (Pawson and Tilley, 1997, p158). Assuming Pawson and Tilley's viewpoint this research team is examining the effectiveness of one particular theory by testing a health and social care programme entitled PARTNERS. The focal point of this particular theory relates to interventions devised to enhance inter agency communication (shared care) whilst collecting data on patient centred outcomes. The evaluation searches for new knowledge where evident and will make recommendations to inform future EHR development.

3. Quantitative Data Analysis Patient Assessment

Part 3 is a summary of the quantitative data analysed from the patient assessment tool. This work has been completed by Ms Mary Sharp, School of Computer Science Trinity College Dublin. The data shows the average assessment score and outcome for each measure within the specified episode range. An individual patient must have two completed assessments within the same time frame for their information to be included. The report will identify several comparable outcomes.

The information is listed below under a number of different headings – Ability to perform main tasks of everyday living, Falls occurrence and the Risk of falling, Pressure ulcers and Skin integrity. To view this data in context a general overview of the observational data is included as follows. The observation data collected by the author noted that there were six patients that showed a general improvement, six patients that showed a general deterioration and four patients that maintained their existing health status particularly in relation to outcome measurements within the study.

Ability to perform main tasks of everyday living

The first group of tasks to be compared were the ability to perform the main tasks of everyday living in the area of hygiene and movement. The abilities covered were those to perform hygiene, dress, groom, bath, mobilise, walk, transfer from a chair to a bed, walk in a room, walk in a corridor, toilet and feed. There were 16 patients in the group and the following Table 1 shows the mean based on functional status where functional status was measured on a scale of 0 to 4 where 0 was Independent, 1 minimally dependent, 2 partially dependent, 3 extensive dependency and 4 totally dependent. Therefore an increase between episodes indicated deterioration in the Functional Status.

Functional Status	Episode 1	Episode 2
Ability to perform hygiene	0.875	0.8125
Ability to dress	0.625	0.6875
Ability to groom oneself	0.625	0.625
Ability to bath	1.625	1.6875
Ability to mobilise	1	1.25
Ability to walk	0.875	1.125
Ability to transfer chair or bed	0.6875	0.625
Ability to walk in room	0.625	0.8125
Ability to walk in corridor	0.75	0.9375
Ability to toilet oneself	0.625	0.5
Ability to feed self	0.25	0.25

Table 1 : Functional status

Using a t-test to compare the overall averages for the abilities did not show a significant difference at $p = 0.118$ for a two tail test. A two tail test was chosen as some of the Functional status measures increased and others decreased. It was then decided to break the Functional Status into those that improved, scores decreased Table 2, and those that disimproved, scores increased Table 3. The following tables show this division. The Functional Status that did not change was omitted.

Functional Status	Episode 1	Episode 2
Ability to perform hygiene	0.875	0.8125
Ability to transfer chair or bed	0.6875	0.625
Ability to toilet oneself	0.625	0.5

Table 2 : Functional status scores decreased showing improvement

A t-test was carried out based on the Functional Status scores that showed a decrease, therefore an improvement, this showed a statistically significant difference at $p = 0.018$.

Functional Status	Episode 1	Episode 2
Ability to dress	0.625	0.6875
Ability to bath	1.625	1.6875
Ability to mobilise	1	1.25
Ability to walk	0.875	1.125
Ability to walk in room	0.625	0.8125
Ability to walk in corridor	0.75	0.9375

Table 3 : Functional status scores increased showing disimprovement

A t-test was carried out based on the Functional Status scores that showed an increase, therefore a disimprovement, this showed a statistically significant difference at $p = 0.002$.

Ability to perform main tasks of everyday living combined with those for Falls, Symptom Management, Nutrition, Fluid Balance and Pain.

Combining the figures for Ability to perform the main tasks of everyday living, Falls and risk of falling, Pressure ulcers and Skin integrity, Breathing & Dyspnoea, Weakness and fatigue and Nausea, Fluid balance and Pain frequency and intensity.

