

Getting the Fundamentals of Care Right

Essence of Care Evaluation of Practice Day

Report

August 2006

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Introduction:

The Essence of Care (benchmarking) Strategy was launched by the Department of Health in February 2001 to provide a practical toolkit for nurses and other team members to focus on 9 aspects of care identified as crucial to the quality of care and patients' experience. These are: -

- o Continence, bladder and bowel care
- o Personal and oral hygiene
- o Food and nutrition
- o Pressure ulcers
- o Privacy and dignity
- o Record keeping
- o Principles of self care
- o Communication
- o Safety of clients with mental health needs in acute mental health and general hospital settings

Benchmarking provides a tool to help practitioners take a patient-focused and structured approach to sharing and comparing good practice. It has enabled health care personnel to work with patients, to identify best practice and to develop action plans to improve care.

Considerable work has been done in relation to some of these benchmarks since they were launched at West Hertfordshire Hospitals NHS Trust in 2002.

A new strategy has been developed to take forward this work in 2006. The purpose of this exercise was to assess the extent to which progress has been made in improving the fundamental aspects of care for patients utilising a focussed and manageable approach. This Evaluation of Practice Day took place in July / August 2006:

The Top Five Priority Areas of each benchmark (see page two) were identified and a three-pronged approach was adopted as the framework for evaluation of practice i.e.

- o review of patient healthcare records
- o evaluation through direct observation of care
- o asking our patients &/or the family / friends for feedback

Audit Process:

The Senior Sister/Charge Nurse for each area led the initiative within their area. They were asked to act as the internal observers (or to nominate a suitable representative) for the Observations of Care and an external observer was allocated.

Three periods of Observation were undertaken during the day. Times for these were suggested to cover periods when activities such as assistance with hygiene needs, nutritional needs and the other fundamental aspects of care would have been expected to be taking place.

The documentation of 8-10 (or 30%) patients was reviewed against an audit tool.

A questionnaire was given to 8-10 (or 30%) patients or their visitors with a plain envelope for them to seal in the completed questionnaire to ensure confidentiality.

The completed documentation audit tool, questionnaires, Observation of Care reports and action plans were returned to the Essence of Care Leads.

Whilst each Ward Manager was expected to review and action the findings for their own area the Essence of Care Leads have summarised the findings for the Trust as a whole and their findings are reported in the sections that follow.

Evaluation of Practice (Top 5 Priorities)

<p>Food & Nutrition</p> <ul style="list-style-type: none"> • Compliance with Protected Meal Times – <i>(Direct Observation)</i> • Assistance for those that require help <i>(Use of Red Trays)</i> – <i>(Direct Observation)</i> • Environment / Hand washing – <i>(Direct Observation)</i> • Evidence of assessment <i>(Nutrition Risk Score)</i> - <i>(Documentation Audit)</i> • Patient satisfaction with meal - <i>(Questionnaire)</i>
<p>Principles of Self Care</p> <ul style="list-style-type: none"> • Patients are encouraged to wear own clothes when possible – <i>(Direct Observation)</i> • Sufficient information materials are available to support informed decisions about care – <i>(Direct Observation)</i> • Patients are involved in decisions about their care <i>(negotiation re. level of involvement)</i> - <i>(Questionnaire)</i> • Discussions with patients / carers are recorded - <i>(Documentation Audit)</i> • Patient / carers are given sufficient information regarding condition / danger signals / on-going management on discharge - <i>(Documentation Audit)</i>
<p>Communication</p> <ul style="list-style-type: none"> • Private discussions / “sensitive” conversations / patient details are not over heard – <i>(Direct Observation)</i> • Patients’ family have an opportunity to talk to a doctor / nurse - <i>(Questionnaire)</i> • Patients receive answers to their queries about care that they can understand - <i>(Questionnaire)</i> • Staff do not speak about (in front of) patients as if they were not there (patients feel involved) - <i>(Questionnaire)</i> • Patients feel able to approach staff to discuss worries / fears / concerns - <i>(Questionnaire)</i>
<p>Personal & Oral Hygiene</p> <ul style="list-style-type: none"> • Care of Dentures – <i>(Direct Observation)</i> • Evidence of Assistance when needed – <i>(Direct Observation)</i> • Evidence of Assessment of needs - <i>(Documentation Audit)</i>
<p>Bladder & Bowel Care (Continence)</p> <ul style="list-style-type: none"> • Hand washing post toileting – <i>(Direct Observation)</i> • Place of toileting (commodes at bedside) – <i>(Direct Observation)</i> • Use of toileting aids (pads) – <i>(Direct Observation)</i> • Privacy & Dignity during toileting – <i>(Direct Observation)</i> • Evidence of assessment - <i>(Documentation Audit)</i>
<p>Pressure Ulcers</p> <ul style="list-style-type: none"> • Moving & Handling <i>(use of appropriate aids)</i> – <i>(Direct Observation)</i> • Repositioning – <i>(Direct Observation)</i> • Use of seating aids – <i>(Direct Observation)</i> • Evidence of assessment & Management <i>(Waterlow, Care Plan)</i> - <i>(Documentation Audit)</i> • Communication / Pt Education - <i>(Questionnaire)</i>
<p>Privacy & Dignity</p> <ul style="list-style-type: none"> • Curtains closed as necessary – <i>(Direct Observation)</i> • Staff knock / announce themselves before entering – <i>(Direct Observation)</i> • Patients are appropriately dressed / covered <i>(including transfer)</i> – <i>(Direct Observation)</i> • Patients are not disturbed <i>(when washing, eating, being examined, having a procedure performed, using a commode or having a quiet time)</i> – <i>(Direct Observation)</i> • Mix Sex Bays are avoided – <i>(Direct Observation)</i>
<p>Record Keeping</p> <ul style="list-style-type: none"> • Discharge Planning - <i>(Documentation Audit)</i> • Patient Assessment - <i>(Documentation Audit)</i> • PAR Scoring - <i>(Documentation Audit)</i> • Spiritual Care - <i>(Documentation Audit)</i> • Care Planning - <i>(Documentation Audit)</i>

Findings:

Food & Nutrition

Audit Process

The Food & Nutrition benchmark has been progressed since November 2001 with a baseline audit report published in April 2002 and a re-audit undertaken in June 2003 and August 2005. The purpose of benchmarking Food and Nutrition across the Trust was to ascertain the level of practice delivery with the agreed patient/client focused outcome of: **'Patients/Clients are enabled to consume food (orally) which meets their individual need'**. (Essence of Care, February 2001)

In response to the previous audit results two key initiatives, Red Trays and Protected Mealtimes were introduced across the Trust with the aim of improving the patient experience at mealtimes. The Red Trays are designed to highlight patients in need of assistance and the Protected Mealtime to minimise interruptions to patients, enabling them to eat their meal in a calm and relaxed environment.

The meal delivery service at WGH/MVH and HHGH/SACH is very different due to the introduction of STEAMPLICITY at Watford and a bulk delivery service at HHGH/SACH. However the principles underlying the organisation and preparation for mealtimes should be standard practice on all sites.

Therefore the focus of this audit was on:

- Compliance with Protected Meal Times – (*Direct Observation*)
- Assistance for those that require help (*Use of Red Trays*)
- Environment / Hand washing
- Evidence of assessment (*Nutrition Risk Score*) - (*Documentation Audit*)
- Patient satisfaction with meal - (*Questionnaire*)

The audit results detailed below give some examples of good practice as well as areas in need of improvement.

A consistent theme throughout the observation process was that the role of the Housekeeper had a significant positive impact on the organisation of the meal service and the communication with patients and staff to ensure patients are provided with the appropriate meal.

