Patient Client Experience Standards

January 2012

Introduction

Patient Experience is a recognised component of high quality care[1]. Within the six Health and Social Care Trusts, there is a comprehensive programme of work in place to support the implementation of the Patient and Client Experience standards. Trusts are required to submit quarterly progress reports to the Public Health Agency (PHA) and Health and Social Care Board (HSCB). This report sets out the key findings and highlights the key actions arising from the findings.

Background to the Standards.

In April 2009, the DHSSPS published the 'Improving the Patient & Client Experience' standards document. The development of the standards incorporated a significant consultation and involvement of patients, carers and services users or their representatives. The document comprises five core standards:

- Respect
- Attitude
- Behaviour
- Communication
- Privacy and Dignity

All Trusts including the Northern Ireland Ambulance Trust (NIAS) adopted these standards during 2009/10 and arrangements were put in to develop methodologies to support their implementation. A Regional working group was established to support the development of the methodologies and arrangements for implementation. This group is led by Pat Cullen, Assistant Director Nursing, Quality Safety & Patient Experience.

The DHSSPS included the following target within the Priorities for Action (PfA) 2010/11:

'Following the adoption of the Patient and Client Experience Standards in 2009, Trusts should extend the clinical care areas monitored and increase the range of monitoring tools, and ensure appropriate reporting and follow up consistent with direction from the Public Health Agency.'

The commitment to continually improving the Patient Experience is reflected within the joint Commissioning Plan 2011/12. The plan notes:

'the core purpose of this Plan is to provide a clear roadmap for the future development of health and social care services in 2011/12 and beyond. The Plan is driven primarily by the desire to improve safety, quality and the patient experience – rather than by money'.

During 2011/12 the PHA and HSCB has continued to monitor the outcome of the patient client experience standards in a range of settings agreed by the Agency and HSC Trusts. Formal work plans were agreed with the Trusts for 2011/12.

Extending implementation and monitoring.

Within the six Trusts, the use of patient satisfaction surveys was tested during the third and fourth quarters of 2009/10. The surveys were tested in acute medical wards, non acute rehabilitation wards and acute mental health inpatient wards. The questionnaires were revised to reflect the learning from the surveys completed during the third and fourth quarters and an easy read version of the standards have been developed for those with learning difficulties.

These surveys have continued to be rolled out throughout a range of areas during 2010/11.

Continuing to build on this work, the Regional Patient Client Experience Working Group developed a work plan for 2011/12 with the emphasis on extending the range of methodologies for monitoring compliance against the five core standards. The additional monitoring tools developed include:

- Gathering Patient/Client stories
- Reviewing compliments and complaints
- Completing observations of practice
- Completing patient satisfaction surveys
- Completing audits of organisational arrangements

Summary of Key Findings from April – September 2011.

For this period, the six Trusts were required to submit reports to the PHA outlining their compliance within a range of care settings. Methodologies used included patient satisfaction surveys, observation of practice, patient stories and a summary of all compliments and complaints received during this period.

Approximately 40 wards/departments were formally monitored during this period.

Where trained observers noted any practice that had the potential to be detrimental to patient care they intervened at the time and reported the incident to senior staff on the ward/department.

Action Plans

Each Trust is required to submit a detailed action plan to address the key issues listed above. Trusts are required to identify timescales for implementation and provide details of the senior lead officer responsible for taking forward the implementation. These action plans are monitored by the working group.

Areas of Good Practice
In summary, the findings indicate patients are generally positive about their experience, and exemplars of good practice are set out below.

Respect
- Patients reported their wishes were respected in choices about care
- Attention was shown to religious beliefs
- Patients felt treated as an individual
- Student nurses where mentioned as being particular kind to older patients
- Kindness featured as a trait in many staff which patients valued highly.
- Medical staff sought permission and checked understanding with the patient before proceeding with procedures.

Attitude
- Staff were consistently reported as willing to help, kind and attentive
- Good humour was used consistently to make patients feel relaxed, calm and at home.
- Personal approaches to the delivery of care noted from all staff
- Time taken to explain procedures
- Descriptions such as care delivered in a compassionate and caring way were evident in the majority of returns.
- Ward sisters were mentioned as key, ‘on top of everything’, ‘settles patients in’ and ‘runs a tight ship’.

