A toolkit for

IMPROVING COMPASSIONATE CARE through Near Real-Time Feedback
Picker

Picker is an international charity dedicated to ensuring the highest quality health and social care for all, always. We are here to:

» Influence policy and practice so that health and social care systems are always centred around people's needs and preferences.

» Inspire the delivery of the highest quality care, developing tools and services which enable all experiences to be better understood.

» Empower those working in health and social care to improve experiences by effectively measuring, and acting upon, people's feedback.

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Department of Health disclaimer

The views and opinions therein are those of the authors and do not necessarily reflect those of the HS&DR Programme, NIHR, NHS or the Department of Health.

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Introduction

Patient experiences are considered to be a key component of high quality health care and provide one important avenue for measuring and improving the quality of patient centred care\textsuperscript{123}.

While patient experiences are frequently measured in the English NHS, the transactional aspects of care have primarily been the focus in these measurements. Transactional aspects of care include waiting times, cleanliness and pain management. These are vital components of the overall patient experience, yet other aspects, commonly referred to as compassionate care or relational aspects of care, have been largely ignored in these data collections. This means, elements of patient experiences, such as trust, communication and being well informed about their treatment require our attention now\textsuperscript{1}.

This toolkit is the result of two and a half years of research funded by the NIHR (project number 13/07/39) to address the priorities regarding compassionate care and faster reporting of patient feedback outlined in the Francis report\textsuperscript{1}.

We offer you a free and validated questionnaire that has been developed specifically for wards providing care to elderly patients and accident and emergency (A&E) departments. In addition to offering a questionnaire, this toolkit provides full implementation support for a near real-time feedback approach to allow hospitals to understand and act on patient experiences of compassionate care more quickly.

Make use of this free resource to improve your care by quickly addressing patient experiences of compassionate care.

Who is this toolkit for?

This toolkit is for anyone interested in improving patient experiences at hospitals. It may be of interest to patient experience teams, quality improvement teams, clinical staff and board members.

What does it aim to achieve?

This toolkit seeks to provide you with all the information needed to improve patient experiences of compassionate care using a near real-time feedback approach. We give you a free validated and reliable instrument to use so you don't have to do the development work. We showcase our learning from a 30 month long research project across England. In addition, we provide you with examples of what happened, what we learnt along the way and what worked especially well. This way, your team can benefit from a shorter learning curve and maximise your chances for success. We also provide you with contact details for some of the trusts that have implemented this approach and references to more information so you can learn even more.
What is included?

The following resources are included in this toolkit.

» **Questionnaire** validated by statisticians at Picker and the University of Oxford. It allows for comparisons across wards and can also be used as a "common core" to which ward specific questions or the Friends and Family Test can be added.

» **Recommendations** to help you think about implementing the questionnaire using a cost efficient near-real time feedback approach with the help of trained volunteers. Resource implications are described but will vary based on existing hospital equipment, software and technical support.

» **Guides** provide detailed information about volunteer training, questionnaire implementation, reporting and evaluating your approach.

» **Case studies** to help you understand what worked well and what was challenging at the six pilot sites. Case studies also present a realistic picture of what initial impacts can be expected after the survey implementation.

» **Contact details** and references are provided to point you in the direction of further information.

See p27 for references
Overview and recommendations

The following points present an overview of research we conducted to develop and evaluate patient experience feedback of compassionate care using a near real-time feedback approach involving trained volunteers. Some background information is presented alongside recommendations for other NHS hospitals aiming to improve patient experiences of compassionate care.

Why compassionate care?

» While understanding patient experiences is a priority in the English NHS, data collections focus primarily on transactional aspects of care, such as cleanliness, waiting times and pain management. Patients’ experiences of compassionate care, also known as relational aspects of care, have been largely ignored in our existing measures of patient experiences. The Francis Inquiry\(^1\) highlighted these deficiencies in great detail and argued the case for a greater focus on understanding experiences of compassionate care, especially on elderly care wards and in accident and emergency (A&E) departments.