Examples of good practice to share

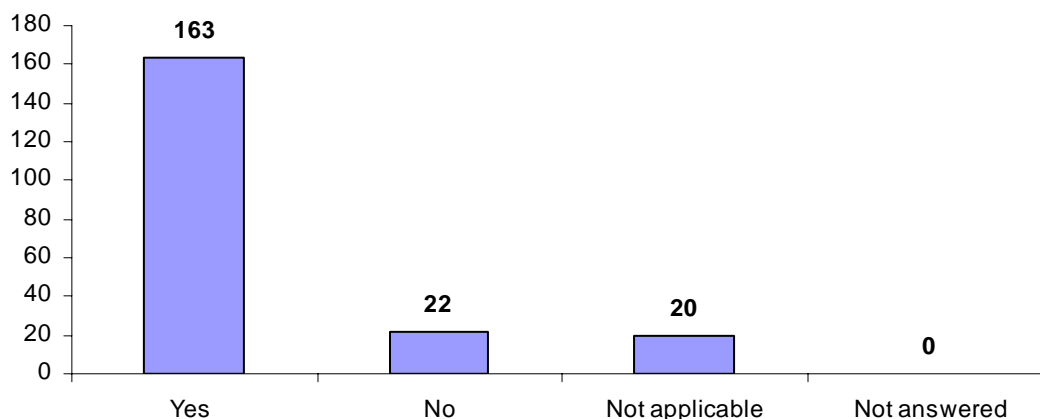
- Quiet ward environment and evidence of Protected Mealtimes observed in 55% of areas
- Staff wearing appropriate apron/protective clothing when serving meals (green apron)
- Red Trays used for vulnerable patients observed in some areas (50%)
- Patient hand wipes in use in many areas (75%) and being used prior to meals
- Evidence of staff organising meal service to accommodate patients who need assistance to feed (offering commodes/ positioning/ hand wipes prior to meal service)

Changes to improve practice

- Need to increase compliance with Protected Mealtimes and address the issues of noisy environment on wards where staff use main corridor of wards as a short cut to other areas
- Ensure adequate supply of red trays in all ward environments and reinvigorate red tray initiative in specific ward areas where initiative not evident
- Encourage and assist patients to use hand wipes prior to meal

- Reinforce 'Patient Feeding Protocol' across all areas to ensure consistency in approach to the organisation of mealtime (everyone is responsible for ensuring patients are provided with an appropriate meal on time, at the correct temperature and of their choosing)
- **Evidence of Assessment (*Nutrition Risk Score*)**

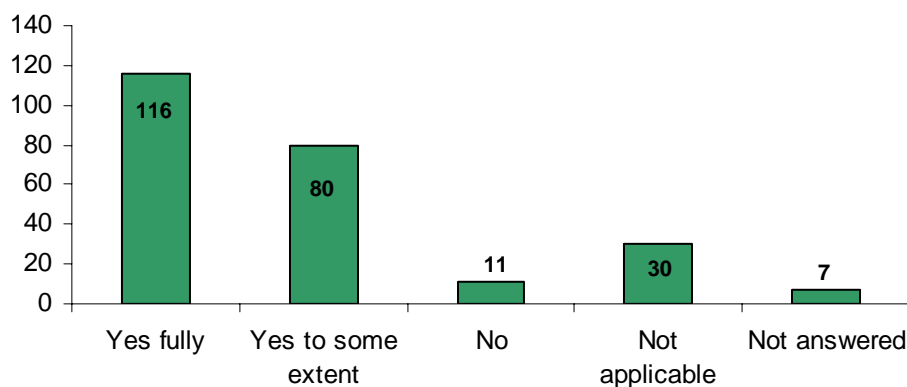
Ward / department staff were asked to audit the nursing sections of the healthcare records of approximately 30% of their patients. The documentation of a total of 205 patients were examined and reviewed. A Nutritional Assessment was completed for 88% (*n=185*) of patients where this was applicable.



It is noted that 22 % of patients did not have a nutritional plan of care. This is a significant percentage of patients that requires addressing at local level. The first draft of a Core Care Plan for Nutrition has been developed and presented to the Clinical Practice Forum and it is expected the introduction of this care plan will improve compliance and subsequent care delivery for patients assessed as nutritionally at risk. In addition to this action there is a need to raise the profile and importance of nutrition when delivering patient care. This can be achieved by re establishing the role of the nutritional link nurse on the Watford site to mirror practice at Hemel Hempstead. It is also intended that the business case for a Nutritional Nurse Specialist will be revisited via the Nutritional Focus Group.

- **Patient satisfaction with meal.**

Patients were asked ... "Were you satisfied with the quality of the food provided?" Of the 244 responses received 47% (*n=116*) were fully satisfied and less than 5% (*n=11*) reported that they were not satisfied.



Comments:

"Excellent."

"Food is good and very tasty."

"Overcooked, under-seasoned, over processed."

"Sometimes not very hot."

"Right sized portions."

"Obviously not home cooking but excellent never the less. The brown bread & rolls are excellent and so is the choice of menu."

"Much better than last time I was in."

"Good portions, good choice."

As the results reflect the patient's response has been extremely positive overall, but this must not generate a level of complacency.

Medirest is currently addressing the reference to the cool temperature of the food, noted mostly on the Hemel Hempstead site. Historically plate lids have not been provided as part of the local catering service but with the introduction of STEAMPLICITY at Watford there is no longer a requirement for plate lids to be used on the site therefore all available plate lids will be transferred to Hemel Hempstead site.

In addition there is a need to identify what the issues were with the < 5% who were dissatisfied with the meal service to prevent further escalation of the problem. This can be achieved through a continuous collaborative approach between Medirest, Patient Representatives and relevant healthcare professionals within the Trust.

Communication

Ensuring effective communication is fundamental to the patient experience with the healthcare service. Communication is often taken for granted when in fact it involves many facets and the skills staff require to ensure effective communication are complex. Staff need to: -

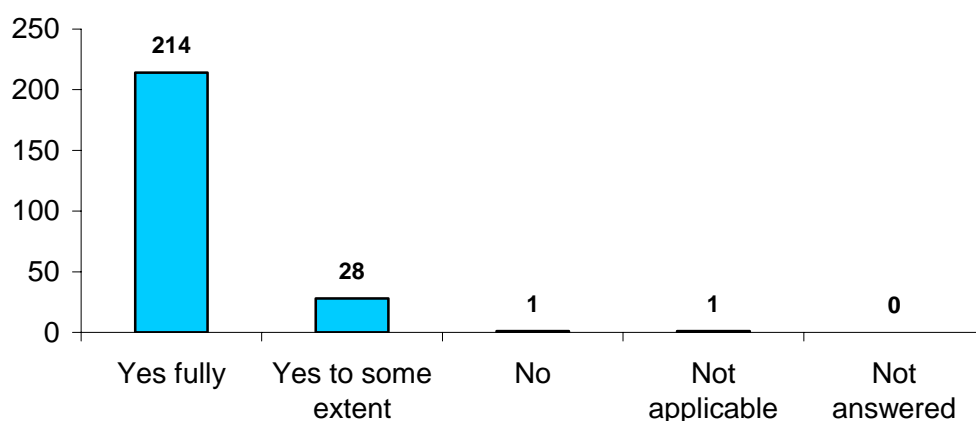
- o ensure openness, honesty and transparency
- o recognise consent and confidentiality issues
- o recognise the principles of common courtesy
- o be aware of the importance of body language and other non-verbal communication
- o have the skills to establish rapport, active and empathic listening, being non-judgemental
- o recognise the importance of using straightforward language and avoiding jargon
- o have the skills to adapt approaches to communication, to be sensitive to language and cultural differences to individual developmental needs and disabilities, to the psychological state and the experience of the patient and or carer

In recognition of the complexity of the issues staff face a “top five” standards of best practice patients have the right to expect from staff at West Hertfordshire Hospitals Trust were selected with the aim of identifying where we are getting things “right” and highlighting areas where efforts can be focused to ensure improvements. These are: -

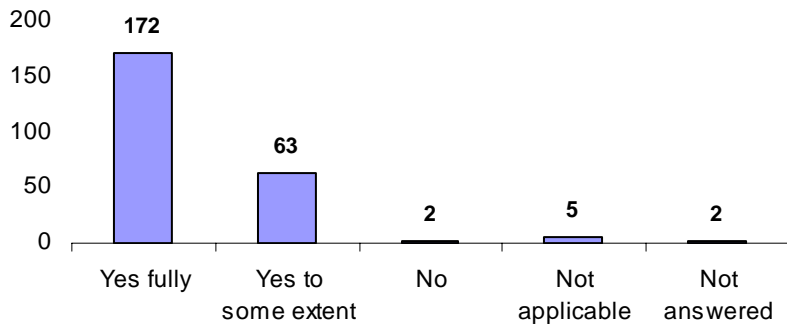
- Private discussions / “sensitive” conversations / patient details are not over heard – (*Direct Observation*)
- Patients’ family have an opportunity to talk to a doctor / nurse - (*Questionnaire*)
- Patients receive answers to their queries about care that they can understand - (*Questionnaire*)
- Staff do not speak about (in front of) patients as if they were not there (patients feel involved) - (*Questionnaire*)
- Patients feel able to approach staff to discuss worries / fears / concerns - (*Questionnaire*)

Our success in meeting these standards of care for patients was evaluated during the 2-3 periods of observation on each ward on one day in July / August 2006 and through asking our patients, and their families for their feedback.