Behaviour
- Staff were reported to be polite and courteous, behaving in a professional matter
- Patients reported feeling safe and secure
- Air of calm in wards made patients feel safe
- Non verbal communication, for example smiling made patients feel better and gave patients confidence in staff.
- Patients impressed with cleaning in many areas.
- Doctors and nurses seen rubbing their hands constantly with gel.
- Support staff seen to engage with patients while at their work

Communication
- Staff welcoming when patients arrived in wards
- Spoke in a way that was easily understood
- Listened attentively
- Involved in decisions regarding care and treatment.
- Some patients enjoyed the company of others felt lonely in single rooms
- Some patients described how a nurse held their hands at times of anxiety how this made a difference.
- Good multidisciplinary communication was noted along with good teamwork.

Privacy & Dignity

- Maintained privacy and dignity through lowering voice or using curtains to maintain privacy
- Took steps to prevent embarrassment during care giving
- Some patient remarked on having their own room.
- Patients reported being given hand wipes before lunch
- Nursing Auxiliaries identified as being particularly sensitive to those with hearing difficulties
- Confused patients managed in a gentle way.
- Sensitive feeding of patients

Other positive issues highlighted

- The commitment of staff even when busy and short staffed
- The food was commended in some Trusts

Areas for Improvement

Whilst there was evidence that Trusts were providing care and treatment in accordance with the DHSSPS standards, there are areas where improvements clearly need to be made. Where there are issues of concern or areas where improvement is required Trusts have developed action plans which are scrutinised by the regional working group.

Examples of areas for improvement under each of the five core standards include:

Respect

- **Interruptions during care delivery** – many patients referred to persistent interruptions when receiving care, particularly care described as personal/intimate. The findings suggest that it is not always clear to patients why such interruptions are necessary, and the need for such interruptions is not always explained to patients. Interruptions at mealtimes continue to feature in responses, and increasing numbers of patients highlight a lack of assistance and support with eating and drinking.

Attitude

- While many staff were reported as engaging some failed to use patients names and failed to engage with patients prior to conducting procedures.
- In one Trust more traditional ward rounds, ‘end of bed discussions’ were reported’ with patient commenting on the lack of involvement and lack of privacy.

Behaviour

- **Noise** - Consistent in all feedback, patients reported frustration with high levels of noise at all time of the day and night. However night time was particularly challenging for patients. Some examples included: - staff talking loudly at nursing stations both on telephones and to each other, nurses shouting from one area of the ward to another area to gain others attention, cupboard doors banging at night, bins being slammed and noise from shunts going to the laboratory.

- **Moving Patients –** Comments were received from carers critical of the impact of moving frail elderly patients around the hospital. This added to confusion and did not support recovery.

Communication

- **Staff too busy** - frequently reported was the issue that staff appeared too busy, with not always enough time to spend with patients. A number of these comments were sympathetic to the staff and felt that there were issues with insufficient staffing levels. A number of reports indicated that patients are left waiting for considerable periods for assistance to use the toilet, and comments from staff such as 'I will only be a minute' are all too common, and in many cases, the 'minute' became an 'hour'.

- **Staff identification and language** Some patients commented that staff did not introduce themselves by name nor did they advise the patient on the procedure they were embarking on. This felt to patients that the care was being imposed. On many occasions, patients were finding they had to 'guess' who the member of staff was, i.e. a doctor, physio etc. Patients also reported they were frequently referred to by 'pet' names such as 'dear', 'petal', 'love' etc, and were not asked for permission for such names to be used.

- **Information –** significant numbers of patients reported they received limited/no information leaflets relating to their care or condition. Patients also expressed they were not provided with clear verbal explanations or information on their care and treatment.

- Some patients reported that they were not always involved in decisions being made about them.

- **Discharge -** Some patients raised concerns about the lack of discharge planning, particularly in relation to their date of discharge and on occasions patients felt they were given insufficient time from being told they were being discharged to actually going home. Some patients reported this can be a matter of 'minutes'. A number of delays due to waits for pharmacy were reported.

- **Single Rooms –** A number of patients described the loneliness of being in a single room.

- Patients reported that nursing call bells are difficult to access often positioned out of reach. When bells are in reach, it takes time for staff to respond.

Privacy and Dignity

- **Mixed Gender Wards –** increasing numbers of patients reported concerns about being cared for in mixed gender wards and bays within wards. This dissatisfaction featured in all five Trust responses. In particular, patients expressed embarrassment at having to use commodes in mixed gender areas.

- **Confidentiality -** Patients described how staff frequently discussed individuals care and treatment in 'earshot' of other patients. White Board Discussions – a new practice of team meetings around for example a white board to aide patient flow was identified as creating a challenge to maintain the privacy of patient information.

- **Personal privacy** - Some patients described that during physical examinations, their privacy and dignity was not always maintained, for example, curtains not fully closed during patient examination, and patients feeling exposed due to clothes not being replaced following examination.

