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# **THE DEVELOPMENT OF NURSING DOCUMENT CONTROL PROCEDURES: A PROCESS OF ORGANISATIONAL CHANGE**

**RICHARD HORNSBY**

A thesis submitted to the University of Huddersfield in  
fulfilment of the requirements for the degree of Masters of  
Arts by Research

June 2011

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## **Abstract**

There were two distinct aims of this research study; firstly, to gain a greater understanding of nursing documentation practice, and, secondly, to study the management of change within a health care setting. The importance of creating high quality nursing documents for the purposes of recording patient care is well emphasised within the published work of key health care figures, such as the Nursing and Midwifery Council (2010) and the Health Service Ombudsman (2006); however the necessary guidance to achieve such high quality documents appears to be lacking. Previous studies have been inconclusive in diagnosing the root causes of nursing documentation issues, and consequently, recommendations for improvement have largely involved the redesign of a single document, which have often failed to address the underlying problem. Collectively, the inconsistencies within the literature marked the need to undertake further research, in order to thoroughly investigate nursing documentation practice and to better understand the organisational and cultural barriers to the successful implementation of change within the NHS.

The research took a case study approach which involved an investigation of nursing documentation practice and organisational change within a single organisational setting. A two phase methodology was developed in order to collect sufficient levels of data to form research findings. Firstly, an analysis of 161 documents provided a degree of quantitative data to gain a greater understanding of the standard of nursing documents in use within the case study organisation. This was followed by eleven semi-structured interviews and a focus group in addition to the use of a diary log, kept by the researcher, to record key observations over a two year period.

The main findings provided evidence of a lack of formalised procedure for the development and management of nursing documentation within the case study organisation. Authors of nursing documents did not always see their role as 'educators', however a number of nurses interviewed within the purposes of the research voiced concerns in relation to a lack of understanding, and, when tested, gave differing responses and interpretations as to the meaning of some of the assessments contained within key nursing documents.

Whilst an improvement model was developed to address some of the issues encountered throughout the research, strong messages emerge in relation to the successful management and implementation of change within a health care setting. A perceived cynicism of change in addition to the entrenchment of routines and procedures were key defence mechanisms used by the nursing workforce.

## **Acknowledgements**

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## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Introduction**

The purpose of this introductory chapter is to provide an account and overview of the research which is portrayed in the next five chapters. This introduction begins with an overview and background of nursing documentation practice and organisational change within the NHS, followed by a determination of the research problem and identification of the research aims and objectives. The chapter concludes with a background of the NHS institution designated as a case study organisation for the purposes of this research, and is followed by a brief summary of the structure of the research depicted in each of the following chapters.

#### **1.2 Background to the Research**

This research forms part of a two year 'Knowledge Transfer Partnership' (KTP)<sup>1</sup> project undertaken to examine nursing documentation practices and the management of change within a single NHS Foundation Trust in England. The impetus for the project arose from discussions between the researcher and the case study organisation's Director of Nursing, in relation to senior manager concerns towards nursing documentation practice and the inappropriateness of previous incentives designed to improve performance. As a consequence, a formal request was made to the researcher to investigate current practice, provide clear recommendations for improvement and produce strategies to ensure successful implementation of change within the organisation. As part of the 'KTP' process, a request was additionally made for the researcher to take on a project management role within the case study organisation to manage, oversee and develop formally agreed solutions for improvement, with a view to handing over completed products to senior

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<sup>1</sup> Knowledge Transfer Partnerships are partially government-funded programmes which aim to improve business operations and competitiveness through the effective transfer of knowledge, skill or technology which reside within Universities in the UK.

management for implementation. The study is consequently split into two sections to accommodate this, as reflected within the 'Research Findings' and 'KTP Involvement' sections illustrated within Chapter Four.

The importance of creating high quality nursing documents for the purposes of recording patient care is well emphasised within the published work of key health care figures, such as the Nursing and Midwifery Council (2010) and the Health Service Ombudsman (2006); however the necessary guidance to achieve such high quality documents appears to be lacking. In addition, the complexities of nursing documentation practice are highlighted in great detail in Chapter Two, and as such, it is apparent that problems exist not only within the case study organisation, but within the NHS spectrum as a whole. Previous studies (Karlsen, 2007; Bjorvell et al 2003) have been inconclusive in diagnosing the root causes of nursing documentation issues, and consequently, recommendations for improvement have largely involved the redesign of a single document, which have often failed to address the underlying problem. Collectively, the inconsistencies within the literature mark the need to undertake further research in order to thoroughly investigate nursing documentation practice and to implement an improvement model capable of effecting change.

Moreover, the management of change within the NHS is often described as a complex and difficult process (Alexis 2005, Bamford and Daniel, 2005). As a result of the current political environment, a review of the literature detailed within Chapter Two determined a need to gain a greater understanding of cultural and organisational issues within the NHS, to acknowledge potential barriers and establish strategies required to ensure the successful implementation of change programmes.

### **1.3 Aims and Objectives of the Research**

Based on the above section indicating the complexities surrounding nursing documentation practice and the effective management of change within a health care setting, the broad aims of the research are:

**1. *To gain a greater understanding of nursing documentation practice within the NHS***

**2. *To study the management of change within a health care setting.***

In order to achieve the research's aim, four objectives have been identified, which in turn, guide the investigation of the research focus.

- 1) To undertake a document analysis to determine the overall standard of nursing documentation in use within a case study organisation.
- 2) To explore nursing documentation practice within a case study setting
- 3) To produce a nursing documentation improvement model
- 4) To identify the perceived organisational and cultural barriers to change within the case study organisation.

#### **1.4 Organisational Context**

The research will not make reference to any individual or hospital name in order to protect the privacy and confidentiality of the case study organisation and its staff. As a consequence, the case study organisation will be referred to as 'Trust A' within the context of this research.

Trust A is based in Northern England, providing healthcare for a local community of over 400,000 people. The organisation operates on two separate sites, which are based within an approximate proximity of five miles of each other (the two locations will be referred to as '**Site 1**' and '**Site 2**' to maintain confidentiality). Sites 1 and 2 merged at the turn of the 21<sup>st</sup> Century, which coincided with the award of 'Foundation Trust' status some 6 months later. At the time of writing there are 46 wards in operation throughout the organisation, each catering for specific medical conditions and patient requirements. Trust A's Annual Report (2009/2010) indicated that services had been recognised as "good" quality by the social care regulator, but that there were still many areas for improvement. Discussions with senior

management identified a newly developed quality improvement programme in relation to 'improving the patient experience', and, consequently, enhancements in nursing documentation practice were identified as a priority area in order to better meet organisational goals and targets.

## **1.5 Structure of the Research**

The initial focus of the research in relation to nursing documentation practice and the management of change are portrayed within **Chapter One** in order to present an overall view of the research, its background, aims and objectives and structure.

**Chapter Two** reviews the literature surrounding the research area. This chapter aims to review and critique the work of relevant studies and identify gaps in current research. The chapter begins with an overview of the importance of nursing documentation, outlining some of the problems associated with current practice and an analysis of the improvement recommendations detailed within previous studies. The chapter also discusses aspects of organisational and cultural change models portrayed within current literature, with relation both to the private sector and the NHS.

**Chapter Three** discusses the methods and tools used within the context of the research. Within this chapter, different research philosophies are discussed and assessed, and reference is made to both ontological and epistemological consideration. The chapter discusses a two phase methodology, including the structure of quantitative and qualitative approaches for data collection. The chapter concludes with an overview of ethical considerations to be made within the context of this research.

**Chapter Four** is split into two sections to incorporate the 'Research Findings' and 'KTP Involvement' aspects of the research. The initial section of the chapter tackles the first and second objectives of the research, presenting a data analysis of the methods included within Chapter Three and a discussion of findings in relation to nursing documentation practice within the case study

organisation. An improvement model is additionally created to fulfil the research's third objective. The second section of the chapter incorporates the 'KTP Involvement' of the research, providing an account of the development of the improvement model provided within the first section of the chapter, including product development, timescales and problems encountered throughout the process.

In order to fulfil the fourth objective of the research, **Chapter Five** provides an account of the organisational and cultural barriers to change within the case study organisation, and identifies pushing and resisting forces to the successful implementation of the improvement model created within the context of the research.

**Chapter Six** forms the final chapter of the research, detailing final conclusions and recommendations. The findings of the research are summarised, taking into account key contributions to the literature, recommendations for future research and an acknowledgement of the research's limitations.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

The researcher utilised the resources available for students at the University of Huddersfield, including the on-campus library and an electronic search engine known as 'Summon,' to access scholarly material. Content was viewed (largely electronically) through the inputting of key words within the search engine i.e. 'Nursing Documentation', 'Organisational Change in the NHS,' 'Corporate Culture'. This chapter aims to critique the literature obtained by the researcher and is subsequently split into four sections;

- 1) A review of **nursing documentation**, including its overall purpose, problems of use in current practice and the identification of previous studies which have investigated potential improvements.
- 2) An analysis of the concept of **organisational change**, including a critique of two approaches which dominate the literature; 'Planned' and 'Emergent' approaches to change.
- 3) An account of **organisational change in the NHS / public sector**, establishing key differences between public and private sector change management, and a critique of previous literature within this area.
- 4) An analysis of the meaning of **corporate culture**, how this affects the change management process and a critique of current models and theory within this field.

The review has been structured in this manner to increase knowledge within this research's area of study, to identify gaps within the literature and to guide the researcher in the formulation of appropriate research aims and objectives.

## 2.2 Nursing Documentation

This opening section of the review seeks to critique the literature surrounding nursing documentation, aiming to provide particular clarity as to overall purpose / reasons for use and to gain a greater understanding of some of the publicised problems for the manner in which it is perceived in practice. In addition, this review will study previous investigations tailored towards making substantial improvements in nursing documentation, both in its overall appearance and perception. Whilst the proposed research takes the form of a case study approach for a single health organisation in the UK, it is hoped that the knowledge gained throughout the review will provide a suitable platform for the researcher to formulate and approach specific research objectives, which aim to provide a different perspective to current literature.

As a starting point, the Nursing and Midwifery Council's (NMC) 'Record Keeping Guidance for Nurses and Midwives' (2010, page 1) sets out the importance of documentation within the nursing role, detailing it as an "*integral*" part of nursing practice, "*which is not an optional extra to be fitted in if circumstances allow*". In addition, the guidance sets out a number of principles for acceptable practice, ranging from the standard of handwriting to the quality of written content. It must be noted, however, that the information contained from this source is intended for guidance purposes only. As a consequence, it would not be appropriate to assume that the contained information truly reflects actual practice.

Whilst Cheevakasemsook et al (2006, page 366) describe nursing documentation as "*one of the most important functions of nurses since the time of Florence Nightingale*", differing viewpoints within the literature confuse the true purpose of its existence. Three distinct purposes dominate the literature, namely; 'care planning and communication,' 'litigation' and 'benchmarking.'



## Care Planning and Communication

Large proportions of the literature cite that a traditional and fundamental purpose of nursing documentation is to plan patient care (Sheppard et al 2009, Hall 2009 and Clemow 2006). Such a viewpoint appears to be closely linked to the previously identified NMC (2010) guidance, particularly in relation for the requirement to record key decisions and identify risk / early detection of complications. Sheppard et al (2009, page 42) define care planning as “*the process of setting goals and interventions based on needs identified by an assessment and planning how to meet these goals with clients.*” Consequently, a care planning approach would result in the use of documentation to assess the patient’s health status and situation, to record the care that a patient has received, and to plan any future care requirements, where necessary. Others propose that the planning of care is one the main tools available for communication between health care staff (Tornvill and Wilhelmsson, 2008; Webb and Pontin, 1997). Particular emphasis is placed on its use for communication between consultant and nurse, and additionally, the efficient transfer of patient information during shift handovers.

## Litigation

Recent publications seem to place a greater emphasis on the requirement of nursing documentation for litigation purposes (Allen 1998, Nazarko 2007, Teytelman, 2002). Nazarko (2007, page 336) seems to blame a rise in complaints and litigation claims within the UK for the shift away from the traditional purpose of nursing documentation, referring to the legal pressures of “*if it was not documented it was not done.*” Allen (1998, page 1229) suggests that nurses fear litigation and take an approach of “*getting everything down in writing to cover your back.*” The author implies that this leads to an abundance of unnecessary information being added to a patient’s record of care. Other authors have reported how negligent documentation cases have incurred heavy financial implications for health institutions (Teytelman 2002, Owen 2005).

## **Benchmarking**

The CRNBC (College of Registered Nurses of British Columbia, 2008) states that documentation “*demonstrates whether or not a nurse has applied nursing knowledge, skills and judgement.*” This source addresses an area which is often dismissed within the literature, indicating the importance of using written entries as an internal means of benchmarking competence and improving the knowledge and skills of nurses.

Whilst it is acceptable for nursing documentation to fulfil a number of distinct purposes, the rise of litigation circumstances is marked as a “*complexity*” (Cheevakasemsook et al 2006, page 366), which has led to widespread problems and concerns. These are addressed in more detail within the following section.

### **2.2.1 Publicised Problems and Concerns Relating to Current Practice**

A number of investigations have diagnosed problems relating to nurse’s written entries within documentation. Of particular mention is the work of Nazarko (2007), Karlsen (2007), North and Serkes (1996); all of whom expose issues with nurses failing to keep accurate records. In an attempt to diagnose the root cause of these problems, four areas of concern are highlighted, namely; *time constraints, poor staff perspectives, education and a lack of standardised approaches.*

#### **Time Constraints**

Cheevakasemsook et al (2006, page 371) establish five common tasks that a nurse must undertake in his/her daily activity; “*Nursing Documentation, Medication Administration, Medication Preparation, Medical Orders and Patient Chart Reviews.*” The results of the study mirror other literature in diagnosing that documenting patient care can take between 25-50% of a nurses time (Duffield et al, 2008; Owen, 2005). The argument that the poor quality of written entries is related to strict time constraints are initially blamed

on staff shortages (Owen, 2005). However, a deeper analysis points to increased litigation and technology alongside shortened lengths of stay which are significantly increasing the necessary amount of record keeping and writing (Duffield et al, 2008). In any case, it is necessary to note from the literature that the time available for a nurse to carry out common tasks is being stretched. This in turn may be detrimental to the quality of written content, illustrated in a recent study in the USA which indicated that, “81% of nurses thought that dealing with documentation directly affected the time spent in providing patient care” (Duffield et al 2008, page 3270).

Critically speaking, it would appear that arguments of time constraint issues are fairly weak in nature, and, on first investigation, it is easy to fall into the trap of labelling such concerns as a mere ‘excuse’ for unsatisfactory performance. Indeed, it could be argued that nurses should simply *find* the time to complete the relevant documentation to the required standard. However, the statistics (Table 1) indicating the sheer intensity of recent clinical activity over the last decade, may prove otherwise. Although the total episodes of care rose by 33% over the period, the number of beds available and average length of patient stay fell dramatically. Consequently nurses are caring for more patients on a much quicker throughput, yet have fewer hospital beds to allocate them. Based on these statistics, there is certainly reason to believe that resources are being stretched, and that subsequently, time constraints are a real cause for concern amongst nurses in the NHS.

<b>Clinical Intensity</b>	<b>1999</b>	<b>2009</b>	<b>Percentage Difference</b>
<b>Episodes of Care</b>	12,167,574	16,232,570	+ 33%
<b>Number of Hospital Beds</b>	185,300	159,000	- 14%
<b>Average Length of Hospital Stay</b>	7.9 days	5.8 days	- 27%

**Table 1 – ‘Clinical Intensity from 1999-2009’**

(Figures taken from Hospital Episode Statistics -<http://www.hesonline.nhs.uk>)

## **Staff Perspectives**

Teytelman's (2002, page 122) assumption that documentation can be "*a nurse's best friend in his or her professional career*," must be questioned as a consequence of the negativity already portrayed within this review. Consequently, it is hardly surprising that the literature largely blames poor attitudes for inconsistent and incomplete nursing documentation (Allen, 1998; Owen, 2005). Cheevakasemook et al (2006, page 368) reinforce this suggestion in determining that nursing documentation is "*devalued as an unimportant task*," which is commonly viewed as a burden amongst nursing staff. Such a statement implies that there is no direct relationship between documentation and patient care, i.e. poor documentation practice can exist alongside good patient care. This, of course, marks a substantial variance from NMC (2010) guidance, and therefore must be acknowledged as a major problem within current nursing documentation practice.

There are a number of authors who are critical of the perceived negative attitudes towards documentation, most notably Allen (1998) and Duffield et al (2008). That being said, Allen (1998, page 1229) does concede that there is "*a very real danger*" of nurses giving priority to written records, rather than administering care to patients on the ward. Such a statement indicates that documentation should not be the priority activity for nurses. Accompanied with time constraints issues, the above studies have strongly indicated that nurses generally have very negative opinions of nursing documentation, which, in turn has had a detrimental effect on the quality of written information.

## **Education**

On a different note, some studies are keen to dismiss poor attitudes and time constraints and argue that some nurses do not have sufficient knowledge or skills to fill in documentation efficiently. Webb and Pontin (1997, page 400) certainly recognise this and describe education in this area as a "*major challenge*." However, it is the work of Cheevakasemsook et al (2006, page 370) which shockingly exposes gaps in nurse competence, and the ability to

efficiently complete documentation. In particular, a participating nurse in the study is said to have confessed that, “*we don’t know how to create a nursing care plan.*” The planning of care has previously been identified as a fundamental and key purpose of nursing documentation. The above statement therefore indicates that issues exist which are far deeper than the initial concerns of time resource indicated within the literature. Pontin and Webb (1997) and Cheevakasemsook et al (2006) diagnose an apparent uncertainty amongst nurses, particularly in the establishment of best practice for completing care documentation. Whilst it must be noted that the work of these authors only reflect the attitudes of staff within two health-care institutions, a sense of nurse insecurity is noted in other investigations, notably in terms of a growing emphasis on litigation (Nazarko, 2007), a reluctance to consider documentation as a high priority activity (Owen 2005) and the impact of the recent emergence of electronic sources of documentation (Ting Lee, 2005).

### **Lack of Standardised Approaches**

In particular relevance to this study, problems have also been associated with a lack of standardisation in terms of the development and management of nursing documentation within health institutions (Cheevakasemsook et al, 2006). In truth it is surprising that this area of concern does not dictate more of the literature, particularly as it is argued that the lack of guidelines or a standard approach to documentation can “*lead to wasted time, high costs and uncomfortable charting.*” (Cheevakasemsook et al, 2006. page 367). Although Cheevakasemsook et al (2006) further highlight the need to promote high quality documents and written responses through the use of standardised procedures or guidelines; little indication is given as to how this may be achieved. Indeed, the literature is unable to clarify exactly what a high quality document is. This is epitomised by the NMC’s ‘Record Keeping Guidance for Nurses and Midwives’ (2010), which concentrates on the information to be written within nursing documentation rather than providing guidance for the creation of high quality documents that are fit for purpose. At this stage it is difficult to tell whether this marks a gap in the literature or indeed a gap within the NHS service itself. It is likely that both apply, but it should be noted that

such uncertainty forms the starting point for this study, in terms of how an approach towards document management and control may improve previous concerns relating to perceived negative attitudes, a lack of education and time constraints.