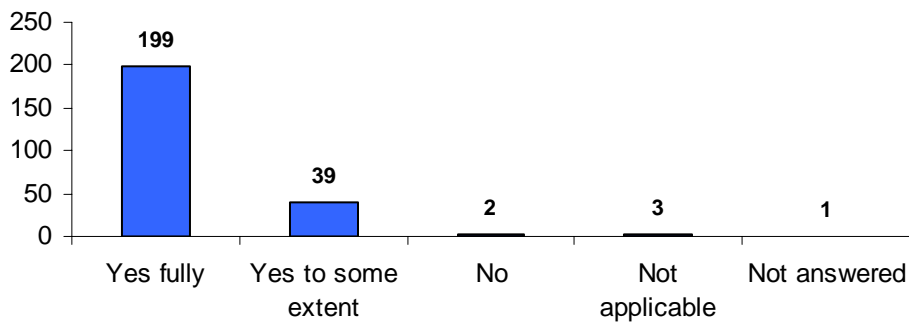
Patients were asked ... “Did staff appear friendly, welcoming and helpful?” Of the 244 responses received 88% ($n=214$) answered yes fully whilst only one patient answered no to this question.



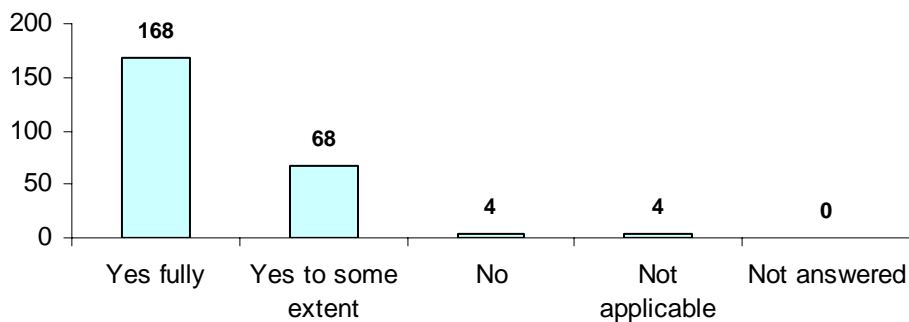
Patients were asked ... “Were staff available for you to ask staff questions?” Of the 244 responses received 70% ($n=172$) answered yes fully whilst only two patients answered no to this question.



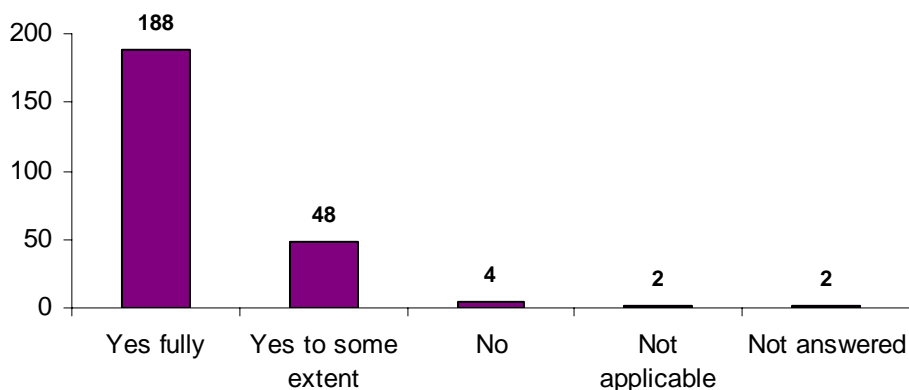
Patients were asked ... “Did you feel able to ask staff questions?” Of the 244 responses received 81% ($n=199$) answered yes fully whilst only two patients answered no to this question.



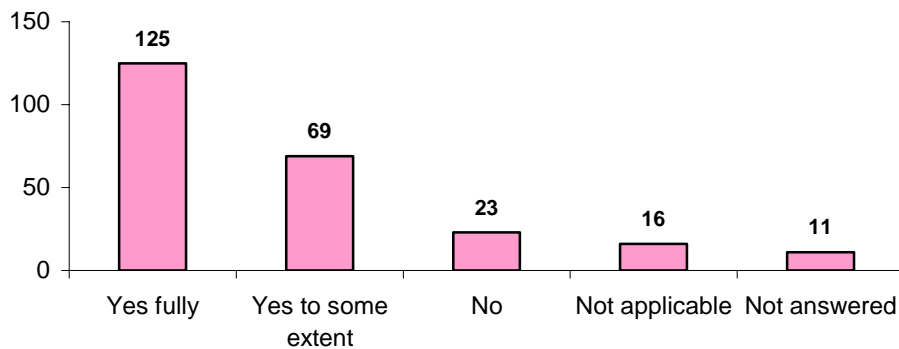
Patients were asked ... “When you had questions to ask, did you get answers you could understand?” Of the 244 responses received 69% ($n=168$) answered yes fully, 29% ($n=68$) answered yes to some extent and four patients answered no to this question.



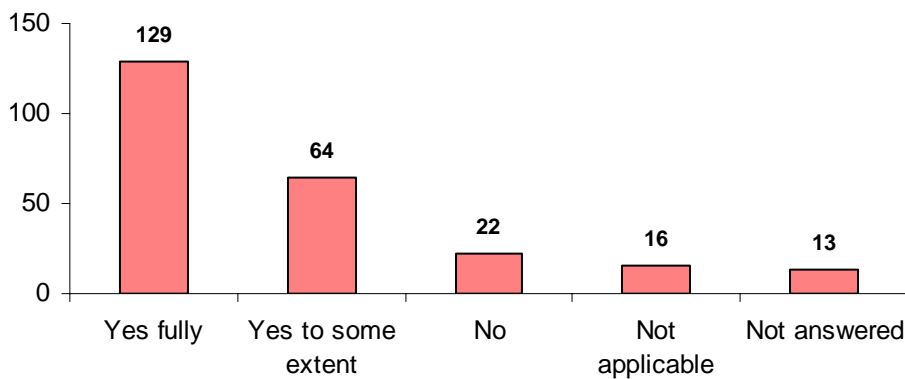
Patients were asked ... “Did you feel staff used straightforward language in discussions with you?” Of the 244 responses received 77% ($n=188$) answered yes fully, 20% ($n=48$) answered yes to some extent and four patients answered no to this question.



Patients were asked ... “Did you feel included in discussions about you?” Of the 244 responses received 51% ($n=125$) answered yes fully, 28% ($n=69$) answered yes to some extent and 23 patients answered no to this question.



Patients were asked ... “Did you feel enabled to contribute to discussions about you?” Of the 244 responses received 53% ($n=129$) answered yes fully, 26% ($n=64$) answered yes to some extent and 22 patients answered no to this question.



A small selection of some of the observations are cited below.

Example of good practice to share

- Many observers reported that the bedside curtains were drawn before conversations with patients to try to maintain privacy for patients. Many also noted that these conversations were not audible to the observers indicating a conscious effort by staff to ensure patient privacy / confidentiality
- Many observers reported that the ward telephones were answered promptly i.e. within 2-3 rings to Trust Standard i.e. giving a greeting, naming the ward/dept and giving the name or title of the person answering
- Many observers reported prompt responses to call bells
- Many observers reported that staff were wearing identification badges and seen to be introducing themselves to patients. This included nurses, theatre porters, physiotherapists and phlebotomists
- There were a few examples of good practice reported regarding supporting patients with communication difficulties. On one ward a nurse was using an “alphabet board” with a dysphasic patient and another nurse was observed spending time with a dysphasic patient unhurriedly and patiently clarifying his request.

Changes to improve practice

- It was observed that during one observation period a lot of the conversations were between staff without involving the patients
- One observer reported “the doctor didn’t draw the curtain around the patient when speaking to him about discharge and treatment and we could hear every word”

Conclusions:

The findings of this evaluation of practice day indicated that whilst there are many examples of good practice regarding communication there is a lack of consistency. A large number of patients reported that staff appear friendly, welcoming and helpful however 37% reported that they feel included in discussions about them only to some extent or not at all. Many observers reported prompt responses to call bells however a few observers reported that some patients waited for a response for longer than acceptable and a few mentioned that patients were left for periods without the call bell within reach. The focus of our improvement initiatives over the next six months will therefore be aimed at reducing the inconsistency and facilitating a culture where staff can learn from examples of good practice. Each ward / department will work on their individual action plans addressing the specific issues they identified for improvement.