- **Access to toilet facilities** – Quite a number of patients commented on the limited access of toilet and shower facilities.

- **Protected meal times** – This issue remains a challenge for staff and patients. Staff in one Trust was observed allowing patients food to get cold.

- **Visiting Times** – there remains a challenge between providing access for visitors and maintaining the privacy and dignity of other patients on wards.

Other

- The issue of the numbers of nurses on wards was as consistent feature in all five Trusts.

Actions

As referenced earlier Trusts are required to submit action plans associated with areas where improvement or attention is required. These action plans have named officers and clear timescale for action. Examples of actions taken by Trusts at a local level include:

- Customer Care training for staff.

- Reinforcement of the importance of the fundamentals of care and additional training for some staff in the skill of feeding patients and the importance of hydration and nutrition to recovery.
- Reviews of staff identification mechanisms.
- Changes to some working practices.
- Reviews of the use of mixed sex accommodation.
- Minor works to the ward/department environment
- Review of information provided to patients and family members.
- Review of the discharge process focusing on the role of pharmacy.
- Reviews of staffing levels.
- Feedback to staff given through local staff bulletins.
- Feedback to HSC Trust Boards.
- Inclusion of patient client experience standards as part of induction and incorporated in documents such as workbooks or policies and procedure manuals.

A number of other actions have commenced at a regional level which will be informed by the outcome of this work and positively impact on the experience of patients/clients including:

- Development of Key Performance Indicators for nursing staff - PHA
- Strengthening the role of the ward sister - NIPEC
- Normative Staffing levels – PHA

Next Steps

Strategic Leadership

The importance of a good experience of being a patient or client in the health and social care system cannot be underestimated. Since the Patient experience standard is currently no longer included from the key Departmental targets some organisations have reduced the support to teams leading this work.

To ensure that this remains a priority clear the HSCB/PHA are embarking on a campaign to gather 10,000 patient stories to inform commissioning and improve services to patients. This work builds on the engagement with patients with neurological conditions completed earlier in the year and will commence with a Ministerial launch later this year of phase one, 3,000 patients stories.

This work will be overseen by the strategic overview group. This group had been primarily led by the Directors of Nursing but will have its membership strengthened to include other professional groups, service users and carers and their representatives. While this group will continue to report to the PHA/HSCB it will now also submit reports to the HSCB/PHA Quality & Safety

Service group whose role is to provide an overview of issues related to Quality & Safety.

A central theme from the failures in Mid Staffordshire appeared to be a reliance process measure and targets and a failure to bring a number of data sources together to give an overarching picture of the organisation, this is the key role of the Quality & Safety Service Group.

Reporting

Whilst each Trust is required to report on the agreed areas, the mechanisms for reporting vary throughout Trust area. An agreed template to facilitate robust review and monitoring has been developed which will require Trusts to provide details on a consistent number of indicators both quantitative and qualitative.

A further schedule of reporting for 2012/13 is agreed:

Quarter 1	Accident & Emergency
Quarter 2	Community Settings (Treatment Rooms, District Nursing)
Quarter 3	community Settings (Residential/Nursing Homes, Day Centres)
Quarter 4	Learning Disability

Trusts will continue to develop action plans to address the findings to improve the experience of patients, and ensure both the patients/clients and frontline staff are involved in developing the solutions.

At the same time the Quality & Safety Service Group is liaising with RQIA who plan an inspection of patient experience.

Staff Wellbeing

There is significant evidence that the wellbeing and morale of staff working in health and social care is directly related to the experience of patients and clients. This was acknowledged in the development of the standards when it was acknowledged that, ***'staff can have a real impact upon the experience of those who use our service by how we communicate, by how we co-operate and support colleagues, and by creating a friendly environment where we can all take pride in the services that we offer.'***

The Overview Group will examine for 2012/13 mechanisms to measure and link the experience of staff to the experience of patients/clients.

Workshop

While many Trusts have progressed actions at a local level it is clear that there are consistent themes where action can be taken on a regional basis.

A workshop has been arranged to share the findings, actions and improvements locally that have been developed to improve the patient care and discuss how best to address the common themes/issues regionally.

Conclusions

Understanding and improving how patients experience their care is a key component to the successful delivery of high quality care. This report highlights the good work already undertaken by Trusts in relation to the patient experience and there is no doubt that in the areas where this work has been concentrated progress has been made in relation to improving the patient experience.

However there are challenges ahead for all HSC organizations, the main one being in relation to spread and sustainability of good practice. It is not just about doing it right once but that we can consistently get it right time and time again. There also needs to be a proactive approach in relation to recurring themes and ensuring the messages are getting to the frontline staff.