The Pleural Procedure: One Tap Towards Improved Documentation

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Aim:

- To develop a pleural procedure documentation form (PPDF).
- The PPDF will aid physicians to be safe, efficient and effective in documenting their pleural procedure.
- To reduce time documenting the procedure, but still be accurate and diligent adhering to NMC 'The Code' (2015).

Objective:

- To change the normal and traditional culture of pleural procedure documentation.
- The PPDF to adopt a tick box approach to aid with streamline patient care.

Rationale, Driving Forces & Barriers For Change:

Documenting procedures within medical notes are the 'norm', yet illegibility, inaccurate log of events and gaps are recognised as a frequent issue within the NHS (Gakhar, Sawant & Pozo, 2005).
Recognition that length of time documenting the procedure will be at least 50% reduced, allowing more time for the physician to have more patient contact, promoting prudent healthcare is the pinnacle driving force.
By developing this PPDF it will advocate use of the Advanced Practice Pillars (RCN, 2018) in which we as advanced practitioner must adhere too.
Specifically, it would mean leading an innovation and managing a change within the Respiratory Unit.
Encompassing aspects from the WHO '*Surgical safety checklist',* will provide a structural standardisation of documentation addressing patient's safety before, during and post procedure.
Key components also from the 1000Lives campaign (2009) are to be incorporated within the documentation, maximising patient safety and ensuring delivery of high-quality care is achieved.
Consideration of barriers of implementing this change have been addressed, as altering the way pleural procedures are documented has not been acknowledged before within the Respiratory unit. Shryock (2018) describes that physicians who have practiced for many years, find comfort in their routine and have extreme resistance when it comes to change. Addressing these issues is not a requirement of learning new knowledge, but simply unlearning old/ outdated practices and applying what is the 'best evidence' (Ubel & Asch. 2015).
In order to streamline the proposed change within the respiratory unit, the change management theory of 'Plan, Do, Study, Act' (Baxley, et al, 2011) will be applied.

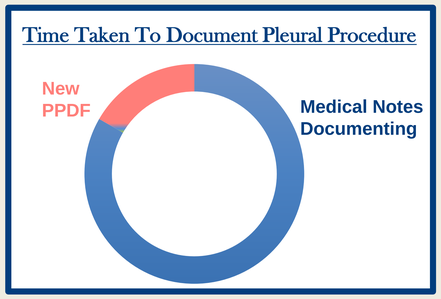

Figure 1. Time taken over an average period. Proposed document estimated average taken. Data taken from SBUHB.

Pleural Procedure Documentation Form

Patient Name:
DOB:
Hospital No:

INPATIENT☐ OUTPATIENT☐

PREPARATION:

Indication: ☐Effusion
☐Primary Pneumothorax
☐Secondary Pneumothorax
Other.....

Side: LEFT ☐ RIGHT ☐

Assess Bleeding Risk:
NO CONCERNS ☐
AT RISK ☐ (comment why)
.....
.....

Consent: Written ☐ Verbal ☐
Other ☐(comment) .....
.....

Ultrasound Undertaken:
☐YES ☐NO
(Document findings)
LEFT.....
.....
RIGHT.....
.....

Supervised : ☐YES. (BY WHOM) .....
☐ NO

Site Identified & Marked:
☐YES ☐NO

PROCEDURE:

Chlorohexidine spray site ☐ Sterile Gloves & Gown ☐
Lidocaine 1% ☐ Volume.....mls (MAXIMUM 3MG/KG)
Diagnostic Tap ☐ ***Therapeutic Aspiration*** ☐
Volume Drained ..... mls.
Fluid appearance.....
Drain Insertion: 12F ☐ 16F ☐ 18F ☐
Tunnel Indwelling Pleural Catheter ☐
Removal of Tunnel Indwelling Pleural Catheter ☐
Pleural Vent ☐
(FOR DRAINS ONLY) Guide- Wire removed ☐
Drain secured: ☐Silk suture Drain Fix & Tegaderm film☐
☐ Drain connected Rocket drain ☐ Filled with sterile water
☐Swing ☐ Bubbling ☐ Draining

Post- Procedure:

Samples Sent: ☐Biochemistry ☐Microbiology ☐Cytology
Blood Gas pH: .....
Chest X-ray ☐ Analgesia Prescribed☐
Antibiotics: NO☐ YES☐.....
Drain Chart☐ Drain Flushes Prescribed☐
Patient Information Booklet given ☐

Additional comments:

Procedure completed by.....
Job Title..... Bleep.....
Date..... Time.....

Figure 2: Document taken from SBUHB Pleural Team- Respiratory Unit.

Transformational Leadership:

A recognised theory within healthcare, as it promotes the vision as being the central concept to the end goal.
Not only found to improve patients' safety but overall team performance improvement, which is enforced by public and government pressures (Bass & Riggio, 2006).
The nursing profession, being an evolving advanced role, with growing responsibilities, with even closer involvement in prominent quality changes. (Van-Knippenberg & Sitkin, 2013).
It allows for clear concepts to be developed, which is crucial for this proposed documentation as it is all about changing the organisational cultures.
The proposed PPDF, has passion about the mission, with valued based decision for the purpose.
Encompasses leadership behaviors and characteristics that positively influence collective performances.
Leads through transforming others with your vision, thus being a long-term goal, all about the development, compared with 'transactional' which is all about the short term and promotion.