Privacy & Dignity

Nursing staff at West Hertfordshire Hospitals Trust aim to do all that they can to protect the privacy and dignity of our patients. Work undertaken at the Trust in 2005 found that on the whole we are successful in this aim. 95% of the 454 patients responding to a questionnaire stated that they were always treated with respect by the hospital staff and 86% stated that their modesty & privacy was maintained during their hospital stay / visit. In a culture where continuous improvement is sought and in recognition that we do not always get things right we do not plan to “rest on our laurels”. Although some “indignities” are unavoidable for hospital patients we believe there are certain standards that every patient should have a right to expect. These include: -

- Curtains closed as necessary
- Staff knock / announce themselves before entering
- Patients are appropriately dressed / covered (*including transfer*)
- Patients are not disturbed (*when washing, eating, being examined, having a procedure performed, using a commode or having a quiet time*)
- Mix Sex Bays are avoided

Our success in meeting these standards of care for patients was evaluated during the 2-3 periods of observation on each ward on one day in July / August 2006; a small selection of some of these observations are cited below.

Example of good practice to share

- A number of observers reported that single sex bays were maintained. No exceptions to this were reported
- A number of examples of good practice being maintained regarding patient modesty were reported. A patient was given a theatre gown to wear as a dressing gown as he did not have one of his own; observers reported that a patient being taken to x-ray was adequately dressed in dressing gown and slippers
- A number of observers reported that staff knocked (announced themselves) before entering a bed space / side room
- A male nurse was observed asking a female patient if she had any objections to him helping her to wash
- A number of areas that see out-patients mentioned using music (appropriately) to help prevent examinations / personal discussions being overheard
- The observers reported a number of examples of good practice regarding confidentiality of patient details e.g. OPD clinic patient list kept face down on the desk, white board on ward up-to-date with clear information

Changes to improve practice

- A male volunteer observed cleaning high surfaces such as the curtain rails in a female bay whilst ladies are washing behind curtains. He had to be asked by nursing staff to come back after the patients had finished their washes
- Patient's curtains were not drawn during conversation between doctors and patients or during procedures; doctors stood at the bottom of the bed to discuss the patient's condition
- A nurse was observed to engage a patient in a discussion about their discharge whilst he was on the commode

Conclusions:

The findings of this evaluation of practice day indicated that whilst on many occasions staff are meeting the privacy and dignity needs of patients we are not consistent in this i.e. by all staff, for all patients, at all times. We do appear to be very successful in the maintenance of single sex accommodation with the exception of admission and critical care areas. Whilst there were many reports of staff announcing themselves before entering a bed space / side room observers also reported that on occasions staff did not observe this standard of best practice. All patients have the right to expect to be able to wash or toilet in private. The focus of our improvement initiatives over the next six months will therefore be aimed at reducing the inconsistency, facilitating a culture where staff can learn from examples of good practice. Each ward / department will work on their individual action plans addressing the specific issues they identified for improvement.

Pressure Ulcers

The incidence of hospital acquired pressure ulcers is regarded as a key indicator of quality of care within hospital Trusts. The Trust engages in a robust and pragmatic approach to prevent and manage the incidence of pressure ulcers, including implementing the Essence of Care benchmarks. The Pressure Ulcer Benchmark contains nine individual factors, which encompass all aspects of pressure area care including assessment, care planning, communication, and allocation and utilisation of resources. To assist in undertaking the initial benchmark, a tool consisting of a documentation audit, patient observation period and patient/carer questionnaire originally developed by the Tissue Viability Nurses Forum – South was amended for local use within the Trust. Following the initial benchmarking exercise, five main areas were identified as requiring a closer focus for this subsequent benchmarking exercise; these were moving & handling, repositioning, the use of seating aids, communication/patient education, and documentation. Information was retrieved through an observation of care, patient questionnaire, and documentation audit. The results are as follows:

Moving and Handling

This was assessed through the observation of care. Documentation relating to moving and handling was identified in observations in three clinical areas. All observations positively reflected good practice, demonstrating patients were appropriately assessed, transferred with appropriate moving and handling techniques, and there was good communication between the nursing staff and the patients. This is a significant improvement on the last benchmarking exercise, which had showed patchy and erratic practice in this area.

Repositioning

Repositioning was more difficult to assess partly due to the shortened observation time, therefore giving greater potential to miss observed regular repositioning. However, where clinical areas observed repositioning, again this was positively commented on. Aspects of good practice included using repositioning to inspect the skin on vulnerable areas where pressure damage is more likely. It was also observed that the staff explained to the patient what intervention was being done, and gained the patients consent before undertaking repositioning. This showed an increase of patient involvement in their care and care planning.

Two clinical areas did not document any observations relating to repositioning; this could be partly due to the short observation time period, or due to not being undertaken. Five areas documented that it was not considered to be applicable due to the types of patients involved; these areas were Outpatients, Endoscopy, and Day Surgery. Within the pre-operative assessment unit patient's pressure area problems and repositioning needs were discussed to establish vulnerability prior to admission.

Use of Seating Aids and Mattresses

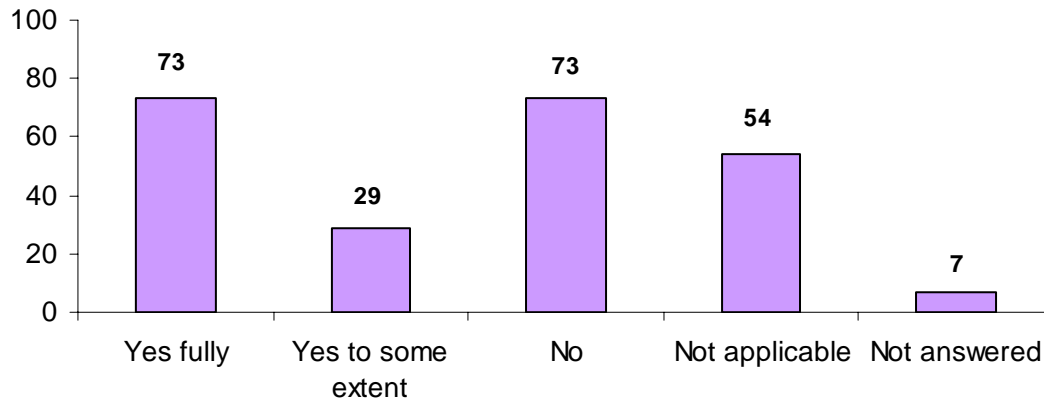
Observed practice relating to ensuring appropriate equipment provision varied between clinical areas. In one clinical area a patient was observed to be assessed as at risk of pressure damage and the appropriate equipment was immediately sought; however in another observation, a patient identified as being at risk failed to be placed on pressure relieving equipment and the nursing staff were not observed to order such equipment and the patient was left on a standard foam mattress.

The majority of clinical observations mention the use of pressure relieving equipment mattresses and electric profiling, both very effective strategies at preventing pressure ulcers. However it was not observed whether this equipment is being used appropriately and being reviewed regularly. The lack of use/availability of pressure-relieving cushions for patients when sitting them out of bed whilst on a pressure relieving mattress so 24-hour pressure relief is obtained was also highlighted in a large proportion of observations. Although this has generally improved since the last benchmark there is still some room for improvement.

Communication / Patient Education.

Questionnaires were distributed to patients and/or their carers where appropriate, to ascertain their views on how their pressure area care needs were managed whilst in hospital. The questions asked focused on whether they were involved in discussing their pressure area care management, and understood the rationale for the interventions taken. A total of 236 responses were received, and the results were as follows:

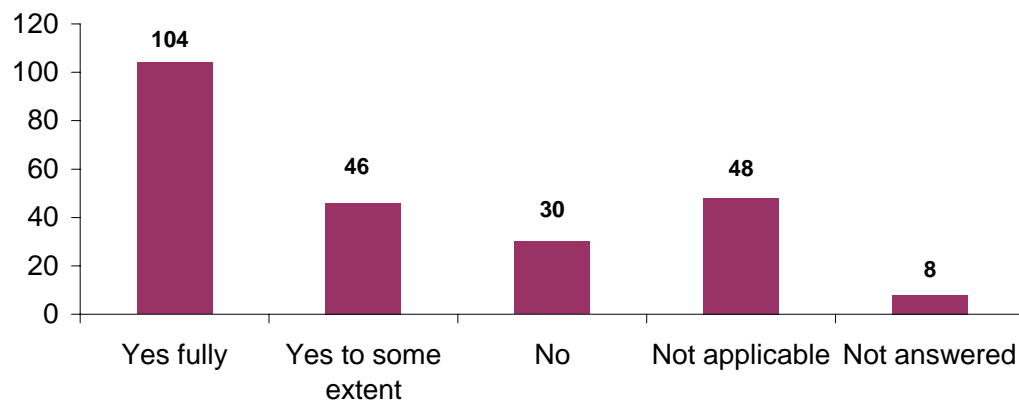
1. *Do you understand why you need to change your position (move around)?*



Of the 236 responses received 31% ($n=73$) stated they were fully informed however an equal number reported that they were not informed.