### **2.2.2 Improvements in Nursing Documentation**

A number of studies have investigated systems designed to improve nursing documentation within healthcare institutions (Karlsen 2007, Bjorvell et al 2003, North and Serkes 1996). Each of these studies has attempted to improve the quality of written information through the re-design of a single nursing document. Whilst the improvement of written information is undoubtedly an important aspect to tackle, especially in terms of an apparent lack of nurse competence, little advancement is made towards the setting up of minimum standards and procedures for all of an institution's nursing documents. This seems particularly bizarre in light of Cheevakasemsook et al (2006) opinions that a lack of minimum standards is likely to have a detrimental effect on a health-care institution.

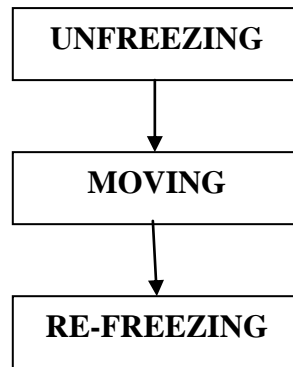
Consequently, there appears to be a general sense of confusion amongst the literature. Although it is generally agreed that there are substantial problems with current nursing documentation practice within the NHS, authors offer differing opinions of both the root causes, and suggestions for improvement. In order to bridge some of the gaps in the literature, this study aims to thoroughly investigate nursing documentation issues within a single NHS organisation. In addition, the study will investigate potential improvements from a differing angle, in anticipation that better systems of document control and management will eradicate some of the aforementioned concerns relating to perceived negative attitudes and inconsistent written entries within nursing documentation.

## **2.3 Organisational Change**

The concepts of organisational change and change management certainly seem to be a popular area for the publication of literature in recent years. It must be noted that, as a consequence, this section of work does not intend to review all the available literature, but, instead, aims to address areas which are relevant to this particular study. Whilst organisational change specific to the NHS and public sector are explored in more detail in the following sections of this review, in the first instance it is useful to grasp an understanding of the basic approaches made towards change management as a concept. A review of the literature points to two distinct approaches to the management of change; 'Planned' and 'Emergent'.

### **2.3.1 Planned Change and Kurt Lewin's Three Step Model**

The literature struggles to produce a concrete definition of Planned change, however Burnes (2004, page 267) refers to the concept as a term, "*to distinguish change that was consciously embarked upon and planned by an organisation, as averse to types of change that might come about by accident, by impulse or that might be forced on an organisation.*" Central to Planned change is the notion of a cyclical, iterative process which identifies a collaborative nature of the change effort (Coram and Burnes, 2001). In this sense, all members of an organisation should plan, and be involved in change. Many authors trace the origins of Planned change to Kurt Lewin and acknowledge his work around 'Force Field Analysis' and 'Group Dynamics' as instrumental concepts to understanding the approach (Bamford and Daniel, 2005; Carnall, 2007; Connor and Lake, 1994). However, it is the 'Three-Step Model' which "*is often cited as Lewin's key contribution to organisational change*". (Burnes, 2004, page 274). The Three-Step Model emphasises the iterative approach in terms of defining a number of pre-planned steps to move from one fixed state to another (Bamford and Daniel, 2005). Lewin argued that all change programmes should involve three vital steps:



**Figure 1: 'Lewin's Three-Step Model (1951)'**

The primary stage of the Three-Step Model, 'Unfreezing', involves organisational recognition that change is required and the need to destabilise current behaviours so that new attitudes and skills can be adopted. 'Moving' involves the exploration and identification of the options available for change. The final stage, 'Re-freezing', involves the stabilisation of change to ensure that new behaviours are adopted and old equilibriums are discarded.

A number of authors have described Lewin's Three-Step model as 'unfashionable' in recent years, and scrutinise an apparent inability for the model to fully address organisational issues (Burnes 2004, Connor and Lake 1994). Consequently recent literature has attempted to elaborate on Lewin's model, to develop additional steps and phases. Of particular mention are Bullock and Batten's (1985) 'Four Phase Model of Planned Change' and Lippitt et al (1958) 'Seven Phase Model of Planned Change'. Seemingly not wanting to be outdone, Cummings and Huse (1989) also developed an eight phase model in relation to Lewin's work.

The emergence of newer models has clearly changed thinking around the Planned change approach, to the extent that some authors refer to a strong association with the newer phenomenon of 'Organisation Development (OD)' (Burnes, 2004; Coram and Burnes, 2001). Consequently Burnes (2004, page 267) concludes that, "*the Planned approach to change is now most closely associated with the practice of Organization Development (OD) and indeed lies at its core.*" That being the case, the existence of OD must be challenged.



Is this a new concept which adds value to the literature surrounding change management, or alternatively is it merely 'Planned change' disguised in new clothes? The answer to such a question will bring about much difference in opinion; however, the evidence portrayed within this review would suggest that OD adds little to the initial 'Planned' approach. Instead, a 're-branding' exercise is suggested, in attempts to tackle the 'unfashionable' criticisms of Planned change, cited within the literature.

Wooten and White (1999, page 7) indicate that, "*much of the existing OD (Planned approach) technology was developed specifically for, and in response to, top-down, autocratic, rigid, rule based organizations operating in a somewhat predictable and controlled environment.*" This has led many authors to take a critical stance to Planned change, particularly in terms of an inappropriate approach to today's world. Specifically, the literature identifies two particular problems, which are as follows. Firstly, many writers are critical of the linear approach of Planned change (Connor and Lake 1994; Burnes 2004, Carnall 2007). In particular, it is emphasised that such an approach is no longer appropriate as, "*change cannot occur from one stable state to another with the turbulent business environment that exists today*". Bamford and Daniel (2005, page 393). There is certainly some substance in the argument that today's world is 'turbulent and chaotic' and that, as a consequence, a more continuous and open ended process is required to manage organisational change (Burnes, 2004). In addition, the literature is critical of the model's inability to tackle radical and transformational change (Schein, 1985; Francis et al, 2003; Burnes, 2004). Secondly, the collaborative approach central to the concept of Planned change is widely criticised as an unsuitable approach towards change management. In particular, it must be recognised that it is unlikely for all members of an organisation to work together, in the same direction, to sustain change. Therefore, the model is often scrutinised for not allowing enough scope for organisational conflict (Bamford and Daniel, 2005; Carnall, 2007; Burnes, 2004).

### **2.3.2 The Rise of Emergent Change**

The concept of Emergent change has gained the support of more recent literature, perhaps in an attempt to overcome the criticised aspects of Planned change. In an attempt to define the concept, this section of work refers to Burnes (2009, page 371), who explains that,

*“the Emergent approach starts from the assumption that change is not a linear process or a one off isolated event but is a continuous, open-ended, cumulative and unpredictable process of aligning and re-aligning an organization to its changing environment.”*

Supporters typically view the Emergent approach as a continuous process that is usually achieved through small, incremental changes. This, in time, will lead to major transformations within an organisation (Coram and Burnes, 2001; Esain et al, 2008; Burnes, 2009). In addition, Emergent change emphasises ‘bottom up’ actions rather than the ‘top-down’ approach associated with Planned Change. *“The rationale behind this is that the pace of change is so rapid and complex, once it occurs, that it is impossible for senior management to identify, plan and implement every action required.”* (Bamford and Daniel, 2005, page 394). Essentially, therefore, it is argued that change management should involve individuals from all levels of the organisation. This marks a substantial difference from the ‘top-down’ approach, through which there is strong reliance on senior management authority and decision making.

Criticisms that the process of change can rarely follow a sequence of pre-determined stages have led to a number of alternative models, which encourage continual improvements. Of particular mention are Deming’s model of ‘Plan, Do, Check, Act’, Kotter’s (1996) ‘Eight Steps to Successful Change’ and Francis et al (2003) who developed a model of ‘Five Competencies’ related to transformational change. It must be noted, however, that these models have a number of similarities with their Planned change counterparts, perhaps most notably that all seem to define a number of pre-determined

steps towards the management of change. This, of course, questions the real need for the literature to promote separate approaches, but these criticisms are detailed more thoroughly within the section below.

Although, the Emergent approach is said to provide a different dimension to the concept of change management, it has notably received a number of critical remarks (Bamford and Daniel, 2005; Connor and Lake, 1994; Hendry, 1996). Critics typically point to three areas of discussion. Firstly, the approach seems to assume that all organisations operate within a turbulent environment. Coram and Burnes (2001, page 98) issue concerns over the applicability of the process in determining that, *“it is, by its own definition, not applicable to organisations operating in stable environments where fine-tuning is the order of the day, or those whose circumstances require major changes through the use of rapid and coercive measures.”* Secondly, Bamford and Daniel (2005, page 393) put forward the argument that supporters of Emergent change *“appear more united in their stance against planned change than their agreement upon a specific alternative.”* It must be noted that the researcher came to a similar conclusion when passing judgement on the information received throughout the literature. Whilst a number of different Emergent models for organisational change have been identified within this chapter, none are accredited with the innovation, or indeed the prestige, that is associated with Lewin’s Three Step Model and Planned change. Finally, it is argued that all processes of change should have a beginning, middle and an end, as indicated within the Planned change model (Coram and Burnes, 2001; Connor and Lake, 1994). Taking a critical stance, there are certainly many similarities between Kotter’s (1996) and Deming’s ‘Emergent Models’ and Lewin’s model of ‘Planned Change’, perhaps most notably that they seek to recognise the need for change, make the necessary amendments and ensure that the new ‘status quo’ is embedded within the organisation. Hendry (1996, page 624) particularly reinforces the opinion of the researcher in stating; *“scratch any account of creating and managing change and the idea that change is a three-stage process which necessarily begins with a process of unfreezing will not be far below the surface.”*

### **2.3.3 Putting Change Management into Perspective**

In view of the literature outlined above, it would appear likely that support will remain divided for the Planned and Emergent approaches to change. Burnes (2004) adds an additional angle to the debate; the 'Contingency Theory', which wisely acknowledges that no two organisations are the same. In this sense the approaches taken towards the management of change should vary in the view of differing organisational structures and operations. *"Consequently the 'one best way' for all organisations is replaced by the one best way for each organisation."* (Burnes, 2004. page 70).

The literature widely criticises the limitations of both approaches, yet does not provide a solid foundation through which to pass judgement over which, if any, models should be selected over another for the purposes of change management. This review has therefore not served to promote a single approach for which to base the research, but instead has indicated the appropriate need to categorise change models as 'situational' (Coram and Burnes, 2001). The key message to be taken into the main body of this study is that the approach to change should therefore be particularly dependant on the environment, structure and size of an organisation.

## **2.4 Managing Change in the NHS / Public Sector**

The previous sections of this review indicated that the concept of organisational change has been a popular area for the publication of literature in recent years. However, it is noticeable that the vast majority appear to focus on approaches tailored around the private sector (Coram and Burnes, 2001; Betts and Holden, 2003; Page et al, 2008). Initially, this marks a substantial gap within the literature, which seems to dismiss a key aspect in relation to this study, namely; the requirement to develop relevant approaches to change within public sector organisations.

The differences between public and private management models seem to split opinion within the literature. In the first instance Coram and Burnes (2001) indicate that public sector managers face different challenges from private sector counterparts, *“especially in terms of public accountability, demonstrating value for money, and in meeting the increasing expectations, regarding service levels and quality, of both the general public and politicians.”* However, this opinion clashes with other authors, most notably Page et al (2008), Esain et al (2008) and White (2000), who suggest that increasingly turbulent environments have led to closer parallels between the public and private sectors. McHugh and Brennan (1994) and Bamford and Daniel (2005) establish a number of structural changes within the UK public sector, which in turn have put new pressures on public sector managers to increase customer focus and further emphasise quality of service. *“Managing change is, therefore, not only the preserve of the private sector, but integral to management in public and voluntary sectors.”* (White, 2000, page 162).

### **2.4.1 Structural Changes within the NHS**

Before judgement may be passed over the debate which has been documented in relation to the extent of the gaps between public and private sector management, it is important in the first instance to note the monumental scale of structural change which has occurred within the NHS over the last 20 years (Esain et al, 2008; Bamford and Daniel, 2005). The

emergence of 'NHS Trusts' in the early 1990s, followed by the more recent creation of 'NHS Foundation Trusts', has aimed to devolve a traditionally centralised government approach, and the intended drawing of clinicians into managerial roles has become more commonplace. In a paper entitled, 'A Short Guide to NHS Foundation Trusts', the Department of Health (2005, page 2) emphasise that current institutions are,

*“at the heart of a patient-led NHS, where local managers and staff working with local people have the freedom to innovate and develop services tailored to the particular needs of their patients and local communities.”*

The structural changes mark a huge shift from the traditionally centralised 'NHS system', and although the organisation is unlikely to ever become fully self-sufficient, the new reforms have been criticised by a number of authors. O'Brien (2002, page 443) describes the new changes as *“top-down radical shock strategies,”* while others reflect on de-motivated staff (Bamford and Daniel, 2005) and the inability for clinicians to carry out managerial roles (Johnson and Scholes, 2001). However, these criticisms generally sit outside the boundaries of this study, and, of more importance are the impact of these changes and the bridging of gaps in organisational thinking and strategy.

Consequently, the re-structuring and privatisation of a number of public sector organisations has led to an *“increasingly hazy”* (Coram and Burnes, 2001 page 95) boundary between the public and private sector. The creation of an independent approach to managing change within the public sector, at least within the example of the NHS, would therefore seem inappropriate, particularly as it would appear that the business styles and management systems of the private sector are frequently crossing over into public sector organisations. Instead, it is imperative that the NHS' management and staff are receptive to the recent structural changes and able to adopt new approaches that are appropriate to the challenges that they face (O'Brien, 2002).

Recent authors are keen to promote the 'Emergent' model as an appropriate mechanism for managing change in the modern NHS (Massey and Williams, 2006; Esain et al, 2008). This seems logical based on the recent radical structural changes of the organisation as a whole. However, it is important to approach such opinions with an element of caution, particularly drawing on previous conclusions that the approach taken towards change should be purely 'situational' (Burnes, 2004). Consequently, the approach taken by one particular NHS institution may not necessarily be transferrable to other healthcare organisations. The ability for Foundation Trusts to formulate their own strategic objectives has opened the doors to the notion of continuous improvement within the NHS (Esain et al, 2008). This poses a major challenge for management. Institutions are no longer expected to simply provide a service, but, instead, are required to adapt to the requirements of customers and mirror strategies which are more closely associated with private sector organisations. This marks a significant transformation from the traditionally stable and static environment of the NHS, and undoubtedly results in critics labelling the 'Planned' approach as an inappropriate mechanism towards the management of change.

In addition, a number of authors indicate that top-down management approaches are no longer appropriate for the newly reformed NHS system (O'Brien, 2002; Massey and Williams, 2006; Johnson and Scholes, 2001). This is particularly well portrayed in a recent study, where a Chief Executive of a UK 'Trust' concedes that, *"some of the decisions (from top management) aren't very good because that small group is so far removed from the information."* (Johnson and Scholes, 2001, page 288). However, it is the work of Massey and Williams (2006) around the role of change agents within the NHS that sparks most interest. Here, the authors identify that radical changes have enabled leaders to step forward, giving them opportunities to *"make a difference to their own and their team's environment while also delivering care to patients."* (Massey and Williams, 2006, page 669). Again, this seems to align with the bottom-up approach associated with 'Emergent' change and emphasises how staff members may be better placed to tackle change management.

#### **2.4.2 Putting Change Management in the NHS into Perspective**

In introducing the management of change within the NHS, the researcher initially suggested that there was a substantial gap within current literature in relation to a perceived lack of public sector focus around organisational change. However, the increasingly 'hazy boundaries' (Coram and Burnes, 2001) which have been revealed throughout this review have established that the proposed gap within the literature is not as severe as originally anticipated. The addition of radical structural changes within the NHS also acts in placing less importance on the divide between the sectors and the desire to develop alternative models specifically suited to organisational change within the public sector. It must be noted, therefore, that this research does not intend to add to the literature in this fashion. The current literature portrays a strong desire to adopt a universal model for organisations to follow in order to manage change. This seems bizarre, as the inabilities of current models to adapt to certain situations or environments are well documented. This is epitomised by a piece of work undertaken by Bamford and Daniel (2005), who attempted to match three theoretical models with a change management approach undertaken by an NHS institution. Their work concludes that 'no suitable model yet exists' for explaining the process of change, and that the approach taken by the organisation involved mixed elements of a number of different theoretical models.

This review has diagnosed the promotion of 'Emergent' models for change management, both in the NHS and the public sector. Whilst authors are able to provide reasoned arguments as to why this should be so, they fail to take into account the differing situations which organisations operate within. Consequently, this review will not be promoting a particular model for use within the intended research, but, instead, aims to reiterate that there is '*no best way*' to manage change. To provide some concluding remarks, the researcher is in firm agreement with Coram and Burnes (2001, page 95), who indicate that is of far more importance for an organisation to, "*balance the structural and cultural aspects of change, especially the need to appreciate and respond to staff fears and concerns.*" Corporate culture is certainly an



important area in the management of change, particularly in view of recent structural changes in the NHS. Consequently, the next section of this review addresses the literature of this topic in more detail.

In conclusion, there are two main points that are illustrated within this section of the literature review. Firstly, the recent structural changes of the NHS and subsequent reforms of other public sector organisations have bridged gaps in the perceived differences through which change should be managed. Secondly, regardless of the organisation, there is 'no one best way' to manage change. This dismisses the need for public sector organisations to adopt differing models to private sector counterparts. As a consequence, this study does not intend to align the case study organisation's approach for change to a particular model, but instead, will promote an approach which matches the situation and environment which the organisation operates within.

## **2.5 Corporate Culture**

The literature widely acknowledges that corporate culture is difficult to define (Burnes, 2004; Brunetto, 2001; Schraeder et al, 2004). As a result there are a number of definitions, however as Brunetto (2001, page 467) explains, “*all make reference to shared assumptions, beliefs, attitudes, rituals and values that shape the organisational life of one group of employees.*” This reference to a single group of employees is intriguing, and is supported by the work of other authors, who identify that the ‘superficial’ culture reflected in an institution’s policies and mission statement rarely reflects the actual culture of an organisation. Consequently it is not uncommon for sub-cultures to exist within different divisions of an organisation (Brunetto, 2001; Johnson et al 2005; Burnes, 2004). In relation to this study, it is therefore important to note that different cultures may exist within separate departments, divisions or even amongst different wards. An investigation of the cultural issues within the case study organisation will therefore need to be undertaken to explore this possibility.

Bearing this in mind, perhaps the best way to define culture is “*the way things are done around here.*” (Burnes, 2004, page 170). It must be stressed that employees who adopt this notion will naturally resist programmes which threaten to change routines and rituals (Schraeder et al, 2004). Consequently, many writers are of the opinion that managers should be wary that a shift in cultural thinking may be necessary for organisational change to be successful (Brunetto, 2001; Schraeder et al, 2005, Burnes, 2004).