» Understanding patient experiences of compassionate care is key in prioritising improvements to care. Imagine your team knowing to what extent patients have trust in the staff caring for them or how fully they feel informed about their care.

» The NHS is interested in understanding experiences of compassionate care and as such, the National Institute for Health Research (NIHR) commissioned research specifically to address this priority in direct response to the Francis Inquiry.

» Researchers from the University of Oxford and Picker, an independent healthcare research charity, have worked for 2.5 years to develop and evaluate an instrument that reliably measures compassionate care in a hospital setting.

» Through this toolkit, we would like to contribute towards a realisation of the recommendations presented in the Francis report\(^1\) by making our tried and tested method for improving patient experiences of compassionate care freely available to all NHS hospitals.

What does this mean for you?

» The short validated questionnaire can be used to demonstrate the standard of compassionate care on an elderly care hospital ward or the A&E department in a reliable way. (It may be used on other wards as well but our validation has focused on data collected from these areas.)

» Evidence from this instrument can be used to provide assurance to ward teams and patients that compassionate care is an important part of what you do.

» Evidence can also be used to satisfy the CARING element of CQC inspections.

» Our questionnaire can be used as a “common core” to which other ward specific questions or the Friends and Family Test may be added. The “common core” allows for response comparisons across wards.

» Results from our questionnaire on compassionate care have been reported to complement findings from other data collections, such as the national inpatient survey.

» Our instrument is completely free to use. Its development has been funded by the NIHR with the goal of making it available to all NHS hospitals. We will never ask for licensing fees, royalties or any other fees to use the instrument.
Why near real-time feedback?

» More widespread use of the near real-time feedback approach was recommended in the Francis report\(^1\) to allow staff to access patient feedback much faster than the national inpatient survey allows.

» As part of our 30 month long research, we evaluated a near real-time feedback approach for measuring and improving compassionate care. We worked with six hospitals who collected data from patients using trained volunteers. Weekly reports were provided to all wards and the A&E departments participating in the research.

» A near real-time approach was chosen as it eliminated time for data entry and collation. This meant that staff received patients’ feedback within days rather than months.

» The following benefits of the near real-time feedback approach were identified by the hospital staff involved in our research.
  
  o Easy and fast data collections which causes the least amount of distress to patients.
  
  o With the help of trained volunteers, clinical staff time is not required to collect feedback.
  
  o Fewer staff resources are required as data entry or collation of responses is not necessary.
  
  o Results are local (ward-based) and received quickly following data collection.
  
  o Volunteers interact with patients during the data collections. For example, they listen to their stories, which can contribute towards better patient experiences. These in turn may be captured in later data collections, such as the Friends and Family Test or the national inpatient survey.
  
  o The questionnaire timeframe is completely flexible. Consider using the near real-time feedback approach when and for as long as it is feasible or useful. This might be a few weeks or months.

  o Wards have complete control and can easily switch to other approaches if the near real-time feedback approach using trained volunteers isn’t ideal.

Read on to decide if the questionnaire on compassionate care and the near real-time feedback approach are right for your team.
Guide: Questionnaire implementation

Considerations

» Establish a working group interested in implementing an instrument on relational aspects of care using the real-time feedback approach. Consider including, clinical and non-clinical leaders, quality improvement experts, patient experience team members and a volunteer co-ordinator. Please note, you may already have an existing group or team that may be interested in this work.

» While the questionnaire presented in this toolkit is completely free to use for NHS organisations, there may be costs associated with the real-time feedback approach, such as costs for obtaining and insuring equipment and costs for hosting questionnaires online. Always check with your IT department as they have the most up to date information and may be aware of free or low-cost resources you can use.

» You may be able to access charitable funds your trust receives for this work as it falls under the “value added” category as it is aimed at improving patient experiences.

» Assign a project lead or co-ordinator, who is keen to drive the patient experience feedback implementation forward.

» Identify potential sources of support for staff, volunteers, patients and the working group. These may include Patient Advice and Liaison Services (PALS), volunteer co-ordinators, and hospital quality improvement experts.

» Check with staff to determine the times during which volunteer visits might be most appropriate.