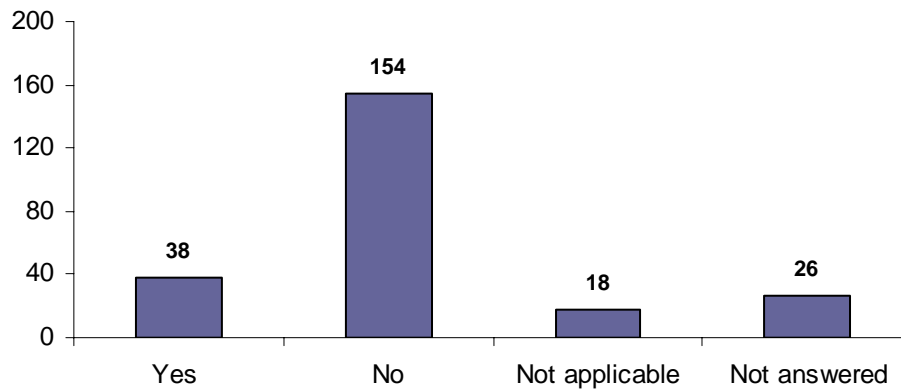
This is a disappointing result as there has been a slight decrease in positive response since the last benchmarking exercise, therefore highlighting a need to re-educate staff in the importance of patient education.

2. *“Have you been informed about the importance of changing your position when in bed?”*



44% ($n=104$) stated they had full understanding of why they need to change their position when in bed however 13% ($n=30$) stated that they did not know this. There has been a significant improvement in positive responses since the last review. A high proportion of answers stating 'not applicable' directly relate to the clinical areas stated previously who do not have relevant in-patient types (e.g. outpatients, endoscopy etc).

3. "Have you been given any information about the prevention of pressure ulcers?"



Only 16% ($n=38$) of patients answered yes to this question while 65% ($n=154$) stated that they had not received any information. This is a significant decrease from 53% of positive responses in the previous benchmarking exercise, which is very disappointing. Following the last benchmarking exercise, all clinical areas were provided with additional training regarding providing different types of patient education in relation to pressure area care, as well as details regarding how to obtain patient information leaflets – this has obviously not been utilised effectively.

Additional comments made by patients

"Given Leaflets" (Flaunden)

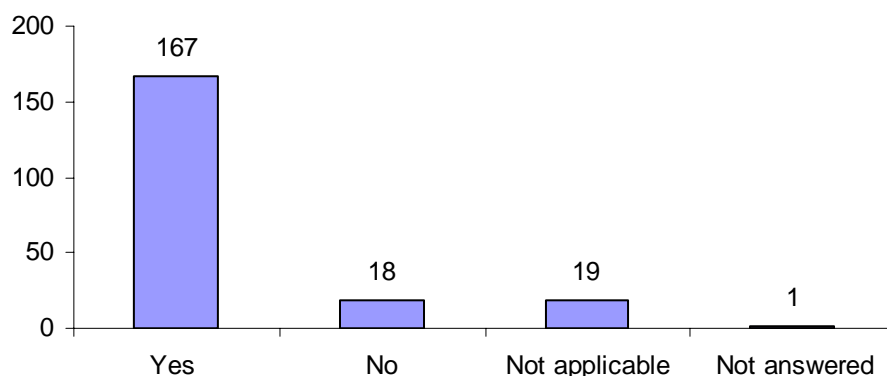
"Verbally told to move position regularly." (Lancaster)

A number of patients reported that they understood why they had been put onto a "special" bed / mattress.

Evidence of Pressure Ulcer Risk Assessment and Management

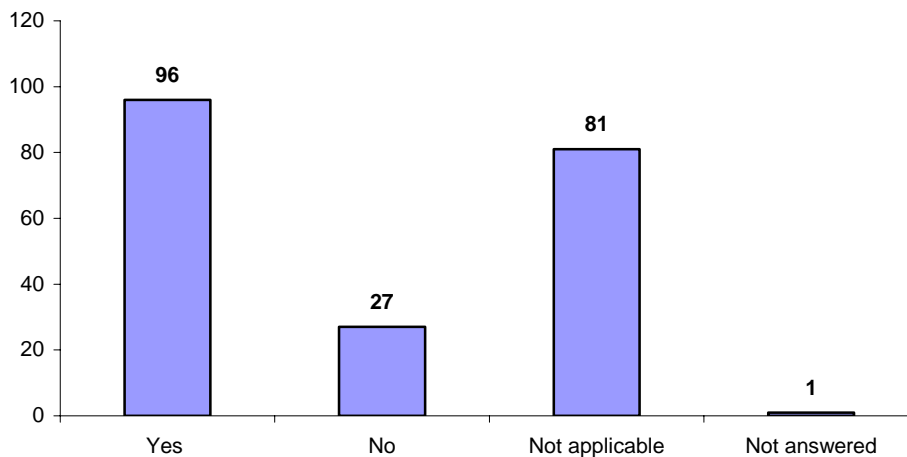
In order to assess the level of pressure ulcer risk assessment, care planning and management that took place in the clinical areas, ward / department staff were asked to audit the nursing sections of the healthcare records of approximately 30% of their patients. The documentation of a total of 205 patients were examined and reviewed.

A Waterlow risk assessment was completed for 90% ($n=186$) of patients where this was applicable.



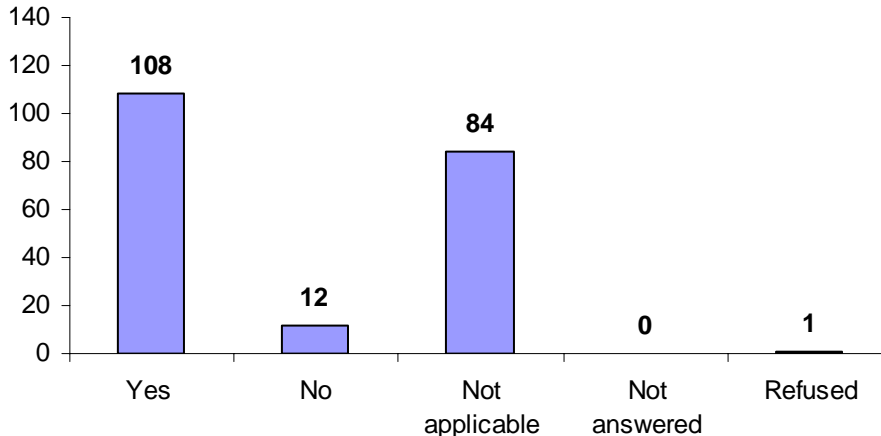
This is a significant improvement (increased from 80%) since practice was last reviewed, although there continues to be scope for improvement. National and Trust clinical guidelines state that 100% of in-patients should have a formal pressure ulcer risk assessment where appropriate.

Where patients were identified as being at risk of developing pressure damage, records were reviewed to see whether applicable patients had a plan of pressure area management recorded; this was only the case for 78% ($n=96$) of patients.



This is obviously an area identified as needing improvement in order to ensure that pressure ulcers are effectively prevented. The reasons for the omission of care planning in these circumstances are not known.

The attainment of appropriate pressure relieving mattresses was also assessed in the health care records. Where applicable 89% ($n=108$) of patients were nursed on a mattress appropriate to their Waterlow score. On one occasion where a patient was identified as being at risk, staff reported that the patient refused to change to an appropriate mattress.



A significant proportion of patients were placed on appropriate pressure relieving equipment although 11% of patients had failed to have their equipment needs met. Relating this data to information gathered through observations, whilst a high proportion of patients had access to pressure relieving mattresses that addressed the basic needs of the patient, a high proportion of such equipment was at a clinical specification that far exceeded the needs of the patients.