When all of the figures were combined for the different criteria as in the following Table 4 carrying out a t-test gave a significant difference of $p = 0.03$ for a two tailed test.

Functional Status	Episode 1	Episode 2
Ability to perform hygiene	0.875	0.8125
Ability to dress	0.625	0.6875
Ability to groom oneself	0.625	0.625
Ability to bath	1.625	1.6875
Ability to mobilise	1	1.25
Ability to walk	0.875	1.125
Ability to transfer chair or bed	0.6875	0.625
Ability to walk in room	0.625	0.8125
Ability to walk in corridor	0.75	0.9375
Ability to toilet oneself	0.625	0.5
Ability to feed self	0.25	0.25
Falls Frequency	0.5	0.5
Falls Risk	1.5625	4.5625
Pressure Ulcer & Skin Integrity	3.875	3.6875
Breathing & Dyspnoea	0.6875	0.875
Weakness & Fatigue	1.3125	1.5
Nausea	0.125	0.1875
Fluid Balance	0.125	0.25
Pain Frequency	0.625	0.625
Pain Intensity	0.3125	0.5

Table 4 : Functional status and other criteria combined

Again these were broken down into two groups those that improved and those that disimproved.

Falls and Risk of Falling

The numbers of falls in each episode were counted as being in one of three categories, Never, Rarely and Frequently. In both of the episodes the number in each category were identical at eight in each of the Never and Rarely categories while no one fell into the Frequently category. The figures for Risk of Falling were also similar in nature using the same categories of Low, Medium and High they were the same for each of episodes 1 and 2 with seven in the Low range and 9 in the medium range while no one was considered to be of a High risk of falling.

Pressure Ulcers and Skin Integrity

Twelve of the patients were divided, with six each, in the None and At Risk groups while of the remaining four two had stage 1 and one each with stage 2 and 4 Pressure Ulcers in episode. This deteriorated somewhat in the second episode with ten of the patients divided, five each, in the None and At Risk groups and three in stage 1, two in stage 2 and one in stage 3 Pressure Ulcer groups. However the changes were statistically insignificant.

Breathing & Dyspnoea, Weakness & Fatigue and Nausea (Nutrition)

Type of Measurement	Episode 1	Episode 2
Breathing & Dyspnoea	0.6875	0.875
Weakness & Fatigue	1.3125	1.5
Nausea	0.125	0.1875

Table 5 : Nutrition measurements

All the factors involved in the Nutrition group deteriorated and a t-test gave a statistically significant result with $p = 0.036$.

Fluid Balance

The average of Fluid Balance deteriorated two fold between the two episodes going from 0.125 to 0.25.

Pain – Frequency and Intensity

The frequency of pain showed no change between episodes but the intensity deteriorated marginally from 0.3125 to 0.5

Overall change for Functional Status

The overall means, 8.5625 for Episode 1 and 9.3125 for Episode 2, were compared and graphed and are shown in the following Figure 1.

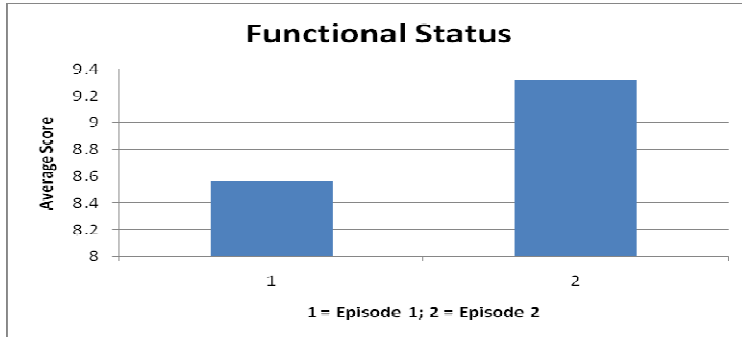


Figure 1 : Overall change in functional status

4. Summary

This evaluation was completed to test the following theory

Do archetypes have the capacity to support the creation and analysis of high quality data that can be shown statistically to be responsive to healthcare interventions across different settings and in different environments?