### **2.5.1 Culture Identification within the NHS**

Previous research suggests that the values and motives of public sector employees are distinct from their private sector counterparts (Brunetto, 2001; Schraeder et al, 2004). This seems bizarre in light of the increasingly ‘hazy boundaries’ (Coram and Burnes, 2001) between public and private sector management, previously identified within this literature review. However, with particular reference to the NHS, it must be noted that considerations should

be made to the possibility that recent radical transformations are yet to be fully embraced, and that subsequently, undesirable staff values and motives remain within the organisation. This links particularly well with Lipsky's (1980) 'Street Level Bureaucracy' concept, through which the policies and objectives of public sector managers are not shared by the lower level participants of the organisation. Indeed, Lipsky identifies the lower level workers of the public sector as the 'policy setters', as they have "*considerable discretion in determining the nature, amount, and quality of benefits and sanctions provided by their agencies.*" (Lipsky, 1980, page 13). Consequently the decisions that nurses make in terms of how they are able to care for patients are almost certainly detached from the result-orientated approach that management take towards performance and cost-saving.

Bearing this in mind, managing change within the NHS can be difficult (Alexis, 2005). Accompanied with the recent structural transformations, it is vital for managers to understand the cultures that exist within the organisation, to identify potential barriers to change and to keep individuals and groups motivated so that they can perform to the best of their abilities (Alexis, 2005).

### **2.5.2 The 'Cultural Web'**

The literature contains many established and well-recognised tools to determine and measure culture within an organisation. Of particular mention is the work of Handy (1986) who categorised culture into the four groups of *power, role, task* and *person*; Deal and Kennedy's (1982) four classifications of organisational culture; Cummings and Huse (1989) 'Four Major Elements of Culture'; and the McKinsey '7-S framework' designed by Peters and Waterman (1982), which defines culture as a central component of all organisational activity. Although each of these models would be suitable for the purposes of identifying culture, after a period of reflection the 'Cultural Web' developed by Johnson et al (2005) was taken forward as the most appropriate tool to determine organisational culture within this research paper. The primary reason for such a selection stems from the researcher's

substantial access to staff members within the case study organisation, and the ability to identify and 're-map' culture as a result. In an attempt to better define the concept of the cultural web, this review makes reference to Johnson et al (2005, page 201), who describe their model as a, *“representation of the taken for granted assumptions, or paradigm, of an organisation and the physical manifestations of organisational culture.”*

As can be seen from **Appendix A**, the 'Cultural Web' comprises of seven key elements, which are described as follows;

- The **paradigm** is the set of assumptions which are taken for granted and are held in common within an organisation. This sits within the centre of the model
- The **rituals and routines** indicate the “way things are done around here” which illustrates the way in which staff members behave towards each other and the organisation as a whole.
- The **stories** which are shared by members of the organisation to stakeholders reflect current attitudes and highlight important events which have occurred throughout the history of the organisation.
- The **symbols** of the organisation i.e. company cars, laptops, titles etc. aid in determining power structures and the nature of an organisation.
- The key individuals or management groupings are reflected within the element of **power structures**. These individuals are most likely to be commonly associated with the organisation's core paradigm, and are identified in anticipation of emphasising what is important to the organisation.
- **Organisational structures** are likely to reflect power, and once again, identify important groups/individuals to promote what is important to the organisation.
- The **control systems** illustrate the various performance measurement and reward systems which focus activities towards what is of overall importance to the organisation.

The development of a cultural web as part of this research is likely to have three distinct benefits. Firstly, surfacing the taken for granted assumptions within an organisation is useful in the first instance for “*questioning what is normally rarely questioned*” (Ambrosini et al. 1998, page 139). Ultimately, change will prove difficult if the very nature of an organisation’s existence and purpose are never fully identified or questioned. Secondly, the web can also be used to identify both the pushing and resisting forces to change. As a consequence, change agents will seek to develop an approach which utilises the strengths of an organisation’s culture and overcomes or reduces the forces which are likely to have a detrimental effect upon the change programme. Thirdly, Johnson and Scholes (2001) imply that the web may be used to ‘re-map’ an organisation’s culture. They argue that mapping the desired paradigm, routines, symbols etc. that would support a new strategy would indicate the difficulties of change management and provide an insight as to what may or may not be managed throughout cultural change (Johnson and Scholes, 2001).

As part of their work, Johnson et al (2005) documented a cultural web of an NHS institution, as portrayed by a small number of the organisation’s Ward Managers. Although information could effectively be drawn from that model, it must be noted that the data is unlikely to add any value to this study. Firstly, the information has been drawn from a different organisation, which although categorised as an NHS institution, is unlikely to share the same cultural issues as the case study organisation. Secondly, the information was drawn from senior management, who, as identified through Lipsky’s (1980) street-level bureaucracy theory are likely to have differing perceptions to lower-level staff members. Consequently, this review has determined the need for a cultural web of the case study organisation to be developed. Whilst the researcher’s perceptions of culture recorded within this model will be open to scrutiny, the advantages of access to the behaviours and routines of large proportions of nursing staff will help in diagnosing potential pushing and resistant forces to proposed changes.

### **2.5.3 Designing an Effective Approach to Cultural Change**

Although changing or 're-mapping' corporate culture is often described as a difficult process (Carnall, 2007; Coram and Burnes, 2001; Johnson and Scholes, 2005), the literature gives little indication as to how this may be achieved. Perhaps this is not particularly surprising based on the arguments portrayed in section 2.4.2, as the required approach will very much vary on an organisation's situation and environment. That being said, there are snippets of useful content within the literature, in particular the work of Schraeder et al (2004), who explore the enhancement of culture awareness through staff training and to a greater extent, through leading by example.

Management clearly have an important role to play in managing the impact that change will have on the performance and self-esteem of their staff. Carnall (2007) indicates that cultural acceptance to any given change programme will require a substantial period of time. In particular, an emphasis is placed on 'coping with change,' and reference is made to the 'Coping Cycle', as illustrated in **Appendix B**. The model suggests that, initially, staff will deny the need for change and defend the current way of doing things. Over time, and with support from management, it is argued that old paradigms will be discarded, and new behaviours will be adopted. Whilst the 'Coping Cycle' is useful in being able to predict and understand the processes that individuals will go through in order to accept change, the model appears to suggest that participants will pass through each stage on a cyclical process. In reality this is extremely unlikely to occur. For instance, some individuals will not proceed beyond the first stage of denial, and subsequently, will fail to fully embrace and accept the proposed change. The model should therefore be approached with caution, and certainly should not be used to predict the exact behaviours of individuals subjected to change.

Bate (1994) identifies four specific approaches that a change agent may adapt in order to achieve cultural change. These are categorised as; '*aggressive*', '*conciliative*', '*corrosive*' and '*indoctrinative*', which in turn are paired with '*design parameters*' in order to illustrate a number of strategies for successful

cultural change. However, whilst these strategies seem relatively straightforward, it is difficult to foresee whether any would entirely suit an organisation's requirements. If anything, this review has determined that culture is a deeply complex subject, which is likely to vary drastically from one organisation to the next. The notion that there is therefore a 'ready made' solution to the successful approach of cultural change seems extraordinarily far fetched. Bearing this in mind, it is perhaps more accurate to assume that the strategies developed towards cultural change should be tailor-made, matching the organisation's situation and the intended requirements of the change programme.

In order to provide some concluding remarks to this section, the literature has revealed that;

- 1) Culture is a deep, complex subject, which appears to have a number of meanings based on differing perceptions of authors.
- 2) Defining culture within the NHS is a difficult task. However, the literature has pointed towards the benefits of diagnosing corporate cultural through the use of a 'Cultural Web'. Subsequently, the literature has identified this as an appropriate model to take forward into the main body of research.
- 3) It is unlikely for any of the documented approaches for successful cultural change to exactly match the requirements and situation of an organisation. The review has indicated that it is impossible to make specific recommendations as to which approach an organisation should select to manage cultural change, but recognises that a unique approach needs to be taken that best suits the exact requirements.

## **2.6 Literature Review Summary and the Identification of Research Aims and Objectives**

In an attempt to provide some concluding remarks, this chapter has sought to review the literature within four specific areas relevant to the focus of this

study. Consequently, the need has arisen to further investigate nursing documentation practices within the NHS, and promote a clear recommendation for change which adds value to the current literature. The critiquing of numerous change models and approaches, accompanied with recognition of areas which require further investigation, aided the researcher in the formulation of specific research aims and objectives. These may be located within the opening chapter of this study, and subsequently form the basis for the overall design of the research.



## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 Introduction**

As was seen in Chapter One, the research has formed a case study approach to the exploration of organisational change within the NHS. This chapter discusses a 'two-phase', mixed method approach towards data collection, which was shaped by a predominantly phenomenological epistemology and subjective ontological position of the researcher.

Ultimately, it is the aim of this chapter to establish an appropriate philosophy for the research, to diagnose the reasons behind such an approach, and to further detail the methods undertaken, both in terms of design and structure. The methods adopted included; *document analysis*, *semi-structured interviews*, a *focus group* and the use of a *diary log/field notes* to capture key information.

#### **3.2 Research Philosophy**

The literature surrounding core concepts, methods and values involved in undertaking research is often detailed and complex in nature. Whilst the selection of appropriate research methods is important in being able to tackle the objectives formulated within the introductory chapter of this study, Guba and Lincoln (1994) argue that these are of secondary importance to the selection of an appropriate research philosophy and approach. This is reinforced by the 'Research Onion' (see **Appendix C**) developed by Saunders et al (2009), who diagnose a number of 'layers' to be considered prior to the centrally focused selection of data collection techniques.

The choice of research philosophy is by no means a straightforward process, but should be determined by the epistemological and ontological assumptions of the researcher (Saunders et al, 2009). In the first instance, however, there

appears to be a degree of confusion within the literature, especially in relation to the differing titles used by authors to identify research philosophies. Saunders' 'Onion', for instance, illustrates four separate philosophies, namely; '*positivism*', '*realism*', '*interpretivism*' and '*pragmatism*'. This chapter, however, will refer to the '*positivistic*' and '*phenomenological*' philosophies portrayed within the work of Bryman and Bell (2003), Cameron and Price (2009) and Hussy and Hussy (1997).

<b>Positivistic Philosophy</b>	<b>Phenomenological Philosophy</b>
Quantitative Objectivist Scientific Experimentalist Traditionalist	Qualitative Subjectivist Humanistic Interpretivist

**Table 2: 'Alternative Terms for the Main Research Paradigms'**

(Adapted from: Hussy and Hussy, (1997), **Business Research**. Hampshire: Macmillan Press Ltd. page 47).

The overarching difference between the positivistic and phenomenological frameworks can be portrayed through the recommendation of either a deductive or inductive approach to research. As indicated by Hussy and Hussy (1997), the deductive approach, which is closely associated with the positivistic philosophy, often seeks to develop an established theory and construct a hypothesis (or hypotheses) through which the theory may be tested. On the other hand, the inductive approach may be carried out in circumstances where there is little or no existing theory within the immediate focus of the intended research. Consequently, a researcher involved within this process aims to produce findings which add new dimensions to current theory.

### 3.3 Ontological Considerations

*“Ontology is concerned with the nature of reality. This raises questions of the assumptions researchers have about the way the world operates and the commitment held towards particular views.”* (Saunders et al. 2009, page 110).

The literature widely acknowledges two aspects of ontology; the *objective* viewpoint which argues that social phenomena are external, almost ‘pre-given’ and beyond our reach or influence, or the *subjective* viewpoint which implies that social phenomena are created from the actions of the social actors who form their existence. (Bryman and Bell, 2003; Saunders et al, 2009; Hussy and Hussy, 1997).

In relation to culture, the literature identified the work of Lipsky’s (1980) ‘Street-Level Bureaucracy Theory’ through which it was argued that sub-cultures exist within public sector organisations that are distinct from managerial assumptions. In addition, the complexity of issues relating to nursing documentation and organisational change within the NHS particularly shapes the researcher’s view towards that of the *subjective* aspect of ontology. Saunders et al (2009, page 111) argue that, *“this follows from the interpretivist (phenomenological) philosophy that it is necessary to explore the subjective meanings motivating the actions of social actors in order for the researcher to be able to understand these actions.”* Consequently, it is argued within the subjective view that social actors are likely to have differing interpretations on certain situations. In essence these interpretations require further investigation in order to understand individual perceptions and actions within an organisation. This approach is very much akin to the researcher’s view of the nature of reality, which, accompanied with the epistemological views below, indicate the requirement for a strong phenomenological philosophy within this research.

### 3.4 Epistemological Considerations

*“An epistemological issue concerns the question of what is (or should be) regarded as acceptable knowledge in a discipline”* (Bryman and Bell, 2003, page 13).

The literature review established the need for extensive research, to gain deeper insights and understanding towards the research area within a single organisational setting. In addition, the purpose of the study became exploratory after a search of the literature indicated that little consideration had been made towards the establishment of document control measures, or indeed for the processes towards managing organisational change within the research context. Subsequently, the findings of this study aim to add new evidence and theory to the research area.

This evidence points towards a strong phenomenological based epistemology, through which qualitative approaches should be considered in order to capture the breadth of information required to satisfy the research objectives. However, this is complicated somewhat by the first objective of the research, which details the necessary need to test (albeit very limited) theory, suggesting that a lack of standardised approaches towards nursing documentation development exist within the NHS. This provides the researcher with a dilemma, as the positivistic approach towards the testing of theory contrasts with the exploratory and more extensive approach required to fulfil the remaining objectives. That being said, the literature suggests that there are few solely qualitative or quantitative research projects, which adopt a single philosophy for use (Cooper and Schlindler, 2006; Sekarin and Bougie, 2010, Hussy and Hussy, 1997). Indeed, Cameron and Price (2009, page 256) indicate that, *“because any single approach offers at best a partial picture, business researchers frequently opt for a mixed-methods approach which generates both quantitative and qualitative data”*. The mixing of methods is often referred to as ‘triangulation’, which is widely cited to enhance the quality and accuracy of findings (Bryman and Bell, 2003; Saunders et al, 2009; Cameron and Price, 2009).

Based on the above, this research has developed two distinct phases of research, which is represented firstly through a quantitative phase of document analysis and, secondly, through a qualitative phase, seeking to gain a deeper understanding of the issues that emerged from the results of Phase 1.

**Phase 1** – This phase is to involve a large scale document analysis designed to produce sufficient quantitative data to provide an initial indication of nursing documentation issues within the NHS.

**Phase 2** – In depth qualitative analysis carried out on both individuals and small groups in order to gain a greater understanding of the issues raised throughout Phase 1. Qualitative data collection techniques used includes; semi-structured interviews, a focus group and the use of a diary log/field notes.

### **3.5 Case Study Design**

As was seen with Chapter One, a case study design within a single organisational setting was chosen as the overall strategy for this research. The primary reasoning behind such a choice relates to the researcher's employment within an NHS organisation actively seeking for research to be carried out within the research area. In addition the exploratory nature of the research must be noted; that is to investigate the implications of a standardised approach to the development of nursing documentation within the NHS. As such, the emphasis based upon a particular context within a single organisation setting allows for substantial data capture from a number of differing sources. This is particularly well suited to both the research objectives and the philosophy portrayed within earlier sections of this chapter. For the purposes of complete confidentiality and anonymity, the organisation participating within the case study design will be referred to as 'Trust A'. Background information about the organisation is portrayed within the introductory chapter of the study.

### **3.6 Methods**

#### **3.6.1 Phase 1 – Content Analysis of Trust A's Nursing Documentation**

The main focus of the first phase is to undertake a content analysis of the nursing documents in current use within Trust A, in order to gain an insight into potential issues. Particular emphasis is placed on whether substantial document control measures exist within the organisation.

The researcher visited each of the 46 wards across Trust A, requesting a hard copy of every nursing document in current use. The search yielded 161 different documents and subsequently, each was categorised and subjected to a thorough content analysis. The following closed questions were asked of each document in order to provide a level of quantitative data around the subject.

- Is the document word processed?
- Is the document identifiable to Trust A?
- Does the document contain Trust A's corporate logo?
- Does the document contain a unique reference number?
- Does the document have a recorded date of creation?
- Is there any evidence that the document is over five years old?
- Does the document conflict or duplicate other documents in use?

#### **Analysis of Data: Phase 1**

**Appendix F** details the approach taken for data analysis. Responses to the seven closed questions detailed above were categorised as 'Yes', 'No' or 'N/A' to provide an initial level of information around nursing documentation practice, particularly in relation to standardised procedures. These findings were utilised in order to formulate and design the questions for both the focus groups and semi-structured interviews that emerge within Phase 2.

### **3.6.2 Phase 2 – Semi-Structured Interviews, Focus Group and Diary Log / Field Notes**

The second phase is designed to produce a degree of rich, in depth qualitative data to establish the 'below the surface' issues in relation to nursing documentation, and indeed, to establish the core values and taken for granted assumptions as a means for cultural identification and the management of change. In addition, the phase is designed to further elaborate on the quantitative data gathered throughout Phase 1, and it must be noted that the design of the subsequent qualitative methods utilised within this process are very much shaped by the findings of the first Phase. Consequently, three further tools for data collection were utilised to provide the researcher with the required information to tackle the research objectives; *semi-structured interviews*, a *focus group* and the use of a *diary log/field notes*.

#### **Semi-Structured Interviews**

Whilst the quantitative data collected throughout Phase 1 will portray an indication of the current standard of nursing documentation within Trust A, further investigation is required to better determine the underlying problems that exist, as well as the identification of the pushing and resisting forces to change in order to successfully answer the objectives of this research. The first qualitative tool to be discussed within this section is that of the semi-structured interview.

Discussions with senior management led to the identification of seven senior nurses, responsible for authoring nursing documentation within their field. The clinical areas selected have been anonymised to protect individual confidentiality.

- Clinical Area A (**Interview 1**)

- Clinical Area B (**Interview 2**)
- Clinical Area C (**Interview 3**)
- Clinical Area D (**Interview 4**)
- Clinical Area E (**Interview 5**)
- Clinical Area F (**Interview 6**)
- Clinical Area G (**Interview 7**)

In addition, and in order to obtain a differing perspective, four interviews were arranged with staff members who regularly use nursing documents to record patient care. As such, a Staff Nurse and Ward Clerk from four wards were identified by senior management as suitable candidates to interview in order to gain the necessary information. Two wards from each site were identified;

**Site 1**            a) Ward A (**Interview 8**)  
                       b) Ward B (**Interview 9**)

**Site 2**            a) Ward C (**Interview 10**)  
                       b) Ward D (**Interview 11**)

The ‘practitioner-researcher’ role detailed within the final section of this chapter proved to be advantageous in terms of access to the identified candidates, particularly in regards to the flexibility to arrange suitable times for interview. A question schedule (see **Appendix D**) was created, although the semi-structured format enabled the researcher to design the interview in relation to the responses of the interviewee(s). As a consequence, certain situations led to the exclusion of some questions or the creation of new ones to further explore the nature of participant response.

## **Focus Group**

Chapter Two indicated that understanding nursing documentation practice within the NHS is complex. In particular, the negative nursing perspectives portrayed within the literature must be noted, especially in relation to potential



bias or over-exaggeration of response within the use of semi-structured interviews. In order to provide clarity and focus, a one hour focus group with Trust A's Ward Managers is suggested. There are two driving forces behind the choice of Ward Managers as participants within the focus group.