Example of good practice to share

- o Manual handling practices were observed to be performed correctly and with the appropriate equipment
- o Nursing staff encouraged patients to mobilise and reposition regularly
- o There was widespread evidence of pressure relieving equipment being used on high risk patients

- o One clinical area was observed to ensure that the type/level of equipment was continued from what was currently installed in the patient's home
- o Good communication between patient and nurses around pressure relieving strategies and advice was observed
- o Pre admission clinics discuss with all patients the risks of developing pressure ulcers and existing pressure damage management prior to admission

Changes to improve practice

- o Inappropriate use of mattresses to be minimised by re-education of staff around equipment selection
- o The Trust needs to invest in the procurement of pressure-relieving cushions to ensure the provision of 24-hour pressure area care
- o The need for patient education and information giving needs to be reinforced to all nursing staff. A specific emphasis needs to be placed on the provision of patient information leaflets
- o Additional training and support to ensure staff plan and document care strategies to minimise the risk of tissue damage after formally identifying that the patient is vulnerable to pressure damage

Summary

Generally there have been improvements in the majority of areas identified as being the focus of the pressure ulcer benchmarking exercise. Repositioning, although more difficult to assess appears to have improved, and involvement of patients in this process has also increased. Pre admission clinic is forward thinking with looking at the pressure ulcer risk of patients in preparation for admission. Pressure relieving mattresses are being widely used, but we need to concentrate on ensuring that the patient is continually reviewed to evaluate that it is still the most clinically appropriate mattress for their needs.

Principles of Self Care

The principles of self-care benchmark was developed to ensure that patients have control over their own health care and to assist health care professionals to support patients to make informed choices in relation to health care and to negotiate responsibility for their own health. Being able to make choices whilst in hospital can be limited and patients often report feeling dis-empowered and vulnerable. The ability therefore to exercise some choices is valued highly among patients.

The observation exercise was designed to determine the extent to which self care was encouraged in the following areas:

- Patients are encouraged to wear own clothes when possible
- Sufficient information materials are available to support informed decisions about care

There were very good examples of patients being assisted to make menu choices, to choose whether to have a shower or wash and the time that they would like to have a bath etc.

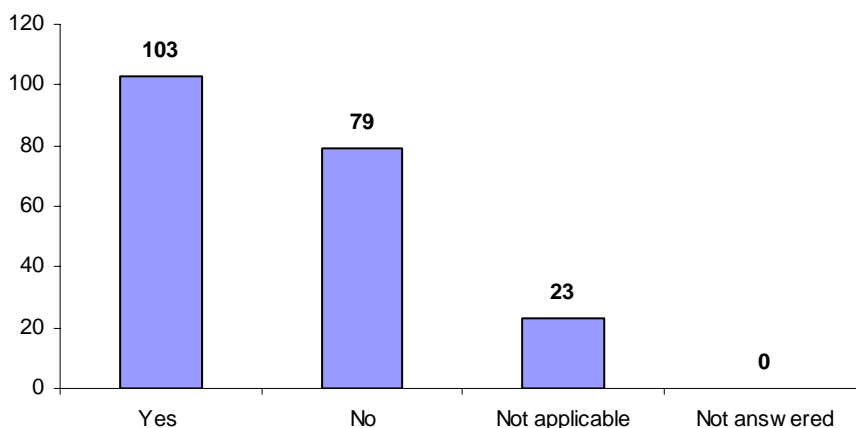
In some clinical areas patients were observed wearing their own clothes and staff encouraged relatives to bring in personal items of clothing.

Some wards had had their bathrooms upgraded to enable better access for patients with disabilities and toilet facilities were labelled '*male*' or '*female*'.

In some areas there was printed information available to patients and laminated information sheets available for patients and their relatives

Evidence that information (written or verbal) given to patients/carers has been recorded

It is important that information given to patients and their relatives is recorded to aid continuity of care, prevent misunderstanding and enable patients to make informed decisions about their care. Of the 182 records where it was applicable for information to be recorded 56% (103) had evidence that information given to patients had been recorded.



Work is continuing in conjunction with the multidisciplinary team and patients panel member to progress the Self-care benchmark. The observation of care exercise has pinpointed the areas that are to be the focus over the next six months.

Example of good practice to share

- Improved signage on toilets in the ward
- Laminated ward information available to patients and their relatives
- Patients being assisted to walk out to the toilet
- Morse Screening tool used for patients at risk of falling

Changes to improve practice

- o Ensure that good quality written information is available for patients about their care especially on discharge
- o Ensure that '*cared for*' patients are given a copy of their discharge summary to take home so that care in hospital can be continued
- o Improve the amount of negotiation with patients and relatives about the level of involvement in self-care

Bladder & Bowel Care (Continence)

According to Philip (2004) there is need to address the variation in practice in relation to bladder and bowel care in healthcare organisations. The Essence of Care Benchmarking tool was developed as a method of identifying areas for improvement and finding opportunities to share best practice. The observations of care exercise, was carried out during July and August 2006 to assess the following areas:

- Hand washing post toileting
- Place of toileting
- Use of toileting aids (pads)
- Privacy & Dignity during toileting

Evidence of assessment

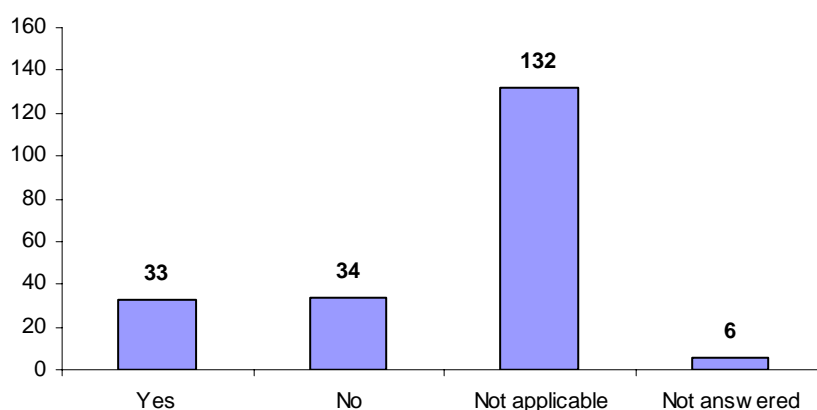
The assessment of continence is often overlooked and therefore continence needs are not always adequately met. It was difficult to tell how the decision that a patient required continence aids or even catheterisation had been made. There was evidence of patients being helped on to commodes at the bedside while other patients were eating their lunch. Patients were observed sitting on incontinence pads placed on chairs with no evidence to suggest the patient had a continence problem.

Patients were also observed being assisted to walk to the toilet and there were a number of examples of wet 'hand-wipes' being offered to patients after they had used the toilet or commode.

Catheterised patients

Some patients (67) had indwelling catheters, despite the multidisciplinary collaborative work to ensure that the reason for catheterisation is documented, that date of insertion is recorded and that catheters are removed as soon as they are no longer required; there was little evidence that this is standard practice across the Trust. The medical and elderly care wards at Hemel Hempstead Hospital appeared to have systems and processes in place to promote good catheter care.

The graph below details the response to the question "If patient is catheterised - Is there a plan of care including why the catheter was inserted?"



Examples of good practice to share

- Catheter bags supported on frames
- Patients assisted to walk to the toilet
- Some examples of labels used to indicate date of catheter insertion, reason for insertion and residual volume

Changes to improve practice

- Avoid the use of incontinence squares to cover chairs and with patients on bed rest
- Encourage patients that are able to walk to the toilet, especially at meal times
- Improve continence assessment and referral to the Continence Referral Team
- Develop a similar Continence Referral Team at Watford General Hospital
- Engage with A&E departments to ensure that continence assessment and reason for catheterisation are consistently recorded

Personal & Oral Hygiene

The principles of the Personal & Oral Hygiene benchmark were developed to ensure that patients hygiene care is negotiated with them or their carers, is based on assessment of their individual needs and that they have access to the level of assistance that they require.

The following standards of best practice that patients have the right to expect from staff at West Hertfordshire Hospitals Trust were selected with the aim of identifying where we are getting things "right" and highlighting areas where efforts can be focused to ensure improvements.

- Care of Dentures – (*Direct Observation*)
- Evidence of Assistance when needed – (*Direct Observation*)
- Evidence of Assessment of needs - (*Documentation Audit*)

Our success in meeting these standards of care for patients was evaluated during the 2-3 periods of observation on each ward on one day in July / August 2006; a small selection of some of these observations are cited below.