» Obtain administrative and research governance approvals, if required.

» Liaise with the volunteer co-ordinator to begin volunteer recruitment. Consider compiling a job/person specification to facilitate recruitment.

» Purchase or obtain tablets. Estimate approximately one tablet per ward to allow for simultaneous data collections. Check with your IT department if any existing laptops, tablets or mobile phones can be used for this purpose.

» Buy insurance to protect the tablet devices.

» Work with the trust IT department to set up tablets on the wireless network. An internet connection is necessary to transmit or send completed questionnaires to be aggregated in reports.

» Collaborate with the trust IT department to select a software provider and obtain licenses for the devices. Common questionnaire software providers include SNAP, Meridian and Digivey but there may be another provider that your trust has worked with previously.

» Work with the software provider to upload the survey onto all tablets.

» Ensure a ward selection question has been added at the beginning of the questionnaire, including all participating wards. This will allow for comparisons across wards.

» Consider carefully whether to collect patient identifiable information. This may affect your trust internal data storage and protection procedures.

» Train all interested volunteers on the survey administration process (Refer to the Volunteer Training Checklist).

Preparation

» Liaise with wards to administer the questionnaire. Obtain staff buy-in and a commitment to implement. To maximise staff buy in, consider getting the Board interested in your work first and state clearly in all communications to staff what the direct benefits of this work are to their work.
**Questionnaire implementation**

» Decide the length of the questionnaire fieldwork period. Can questionnaires be carried out on a rolling basis or will this be done during certain months only?

» Set and communicate questionnaire completion targets with ward staff and volunteers. Depending on the ward size and patient turnover, realistic recruitment targets may range from 20 to 60 completed questionnaires per month and ward/department.

» Volunteers should understand that questionnaire completion times vary greatly across patients. For example, one patient may complete a questionnaire in 10 minutes and another patient may relish the opportunity to chat with the volunteer between questions, resulting in a questionnaire completion time of 45 minutes. Volunteers should not feel pressured to complete questionnaires quickly or to get a certain number of completed questionnaires per day.

» Ensure that volunteers and staff understand that recruitment targets are guidelines only and are not associated with negative consequences for them or their teams.

» Volunteers should check in with a staff mentor to pick up a tablet and obtain their ward assignment.

» Volunteers need to approach ward staff to be made aware of any patients lacking the capacity to consent.

» Volunteers can approach all patients deemed to have capacity to consent by wards staff and survey those interested in participating (review the volunteer training materials for more details on capacity to consent and obtaining informed consent). For patients who do not have capacity to consent, visitors may complete the questionnaire on behalf of the patients.

» Each patient is only surveyed once. If they have already participated, most patients will let the volunteers know.

» Volunteers to return tablets at the end of their shifts and connect them to a power source.

» Ensure volunteers have an opportunity to share their experiences or ask questions.

» If possible, share the questionnaire results with volunteers as well. Encourage them to present findings to staff in rapid briefings to encourage volunteer and staff engagement.
Guide: Volunteer training

The following should be considered when planning the volunteer training event:

Scheduling the training
» Book a room for at least 2 hours.
» Inform volunteers of training date and times well in advance.
» Consider having refreshments available.
» Provide printed copies of training materials for volunteers to annotate and keep for future reference.
» If possible, give volunteers time to practice questioning patients on wards.
» This volunteer training may be integrated with existing trust volunteer induction or training events.

The following points should be covered during the volunteer training:

Using the device
» How to turn the device on and off.
» How to login/open the questionnaire software.
» How to navigate through the questionnaire.
» How to submit the questionnaire once completed.
» How to stop the questionnaire part way through with or without keeping the responses – this is dependent on if the patient wishes to submit responses already provided.
» How to troubleshoot the device.

Determining capacity to consent
» Understand what capacity to consent means, and what it entails.
» Staff can assist in determining patients’ capacity to consent.
» If a patient does not appear to have capacity to consent after approaching them, family, friends or carers may provide feedback on their behalf.