On completion of this pilot study the PARTNERS group have gained a greater clarity and understanding of what is now required to develop clinically appropriate archetypes and associated templates to support shared care across different service settings. Whilst the data collected is small and cannot be said to be statistically significant, the data demonstrates a purposeful selection of patients in context and the existing nursing expertise that is applied in this particular setting. Only a portion of the data collected on the PARTNERS form for the duration of the study has been included in this evaluation report. It is anticipated that additional data analysis will be reported upon by the EHRland team and further development on this particular archetype will be tested for statistical significance in the future. For the evaluation of this pilot study the following short and long term objectives were identified.

The archetypes will improve the patients experience during contact with health service providers by enhancing interagency communication across service boundaries.

A total of 3 out of a potential 18 patients successfully managed interagency communication across and between service providers. Also where cases moved beyond the boundaries of the catchment area where the study was planned to occur and where patients were recruited outside of catchment area, participation by nurses did not always occur. This is demonstrated in Figure 2.

Long term objective one which focused on collecting;

Data which would be statistically sensitive to making evident the nursing contribution to patient centred outcomes measured during assessment over extended time intervals

The statistical analysis on the data will be completed as part of a PhD study in TCD and is ongoing; some of the initial findings are included in this summary report for consideration. Interventions which are most evident from the study related to medication management, functional status and symptom management this included supporting patients with medical devices such as oxygen and nebulizers. Although the sample is

small and is not generalisable there is evidence of change in functional status particularly with the patients recruited by the primary care 2 area (Case 2 and 14). Whilst in the continuing care and primary care one area, the cases recruited are chronically ill and although many of the cases are deteriorating the outcomes are maintained at a constant level, with one case being admitted to the acute services for additional care (Case 9 and 10 and 11). In the acute care sector, acute care area 1 identified and initiated a recruitment process on a number of patient n = 4. Identification of cases from the acute care area 1 was difficult due to the over 65 year old inclusion criteria, and also identification of patients within the specific catchment area was also problematic. Also the acute care area 1 group had a tendency to see patients from the entire north side of Dublin crossing existing service boundaries and the age profile of patients is broad in scope. Other issues which impacted on acute care area 1 recruitment process included a delay in access to the acute care area 2 services as previously mentioned.

In case 1 where a number of services were involved in a care package the researcher failed to recruit the public health nurse directly involved in his care, this was due to workload. In the author's opinion the primary care area 2 group were most effective in using the prototype form; this may be due to the timeframes that they care for patients over and the existing relationships which are well established with the public health nurses and acute services. Excellent working relationships were also evident between the public health nurses and the home help services in Dublin North East and this directly impacted on maintaining patient outcomes at a particular level with appropriate use of environmental resources tailored to current patient needs.

The third and final long term objective acted upon the process of PARTNERS and sought to consider whether *the process of developing archetypes assists nurses to understand health information standards and reference terminology and concepts*

This would appear to have been achieved particularly for those individuals who have participated and remained in the PARTNERS programme for the two year timeframe.

However it is difficult to ascertain whether it was the process of engagement or the personalities which has had a direct bearing on this particular objective.