Examples of good practice to share

- Mouth care for compromised patients
- Care of dentures
- Hand wipes offered after using bedpan, commode and before meal times
- Self care encouraged where appropriate and facilities offered
- Personal grooming i.e. brushing of hair
- Cool compresses offered to hot patients
- Privacy and dignity maintained during hygiene; curtains drawn around patients on all occasions
- Permission gained from patient to access bed space
- Shaving male patients
- Examples of teamwork with more dependent patients needing additional support
- Assistance provided where needed
- Equipment offered to facilitate hygiene

Changes to improve practice

- Stop domestic duties being performed when general hygiene is being carried out
- Ensure call bells are placed within easy reach of patients
- Need to gain permission to access patients behind curtains
- Education of staff in the provision of hygiene to include mouth care, care of hair, hands and nails and shaving

Conclusions

Some examples of good practice have been generated through direct observation of personal and oral hygiene. However the evidence generated through the observation of care process was limited. The tool of direct observation may not be the most appropriate to evidence practice relating to hygiene. Patients cannot be directly observed in order to maintain privacy and dignity; listening skills have to be utilised.

Record Keeping

Background

Record keeping is viewed as a fundamental part of care delivery to support continuity of care, ensure effective communication between health professionals and a mechanism for reducing risk. In the past three years, the areas of record keeping practice that consistently required specific improvement were *Discharge Planning, Patient Assessment, PAR Scoring, Spiritual Care and Care Planning*. During the observations of care exercise an audit of the records was undertaken to determine the extent to which practice had improved in these areas

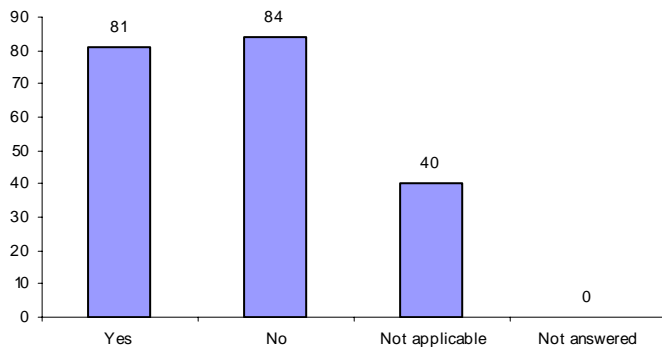
Progress to Date

Record keeping continues to be a key indicator of good quality care. During the observation of care exercise, a selection of nursing records (205), representing approximately one third of the number of patients in each clinical area was examined. The findings are outlined below.

Discharge Planning

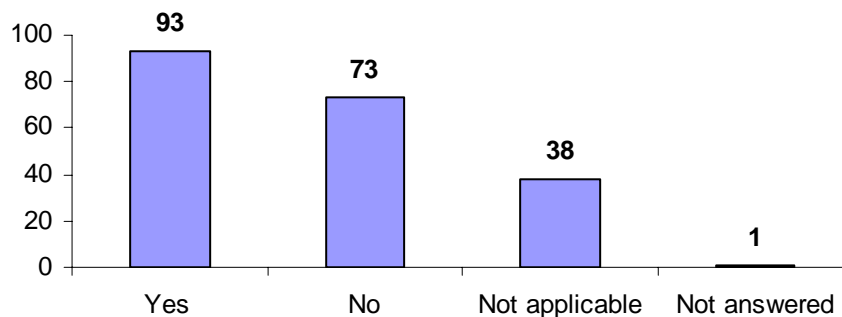
Anticipated discharge date recorded

The discharge planning process should start from admission, and in some cases prior to admission. It is important therefore for patients to have an anticipated discharge date agreed as early as possible in the process to enable both staff and patients to plan for successful discharge home. Of the 165 patients, that should have had an anticipated discharge date recorded, only 49% (81) of records had evidence of this.



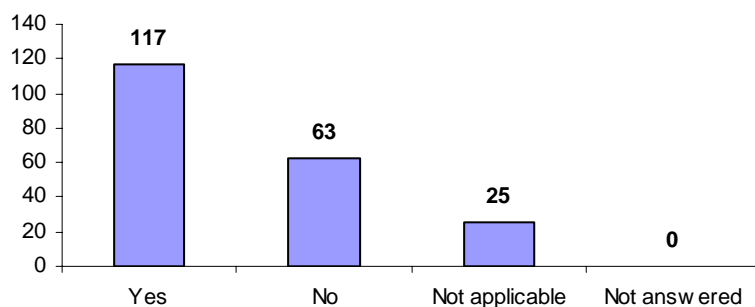
Evidence that the discharge planning process has either started or completed

Of the 166 patients for which the discharge planning process should have been recorded, only 56% (93) of the records had this information available



Evidence of patient/carer involvement in the discharge process

The records were examined to see whether discussions with patients or their relatives about discharge were recorded. The results show that of the 180 records where this information should have been recorded 65% (117) made reference to discussions with patients and/or their relatives about discharge.

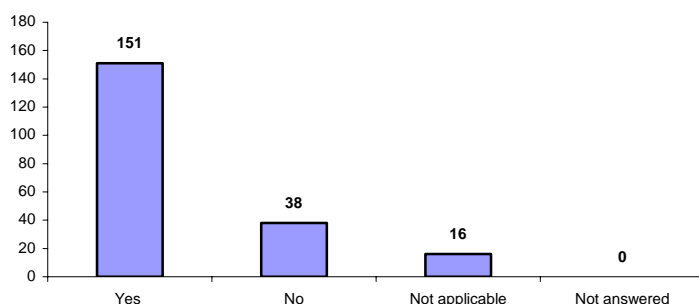


Patient assessment

In order to ensure that patients receive the appropriate level of care and that all care needs are identified, it is important that patients are assessed on admission and are continually reassessed throughout the hospital stay. During the audit process, the records were reviewed to find evidence of assessment and reassessment.

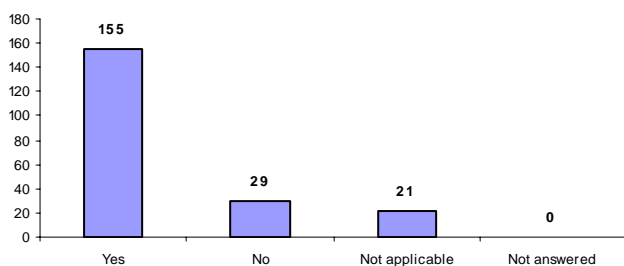
Social assessment

An assessment of the patient's social circumstances is important to ensure that they can return home safely after their hospital stay and ensure that staff initiate the appropriate level of support if required. The records were reviewed to find out whether social assessments were completed for all patients. Eighty percent (151) of the 189 patients for whom social assessments were required had a completed social assessment.



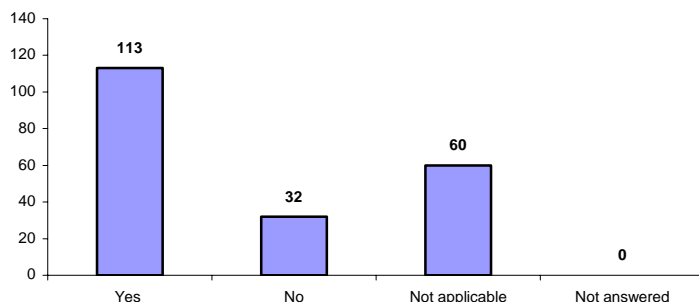
Manual Handling Assessment

Manual handling assessments are important to prevent harm or injury to staff or patients. The records were reviewed to find out whether patients were assessed to identify moving and handling needs. One hundred and fifty five (84%) of eligible patients had a manual handling assessment completed. In addition, only 67% of patients (93) that had an identified manual handling risk had a subsequent method of manual handling written in a care plan.



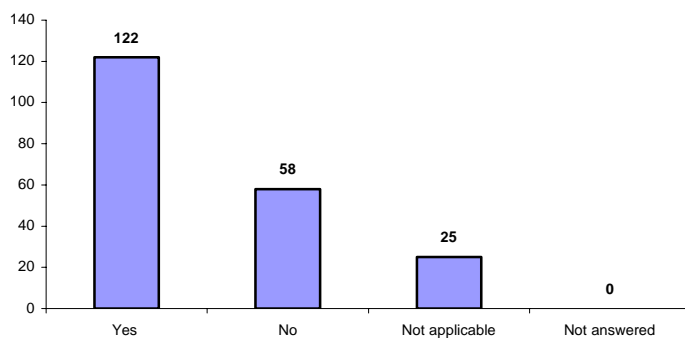
Evidence of regular reassessment if indicated

Patients need to be regularly reassessed to identify changes in their condition and care delivery modified accordingly. The review of the records revealed that of the 145 eligible patients 86% (113) had been regularly reassessed.

