A mechanism for measuring and improving patient experience on an acute medical unit

This Future Hospital Programme case study comes from Grantham and District Hospital, part of the United Lincolnshire Hospitals NHS Trust (ULHT). Here, Dr Shirine Boardman and Dr Chris Asplin discuss how applying a validated national survey to can help identify ward-specific areas that need improving upon from a patient's valuable point of view.

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Key words: acute medicine, patient involvement, patient centre care, survey

Person-centred care

Key recommendations

- Use the National Adult Inpatient Survey (AIPS) to assess how patients perceive their care during hospital admission in a standardised way.

- From the AIPS results, identify the core areas requiring improvement and work collaboratively to improve them.

- The AIPS can be used in a targeted way to specific departments, allowing for more precise action to be taken.

- Empower patients by allowing them to have a say in their own care and how their inpatient experiences could be improved. This empowerment, during and following a hospital admission, will often lead to better health outcomes for the patient.

- Seek engagement from three main stakeholder groups (medical, nursing and trust) for most successful implementation

The challenge

Just before they were to be discharged a patient asked whether there was a more comprehensive way to leave feedback. They felt that the care had been excellent and wanted this recorded in a more comprehensive way than the Friends and Family Test (FFT) currently allows.

We were keen to address this. Her comments, and those of other patients, can be utilised to guide the care that others will receive. By engaging patients to tell us (the medical team) how and where improvements can be made systematically, we can work towards better patient care and improve patient experience.

Local context

Grantham is a small, rural district general hospital. It is part of the United Lincolnshire Hospitals NHS Trust, with the main emergency hospitals based in Lincoln and Boston. These sites provide urgent and emergency care to a population of around 125,000.

The hospital has about 100 medical acute beds and a ward for both emergency and elective orthopaedics. The hospital does not admit acute surgical emergencies, paediatrics or maternity /gynaecological emergencies, but does elective work in both medical and surgical specialties. The Acute Medical Unit (AMU) has 28 beds and serves as both an Emergency Assessment Unit (EAU) and a short stay ward.

- the A&E department sees about 28-30,000 patients/year
- local GPs work in A&E alongside the A&E clinical staff
- local community services include neighbourhood teams and a wellbeing service

In November 2015 we opened our ambulatory unit which has eight trolleys and a clinic. Therefore, the number of beds on EAU has been reduced to 24. Through the winter period (2015–2016), the bed numbers were increased to 28 again.

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AIPS in the AMU

The AIPS is an effective and validated tool for measuring how patients perceive their care while admitted in a hospital.

The AIPS conducted by the Care Quality Commission surveys patients that have had an admission to hospital within a trust over the last year. They ask a series of questions on a variety of aspects of the hospital and the care provided from A&E to discharge. It also surveys patient's views of the service they receive at outpatient appointments and car parking and the results are reported online on their website. However, this survey falls short currently as it is used to measure and report care across an entire trust.

The end result of this is a collated score which, in ULHT's case, is derived from patients who were admitted in five different hospital sites. The score given for each question applies to the entire trust and gives no meaningful information to an individual unit or clinician. We are therefore unable to show how their actions may have impacted on the score. The information obtained may also be based on a patient's experience on which they are recalling from some time ago instilling a degree of memory bias.

> *'The AIPS is an effective and validated tool for measuring how patients perceive their care while admitted in a hospital.'*
> Dr Shirine Boardman, Grantham and District Hospital

Dr Paul Sullivan (The Health Foundation Quality Improvement Fellow) and Professor Derek Bell (Imperial College) used National Institute for Health Research funding to do the ground work in this area, identifying the questions which are most relevant to AMUs. They then analysed the CQC AIPS data for 2010 and extracted what they identified as the most likely results for AMUs. From there they developed national average (NA) scores for each question with regard to AMUs. This data then allowed us to compare our results with a NA.

We used the survey questions identified by Sullivan and Bell to specifically look at our own AMU at Grantham and District Hospital. To ensure validity in the results, the questions were not modified to suit Grantham. However, we did include an additional question: 'Overall how would you rate the care you received?' (from the original AIPS validated questionnaire collected by the CQC which publishes national data for this question) and added a comments section. This was in an attempt to allow patients to give us an overall rating/general impression of their experience, as well as the ability to share any aspects that were not directly asked by the survey or elaborate more on anything they felt noteworthy.

The survey helped us identify specific areas for improvement within our own singular unit. We could then compare our results directly against the 2010 national average scores identified for AMUS published by Sullivan. This gives us a comparable set of data which comprised our AMU scores, the AMU scores of organisations nationwide (NA) in 2010 and an overall organisation average score published annually. This meant that we could quickly identify particularly poor scores and concentrate on finding solutions to rectify these, as required.