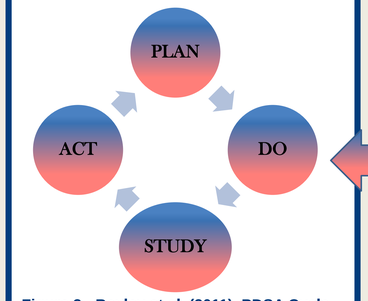

Figure 3: Baxley et al, (2011). PDSA Cycle. Change management theory.

Plan:
- Produce proforma
- Decide patient group

Do:
- Undertake plan
- Apply leadership style

Study:
- Collect feedback- questionnaires.
- Compare plan to outcomes
- Make amendments

Act:
- Target stakeholders
- Disseminate the document
- Focus on what needs changing.

Transformational & Emotional Intelligence:

Many common qualities, when brought together. Emotional Intelligence (EI) (Goleman, 1995) allows better collaborative outcomes. Akerjardet, et al, 2010 promotes EI contribution as effective to change within an organisation.
Constructs of EI have positive co-relation with transformational leadership, with higher EI shown to improve quality work performance.
Empowering & motivating stakeholders is key, compared with transactional which focuses on reward (George, 2000).
With role modeling, transformational leadership brings about strong emotions used to drive colleagues through EI competencies.
Allows PPDF to be promoted, yet with emotional awareness constructed thinking and problem solving can be applied.
Feedback taken for improvement of the PPDF is utmost goal, not personal or reaping the benefits.
EI applied with transformational leadership aids occupational success and productivity because influences one's ability to cope with environmental demands and pressures (Gardener & Stough, 2002).
When EI is not applied and leaders lack EI, failure of project/ task is recognised with reduced outcomes and negative performances (Welch, 2003). Importance in recognising changing things to better the service with best evidence, opposingly not using transactional; maintaining the status quo- with no progress (Judge & Piccolo, 2004).

Conclusion

The PPFD development will take to provide safe and effective documentation. Aspects encompassed from the WHO surgical checklist and the 1000Lives will be applied in order to standardise and provide a structured approach. Managed with use of the PDSA cycle (Baxley, et al 2011) being vital as continuous cycle, allows improvements. Incorporation of transformational and EI are qualities within the proposed PPDF.

References:

1000 Lives Campaign (2009) The How to Guide for Reducing Surgical Complications. Accessed from: http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Reducing%20Surgical%20ComplicationsWHOFinaldraft%20v2%201.pdf

Akerjardet,K., & Severinsson, E. (2010) The state of science of emotional intelligence related to Nursing Leadership. An integrative Review. Journal of Nursing Management. 18. (4). P363-382.

Baxley, E. G., Bennett, K. J., Pumkam, C., Crutcher, S. & Helms, M. G. (2011). "PDSA-ADHD": A newly reported syndrome. *Journal of the American Board of Family Medicine*, *24*(6), 752-757. doi: 10.3122/jabfm.2011.06.100244

Bass, B. M., & Riggio, R. E. (2006). *Transformational leadership* (2nd ed.). Lawrence Erlbaum Associates Publishers

Gakhar H, Sawant N, & Pozo J. (2005) Audit of the legibility of operation notes. In: Royal College of Surgeons of Edinburgh Audit Symposium 2005. Edinburgh: RCS Ed, 2005

Gardener, L., & Stough, C., (2002) Examining the relationship between leadership and emotional intelligence in senior level managers. Leadership and organisational development journal. 23. p.68-78

George, J., (2000) Emotions and Leadership: the role of emotional intelligence. Human Relations. 53. p.1027-1041

Goleman, D. (1995). *Emotional intelligence.* Bantam Books, Inc.

Judge, TA., &. Piccolo., F., (2004) *"Transformational and Transactional Leadership: A Meta-Analytic Test of Their Relative Validity."* Journal of Applied Psychology 89.5: 755-68.

Nursing and Midwifery Council, NMC (2015). The Code. Accessed from: https://www.nmc.org.uk/standards/code/

Royal College of Nursing, 2018. Advanced Level Nursing Practice: Introduction. Clinical Professional Resource. Accessed from: https://www.rcn.org.uk/professional-development/advanced-practice-standards

Shyrock, T. (2018) Why is it so hard for doctors to change? In Medical Economics. Accessed from: https://www.medicaleconomics.com/view/why-its-so-hard-doctors-change

World Health Organisation WHO, (2009) Guidelines for safe surgery. Accessed from: https://www.who.int/teams/integrated-health-services/patient-safety/research/safe-surgery

Ubel PA, Asch DA. (2015) Creating value in health by understanding and overcoming resistance to de-innovation. Health Aff (Millwood). 2015;34:239–44.

Van Knippenberg, D., & Sitkin, S. B. (2013). A Critical Assessment of Charismatic- Transformational Leadership Research: Back to the Drawing Board? The Academy of Management Annals, 7, 1-60. https://doi.org/10.5465/19416520.2013.759433

Welch, J (2003) *The best teams are emotionally literate.* Ind Commer Train.; 35:168–71