- 1) Although Ward Managers may have an active involvement as to which documents are used within their specific area, they are not accountable within the authoring process and are not responsible for utilising nursing documents on a daily basis to record or plan patient care. It is therefore envisaged that a 'neutral' perspective can be cast on the issues raised throughout the interviewing process.
- 2) They are well placed to pass on extensive knowledge of staff operations in relation to the four issues encountered within the literature review, namely;
  - a. Time Constraints
  - b. Negative Attitudes
  - c. Education
  - d. Lack of standardised approaches.

Discussions with senior management led to an invitation for the researcher to attend a monthly Ward Manager meeting to carry out a focus group, entitled, *'Nursing documentation practice within the context of 'Trust A'. What are the issues?'* Fifteen participants attended (from an initially invited twenty). The researcher prepared four open ended questions/statements to be asked, designed specifically to relate the concerns documented within the literature to the situation within Trust A. These are listed overleaf;

<b>Question</b>	<b>Duration</b>
1. Tell me about potential time constraints and where nursing documentation fits in with this.	15 mins
2. How do you perceive current staff attitude towards nursing documentation?	15 mins
3. "There is evidence of underdeveloped assessment skills within nurses and this is reflected within the poor quality of their written documentation". Discuss this statement	15 mins
4. Are there any changes that you would like to make to current nursing documentation practice?	15 mins

**Table 3 – ‘Focus Group Questions’**

The role of the researcher within this process was to promote the engagement of each participant, ensure that discussions were kept on track and to ask additional questions to encourage further discussion, to ultimately fulfil the requirements of the research. Responses were transcribed by hand and key findings are illustrated within Chapter Four of this research

### **Diary Log/Field Notes**

It must be reiterated that the researcher was approached by Trust A’s senior management to lead a project specifically around the focus of this study, and as such, was responsible for identifying barriers and ensuring that any transition of change ran smoothly. Consequently, the researcher attended/led many meetings, informal interviews and presentations within Trust A over a two year period. Whilst it would be inappropriate to list the information received on a day to day basis, key events and areas of interest were recorded within a personal diary log, which, in turn, served as a vital tool for reflecting upon staff opinions and views. Extracts from this diary will be used within this study, in addition to the data collected in the semi-structured interviews and focus group, to produce the rich level of data required to fulfil the research objectives.

### **Limitations of Methods Used.**

Although there are numerous advantages associated with the use of semi-structured interviews and focus groups (particularly the ability to obtain rich, qualitative data and to build rapport with the organisation's members of staff) the limitations of each method must be acknowledged within the context of this study.

Firstly, it is difficult to validate the responses which are provided within semi-structured interviews and in this sense a degree of trust is placed in interview candidates providing honest and truthful answers. In addition, the semi structured nature of the interviews makes it difficult to standardise questions, and consequently it is likely that the questions asked will vary from interview to interview. Ultimately this causes problems in terms of the ability to generalise interview responses as interviewees may essentially be answering different questions. There are additional limitations associated with the use of focus groups within qualitative research, particularly as the researcher can have limited control over the interaction between participants and the subsequent ability to keep discussions within the parameters of the research context. Although the researcher attempted to keep conversations focused at all times, there were occasions where candidates appeared to lose concentration or were keen to initiate conversations in areas which were outside the parameters of the study. In addition, participant responses within focus groups do not remain anonymous (as in semi-structured interviews) and it must be acknowledged that certain information may not be shared, perhaps through participant fear of how their views will be perceived by other members of the group.

These limitations are perhaps inevitable and reflect some of the issues present in all business research within an organisational setting. That being said, whilst every effort was made to ensure a consistent approach towards data capture, the associated limitations of each research method must be acknowledged and accepted within the context of the research findings.

## **Methods Used to Record Semi-Structured Interviews and the Focus Group**

It was the intention of the researcher to capture each of the semi-structured interviews and the focus group with a voice recording device. This approach would have carried a number of advantages, particularly as conversations could be played back and transcribed at a later date thus eliminating the possibilities of poor note taking and the recording of inaccurate responses. Unfortunately the voice recorder which was used to record the first semi-structured interview failed to record a large proportion of the conversation between the researcher and the interviewee. As a consequence, the researcher recorded the remaining interviews by hand, jotting down notes throughout the conversations. It must be noted that this method had a number of disadvantages, particularly as note taking can detract the focus of the interview and disturb the development of rapport between the interviewer and the interviewee. In addition, it must be recognised that note taking increases the likelihood of failing to record key information, which would have otherwise been transcribed had the interview been captured on a voice recording device. Finally, the constant jotting down of notes reduced the level of eye contact between the researcher and the interviewee and consequently it must be noted that there may have been occasions where interviewee's responses, facial expressions or body language were not picked up upon or interpreted correctly by the researcher.

A note taker was present to record key information and participant's responses throughout the focus group. This allowed the researcher to initiate an open, free-flowing discussion, and regular eye contact with the focus group members allowed for further interpretations to be made, which were added to the notes immediately after the meeting. Again, it must be noted that it would have been advantageous for the meeting to have been captured with a voice recording device, and although substantial notes were taken throughout the meeting it must be recognised that certain parts of the focus group may have been missed or incorrectly interpreted by the note taker. Consequently, the note taking methods used to record the semi-structured interviews and the

focus group may have led to the passing over of information which would have otherwise added further value to the study's findings.

The diary log / field notes were recorded over a two year period, often retrospectively, to record key events, reflections and interpretations. Whilst the retrospective nature of recording this information can lead to issues regarding reliability, it must be noted that it would not have been practical to record this information on a voice recording device, particularly as many entries with the diary log were based on unplanned, spontaneous meetings with members of staff.

## **Analysis of Data: Phase 2**

With reference to Burnard (1991) the researcher undertook a specific approach to ensure the effective analysis of data throughout the second phase of research. The transcripts produced as a consequence of the semi-structured interviews, focus group and field notes were collected, re-read and notes / memos were made by the researcher in order to develop particular themes or a specific area of interest. This was followed by a process of categorising to group key themes and 'coding' to extract relevant sections of the transcripts. The categories that emerged and the examples of data collected through the research's methods are presented within Chapter's Four and Five.

### **3.7 Access and Ethical Considerations**

In relation to the work of Saunders et al (2009) the role of 'practitioner-researcher' would apply to this particular study. There are a number of implications to understand from the researcher's background as an employee within the case study organisation, which is both advantageous and disadvantageous to the content of data collected. Whilst the situation would imply beneficiary outputs in terms of open access to the organisation and its staff, the researcher was obliged to approach access considerations by discussion with the Director of Nursing. In order to maintain access and

necessary approval to carry out each stage, the aspects of data collection were presented to the Director of Nursing and informed consent was granted to publish responses within the context of this research. In addition, the researcher's position may be viewed as advantageous in terms of the extensive knowledge and understanding of the organisation which had been gained through previous daily activities. This is beneficial in being able to understand the operations and the context of the organisation. However, as Saunders et al (2009) argue, this knowledge may also carry a number of dangers, particularly in relation to the inaccuracies of assumptions held and the 'ignorance' of failing to ask basic questions about the organisation. In addition, the implications of critiquing the actions and strategies of senior management and other staff may inhibit interaction and the asking of critical questions, in fear of the detrimental effect that this may have on career progression. It is necessary to acknowledge the potential problems of the practitioner-researcher role, which is ultimately diagnosed as a limitation of the study (Chapter Six). However, the positive aspects are envisaged to be advantageous in terms of being able to provide rich, qualitative data, necessary to successfully tackle the research aims and objectives.

In the granting of access, the researcher is obliged to ensure that privacy and confidentiality of all participant information is maintained. As a consequence, all interview transcripts will be anonymised and the identity of participants will be protected at all times. This not only removes the identity of the organisation to the potential criticisms of current practices, but it is also hoped that this will enable the candidates chosen to share truthful and vivid accounts of particular issues, in the knowledge that their information will be treated in a sensitive manner.

It must also be acknowledged that the researcher additionally gained approval from the Ethics Committee within the University of Huddersfield Business School (HUBS) to carry out the research.

## **CHAPTER FOUR**

### **FINDINGS**

#### **4.1 Phase 1 - Content Analysis of Trust A's Nursing Documentation**

In order to fulfil the requirements of the research's first objective, a document analysis was carried out to identify the standard of nursing documents in circulation within Trust A. The researcher visited each ward within the case study setting, collecting 161 different nursing documents intended for the purposes of recording and planning patient care. In addition, a meeting was arranged with two senior managers to provide a suitable platform for the comparison of current nursing documentation standards against managerial expectation. Acceptance criteria were identified during this meeting in order to determine the perceived constitution of a 'quality nursing document'. Three key themes were identified which are portrayed within **Appendix E**.

Each of the 161 documents was subjected to the seven closed questions identified within the methodology. **Appendix F** illustrates the approach developed by the researcher in relation to the proportioning of 'Yes', 'No' or 'N/A' responses as a means to identifying current nursing documentation practices within Trust A. Key findings in relation to 'document identity and appearance', 'up-to-date content and version control' 'duplication' and 'unique reference numbers' are detailed below.

##### **Document Identity & Appearance**

- 71% of the 161 documents had some form of corporate identification i.e. a visible recognition that they belonged to, and were written by, Trust A.

Whilst approximately three-quarters of the documents were recognisable as 'belonging' to Trust A, only 50% of these contained the organisation's official

logo. Some documents incorporated an older logo, suggesting that they were created prior to the rewarding of 'Foundation Trust' status in 2002.

The physical appearance of the documents varied. Over 90% were word processed, incorporating variances in text style, size and the use of colour. The remaining documents were written by hand, and subsequently reproduced through photocopying. It was clear that the majority of documents collected had been photocopied at some stage. These were largely of good quality, but there were examples of documents which were clearly copied from copies, resulting in 'grainy' text and/or images as a result. A handful of documents were illegible, and there was one example where two separate documents had been spliced into one through a photocopying error. The 'ad-hoc' nature of document presentation sparked suspicions that there were no predefined standards in place for the development of nursing documentation within Trust A. However, the most striking observation was the fact that all the collected examples were intended for use on the wards as a mechanism for recording patient care, regardless of poor appearance or even illegible content. It would be fair to say that many of the documents collected failed to meet **Appendix E's** criteria for 'professional' appearance, which in turn is likely to give a negative impression of the organisation when viewed by outsiders.

### **Up-to-Date Content and Version Control**

- 66% of the 161 documents collected had a recorded date of creation
- 11% of the documents that had a recorded date were over five years old

Without a recorded date of creation, it is difficult to determine whether the information contained within a document is appropriate and refers to current practice. A significant proportion of the documents collected were over five



years old; the oldest example collected was created in September 1995. On further investigation it was found that this document was obsolete, its outdated content had since been superseded by three additional documents over time. Again, this document was collected directly from a ward, with the intention for use to plan and record patient care. Subsequently, this threatens to fall short of the expectations to provide the best possible level of care to patients, and places Trust A at significant risk every time it is utilised on the wards. Four additional examples were noted which portrayed evidence of poor version control. In particular, five different versions of one document were collected, which questioned the organisation's ability to recall outdated information and promote the relevant versions of nursing documentation for use on the wards.

### **Duplication**

- 34% of the 161 documents collected were 'Activity of Daily Living' based.

A large proportion of the documents collected conflicted with the content of other documentation already in place. Duplications were most common in the area of planning care in relation to patient ability to perform basic activities of daily living i.e. personal hygiene, dressing / undressing, feeding and elimination. Further duplications were acknowledged throughout this phase of research and are recorded within Table 4.

**Duplications**

- 3 x Oral Care Plans
- 4 x Elimination Care Plans
- 6 x Nutrition
- 3 x Sleeping Care Plans
- 3 x Pain Care Plans
- 4 x Mobility Care Plans
- 3 x Hygiene Care Plans
- 7 x Pressure Ulcer documents
- 3 x Patient Moving and Handling Documents
- 5 x Patient Admission Documents
- 3 x Fluid Balance Charts

**Table 4 – Examples of Duplicated Documents in Use within Trust A.**

It must be noted that, in some instances, it appeared that attempts had been made to standardise some of the documents in use within Trust A. For example, one of the 'Pressure Ulcer' documents mentioned in Table 4 clearly marked the author as the organisation's 'Tissue Viability Team'. This document was picked up from over twenty separate locations, indicating that it was intended for use as a standardised, 'Trust-wide' document. However, the data collected throughout this research suggests that there is evidence of non-compliance in relation to the standardisation of certain documentation. Six wards within Trust A had developed their own documentation in relation to 'Pressure Ulcer Management'. Their motives for doing so are diagnosed within the second phase of this study, however, at this initial stage, the ability for staff to bypass standardised content and information, and develop their own documentation for use is of great concern, particularly if content is incorrect or unfit for purpose. The findings therefore indicate that a number of the documents collected do not meet the acceptance criteria detailed within **Appendix E** (Section 3).

## Unique Reference Numbers

- 60% of the 161 documents collected were not assigned with a unique reference number.

A number of different referencing systems were identified; many incorporated sequences of numbers and letters, whilst others simply referred to the document's name or the author. The lack of a universal referencing system is likely to be problematic for the organisation, particularly for senior management, who are likely to encounter difficulties in being able to effectively monitor and manage the documentation that is in use at any given time. The lack of reference numbers also suggest that there is no formal consultation process for the approval or ratification of nursing documents, and consequently, this perhaps justifies the many cases of duplicated or obsolete documents in operation throughout the Trust.

### **4.1.1 Phase 1 - Summary of Findings**

This first phase of research has sought to add to current literature through the promotion of a model to assess the standard of nursing documents in use within a health care organisation. With reference to the first objective of the research, several areas of concern have been diagnosed, ranging from unprofessional appearance and layout, to the risks associated with the continued use of obsolete and duplicated documentation. The data collected provides strong evidence that current nursing documents do not match the expectations of senior management, as identified within **Appendix E**. The evidence of a lack of document control procedures within Trust A is also of concern, and, in an attempt to gain a greater insight, the quantitative data forming this section of the study is to be taken forward into the research's second phase, where in-depth data collection techniques will be used to further explore nursing documentation practice within the case study organisation.

## **4.2 Phase 2 – Further Exploration of Trust A's Nursing Documentation Practice**

### **4.2.1 Semi – Structured Interviews**

Interviews were arranged with each of the eleven departments and wards identified within the methodology. The semi-structured nature of the interviews enabled the researcher to design questions in relation to the candidate's response. Three key findings emerged from the interviewing process, relating to document accessibility, approval systems and assumptions made towards nursing competence and the understanding of assessments contained within nursing documents.

#### **The Accessibility of Nursing Documents**

Data collected within the first phase of the study provided strong evidence of poorly photocopied documentation within Trust A. Question three of the interview schedule (**Appendix D**) was consequently devised to gain a greater understanding of how nursing documents are accessed, in addition to identifying how stock levels are maintained on the wards in which they are used.

There were some positive indications that members of the organisation were making every effort to ensure that nursing documents were easily accessible to all members of staff. The below extracts strike a particular emphasis with conclusions previously detailed within Chapter Two in relation to the importance of nursing documentation (Teytelman, 2002; NMC Guidance, 2010) and the subsequent necessity to ensure that key documents are widely accessible across the organisation:

*“All Infection Control based nursing documentation is available on our Trust intranet page. This makes the documents accessible to all and we advise all members of staff to print directly from this source.”*  
(Interview 2).

*“We’ve stated that our documentation must be printed on yellow paper. We appreciate that this is difficult for the wards, so these documents are sent to the stationery department for external printing. Documents are stored within the ‘stationery store’ and then distributed to the wards that use them.” (Interview 7).*

The data collected would indicate that these are isolated cases, however. Only one of the remaining specialist department nurses interviewed confirmed that their documentation was available to view on the company intranet, and it must be noted that the interviewee did concede that it was “unlikely” that all members of staff were aware that this facility was available to them. A visit was arranged to the internal ‘stationery store’, as identified within Interview 7. Whilst the store contained some of the 161 documents collected within the first phase of this research, the large quantities of unopened boxes and accumulation of dust suggested that wards were not fully utilising this source to maintain a continuous supply of nursing documentation. This was reflected through the comments received throughout the interview process. One particular interviewee emphasises the problems of a lack of standardised approaches, echoed in Chapter Two by Cheevakasemsook et al (2006), through seemingly passing on responsibilities of nursing document accessibility to other users, personified in the below instance by a ward clerk:

*“We don’t send the documents we create to the printers (stationery department). Maintaining stock is the duty of the wards. I presume that the ward clerk will photocopy them and store them on shelves somewhere on the ward.” (Interview 1).*

The presence of Ward Clerks in interviews 8, 9, 10 and 11 provided an opportunity to gain some clarity over the above assumption of photocopying practice. The data relates strongly to other information gained throughout the interview process, identifying two distinct approaches to maintain constant supplies of nursing documentation. Firstly, wards are able to order directly from the Stationery Department. These were usually frequently used documents, or documents that are printed on coloured paper. Secondly, it is

common practice within Trust A to photocopy documents once supplies are running low. In some instances the Ward Clerk may develop a 'master copy' of each document, which will then be used as a template for the purposes of replication.

The process of maintaining a constant supply of nursing documentation was viewed upon negatively. For example, interviewees remarked:

*"There's no point involving the stationery department. It takes over a month for them to get supplies to us. What use is that to me when I usually need new paperwork instantly?" (Interview 10)*

*"I spend half my time at that bloody photocopying machine, turning the pages over and over. Some of these documents are thirty pages long. It can take me an hour to do three copies." (Interview 9)*

*"I've had these 'master copies' for a couple of years now. There are probably newer versions out there somewhere, but this is what we use on this ward." (Interview 11).*

The data therefore diagnoses issues relating to accessibility. The practice of photocopying and the perceived lack of urgency to update 'master documents' to maintain up-to-date content not only relates to the assumption that nursing documentation is "*devalued as an unimportant task*" (Cheevakasemsook et al. 2006, page 368), but, also offers an explanation as to why Trust A have documents in circulation which are poorly presented and/or obsolete.

### **A Lack of Formal Approval Systems**

The findings diagnose key differences in approval systems and the ratification of nursing documents for use within Trust A. Nurses from specialist departments generally discussed pressures to ensure that documentation met strict external requirements, but were unable to identify any internal policy to approve the content and/or appearance of any documentation produced. In

accordance with conclusions detailed within Chapter Two (Cheevakasemsook et al, 2006) it was suggested throughout the interview process that Trust A needed to establish and define a standardised approach to approve documents for adequacy prior to use.

*“We’ve created documents which are intended for use across the Trust. These have been through a number of external bodies to ensure that content matches current practice. We’ve had real difficulties in spreading these across the Trust. There is just nothing in place to enforce compliance.” (Interview 1)*

*“Some wards have developed their own paperwork, and use this instead of the documentation that we’ve produced. Some of these documents do not reflect current standards or practice.” (Interview 6)*

*“We’ve visited wards and taken all duplicated materials from them. The Ward Clerks must have a master copy somewhere. As soon as our backs are turned they photocopy some more and fill their shelves back up.” (Interview 6)*

*“A nurse can sit down with a blank piece of paper and pen, write down some content, send to the photocopier and obtain 250 copies. That then becomes a nursing document.” (Interview 4)*

The Staff Nurses and Ward Clerks interviewed confirmed that, on occasion, they had created their own documentation to suit specific needs. The reasons for doing so ranged from a document’s inability to capture specific information, to general negativity over document appearance and presentation of information. When questioned, all interviewees confirmed that there were no controls in place to approve nursing documents prior to use. In relation to the literature, the findings strike a particular emphasis with Lipsky’s (1980) ‘street-level bureaucracy’ theory, through which the lower level workers are able to “exercise discretionary judgement” (Lipsky, 1980, page 14) in regards to

which documents are chosen to plan and record patient care, in addition to procedures for accessibility and document replication.