From the perspective of an AMU, only certain aspects of the AIPS survey apply. Thus by using the questions identified by Sullivan et al we can use a directly targeted survey for this type of unit. The data is also obtained at the point of discharge by a volunteer which provides a more accurate assessment of a patient's experience. Using this method allows individual units and clinicians to directly monitor their own individual and unit's performance and see how their actions impact on the patient's experience thereby allowing the team to vary systems and behaviours in a way that they can see first-hand working by re-measuring.

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Outcomes

Interestingly, the results taken from Grantham's AMU scored higher than the 2010 NA scores published by Sullivan for the vast majority of questions. In fact, out of the 23 questions, selected from the AIPS, 21 scored higher than the Sullivan results.

Some of these are highlighted below:

- 100% of the patients from Grantham's AMU stated that they were treated with dignity and respect. The NA published by Sullivan for this same question was 76%.
- 95% of Grantham's AMU patients rated the unit as good or excellent whereas the NA was only 73%.
- 94% of our patients felt that they had confidence in our doctors and nurses. The NA for this was 74%.

The few questions that scored *lower* at Grantham hospital, when compared with the NA from Sullivan's readings, are listed below:

- 63% of patients at Grantham reported that they felt they had received sufficient information about their condition and care plan, where 74% reported the same in the NA.
- 56% of our patients felt that they received printed information about the medicines they were prescribed. The NA for this was higher at 62%.
- Both Grantham and the NA identified 19% of patients that felt that the nurses spoke as if they were not there; that they were 'spoken over'.

Our survey sample consisted of approximately 32 patients and so is small when compared to Sullivan's national dataset. Results comparisons here should therefore be interpreted with some caution. In spite of this, the goal for this work was to identify the problems specific to our admissions unit, with 100 % being the ideal score and action taken to address low scores.

Staffing

Staff mix involves:

- three consultants (usually involving two consultants at any one time who also provide cover for the critical care unit jointly with anaesthetists)
- two registrars (one of whom may be on nights or on call or leave etc)
- one acute care common stem trainee
- one Trust doctor
- one foundation year 1 and one foundation year 2 (ie total of 4 junior doctors – some of whom might be on call/nights or on leave).

There are three handovers daily at 9am, 5pm and 9pm, the main handover being at 9am. (To learn how a more concise and effective handover, where safety-related situation can be reported and dealt with urgently (if required), can boost training opportunities for junior doctors, read our story: *Standardised handover protocol: increasing safety awareness*)

Key learning

From these results our patients helped to identify where they felt our service was at its weakest, which in turn allowed us to draw up solutions to improve the service. We were able to highlight three key areas to improve upon:

1. **Culture**: patients wanted to feel more involved in their treatments and plans for the future. They also felt that at times the nursing staff appeared to speak as if they were not there. We addressed this by presenting the findings to the medical faculty and launching a campaign on how to be an emphatic clinician on ward rounds and called it the 'GrEAT wardround'. The campaign was supported by posters in the doctors' offices and mess, as well as the nurses'

coffee room. These posters promoted desirable behaviours which enhance the overall patient experience, in accordance with established evidence.

The GrEAT ward round campaign can improve the quality of ward round interactions by the promotion of four key researched patient-centric principles which have previously been shown to improve patient understanding and satisfaction. These principles have been digested into a memorable mnemonic and have been promoted both in poster format (available to download below) and as part of the induction of new junior doctors.

Greeting: Introduce yourself
Explain: What will be happening in terms of tests and treatment? What are we looking for?
Ask questions: Ask the patient if they have questions
Talk in an easy-to-understand way: explain things without medical jargon

The campaign to date has included presentations and posters with reminders of these good practices included during morning handover and during ward rounds on the AMU.

2. **Pressure**: The findings that suggested patients were 'spoken over' were shared with the nursing teams, who felt that it was caused by several factors. These included: high volume of patient turnovers, a busy work environment and staff shortages; all of which contributed to a clear lack of time for the nursing teams to fully care for their patients. Another factor that became evident was the concern of agency staff perhaps not delivering care to the best of their abilities due to the stresses of working in a new, busy environment. This was addressed by engaging the senior nursing staff and management with these survey results and looking to the dedicated and enthusiastic staff to put right any wrongs or short fallings in their care.

3. **Process and systems**: patients wanted more written information about their medication and treatment. The norm before was for patients to leave hospital with a copy of their discharge summary and the medication they were expected to take. We designed a simple discharge information sheet for patients, but the medical director felt that we had to improve our EDD completion rates before we could introduce more forms.

What's next?

To follow up these initiatives in improving the patient experience we intend to carry out another survey using the same questionnaire. This will offer us a clear comparison and we will be able to determine whether these solutions have had a beneficial effect on our scores with 100% being the ideal score. It will also allow us to monitor the areas where we were strong before, to ensure that the high standard has been maintained.

We have also targeted improving the EDD (discharge summary) completion rates and emphasised the need to provide a copy of this to every patient on discharge as part of the 'discharge bundle'.

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