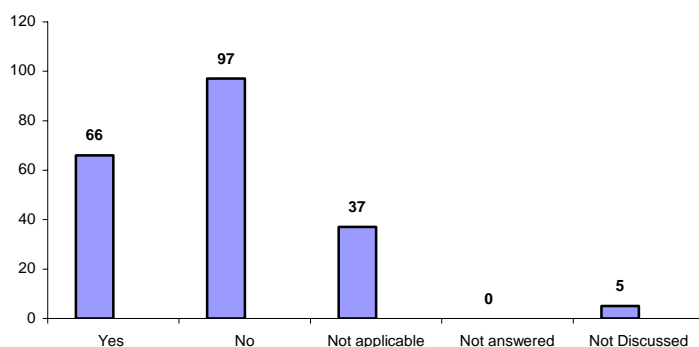


Spiritual beliefs recorded

When patients come into hospital faced with potentially life-changing experiences, the expression of faith becomes more important. As health care professionals we recognise the rights of patients to express /practice their spiritual/cultural needs. As well as recording the patients' faith, it is also important to capture how they wish to express that during their hospital stay. The records revealed that the spiritual beliefs of 68% (122) of the 180 eligible patients were recorded.

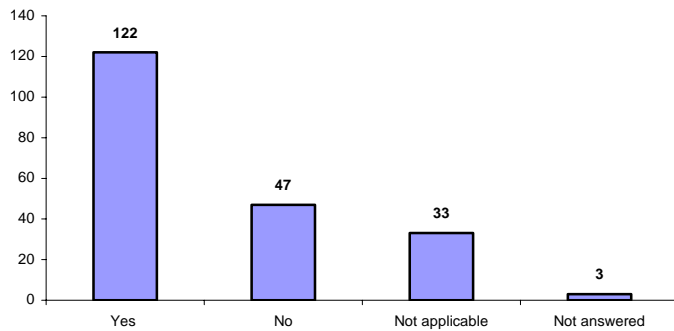


Thirty nine percent (66) of records also recorded any special requirements of patients related to their spiritual/cultural needs and 3% (5) reported that spiritual/cultural needs were not discussed



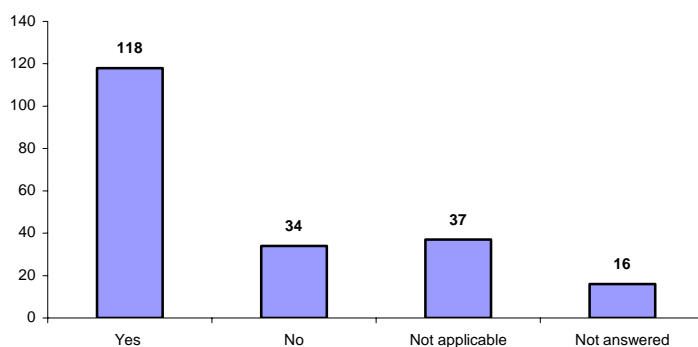
Care planning and daily management

Care planning is viewed as a reliable method to aid consistency, to promote continuity of care and promote evidence based care if plans are based on best available evidence. The nursing records were audited to identify whether patients had a plan of care to address all the problems identified on assessment. Of the 172 eligible patients, 71% (122) had a care plan to address identified needs. However in 2% (3) sets of records the question was not answered.



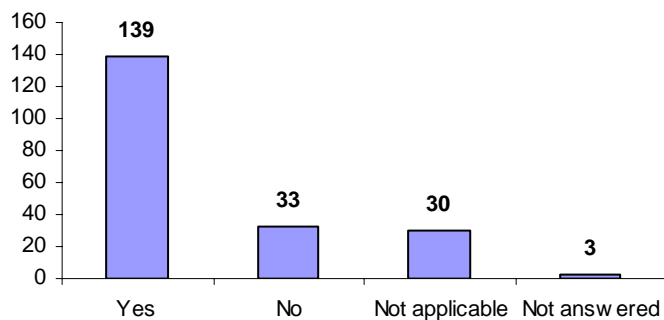
Evidence of patient/carer involvement in care planning

In delivering a high standard of care to patients it is important to involve them in every stage of the care process. It was recorded that patients or their carers were involved in planning their care in 70% (118) cases. In 16 cases (10%), the question was not answered.



PAR Scoring

Being able to identify patients at risk of deterioration at an early stage is vitally important to ensure that staff respond quickly and appropriately to the patients' needs. PAR Scoring was introduced to the Trust as a tool to assist this process in 2003. PAR Scoring was carried out consistently each time the patients' observations were recorded in 80% (139) of eligible cases. The remaining 20% were either not recorded or not answered.



Discussion

A review of the records revealed that significant work is still required to improve the quality of discharge planning, ensuring that information given to patients or their relatives is recorded, recording spiritual and cultural needs and to ensure 100% compliance with PAR Scoring. However in some clinical areas there was excellent record keeping practice but practice across the organisation remains variable.

Conclusion and Recommendations

General observations

There were a number of observations that did not fit into the Essence of Care framework, but had a direct influence on the way that care was delivered in some clinical areas.

The general environment of care was variable, the majority of wards were tidy and staff ensured that bed areas were tidy after delivering care to each patient. Some wards however appeared cluttered, had little storage space for large equipment and bed areas were generally untidy.

Infection control

There were many examples of good infection control procedures and universal precautions followed. Staff were observed washing their hand after contact with each patient and applying hand gel. There were however examples of confusion over whether a patient was being barrier nursed and therefore universal precautions were not followed.

In some cases ward staff followed universal precautions but other staff such as doctors and phlebotomists failed to wash their hand between patient contacts.

Leadership

The quality of leadership behaviours demonstrated in some areas had a direct bearing on the way that care was organised. This concurs with a study by the Hay Group (2006) that suggests that there are clear and measurable links between how a leader leads and the impact on the team and as a result, the impact on performance.

This was apparent during two observations of the mealtime, in one clinical area, the manager ensured that all staff were available to assist with the meals, and to ensure that the mealtime was protected and patients received assistance if needed. Meals were covered to keep them warm.

In the second clinical area, there were two health care assistants and a ward housekeeper delivering meals, consequently they had to walk long distances to deliver meals to patients, they were constantly distracted and interrupted and had to remove their aprons and wash their hands several times during the meal service. Doctors disturbed patients and trained staff were occupied administering medicines or performing other tasks.

In the first ward, the process took 20 minutes from beginning to end, in the second ward the process took 45 minutes and some meals were cold.

Limitations

The observations of care exercise was conducted during July and August 2006, which is a difficult time for many wards and departments due to staff taking annual leave. It was therefore an enormous achievement that only 5 clinical areas were unable to participate.

One area (Private ward at Hemel Hempstead) was closed, two areas experienced staffing shortages (ITU and Day Hospital at Hemel Hempstead). One clinical area ran out of time (Endoscopy at Hemel Hempstead) and in one area, a number of external observers cancelled at short notice (Day Surgery at St Albans).

There were limitations to the process in that it provided only a brief snapshot of practice in a given time frame. Some observers expressed concern that staff may be influenced by the 'Hawthorn effect' – that staff may change their behaviour because they are being observed. This was overcome by the observations taking place over a whole day; it is difficult therefore to maintain the 'changed behaviour' over a prolonged period of time.

Benefits

Staff positively engaged with the process and without exception found it a positive experience and a worthwhile exercise. Internal observers welcomed the opportunity to give positive feedback to their staff, who often work extremely hard in difficult circumstances. Staff also had the opportunity to work together as a team to develop action plans to improve the areas for development.

Recommendations

In order to ensure that the agreed actions are taken forward the following recommendations are suggested:

- Ensure that the actions agreed to improve practice are included in the annual objectives of senior sisters
- Encourage ward sisters to present their findings at a range of forums such as clinical governance meetings and Clinical Leaders Development days
- Essence of Care leads and Practice Development team to support ward teams to liaise with other staff groups to address areas for development that impact across professional boundaries
- To repeat the observation exercise in six months to evaluate changes in practice

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August 2006