### **Assumptions Made Towards Nurse Competence**

The interview process found evidence of clear divides in opinion between specialist nurses responsible for authoring certain documents, and the ward staff regularly using them to plan and record patient care. In particular, there is evidence of confusion in relation to nursing documentation and staff education. The following extracts are typical of the opinions voiced by Staff Nurses in interviews 8, 9, 10 and 11 and typify assumptions previously made regarding skill gaps and cases of nursing inability to complete documentation effectively (Webb and Pontin, 1997).

*“Sometimes new documentation is simply pushed onto us, without any prior warning. I have often looked at documents and been unsure what it is really asking of me. Sometimes documents are too complicated and I haven’t understood the wording.” (Interview 8)*

*“The documentation expects me to understand and carry out certain procedures. I have to be honest and say that this is not always the case. I often refer the patient to the specialist nurse when I’m unsure.” (Interview 9)*

A number of specialist nurses seemed to relate to the educational concerns detailed by Webb and Pontin (1997), through questioning the current competence of the nursing workforce within Trust A, remarking that, in some instances, *“underdeveloped assessment skills”* were responsible for a failure to complete documentation correctly. One interviewee voiced clear frustrations in relation to the amount of referred cases to her department, and linked this to a gap in nurse knowledge and understanding. However, the data collected throughout the interview process strongly suggests that authors of nursing documents do not view staff education as part of their role. Indeed, responses to question 5 of the interview schedule confirmed that there were



no known processes in place to verify whether current nursing ability matched the requirements to successfully carry out assessments detailed within the documentation. One specialist nurse remarked:

*“They (nurses) are professionals. They ought to have the clinical skills to carry out the assessments detailed within the documentation”.*

**(Interview 1)**

In view of the data collected as part of this study, there is evidence that assumptions made towards nursing competence are ill judged, and that consequently, further education initiatives may be required to ensure that nurses are able to carry out the assessments detailed within nursing documentation. Although this strongly relates to the work of Webb and Pontin (1997) and Cheevakasemsook (2006), particularly in regards to the establishment of educational issues in other healthcare institutions, this research additionally indicates a missing link in the process of document development to successful implementation, with nurses stressing a regular lack of uncertainty in relation to the information they are required to record.

#### **4.2.2 Focus Group**

Fifteen participants attended the focus group from an initially invited twenty. Each participant was reminded of the purpose of the focus group and of the questions identified within the methodology. Key findings / responses within the areas of ‘time constraints’, ‘staff perspective’, ‘education’ and ‘changes to current practice’ are identified below.

##### **Time Constraints**

Participants unanimously agreed that nurses are often very busy, and subsequently blamed time constraints for a failure to record patient care. Participants also spoke in length about how the situation has deteriorated in recent years:

*“I can assure you that my staff are carrying out adequate care. However, there is not always time to record it”.*

*“It can take two hours a day to fill in just one patient’s documentation”.*

*“Nursing resources are being continually stretched. Documentation is a time intensive activity. It’s a constant battle trying to find time to record necessary information”.*

The perception that ‘nurses are very busy’ appears to be universally recognised throughout the organisation and very much accepted as the norm. Apportioning poor documentation practice to time constraints mirror the findings of other studies detailed within Chapter Two, most notably; Duffield et al (2008), Owen (2005) and Cheevakasemsook et al (2006). However, it must be noted that the researcher was subjected to a number of situations over the two year period of research within Trust A which exposed a degree of empathy to this view. An afternoon spent with a senior nurse on one of the wards revealed the extent of the tasks that a nurse must undertake in his/her daily activity. The five common nursing tasks identified within Chapter Two (Cheevakasemsook et al, 2006) were witnessed, but the author fails to take into account the amount of interruptions that are detrimental to the ability to carry out these activities. In one instance the researcher recorded that a nurse walking from one end of the ward to the other was interrupted nine times by doctors, patients and/or carers requesting information or assistance. At the end of the shift, three or four nurses were seen to be frantically filling in patient documentation in the staff room. Some remained an hour after their shift to ensure completion, implying that there are occasions when nursing time is stretched.

The nature of focus group responses implies that the standard of written entry will improve when a nurse has more time at their disposal. The researcher tested this assumption, comparing the standard of written entry on one of the wards on two separate occasions (once when the ward was operating at full capacity, and once when this capacity had been halved). Findings did not

show any signs of improvement, with areas of document non-completion remaining relatively constant. This challenges the arguments made by members of the organisation and indeed with the findings of the literature (Duffield et al 2008; Owen, 2005; Cheevakasemsook et al 2006). Although issues of time constraints are acknowledged, there is evidence which suggests that it is not always to blame for poor or non completed documentation.

### **Staff Perspectives**

Participant's experiences and general negativity towards nursing documentation closely match previous findings detailed within the literature. In a similar light to the work of Duffield et al (2008) and Allen (1998), the general consensus was that documentation was viewed as a burden and should not be a prioritised activity for nurses:

*“Writing everything down is time consuming and tediously repetitive”*

*“At the end of the day its just paperwork. Paperwork is viewed as a chore in all professions, isn't it?”*

*“Constantly writing down information prevents the nurse from looking after her patients. The priority has to be patient care.”*

In accordance with the literature (Cheevakasemsook et al 2006 and Owen, 2005), Ward Managers seemed, at times, to devalue nursing documentation as an important activity, expressing throughout the focus group that the poor standard of entry within nursing documents was not a reflection of the “*excellent*” standard of care that patients regularly receive. The argument therefore implies that a satisfactory level of care can co-exist alongside poor documentation practice, which in turn, contradicts NMC guidance (2010) stating that nursing documentation “*is not an optional extra to be filled in if circumstances allow*” (NMC, 2010, page 1).

## Education

Ward Managers were quick to dismiss the opinions of underdeveloped nursing assessment skills that were implied by some candidates taking part within the interview process of this research. Time constraint issues were revisited, but participants also seemed unanimous in apportioning blame to the standard and format of current nursing documentation rather than the decision making of the nurse.

*“This suggestion is nonsense [gaps in nurse competence]. The problem lies with the documentation itself. It isn’t fit for purpose”*

*“We do not have the right tools to record and plan patient care”.*

*“There is too much documentation and not enough time to fill it all in. There are no issues with staff education.”*

The data collected throughout the first phase of this study provided strong evidence that some of the organisation’s nursing documentation was not fit for purpose, and in this sense there is certainly an acknowledgement towards the criticism of poor appearance and format mentioned within the focus group. In relation to the literature the responses may be related to ‘the coping cycle of change’, (**Appendix B**) through which the first two stages of ‘denial’ and ‘defence’ are apparent in the caution displayed by participants, particularly in the exploration of an approach which radically differs from present ways of thinking. However, in an attempt to study the perceived gaps in nursing competence further, participants of the focus group kindly agreed to ask their nursing staff a number of questions in relation to the information contained within the table overleaf and to report back to the researcher with their findings.

Fall Assessment:			
<b>Gait:</b>	<b>Steady</b>	<b>= 0</b>	<b>Score:</b>
	<b>Hesitant</b>	<b>= 1</b>	
	<b>Unsteady</b>	<b>= 3</b>	

**Table 5: ‘Assessment Criteria Taken from One of Trust A’s Nursing Documents’**

Table 5 illustrates a small proportion of Trust A’s document for assessing and planning care for patients vulnerable to falls. Within this assessment, nurses are expected to numerically score a patient based on their ‘gait’. Based on further assessments an overall score is calculated which determines how susceptible a patient is to a fall on the ward. In order to determine understanding and interpretation of the information detailed within Table 5, participants of the focus group were informed to ask the following questions to nurses on their ward:

1. What is meant by the term ‘gait’?
2. How would you determine a patient who is ‘steady’?
3. How would you determine a patient who is ‘hesitant’?
4. How would you determine a patient who is ‘unsteady’?

Nursing interpretation and understanding of the information detailed within Table 5 seemed to mirror the education concerns detailed throughout the literature (Webb and Pontin, 1997) and within the responses of participants in the interview process of this research. Ward Managers widely concluded that there was general confusion over the subjective nature of the wording and of

the requirements of the particular nursing assessment. One Ward Manager acknowledged that the variety of response received was unexpected, remarking that:

*“I was surprised that most members of staff were unaware of the meaning of the word ‘gait’. I asked five nurses to tell me the difference between ‘steady’, ‘hesitant’ and ‘unsteady’, and subsequently received five very different answers in return.” (Field Notes)*

Further evidence was collected within a nursing document which was intended for use in circumstances of patient malnutrition, which informed the nurse to “*ensure that adequate fluids are given*” to the patient. The researcher regarded this as a very loose statement, which led to the initial asking of the question, ‘what does adequate mean?’ Further investigation with a specialist nurse led to an understanding that the required fluid intake for each patient varied and was dependent on medical condition, weight and sex. In order to test nurse understanding of this the researcher visited two wards, identifying three patients from each. Nurses were asked to determine ‘adequate’ fluid intake for each patient, which seemed to result in confusion and a general acknowledgement of uncertainty as to how adequate fluids should be calculated for each patient. The researcher repeated the process with assessments contained within further documents, randomly selecting nurses to provide an interpretation of overall meaning or the actions which would be required to satisfy the assessment process. The variety of response and, at times, uncertainty, amongst the nurses who were questioned diagnosed potential educational issues with the organisation.

It must be noted, however, that the data collected must be interpreted carefully. The researcher was left with an overall impression that the nursing staff were hard-working, dedicated and a credit to themselves and the case study organisation. No criticism is intended in their ability to successfully carry out their daily roles. Instead, the study points towards evidence that there is a lack of education and understanding of assessments detailed within nursing documentation. The lack of standard definitions for ‘steady’, ‘hesitant’ and

'unsteady' patients, for instance, is likely to result in differing nursing interpretations, leading to inconsistent recording as a consequence. Essentially, the ill judged assumptions of nursing competence made within the organisation's nursing documents is re-visited, and is consequently identified as a key area for improvement within the final section of this chapter.

## **Changing Current Practice**

Two key themes emerged from focus group discussions regarding desired changes to nursing documentation practice. Firstly, the focus group were critical of duplicated nursing documents in circulation. Participants expressed resentment over 'unnecessary' paperwork and repetition of information.

*"Patients transfer from ward to ward. Each of these wards has different paperwork. Most of the time we are filling in the same information on different pieces of paper. This not only wastes the time of nurses but is also very frustrating for patients, who are often asked the same questions over and over again."*

*"Some departments do need separate paperwork, but most of the documents in use could be standardised. It would be a real improvement if the Trust could produce standardised admission and A.D.L [Activities of Daily Living] documentation, for instance."*

Secondly, participants were critical of the 'tick-box' format incorporated into some of the nursing documents. They argued that these were leading to a 'de-skilling' of the nursing workforce and an inability to 'capture the patient's story.' The following extracts are typical of the Ward Manager's views:

*"Tick boxes were designed to reduce the time necessary to complete documentation. I hate them. Nurses will go down a long list of assessments, quickly ticking and signing that they've been done. Sometimes they just tick boxes for the sake of completing the form, and don't give much thought to the care that they've given."*

*“Tick boxes tell us nothing about the patient. A page full of ‘ticks’ does not inform me of any complications or any evidence based information to make future decisions or assessments.”*

Whilst participants were keen to see developments in nursing documentation practice, the work required to enable change appeared to be overwhelming. In particular accordance with the work of Alexis (2005) the responses clearly mark the perceived difficulties in managing change within the NHS. Although the difficulties of managing and implementing change within a health care setting are addressed in greater detail in Chapter Five, participants of the focus group suggested that nursing documentation problems within Trust A were so complex that the current situation was almost beyond repair.

*“I wouldn’t know where to begin [making improvements]. The situation has got completely out of hand.”*

*“Making these changes would be a massive piece of work. I’m neither brave enough nor have the time available to take on board such a challenge.”*

#### **4.3 Discussion of Findings and the Creation of an Improvement Model**

The data establishes some similarities with previous findings detailed within the literature review, perhaps most notably in issues relating to time constraints (Owen, 2005; Duffield et al 2008) and poor staff perceptions towards nursing documentation (Allen, 1998; Cheevakasemsook et al, 2006). However, there are two key findings which must be acknowledged and recognised as areas requiring significant improvement. Firstly, phase 1 of the study found evidence of poor document appearance, insufficient management and duplications, which subsequently failed to meet managerial expectations detailed within **Appendix E**. Further analysis found evidence of a lack of formal approval processes, accessibility issues and poor photo-copying practices, which, collectively, are diagnosed as areas requiring improvement.



Secondly, the findings diagnose educational concerns, particularly in relation to nurses failing to understand or carry out the assessments contained within some of the current nursing documents. Additional risks associated with tick boxes and a failure to 'capture the patient's story' illustrates a requirement to re-design some of Trust A's nursing documentation, in addition to the development of educational materials designed to aid a nurse through document completion.

In order to fulfil the third objective of the research, the following information is put forward as an improvement model, through which two specific 'strands' of work are identified in order for Trust A to improve nursing documentation practice and reduce areas of risk which have been diagnosed throughout this chapter.

### **Strand 1 – Creating New Systems of Document Control and Management**

- Creation of a standard document template to ensure a professional appearance of Trust A's nursing documents.
- Development of new policy and procedure including the creation of a staff committee responsible for approving the appearance and content of documentation prior to use.
- Creation of a central electronic document repository and universal reference system to easily locate all of Trust A's nursing documentation. This is to become the only mechanism for obtaining approved documentation and will have the ability to archive older documents, and help promote up-to-date and appropriate content to the wards.
- All documents are to be printed directly from the repository or via the Trust's stationery department to avoid implications associated with poor photo-copying practice.

## **Strand 2 – Document Development and Education / Training**

- Re-development of current nursing documents to 'better capture the patient story' and drive nursing assessment processes, rather than current retrospective recording activities.
- Development of electronic education materials to support nursing assessment and ability to complete documentation to the required standard.

### **4.4 KTP Involvement**

As was seen within Chapter One, this study aims to capture the events of a two year 'KTP' project undertaken by the researcher within Trust A. After a period of discussion with Trust A's senior management, the improvement model detailed within this chapter was approved, and the researcher was subsequently assigned as 'Project Manager', responsible for ensuring the successful creation and delivery of new products and policy in relation to nursing documentation practice. Responsibilities for implementation were assigned to Trust A's Nursing Directors, who, due to the perceived severity of the situation, identified a desire to create steps to move from one fixed state to another, in a 'one-off isolated event.' Although this approach towards change is criticised in light of the findings detailed within Chapter Five, in the first instance this marks a clear symmetry with Lewin's 'Three Step Model', through which a top-down approach to destabilising old behaviours and adapting to change is envisaged.

#### **4.4.1 Overseeing the Development of New Nursing Documentation Policy / Procedures within Trust A**

**Appendix G** portrays three key strands of work which were required to develop the products identified within the research's improvement model, namely; '*Document Minimum Standards*', '*Document Repository Development*' and '*Document Re-Development and Training Materials*.'

Team Managers were assigned leading roles within each of the identified sub-groups and an overarching 'Nursing Documentation Steering Group' was created to oversee progress and manage the inter-dependencies between all aspects of the project. Terms of reference were created and agreed within each of the sub-groups identified within **Appendix G**, defining overall deliverables, work breakdown structures and schedules for completion. Work undertaken within each of the three sub groups are detailed below:

### **Sub Group 1 – Document Minimum Standards**

The appearance of some of Trust A's nursing documents (as detailed within Phase 1 of this chapter) portrayed a requirement to produce a template to standardise document presentation. In addition, the acceptance criteria previously detailed within **Appendix E**, heightened the importance of incorporating fields such as trust logos, reference numbers, author names and review dates to allow the organisation to better manage and monitor the nursing documents in use at any given time.

The researcher liaised with nursing staff, senior management and the organisation's internal 'Medical Records Team', to gain a greater understanding of the specification for the final product. It was noticeable from the outset that each user represented a differing interest, each of whom expressed specific needs and requirements. The Medical Records team, for instance, expressed a requirement for margins to be large enough to incorporate hole punching, and the addition of a 'patient label box' on each page to record patient information. The researcher attended many meetings with nurses on various wards to discuss document template requirements; most of whom stressed the importance of maximising the space available to record information to assess and plan patient care. In comparison, and as previously expressed, management required the incorporation of mechanisms to better manage and control nursing documents in use, such as establishing a unique referencing system, review dates and version numbers.

Taking into account the specification, a number of document templates were created and sent out to users for feedback. The finalised template is portrayed within **Appendix J**, and incorporates the following fields to match user requirements and allow senior management to better monitor and manage the nursing documents in use throughout the organisation:

- Document Title
- Unique Reference Number (detailing date of creation)
- Trust Logo
- Author Name
- Review Date
- Version Number
- Patient Label Box
- Main Text Font - 'Arial'
- Main Text Font Size – 11pt
- Margin: 2.1cm to allow sufficient space for hole-punching

Furthermore, the researcher worked alongside key individuals within the organisation's 'Risk Management Team' to develop formal processes for the approval and ratification of nursing documents within Trust A. These processes are portrayed within the flowchart in **Appendix K**, which presents a number of sequential steps for the creation of nursing documents, beginning with the initial requirement and document development through to ratification and the determination of monitoring / compliance processes. A policy document was drafted, establishing new processes and procedures in terms of document accessibility and approval prior to use. The draft was approved and handed over to senior management for implementation across the organisation.

### **Sub Group 2 – Document Repository Development**

The communication of the proposed electronic document management system as the only mechanism for accessing Trust A's nursing documents was initially met with a degree of uncertainty amongst some of the nursing

workforce. These are discussed in much greater detail in Chapter Five, however, in the first instance, the perceived complication of introducing an I.T based solution heightened the importance of determining and managing user requirements. Consequently, the researcher held a number of meetings with stakeholders, whose requirements are illustrated within the table below.

<p>The document repository system should:</p> <ol style="list-style-type: none"> <li>1. Have a simple interface design and be easy on the eye.</li> <li>2. Be easily integrated within the Trust's intranet page.</li> <li>3. Store large numbers of documents in either Microsoft Word or pdf format.</li> <li>4. Display the following information for each document uploaded: <ul style="list-style-type: none"> <li>- Document Title</li> <li>- Unique Reference Number</li> <li>- Author Name</li> <li>- Date of Creation</li> <li>- Review Date</li> <li>- Version Number</li> </ul> </li> <li>5. Automatically archive old material</li> <li>6. Send email alerts to administrators and document authors two months prior to a document's review date to allow sufficient time for any document amendments to be carried out.</li> </ol>
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**Table 6 – ‘User Requirements for Document Repository System’**

The requirements illustrated within Table 6 were presented to a software developer within the organisation's internal I.T Department, and a work package was agreed for completion. Developments ran smoothly, taking approximately two months to complete to specification. On completion, the repository was populated with newly approved nursing documents and handed over to senior management for implementation. A user guide was created by the researcher to provide staff with key information and printers were purchased for each clinical area, for the purposes of maintaining a constant supply of approved nursing documents and the eradication of previous photocopying practice. Regular liaison with the organisation's

stationery department resulted in an agreement for commonly used nursing documents to be externally printed. Large quantities of particular documents were stored on both sites, with staff able to access new material on implementation of the project's products.