As the matrices evaluated this objective from nurses both who were participants and not active participants from the core PARTNERS group, the final judgement will note that

with the sample n=14 When asked did the process of PARTNERS help them understand health information standards 57.1% indicated that the process of partners helped them to a considerable extent with 42.9% indicating to a moderate extent. Likewise, 78.6% indicated that the PARTNERS process helped them to a considerable extent to form basis for selection of concepts and terms in future documentary practices with 21.4% assisted to a moderate extent. The data collected in this study on the individual patients and participants is crude and is limited in its statistical significance for either generalisability or validity. However this was never the focus for this particular thesis. The overall practice orientated focus of collecting individual patient centred outcomes on patients to demonstrate to the nursing community the individual contribution that nursing interventions were having on patients is evident. The pilot study also sought to ascertain if formal interagency communication between nurses could be enhanced by adopting a shared discharge form for use across and between agencies. This information could then contribute to future work of the EHRLand project that is testing the European standard for electronic healthcare record exchange. It was disappointing that the PARTNERS group did not expand to include members of the multidisciplinary team although invitations to join the group were extended none were accepted. The design method adopted within the study on a vulnerable sample of patients carries with it a degree of risk particularly in relation to indemnity. Similar projects in the future will need to be cognisant of this fact, and accommodate additional time into the project plan. Likewise recruiting patients into a study across service boundaries can be problematic and a time consuming exercise. In the final analysis only 3 patients were successful in achieving interagency communication this is presented in the following Figure 2.

