Let's talk about…

Documentation

A significant and integral requirement for this profession

The professional work of hospital play specialists (HPS), like other healthcare professionals, is based upon a clear system of assessment, planning, intervention and evaluation of outcome. The existence of appropriate HPS documentation helps to confirm the profession as a significant and integral part within the healthcare team and the function of the profession.

There are constant challenges within healthcare teams due to staff shortages, rotation of medical and nursing personnel, to ensure that others understand the work of HPS. Documentation of the services of HPS is one of the most challenging, yet potentially rewarding of HPS practice.

HPS often have large caseloads. It is not unusual, therefore, for them to be faced with the choice of either documenting the care they have given or providing direct patient care. HPS may see the task of documenting the care/intervention provided as separate from their clinical practice and an extra demand on their time that deprives other children, young people and families from accessing their services. The documentation of patient assessments and interventions in the medical record should be considered an essential responsibility and primary function for all HPS as it is with other health professionals.

Effective documentation is a skill. As with other HPS competencies, clarity on the requirements within documentation and opportunities to practice assists building the confidence effective documentation requires. The medical record/or patient chart is the most used form of documentation. The chart is a legal record that contains the history, assessment information and a clear record of the patient's plan of care within the hospital/ healthcare facility. This chart also serves as a method of communication with all healthcare professionals to provide the most comprehensive and appropriate treatment possible. HPS often contribute a unique perspective and expertise to the care of children, young people, and families. The quality of care improves when all caregivers share an understanding of how the child/young person is coping, the goals of the HPS Service, the purpose of the interventions to be provided as well as the outcomes of the interventions.

Assessment and documentation of plans of care

Through the documentation of the HPS Service plan of care for individual patients and families there can be improved understanding of the rationale of the specific interventions provided and an increased appreciation of the possible outcomes from collaboration with hospital play specialists. Documentation of clearly written HPS Service plan of care and the interventions that have been provided and the outcomes achieved allows hospital play specialists to leave a "footprint" of their work.

In the guidance document *Let's talk about …framework for a case study* there is an introduction to the clinical thinking and clinical reasoning that underpins the development and implementation of an HPS Service plan of care for an individual child, young person and their family.

Each form of documentation, including HPS Service plans of care, intervention and update chart notes, and discharge notes should include a clear statement of outcome(s).

Statement of outcomes

The statement of outcome should be derived from the outcomes of an intervention linked to a goal within the plan of care and the changes in behaviours observed.

> *For example, a goal may be to increase understanding and coping for a specific medical procedure. The healthcare intervention could be to provide a developmentally supportive preparation and coping programme for patient and supportive family member to increase their coping. Therefore, the HPS should identify the behaviours from the intervention e.g., that the child/ family members are able to cope better because of the preparation provided as child was less fearful of the equipment and better able to accurately explain what will happen in the procedure or demonstrates in role rehearsal the coping strategies to be utilised*.

Other HPS outcomes could relate to ongoing development, social contacts, decreased emotional stress, building self-esteem, increased understanding of hospitalisation, their medical condition or a specific procedure, encouraging a child to mobilise/ be active after a long stay in bed or where mobility is minimised, or increased adjustment to the health setting.

Consider in your documentation your role with children, young people and families and the parent's contribution to psychosocial care.

Charting policy

The key for successful documentation is the development of a charting policy for the staff in the HPS Service, even if this is a single person who provides the service. Individual hospitals have established basic standards and policies for charting that may include: where the HPS should chart, how the profession is to be identified, content for various types of documentation, required timeframes for documentation and often the format to be used. Common formats used internationally include the S.O.A.P (subjective, objective, assessment, plan) and A.P.I.E (Assessment, plan, intervention and evaluation). No matter what format is used, the content of each comprehensive note must include assessment information, a plan of care and the outcomes from the care/interventions provided by a hospital play specialist.

Strengthening performance improvement in documentation

Establishment and regular review of charting policy.

Consider the development of exemplars of the various forms of documentation i.e., comprehensive note, intervention provided, update note of plan of care or discharge note.

Collaborate with colleagues in other services on strengthening performance improvement within documentation across healthcare regionally and nationally. What information would be helpful?

Development of inservice learning on charting techniques for new staff and continuous education for existing staff. Establishment of regular review of staff charting notes as part of the performance improvement programme within an HPS Service.

Where services are provided in a group situation is there a record system for documentation i.e., what is recorded in the medical notes about play/recreation in the designated activity room/adolescent room.

Documentation requirements within an application for Registration

The clinical portfolio submitted for initial Registration requires three case studies with an example of the documentation relating to the case study. The charting note must identify assessment and any stressors identified, the HPS Service plan of care, intervention(s) made by the HPS and an evaluation/outcome statement. It must also meet the legal requirements for documentation in medical/ clinical notes within healthcare.