### **Sub Group 3 – Document Redevelopment and Training Materials**

Within the context of the KTP, senior management identified six priority areas for document redevelopment and creation of new training materials. The researcher targeted specialist nurses within each of these areas to establish membership of the third sub-group and fortnightly meetings were scheduled to discuss the group's progress. Managing activity within this sub-group proved to be a real challenge, which was initially heightened by a general lack of understanding of what was required, with certain members, at times, failing to conceptualise the approach. Such confusion led to substantial non-attendance at the arranged meetings, with general feelings of negativity and a perceived lack of motivation to complete work packages. One specialist nurse reflected upon the difficulties of implementing change within the NHS, again marking clear symmetries with the work of Alexis (2005), detailed within Chapter Two:

*"It's not as if we've never thought about developing standardised documentation before. I've been trying without success for the last ten years. You'll really struggle to ensure staff compliance."* **(Field Notes).**

An initial lack of tangible output from the group led to the adoption of a 'hands on' approach, through which the researcher had a large involvement in the development of one of the nursing documents. The development of the document proved to be an experimental process, incorporating much trial and error and rigorous piloting to gain feedback from various wards across the organisation. The document was structured in a manner which differed from nursing documents previously collected, through which four key segments emerged to better capture the 'patient's story':

1. An initial nursing assessment
2. Ongoing assessments to be carried out as dictated by patient condition.
3. Plan of patient care
4. Implementation – i.e. actions undertaken to carry out the plan.

Continual improvements were made to the document, in a similar fashion to Deming's 'Plan, Do, Check, Act' model, as cited in Chapter Two. The document was subsequently finalised and signed off by senior management. The completion of this piece of work allowed members of the sub-group to better conceptualise the overall approach and the work required, and subsequently, the remaining documents were all developed within the same format. Once completed, the researcher liaised with each of the specialist nurses, dissecting content to produce a list of information to take forward to successfully produce training materials. Throughout the process the researcher would ask questions in relation to the completed documents, to the extent of or similar to: *"What do you mean by this?" "When would it be appropriate to carry out this action?" "How would this assessment be calculated?"* The responses were recorded and electronic materials were drafted, educating nurses in regards to how to successfully complete and carry out the assessments contained within the documentation. The materials were tested on numerous wards over a three week period, and after making necessary amendments seemed to be overwhelmingly well-received. Once finalised, all of the re-developed documents and training materials were handed over to senior management for final sign off and implementation.

#### **4.4.2 Summary of KTP Involvement**

In some ways the development of the recommendations made as part of this study were untimely, particularly in relation to a poor economic climate and consequent re-structuring of operations within Trust A. A significant number of staff redundancies placed extra workloads on nurses, and, as such, the development and piloting of new nursing documents was rarely viewed as a priority activity. The additional strain that this placed on senior management

led to a visible lack of interest and involvement within the project, and consequently, delivering the project on time and to specification proved most challenging, overwhelming and, at times, frustrating.

At the time of writing, however, it is clear that the work undertaken as part of this research has had a number of positive effects on the case study organisation. Although staff initially held high levels of uncertainty and, at times, resistance, an eventual conceptualisation of the approach led to increased levels of engagement and a desire to address documentation issues in ways they were not prior to the research project. On a quantitative basis the development of recommendations made earlier in this chapter have led to the creation of new systems of document control and management which did not previously exist. This not only reduces associated levels of risk for the organisation by removing duplicated and outdated content, but also has the potential to improve nursing assessments, reduce patient complaints and length of hospital stay. Although it is impossible to calculate and measure accurate benefit realisation at the time of writing, the work undertaken as part of this research has enabled the embedment of a methodology within the case study organisation, through which it is envisaged that further areas will be identified for nursing document re-development and training material creation. Although the products developed as part of this research are yet to be fully implemented, senior management are encouraged to reflect upon the recommendations illustrated within Chapter Six to ensure a smooth transition of change across the organisation.



## **CHAPTER FIVE**

### **BARRIERS TO CHANGE**

The previous chapter diagnosed several areas for concern in relation to nursing documentation practice within Trust A. Whilst an improvement model was created and developed within the context of the 'KTP Involvement', further investigation is required to determine the organisation's compatibility with the proposed changes. This chapter subsequently seeks to fulfil the fourth and final objective of the research, through the identification of organisational and cultural barriers to change within the case study organisation.

#### **5.1 Motivational Issues and Resistance to Change**

As seen within Chapter Four, it would be fair to state that the risks associated with current nursing documentation practice were of particular concern for senior management, which, in turn, acted as a key motivational force for change. Such motivation for change, however, appeared to be lacking in other areas of the organisation. In the first instance, the researcher perceived a level of resistance from some of the nurses operating on the wards. Some members of staff were unwelcoming and seemed reluctant to provide examples of the nursing documents they used, often asking questions with words to the effect of, "*what do you want our documents for?*" The reasons behind the perceived resistance are unclear, but perhaps the non-nursing background of the researcher can be regarded as a hindrance. In this sense nurses may have perceived the researcher as an 'outsider', with little right to meddle in nursing affairs. Many individuals appeared to be threatened by talks of change. In particular, one nurse abruptly remarked:

*"There's no chance of you removing our documentation [from practice]. We've only just finished sorting it all out."* **(Staff Nurse; Field Notes)**

Whilst working relationships and the building of trust between the researcher and nursing staff improved over time to dramatically reduce the initial levels of resistance portrayed within the above quotation, there are still a number of underlying problems to be taken forward and considered within the implementation of new procedures for nursing document control and management. Many wards appeared to be threatened by the prospect of the removal of some of Trust A's nursing documentation, seemingly denying the requirement for improvements to be made. The strong belief that nursing documentation is an important aspect of patient care (Teytelan, 2002; NMC, 2010; Allen, 1998) is not evident within the findings of this research, through which large numbers of Trust A's nursing workforce seemed to argue that poor nursing documentation practice has no bearing on the standard of care received by patients. The researcher challenged this argument on the basis that patient safety could be breached if good quality care was delivered but not recorded. For instance, a failure to record a drug that had been administered might lead to the drug being given again. The argument was often acknowledged but dismissed as being unrealistic on the grounds that it had never happened on that unit before. Consequently it can be concluded that there are disagreements regarding the need for change within the organisation, with some nurses putting forward the argument that good nursing care can co-exist alongside poor documentation practice.

There were other instances where nurses defended current practice, portraying uncertainties over the ability to adapt to change. On initial communication of the improvement model detailed within Chapter Four, one particular member of staff remarked that they were not confident in regularly using computers systems, defending the photo-copying practices which were previously subject to heavy criticism. The following represent the views of some of the nursing workforce within Trust A:

*"You won't find any poorly presented documentation on my ward. There's no need for change on this unit."* **(Ward Clerk; Field Notes)**

*“You’ll never get that to work [electronic document storage]. For a start I wouldn’t even know how to turn a computer on.” (Ward Clerk; Field Notes)*

*“This looks all well and good, but you’ll struggle to obtain compliance. Wards will continue to use documentation, whether it has been previously approved or not.” (Specialist Nurse; Field Notes)*

The remarks of the Ward Clerks (detailed above) portray clear symmetry with Carnall’s (2007) adaptation to change model illustrated within **Appendix B**, through which the ‘denial’ for the need for change and ‘defence’ of current practice mark substantial blockages to the implementation of change. On the other hand, the comments of the specialist nurse reflect an almost ‘defeatist’ attitude, which perhaps can be related to Bamford and Daniel’s (2005) assessment of de-motivated and cynical staff (in relation to the prospect of change) as a result of previous “*top-down radical shock strategies*” (O’Brien, 2002 page 443) within the NHS. Consequently, this suggests that senior management face a number of challenges in motivating staff towards the need for change and successfully discarding old behaviours and practice to implement the research’s improvement model. Over the course of the two year involvement with Trust A, the researcher perceived that Matrons and middle management appeared to be much more appreciative in terms of recognising the need for change. The risks of poor management and control which were diagnosed within Chapter Four were acknowledged, but improvements in nursing documentation practice were often viewed as a ‘low priority’ in relation to other areas of work to which they were assigned. It must be noted that similarities can be drawn between the research’s findings and Cheevakasemsook et al’s (2006, page 368) assumption that nursing documentation is “*devalued as an unimportant task*”. As a direct consequence, the problems associated with a lack of ownership and the defending of current practice seem to confirm a general lack of motivation towards changing nursing documentation practice within Trust A.

## 5.2 Power Structures

The findings discussed in Chapter Four suggest that power (in relation to the management and development of nursing documentation) lies predominantly within the end user, rather than senior management or specialist nurses. A number of nurses seemed unwilling to relinquish the power which they obtained and also questioned the authority of Trust A's senior management, particularly in their subsequent ability to enforce change within the organisation and the requirement for approving nursing documents prior to use.

*"This is the way things have always been done around here [nursing documentation practice]. (Ward Clerk; Field Notes)*

*"They're [senior management] detached from the reality of current situations and practice and not well placed to instigate change" (Staff Nurse; Field Notes)*

*"I've never spoken to them [senior management]. In fact, I'm not even sure what they look like." (Staff Nurse; Field Notes)*

The above quotations revisit the criticisms of Planned change detailed within Chapter Two and the effectiveness of radical, top-down strategies (Bamford and Daniel, 2005; Burnes, 2004). Johnson and Scholes' (2001) observation that senior management are too far removed from the information to make key decisions (see Chapter Two) is also apparent within the above quotations. As a consequence, the findings diagnose an apparent inability for senior management to enforce change within the organisation, and as such, this heightens the necessary engagement and project ownership of middle managers and Matrons. Their acknowledgement of the benefits of change and influence over nurses are identified as key pushing forces towards advancing nursing staff through the 'Coping Cycle of Change' (Carnall, 2007), overcoming current stages of 'denial' and 'defence' to allow for successful adaptation of new behaviours and processes. The perceived 'low priority' of

the change programme however, can be regarded as a substantial barrier, and one which must be recognised and overcome if change is to be successful.

### **5.3 Culture**

As was suggested within the literature (Brunetto, 2001; Schraeder et al 2004), the culture of the case study organisation proved, at times, difficult to define. Perhaps the most notable observation was the cultural differences between the two geographical locations of the organisation (Site 1 and Site 2), which merged in 2002. Through regular observation of both sites, the researcher perceived aspects of cultural clashes and failures to merge values, beliefs and patterns of behaviour. This was reflected by a perceived refusal to adopt standardised nursing documents; many of the documents collected were intended for use on a specific ward or location rather than the organisation as a whole. In addition, nurses seemed to be predominantly stationed at either one location or the other and often jokingly referred to the other site as, “*the dark side*”. (Field Notes).

In accordance with the literature, further sub-cultures were identified, particularly at ward level (Johnson et al 2005; Burnes, 2004). The researcher perceived a strong mechanistic culture, through which assigned duties and specialism seemed to dictate that employees were responsible for their own specific area rather than the organisation as a whole. The researcher was able to visit all of the 46 wards in operation over a two year period, observing that each appeared to have their own distinct way of doing things. On questioning why this was so, many members of staff responded by explaining, “*this is the way we’ve always operated*”, which re-visits elements of resistance detailed within this chapter and implies that various routines are entrenched within the organisation. As such this marks a notable blockage to the implementation of standardised nursing documents, and the existence of numerous sub-cultures could be problematic for the organisation in terms of the ability to successfully embed and sustain new policy and procedures. Some wards appeared to be more receptive to change than others, which was

particularly notable throughout the piloting stage of new nursing documents (as determined within the improvement model developed in Chapter Four). Whilst some wards were happy to test new material, others were more reluctant to do so, stating that they preferred the documents which they currently used. Current practice was often defended in addition to impracticalities with documentation deemed not to suit specific needs.

#### **5.4 Identifying Pushing and Resisting Forces to Change from a Cultural Web**

In order to better understand Trust A's culture, a 'cultural web' was created which is illustrated in **Appendix H**. The 'web' was created by the researcher and is based on field note / diary log data collected over the two year period. The information portrayed in **Appendix H** is used to diagnose taken for granted assumptions within Trust A and to determine pushing and resisting forces to change within nursing documentation practice.

#### **Power and Organisational Structures**

The researcher observed a very hierarchical view of Trust A's organisational structure, which is perhaps best personified through the numerical 'Banding' system used throughout Trust A to determine job roles and salary (Band 1 being the lowest, Band 8 the highest). The mechanistic nature of the organisation led to a clear pecking order of priorities and the power that one 'Band' of employee is able to exert over another. Departments and divisions seemed to concentrate on areas relevant to their specific interests and staff seemed reluctant to take responsibility for areas which fell outside of their 'Band' and/or pay packet. Nurses generally associated power with clinicians and external bodies, although neither of these groups is suitably placed to influence change within the context of this research. The identification of sub-cultures and separate ways of working mark a real blockage to the adaptation to change and attempts to standardise documentation practice, although Ward Mangers and Matrons are identified as powerful figures, capable of influencing nursing staff and promoting the visions of senior management.

## **Symbols**

Nurses often addressed their immediate superiors by job title rather than name. This was most common at ward level, where senior nurses were often referred to as 'Matron' or 'Sister'. Nursing uniform was also perceived to be heavily symbolised, particularly as differentiations exist dependant on department or nurse status. Senior management were often based away from the wards, operating within formal office layouts, which seemed to alienate segments of the nursing workforce, who remarked that senior management were "*detached from the realities*" (Field Notes) of what it is like to work on the wards. Subsequently there was a general feeling that senior management were not well placed to make informed decisions on changes to every day nursing practice, which, in accordance with the literature, provides evidence of potential issues with the effectiveness of a top down approach to change management (Wooten and White, 1999; Connor and Lake, 1994; Bamford and Daniel, 2005).

## **Control Systems**

Management within the organisation seemed, at times, to give priority to 'completed clinical episodes' as key performance indicators, rather than the quality of care. This is perhaps understandable based on the strains of accommodating increased levels of patients with fewer nurses and beds available. However, such control systems do not align with proposed changes in nursing documentation, aimed at performance improvement and enhancements to the patient's experience. In order for change to be successful, the organisation may consider the adoption of strategies to allow for better alignment with project objectives, particularly in terms of promoting the importance of nursing documentation and standards of care. Senior professionals were seen to obtain control over nursing staff, but the lack of visible reward systems such as performance related pay or training incentives may be detrimental in terms of staff compliance with change. As a result, it must be questioned whether there are any real incentives for staff to discard old behaviours and embrace change within the organisation. In particular

accordance with Mukherjee (2005, page 1) the findings of the research reinforce the opinion that “*potential mismatches between a project’s objectives and public officials’ incentives can cause implementation slowdowns*”. Consequently, this is taken forward within the final section of Chapter Six to establish recommended strategies to improve staff incentives and compliance with change.

## **Rituals and Routines & Stories**

Previous sections of this chapter have sought to identify and explain the researcher’s observations in relation to entrenched routines and behaviours, and, accompanied with aspects of nursing cynicism towards change, a substantial barrier towards the implementation of new routines and practice is ultimately illustrated. A close working relationship with Trust A’s nursing workforce over the course of the two year project enabled the researcher to gain a greater understanding of the stories which were told within the organisation, which seemed to convey acts of nursing heroism in relation to the saving of lives or ability to deal with difficult or distressing situations. The emphasis placed on the ‘physical’ aspect of patient care counteracts the opinions of those who place a great importance on nursing documentation practice (NMC, 2010; Teytelman, 2002), seemingly establishing greater symmetry with the likes of Allen (1998) and Duffield et al (2008) with regards to the ideology that nursing documentation should not be a prioritised activity in relation to patient care. This viewpoint should be acknowledged by Trust A’s senior management and recognised as a real concern for the implementation of new policy and procedure.

## **Paradigm**

The taken for granted assumptions formed as part of the web diagnosed encouraging nursing perceptions of organisational life. In particular, the central nursing values of providing a quality service towards patient care counteracts previously established organisational control systems of ‘completed clinical episodes.’ The perceived benefits of change and core



cultural values are therefore closely aligned, although management must clearly embark on a strategy which eradicates misconceptions that nursing documentation does not form part of good patient care. A particular observation of the researcher resulted in a central value of “*we [nurses] know best*”, which, in accordance with the literature, this strikes a particular emphasis with Lipsky’s (1980) ‘street-level bureaucracy’ and the role of lower level public sector workers as ‘policy setters’. The evidence of a Lipskian (1980) based environment is not necessarily problematic, however senior management need to recognise the likelihood of staff resilience and non-compliance with change initiatives which are effectively developed away from the ‘front-line’ and enforced onto the nursing workforce. Strategies to enable nursing engagement and involvement within implementation are subsequently portrayed within the final recommendations section of Chapter Six.

## **5.5 Chapter Summary**

In summary, this section has sought to tackle the research’s final objective, through the identification of a number of pushing and resistant forces to change; the most crucial of which are documented within Table 7. The cultural issues identified diagnose incompatibilities with the top-down approach towards the implementation of change portrayed by senior management within Chapter Four (Section 4.4). Consequently, senior management within Trust A need to recognise cultural themes which do not support the successful implementation of new nursing documentation practice developed within the ‘KTP Involvement’ of Chapter Four, and create strategies which eradicate, reduce or overcome them. Recommended strategies to ensure the successful implementation and long term sustainability of the proposed changes are detailed within the final section of Chapter Six.

Pushing Forces	Resisting Forces
<ul style="list-style-type: none"> <li>• Capability of Ward Managers and Matrons to effect change on nursing staff.</li> <li>• Common values amongst nursing workforce to provide the best level of care to patients</li> </ul>	<ul style="list-style-type: none"> <li>• Nursing staff cynical of change</li> <li>• Mechanistic structures</li> <li>• Nurses 'know best'</li> <li>• Perceived lack of senior management authority to change daily activities</li> <li>• Documentation does not form part of patient care</li> <li>• Nursing documentation negativity</li> <li>• Lack of reward systems and incentives to change</li> </ul>

**Table 7 – A Summary of Key ‘Pushing’ and ‘Resisting’ Forces to Change within Trust A**

## **CHAPTER SIX**

### **CONCLUSIONS AND RECOMMENDATIONS**

This section of work forms the final part of the research study and is subsequently split into six areas;

- 1) A summary of the research's findings.
- 2) Recommendations for future research.
- 3) A summary of the research's contribution to knowledge.
- 4) An account of the key limitations of the research.
- 5) Conclusions.
- 6) Final recommendations to ensure the successful implementation and sustainability of change.

#### **6.1 Summary of Findings**

This section aims to present the research's findings, particularly in accordance with the research objectives detailed within Chapter One. Three key findings are identified, which are illustrated in greater detail below.

#### **Establishment of Documentation Practice and Procedures within Trust A**

As was seen within Chapter Four, a quantitative analysis of 161 documents was undertaken in order to determine the overall standard of nursing documents in use within the case study organisation. Each document was subjected to seven closed questions, as identified within the methodology, to provide sufficient data for the researcher to tackle the first objective of the study. Key findings from this phase of research exposed concerns in relation to:

- A lack of corporate identity
- Unprofessional appearance

- Poor reproduction of documents
- Outdated content and poor version control
- Duplicated content
- Lack of a universal referencing system

Collectively, the data diagnosed a lack of formalised procedure for the development and management of nursing documentation within the case study organisation, which in turn led to a general standard which, at times, failed to meet the expectations of senior management (as detailed within **Appendix E**).