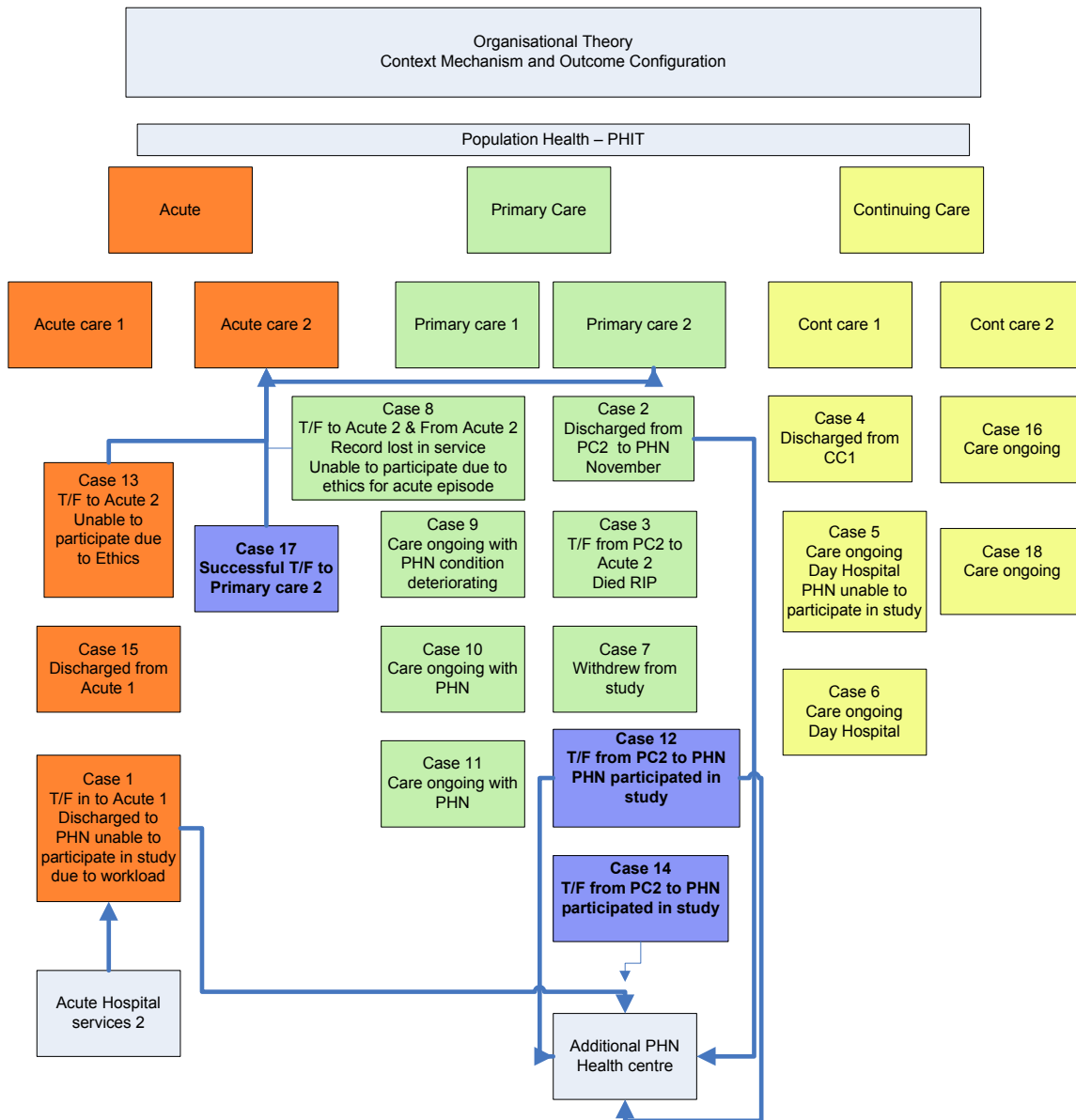


Figure 2 : Interagency communication overview

Note case 17, 12 and 14 achieved successful inter agency communication with the PARTNERS tool.

5. Conclusion

EHR and their variants are necessary tools to support the often complex and dynamic nature of interagency communication within the sphere of health care. Future HSE initiatives seeking to support integrated care processes for health service providers will require clinically appropriate designed forms fit for local purpose. Adopting a bottom up approach to define user requirements using conceptual maps in the form of concept mechanism and outcome configurations is one method to achieve consensus across service providers. Translating local nursing language using formalised terminology such as ICNP and C.HOBIC outcomes is a helpful technique to achieve consensus on language that is fit for purpose and supports semantic interoperability. This report describes the core process of an evaluation completed on a prototype patient assessment form designed by clinicians and health informatics researchers in line with best available evidence. The intention of completing this evaluation is to identify what processes work for which service providers, what components within the form are relevant and what insights can be gleaned to inform the next phase of archetype development in the EHRland project. The notion of not treating research as a black box but rather attempting to discern at least some quite distinct shades of grey is argued as significant by some researchers and is one that the PARTNERS group ascribe to (Pawson and Tilley, p.114). Nursing as one of the largest professional stakeholder groups within health care in Ireland cannot be inactive recipients, but rather must articulate their experiential knowledge on clinical core processes within healthcare in order to inform future service delivery programmes. This tenet is documented well by O'Shea, when she describes nursing and midwifery as the lynchpins for the success of the clinical directorate model because of their role, scale of presence, and their close position to the patient or client (O'Shea, 2009, p. 127). Despite the educational and training initiatives introduced over the course of the past two years the complex outcome pattern made evident in this evaluation cannot be entirely explained by the PARTNERS project alone. In order to understand the often complex outcome patterns additional non PARTNERS interventions triggered a series of mechanisms which could have affected the outcomes identified in the study. The agenda of the PARTNERS group on reflection and given the existing resources available to them could be described as ambitious. However the blending of local practitioner wisdom and formal

academic knowledge has led to the development of new social networks and offers a more informed choice and set of preferences for nurses engaged in the process of developing documentation of archetypes in the future. In summary this evaluation concludes with a lengthy but appropriate quote from Weiss who states that

Evaluation will never provide all the answers. What it can do – and this is no minor contribution – is help to rally support for effective programs, identify innovative programs that are making advances over current service, and expose the failings of existing programs, along with indications of the kind of change that would make them work. At one point I bemoaned this slow and indirect approach to social change and yearned for bolder contributions. In recent years, however, I have come to appreciate how difficult social change is and how resistant social problems are to intervention. I am more impressed with the utility of evaluation findings in stimulating incremental increases in knowledge and in program effectiveness. Over time cumulative increments are not such small potatoes after all.

Weiss, C.H. 1998: 319

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