Qualitative data collected in the form of semi-structured interviews and a focus group diagnosed a lack of formal document approval systems, which resulted in difficulties in terms of measuring and controlling the nursing documents in use at any one time. Specialist nurses participating within the semi-structured interview process voiced clear frustrations around a general lack of end user compliance and the power obtained by ward staff to create duplicated, and at times, inappropriate and risky content. The impracticalities of photo-copying practice were also diagnosed, particularly in relation to document appearance and reproductions of outdated content. Collectively, these issues enabled the researcher to fulfil the second objective, through the thorough exploration of nursing documentation practice within the case study organisation.

### **The Relationship between Nursing Documentation Authors and the End User (Nursing Staff)**

The literature portrayed within Chapter Two illustrated a number of studies which established time constraint issues (Owen, 2005; Duffield et al, 2008) and incompatible staff perspectives (Cheevakasemsook et al, 2006) as problematic areas within the field of nursing documentation practice. Both of these issues were distinctly apparent within the case study organisation, seemingly entrenched within staff behaviours and accepted as the 'norm'. However, a finding of the research, which adds a differing dimension to the

common issues detailed within the literature, is that of continued professional development. In this sense the researcher questions the usefulness of formally approved, well presented documents if nurses do not have the correct competence or understanding of procedures to record correctly. The research identified that document authors did not always see their role as educators, establishing that nurses are '*professionals*', who should ultimately be able to carry out all procedures detailed within a nursing document. Such assumptions, however, appear to have been ill judged. Many of the nurses interviewed within the purposes of this research voiced concerns in relation to a lack of understanding, and, when tested, gave differing responses and interpretations as to the meaning of some of the assessments contained within key nursing documents. The research consequently diagnosed a gap in current practice; a missing link in the relationship between the authoring of a nursing document and how it is then understood by staff / end users. The 'mapping' of assessment skills contained within specific nursing documents to create new educational strategy was subsequently identified as an area for improvement, enabling partial fulfilment of the research's third objective.

### **Barriers to Change**

The findings discussed in Chapter Five found evidence of substantial barriers to change within the case study organisation, perhaps most notably with the incompatibility of a top down, autocratic approach to change initially suggested by Trust A's senior management within Chapter Four. In addition, the researcher created a cultural web (Johnson et al, 2005) of the case study organisation, which identified large quantities of 'sub-cultures' (Brunetto 2001; Burnes, 2004), entrenched behaviours / routines and a general fear of change amongst the nursing workforce.. The findings of the research closely match those of previous studies detailed within the literature, most notably; Alexis (2005) and Carnall (2007). Managing a programme of change within the case study organisation was immensely difficult and the breaking down of old behaviours proved to be complex and, at times, frustrating. As a consequence, strategies for the successful implantation of change are detailed within section 6.6 of this chapter.

## **6.2 Recommendations for Future Research**

Within the two year period in which the study was undertaken, the researcher identified a number of areas for future research, diagnosing additional areas which require more comprehensive investigation. Four particular areas requiring further research are as follows:

- a) In relation to the data collected throughout this research it has to be noted that the analysis, recommendations and conclusions are based within the context of the case study organisation. As a consequence this highlights the need for further investigation; particularly in the requirement to study nursing documentation practice in additional NHS institutions so that comparisons can be made. Further research will additionally aid in determining whether the improvement model discussed in Chapter Four are transferrable to other organisations.
- b) The research supported theory in relation to complexities within nursing documentation practice, (Cheevakasemsook et al, 2006) and developed an approach towards improving the management and development of nursing documents in and staff education initiatives. It is recognised that a number of areas which dominate the literature fall outside of the boundaries of this approach, perhaps most notable time constraint concerns (Owen, 2005; Duffield et al 2008) and negative staff perspectives (Allen, 1998). As was seen within Chapter Two, few studies have appeared to tackle these issues, and consequently it is recommended that further research is carried out within the complexities of nursing documentation practice to produce further methodologies for improvement.
- c) The process of change management within the case study organisation is by no means complete. This research has sought to identify areas of risk, develop solutions for improvement, and identify barriers to change. The strategies which form the final recommendations of this research (section 6.6) are intended to be used at the discretion of Trust A's

senior management, and as such it is recommended that further research is carried out within the case study organisation, to effectively oversee the implementation of change and investigate further improvement initiatives within nursing documentation practice.

- d) As the project grew in stature and gained exposure, a number of the organisation's Clinicians questioned whether the process could be transferable to Medical Records practice (i.e. the documentation filled in by Doctors/Clinicians to plan and record patient care). Further research is therefore recommended to determine the scope for such an initiative and whether the models built within the context of this research may be transferable to other divisions within the NHS.

### **6.3 Contribution to Knowledge**

This research has sought to make an original contribution to knowledge through the investigation of nursing documentation practice and change management implications within a case study organisation. Four specific contributions are identified, which aid in the bridging of gaps identified within the literature review.

The first significant contribution is that of a large scale analysis of 161 key documents to diagnose a true account of nursing documentation practice within a case study setting. The study is one of the first to undertake an analysis in relation to the overall standards of an organisation's nursing documents on such a scale, and is able to promote mechanisms and criteria (as shown within **Appendix F**) for future document analysis in other departments or organisations.

The second contribution relates to a better understanding of the constitution of a 'high quality' nursing document. The study has produced a number of specific acceptance criteria for 'high quality' nursing documentation, as detailed within Chapter Four and **Appendix E**, and additionally, a standardised document template (**Appendix J**), containing key information for

successful document monitoring and control. Collectively, this has aided in bridging gaps identified in the literature, particularly in terms of the NMC's (2010) limited guidance for the creation of high quality documents which are fit for purpose.

Thirdly, the research has diagnosed areas of concern which appear to have been overlooked within the literature; namely, a lack of standardisation and control within nursing documentation practice, and the requirement for enhanced staff education mechanisms. Previous studies have sought to make improvements through the re-design of single nursing documents (Karlsen 2007, Bjorvell et al 2003, North and Serkes 1996), however, the research has sought to contribute in a different manner, producing an improvement model with the capacity to transform procedure and policy and tackle underlying issues in terms of ill judged nursing assessment skills and education. Although issues recorded within the literature (particularly time constraints and poor staff attitudes) were largely apparent within the case study organisation, the research has contributed to knowledge through the identification of risks associated with a lack of formalised procedure and the regular use of obsolete, duplicated and illegible content contained within nursing documentation.

Finally the research has added value to current literature in relation to change management, and the particular difficulties in implementing change within the NHS. The study is one of the first to diagnose cultural and organisation barriers to change in nursing documentation procedures within an NHS setting. The development of a cultural web led to an identification of blockages to successful change, and although these are only relevant within the context of this research and the case study organisation, the elements of staff resistance and cultural implications may help to shape future work around the subject area.



#### **6.4 Limitations of the Study**

The research was carried out with the intention of being as accurate as possible; however, it is acknowledged that limitations to the findings recorded within previous chapters do exist and must be interpreted in an appropriate manner. Three key limitations are detailed below.

Firstly, the case study approach selected as part of the research design relates to the practices and issues within a single NHS organisation. The findings of this study therefore relate to this organisation only, and should be interpreted carefully in relation to similar healthcare institutions, or indeed the NHS as a whole.

Secondly, the findings and conclusions portrayed throughout the course of this research, particularly in relation to the use of the diary log as a data collection tool, must be noted as interpretations of the researcher's experiences within the case study organisation. Whilst, every effort was made to provide an accurate account of reality, it must be noted that other individuals may have interpreted key information in a completely different fashion. In relation to the 'practitioner-researcher' role (Saunders et al, 2009) as discussed in Chapter Three, it is possible that the researcher's familiarity of the organisation led to a number of pre-conceived assumptions which are detached from reality. The research approach of an 'outsider' may well have yielded different results.

Thirdly, it must be noted that, at times, the researcher felt a degree of resistance from some of the nursing staff within Trust A. Perhaps this can be related to the non-nursing background of the researcher and the criticisms that were made towards current practice. Although there was no doubt in the researcher's mind that responses were honest and truthful, it must be acknowledged that an initial lack of trust may have led to the holding back of key information in certain circumstances. That being said, the building of trust and familiarity grew significantly throughout the process.

These limitations are perhaps inevitable and reflect some of the issues present in all business research within an organisational setting. That being said, whilst every effort was made to ensure a consistent approach towards data capture, the results and findings of this research must be interpreted in a careful manner, particular in relation to transferability across other organisations of a similar structure/operation.

## **6.5 Conclusion**

Nursing documentation practice and the management of change within a single case study organisation were investigated throughout this research, resulting in the identification of a number of valuable findings and new knowledge. In particular, an analysis of 161 nursing documents diagnosed areas of risk for the participating organisation; data collected illustrated concerns ranging from variation in document appearance and lack of corporate identity to the circulation of outdated and obsolete content. In addition, a lack of staff education initiatives was predominantly blamed for the standard of nursing documentation practice and areas of non-completion. Consequently, an improvement model was created to ensure greater document control within the organisation, in addition to the creation of new educational strategy designed to improve nursing competence in line with the assessments contained within specific nursing documents. The research has additionally discussed the management of change within the case study organisation, diagnosing potential blockages to the successful implementation of new nursing documentation policy and procedure. Although it may be concluded that the management of change within the NHS is complex, the findings have discussed key areas which the case study organisation's management must address if change is to be successfully implemented and sustained within Trust A.

## **6.6 Final Recommendations**

This section aims to provide a number of final recommendations, aimed predominantly at Trust A's senior management, be taken beyond the

parameters of this research in regards to the successful implementation of change within the case study organisation. As was seen in Chapter Five, the cultural web and subsequent resisting forces strongly imply that it is unrealistic to expect a universal acceptance of the proposed changes within Trust A's current situation. The literature acknowledged benefits of 're-mapping' the cultural web (Johnson and Scholes, 2001) in order to outline desired situations to better align with change programmes, and as a direct consequence, **Appendix I** provides Trust A with a clear indication of desirable situations/environments to ensure greater organisational compatibility to successfully embrace the proposed changes detailed within the concluding section of Chapter Four. The following recommendations have been constructed to promote strategies for the successful implementation of change within Trust A.

### **Recommendation 1 – Nursing Staff Require Extensive Support, Direction and Time to Fully Embrace Change**

Whilst newly developed systems and infrastructure are designed with every intention of transforming practice, the role of nurses as 'policy setters' (Lipsky, 1980) within the organisation must be recognised, and consequently, strategies must be initiated which result in staff adapting to new ways of thinking and embracing change. Johnson et al (2005) identify five roles in the management of strategic change, namely; '*education and communication*', '*collaboration*', '*intervention*', '*direction*' and '*coercion*'. Within the context of this study it is recommended that a combination of '*direction*' and '*education and communication*' is required to successfully manage the changes identified. The reasons for this approach are as follows:

- The traditionally mechanistic structures of the organisation results in fragmentation, with nursing staff perhaps lacking a sense of overall direction in terms of standardising practice or working towards organisationally based goals and objectives. In addition, the vast scale of individual specialisms and departments (as seen within Chapters Four and Five) has led to many different staff perspectives and

opinions as to how nursing documentation practice should be improved. Involving too many people within the change process would potentially cause conflict and an inability to agree on worthwhile objectives. Consequently, authoritative figures are recommended to involve a degree of 'direction' within their approach in order to establish "*a clear vision, future strategy and how change will occur.*" (Johnson et al, 2005, page 516).

- The cultural web diagnosed negative staff perspectives towards nursing documentation and the entrenchment of current routines and rituals within the organisation. As opposed to the coercive, top down approach to change initially conveyed by senior management in Chapter Four, it is recommended that staff education and communication would be more appropriate in terms of explaining the reasons for change, resolving misconceptions and allowing sufficient time for individuals to come to terms with change. In relation to the literature, Burnes (2004) and Johnson et al (2005) seem critical of this approach, particularly in terms of '*naïve*' assumptions that reasoned arguments will overcome many years of entrenched behaviour. Whilst such opinions are acknowledged, they are challenged within the context of this study. Enforcing new procedures onto staff who are fearful of adapting new behaviours and do not recognise the need for change is likely to result in non-compliance. Having spent a significant period of time within the case study organisation, the researcher is in firm agreement with the work of Alexis (2005) detailed within Chapter Two. Managing change within the NHS can be difficult, and consequently, successful implementation of change can take time, with individuals requiring extensive education and open lines of communication to prepare, accept and buy into new ways of thinking. In the context of the findings portrayed in Chapter Five, it is therefore recommended that senior management allow for necessary support, direction and more importantly, time, to allow proportions of nursing staff to move from the current stages of 'denial' and 'defence', to the

discarding of old behaviours and adaption to change (as detailed within the 'coping cycle of change' Carnall, 2007).

## **Recommendation 2 – The Importance of Matrons and Middle Management**

The findings of Chapter Five portrayed evidence of potential problems in relation to the successful implementation of a senior vision and subsequent change programme within Trust A, particularly in accordance with a “*detachment*” from the realities of practices on the wards. The creation of a cultural web determined the influence of middle management and Matrons, and consequently it is strongly recommended that these groups are utilised in bridging the gaps between senior management and members of staff operating at lower levels of the organisation. In accordance with the literature Johnson et al (2005, page 521) refer to middle management as ‘*translators*’ of strategy, responsible for ensuring that change is understood and acknowledged throughout the organisation. Within this context it is vital that middle management feel an ownership of the vision and are in a position to monitor and control the changes determined by senior management.

## **Recommendation 3 – Establishing Staff Incentives to Change**

The cultural web additionally diagnosed a lack of incentives or reasons for the nursing workforce to transform current practice and adapt to change. The findings of this research strongly support the viewpoint that nurses are often working at full capacity (Cheevakasemsook et al, 2006; Duffield et al, 2008; Owen, 2005) and in light of this strategies should be created which both encourage and allow staff to take the necessary time to participate within newly designed systems and procedures. Senior management are encouraged to embed the six new nursing documents and training materials (created in Chapter Four) into new starter packages or even incorporate them into job descriptions. The completion of relevant educational materials as a necessary requirement for all Band 3 nursing roles, for instance, acts as an incentive for staff to embrace and comply with change, as a motivation for

future career progression and employment opportunities. Ultimately, compliance with change will not only improve the assessment skills of the organisation's nurses but also greatly reduce the risk which was previously of huge concern for senior management. It is therefore important to initiate strategies not only for exposure of new educational materials, but also to provide incentives to maximise staff engagement in new procedure.

#### **Recommendation 4 – Sustainability of New Procedures and Policy**

Finally, it is recommended that the organisation takes steps to ensure the sustainability of new procedures and policy once they have been implemented. This will involve regular auditing processes to ensure compliance and the assignment of new roles and job descriptions will also be necessary in order to maintain and take ownership of the document repository system and document formatting process. Perhaps most importantly, however, is a recommendation for further work to be undertaken within Trust A. As was seen within the 'KTP Involvement' section of Chapter Four, this research has sought to develop new nursing documentation and educational materials within six priority areas. It is envisaged that the process will create a methodology for future nursing document development within Trust A, and subsequently it is recommended that senior management identify key figures to lead on the development of documentation and training materials in new areas, so that a 'legacy' is maintained once the researcher's role within the organisation comes to an end.

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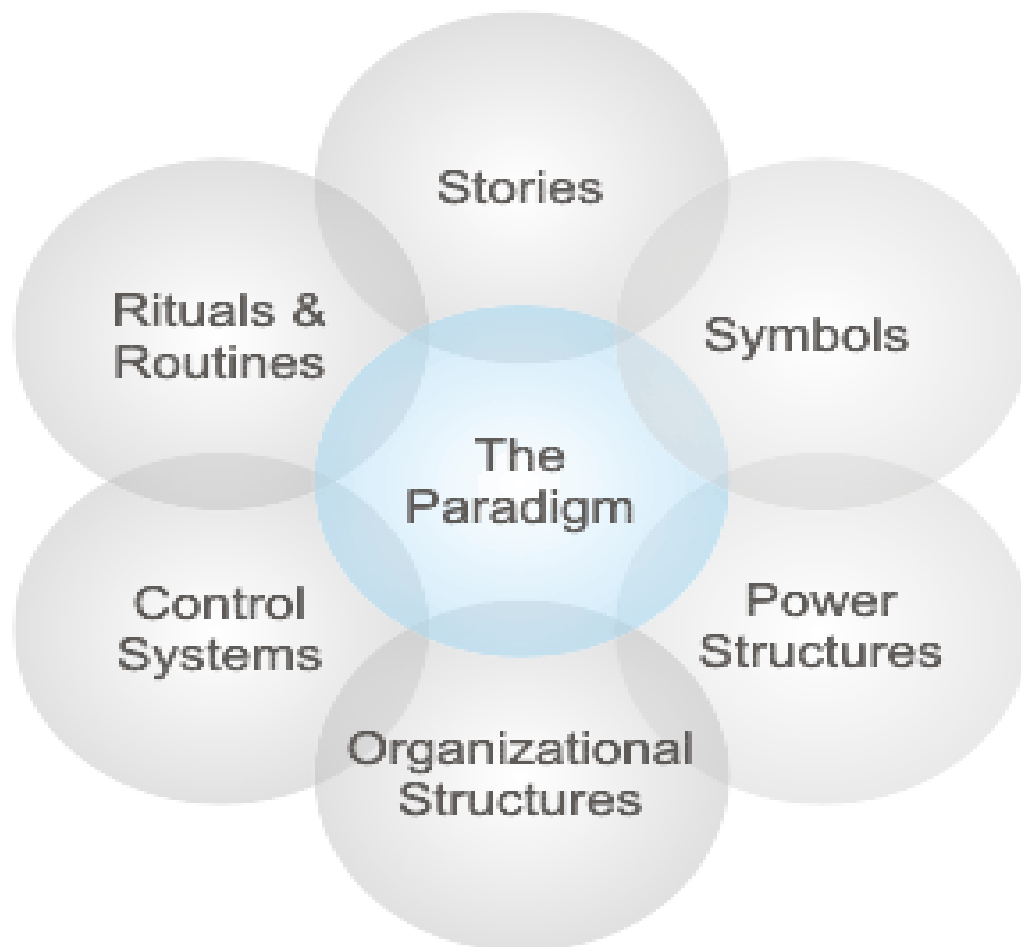
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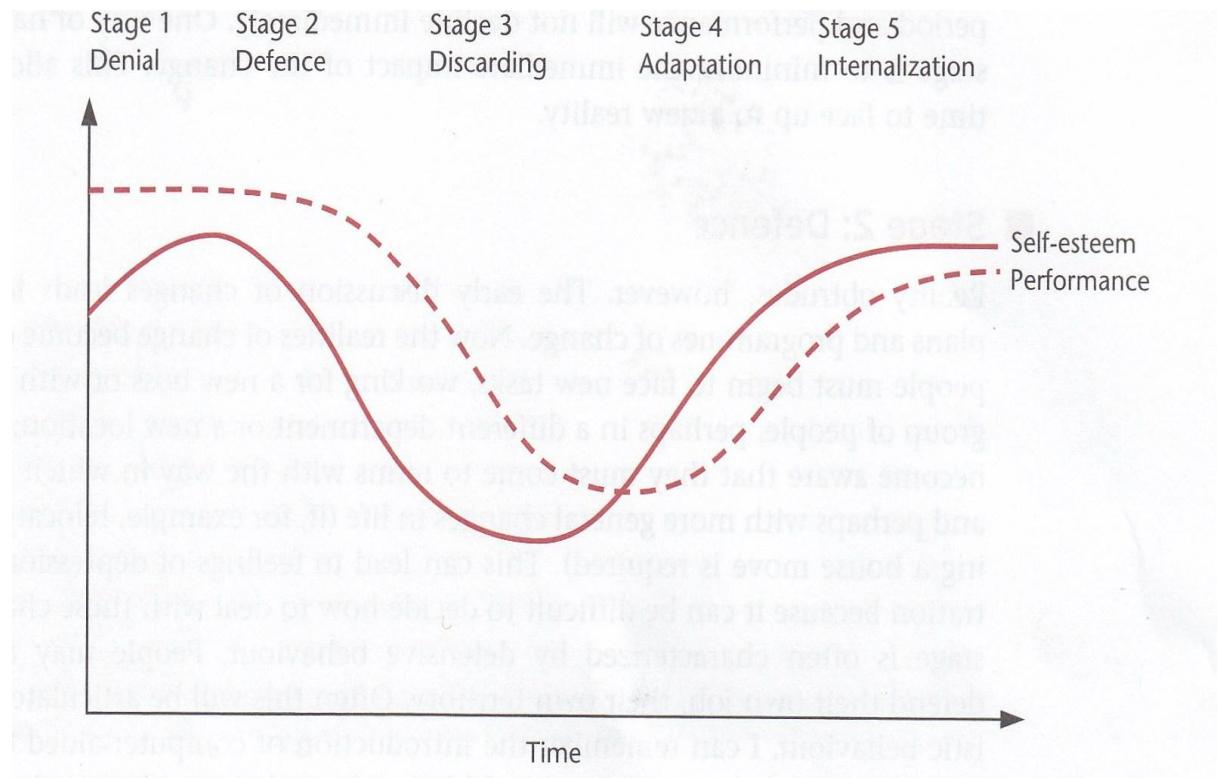
## **APPENDIX A – The ‘Cultural Web’**

Adapted from Johnson et al (2005, page 202)

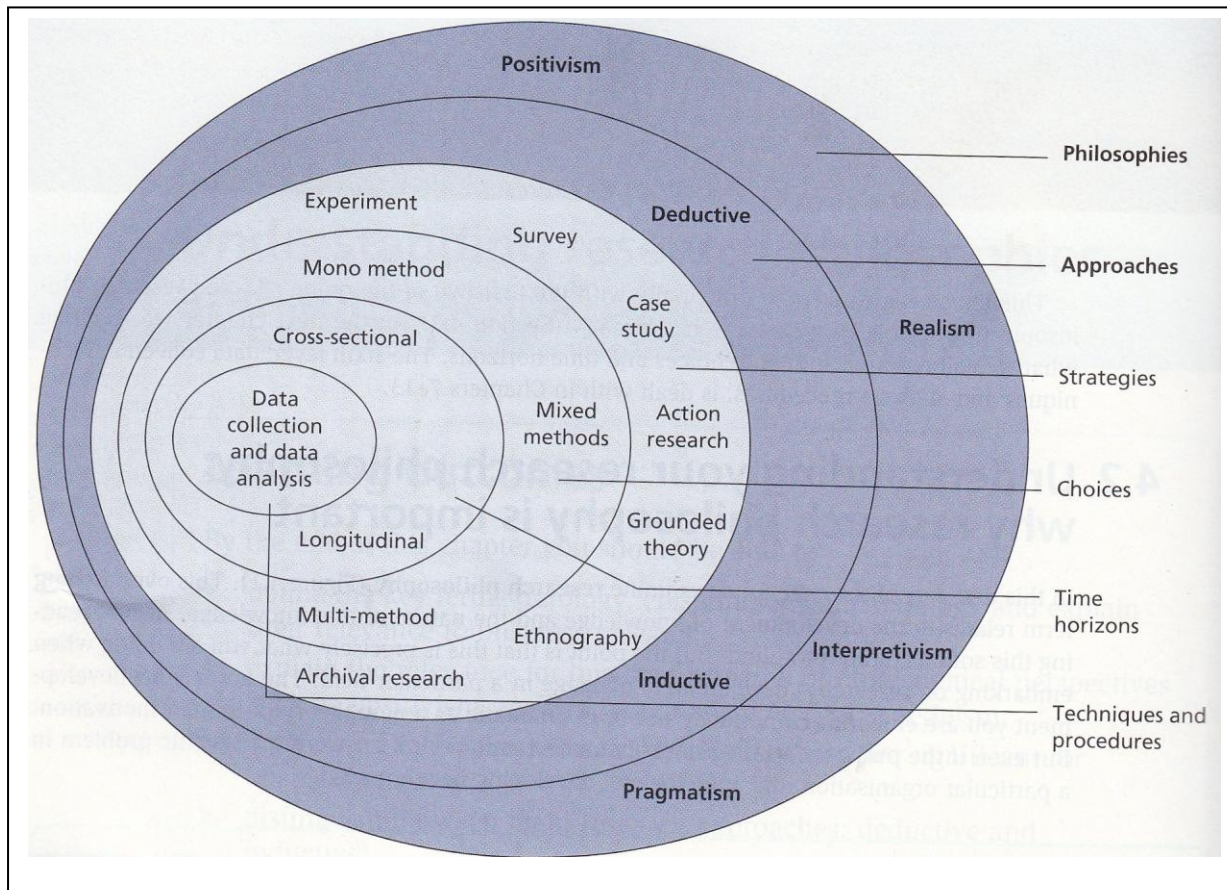


## **APPENDIX B – ‘The Coping Cycle’**

Adapted from: Carnall (2007, page 241)



## **APPENDIX C – ‘The Research Onion’ – Saunders et al (2009)**



## **APPENDIX D – Interview Question Schedule**

1. What care documentation do you have? What care documentation have you produced?
2. Who is the target audience for the care documentation?
3. How is it accessed?
4. What grade of staff authors care documentation?
5. Who verifies completed documentation? Are there peer reviews?
6. What might prompt development of new care documentation or review of existing documentation?
7. Do you set times for review of care documentation?
8. How is new care documentation embedded into the organisation?
9. Prior to release does new care documentation need to be approved by line managers/senior management?
10. How is material archived and old versions recalled?

## **APPENDIX E – ‘Acceptance Criteria for Trust A’s Nursing Documentation’.**

Adapted from ISO 9001:2008 – Section 4.2.3 ‘Control of Documents’

*As a minimum:*

***1. All documents should be professional in appearance and identifiable to the Trust.***

### Acceptance Requirements

- Documentation should be legible and word processed
- All documentation should clearly display the Trust’s corporate logo.

***2. All documents should contain up to date and appropriate content to provide the best level of care for patients***

### Acceptance Requirements

- All documentation should be approved for adequacy and issued with a reference number prior to use.
- A date of creation should be included. This is required to set the necessary review dates to re-approve documents.
- Document control procedures should ensure that the relevant versions of applicable documents are available at points of use.
- The use of obsolete documents is prevented.

***3. The content of a document should not conflict other documents in use.***

### Acceptance Requirements

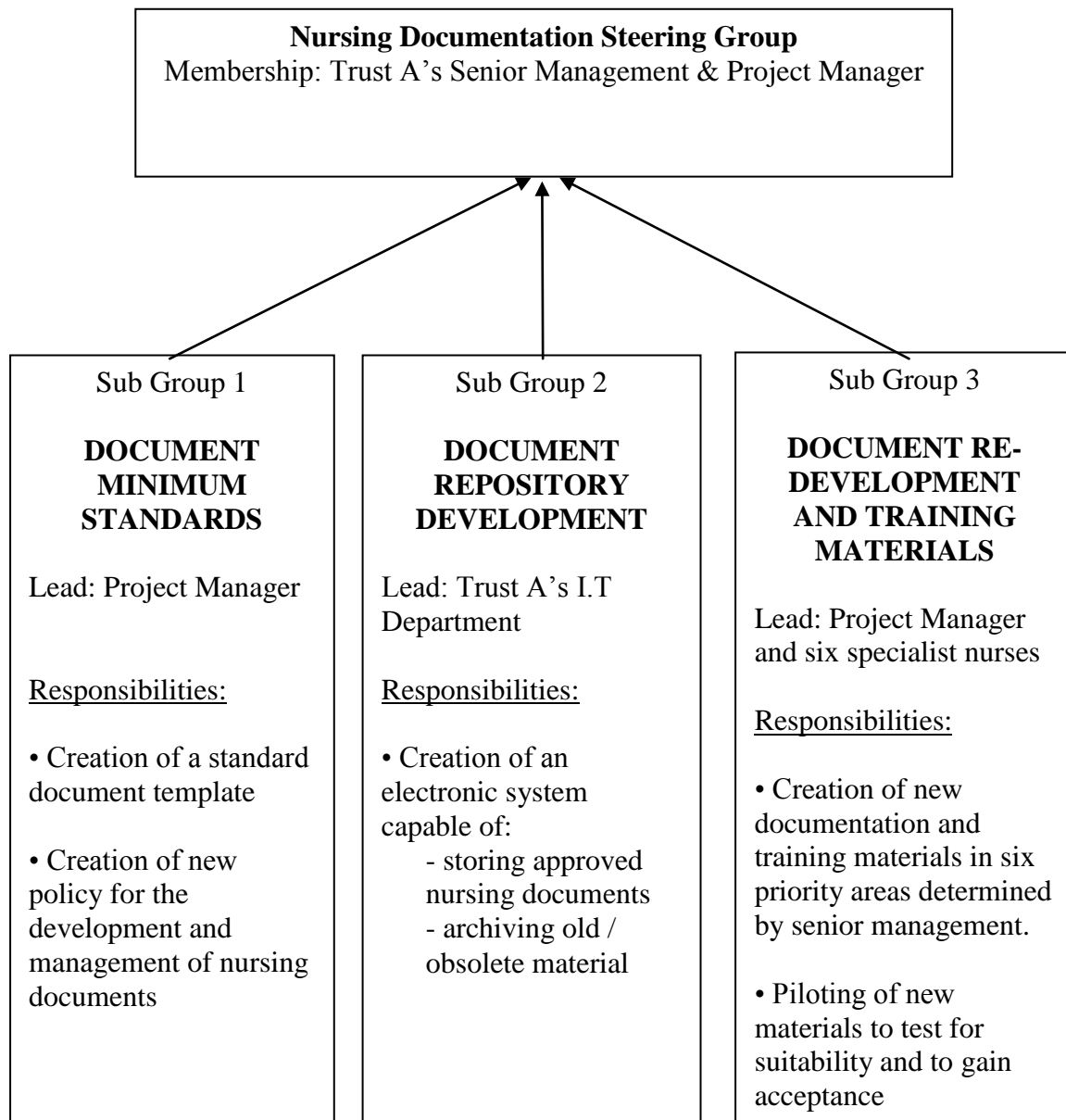
- Newly created documents should not duplicate documents already published or in development



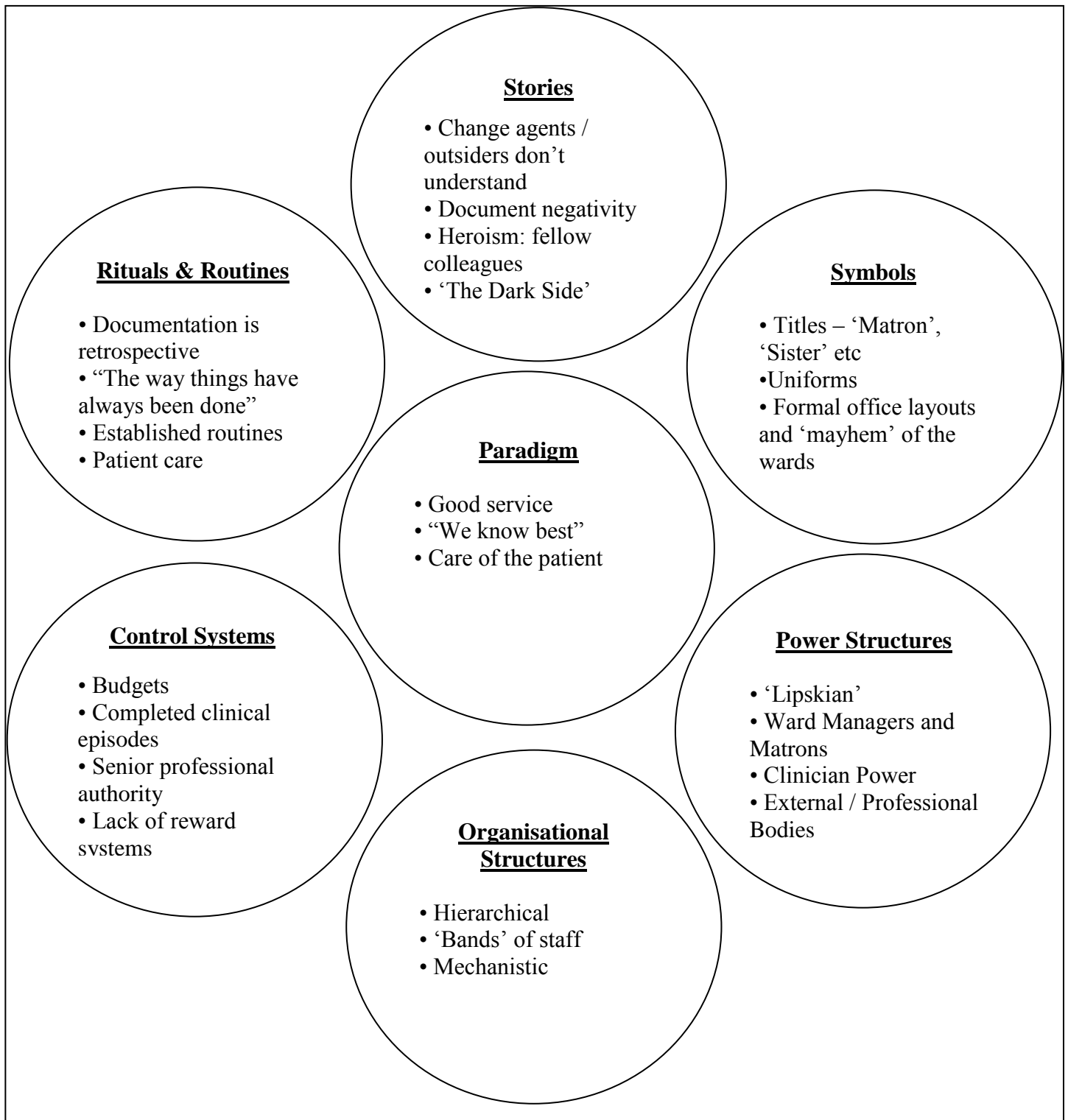
**APPENDIX F – The Researcher’s Approach to Data Calculation – A Sample of 15 Nursing Documents**

<b>Document Name</b>	<b>Is the document word processed? (Yes / No)</b>	<b>Is the document identifiable to Trust A? (Yes / No)</b>	<b>Does the document contain a corporate logo? (Yes / No)</b>	<b>Is there a Reference Number? (Yes / No)</b>	<b>Is there a date of creation? (Yes / No)</b>	<b>Is the document over 5 years old? (Yes / No / N/A)</b>	<b>Are there signs of duplication? (Yes / No)</b>
<i>Pain Care Plan</i>	Yes	No	No	No	No	N/A	Yes
<i>Varicose Vein ICP</i>	Yes	Yes	Yes	Yes – ‘VV ICP’	Yes – June 2004	Yes	No
<i>Consent Form 4</i>	Yes	Yes	Yes	No	No	N/A	No
<i>Assessment of Nutritional Status</i>	Yes	Yes	Yes	No	Yes – Dec 2001	Yes	Yes
<i>Waterlow Assessment Chart</i>	Yes	No	No	No	No	N/A	Yes
<i>Mobility</i>	No	No	No	No	No	N/A	Yes
<i>Anxiety Care Plan</i>	Yes	No	No	No	No	N/A	Yes
<i>Falls Referral Form</i>	Yes	Yes	No	No	No	N/A	No
<i>Theatre ICP</i>	Yes	Yes	Yes	Yes ‘ICP Theatre’	Yes – Feb 2007	No	No
<i>Wound Assessment Form</i>	Yes	Yes	Yes	No	Yes – Dec 2006	No	Yes
<i>Signature Register</i>	Yes	Yes	Yes	No	No	N/A	Yes
<i>Patient Profile – 1</i>	Yes	Yes	No	Yes – ‘WQN 822’	No	N/A	Yes
<i>Patient Handling Assessment</i>	Yes	No	No	No	Yes – Sept 1995	Yes	Yes
<i>Patient Profile – 2</i>	Yes	Yes	No	Yes ‘MDCR-PP2’	No	N/A	Yes
<i>Fit Record</i>	Yes	Yes	No	No	No	N/A	No
<b>TOTAL</b>	<b>YES = 93% NO = 7%</b>	<b>YES = 67% NO = 33%</b>	<b>YES = 40% NO = 60%</b>	<b>YES = 27% NO = 73%</b>	<b>YES = 33% NO = 67%</b>	<b>YES = 20% NO = 13% N/A = 67%</b>	<b>YES = 67% NO = 33%</b>

**APPENDIX G – ‘The Identification of a Steering Group to oversee  
Product Development and Implementation.’**



**APPENDIX H – ‘Cultural Web Identifying the Values, Beliefs and Behaviours of Trust A’s Nursing Workforce’**



**APPENDIX I – Desired Changes to Ensure Successful Implementation of  
New Nursing Documentation Practice.**

<b>Current Situation – Resisting Forces</b>	<b>Future / Desired Situation</b>
Nursing staff cynical of change	Challenge the way of doing things and encourage change to improve performance.
Mechanistic structures	Emphasis on organisational goals and objectives rather than individual targets.
Lack of trust between ward staff and senior management	Established level of trust between ward staff and senior management
Documentation does not form part of patient care	Documentation is viewed as an important aspect of patient care.
Nursing documentation negativity	Nursing documentation negativity
Lack of reward systems and incentives to change	Reward systems which encourage compliance with key change programmes.

## **APPENDIX J – ‘Nursing Document Template’**

(Not drawn to scale)

<p>Unique Identifier NO:</p> <p><b>Document Title</b></p> <p>Status: (I.E. ‘Operational’, ‘Draft’)</p>	<p><b>TRUST LOGO</b></p> <p>(Patient ID Sticker)</p> <p>Name: D.O.B: NHS No: Hospital No:                      Ward:</p>
<p><b>Main Text of Document</b></p> <p>To be formatted in ‘Arial’ font, size 11pt</p>	
<p>Author: Version / Review Date:</p>	<p>Page 1 of 1 ‘Trust Name’</p>

## **APPENDIX K - Flow chart for the Creation, Implementation Approval/Ratification of Nursing Documents**