Inviting people to take part
» Inform participants about the study.
» Share laminated participant information sheets.
» If necessary, capture explicit consent on electronic questionnaire.

Understanding the data collection procedure
» Check in with volunteer coordinator and receive ward or department assignment.
» On arrival identify yourself as volunteer to staff in charge.
» Ask which patients cannot be approached for interviews.
» Introduce yourself to all eligible patients and ask if they are willing to do a questionnaire.
» Do not approach patients when:
  o Curtains are drawn around the bed.
  o Patient is receiving care/treatment.
  o Patient is asleep or eating.
  o Indicated as not to be approached by staff.
» Volunteers may approach patients with visitors provided you are not interrupting them.
» Return the device to where you collected it.

Learning the interviewing technique
» Introduce yourself and explain you’re carrying out a questionnaire to help improve care provided by the trust.
» Hand the patient the information sheet.
» Ask and answer any questions they may have about the questionnaire.
» Check if they would like to be handed the tablet, for you to read the information, or both. Encourage and assist the patient to complete the questionnaire as independently
Ensure introductory text is read exactly as it appears so patients are fully informed and can give consent.

**Understanding question wording and response options**

- Everyone is asked the same questions.
- Questions and response options should be read out exactly as they appear on the screen.
- Do not assume the patient’s answer based on body language, speed of reply or perceived positivity/negativity of response.
- Some patients need additional time to consider the question before replying. Give them time to consider then follow up with available response options exactly as they appear.

**Following hygiene and infection control procedures**

- Use hand cleaning liquid provided, or wash hands before each interview.
- Use sterilising wipes or a small amount of hand cleaning liquid to wipe down the tablet before each interview.

**Following up on patient concerns**

- You can escalate issues of concern, provided the patient gives you their permission.
- To escalate an issue, talk to the PALS officer, or follow normal safeguarding procedures.
Guide: Reporting

This guide presents some considerations that may be helpful for designing a user-friendly reporting format so staff can access patient-reported feedback in near real-time.

Thinking about your audience

» Who will be reading the reports?
» Who will use the reports to make decisions of improvements?
» Who has an interest in patient feedback and relational aspects of care?
» Who has a right to access the results?

Understanding the needs of your audience

» What information do they need to make decisions or improvements?
» What reporting formats are they accustomed to?
» How much time do they have to review reports?
» Do they prefer to have a paper or electronic version?
» When and where do they look at reports?
» With whom do they discuss or share the findings?
» How do they usually share the findings?

Selecting a team to develop the initial reporting format

» Consider compiling a team of interested persons who can help develop your first report. After the first report has been developed, the script or syntax used can simply be reused to generate future reports, requiring only a fraction of the time.
» Who has expertise working with Excel or other statistical programmes to make sense of large amounts of data?
» Who has time to help develop a report?
» Who has designed other reports the hospital uses to showcase patient experiences?
» Ask them to join your team and schedule regular but brief update meetings.

Thinking about the content of your report

» Do results need to be displayed for every question every week or are certain key indicators sufficient?
» Do results need to be presented graphically?
» Should changes be easily visible?
» Should changes be highlighted in colour?
» Are there cut-off scores for acceptable performance?
» Should trends over time be shown? If so, are monthly or weekly trends more meaningful considering the amount of data collected?
» Should the reporting match existing reports of patient experience feedback so they can be integrated later on? Figure 1 on the following page presents an example of a report that was developed specifically to match one trust’s existing way of reporting patient experience feedback.
» Can you add a printable option?
» Can you add an at-a-glance dashboard to highlight areas needing attention? Figure 2 presents a printable dashboard that shows percentages for each ward side by side.

Refining your reports over time

» Encourage those using your reports to provide feedback about what they like, what’s missing and what isn’t working.
» Ask the people who use your reports to share what has helped them the most to make meaningful changes.
» Compile and share all feedback you receive with your team.
» Make a joint decision on which feedback to incorporate into future reports. (This can be done based on the number of people who shared similar suggestions and the feasibility of implementing them.)
» Let those using your reports know when you have made changes and what they were.
Figure 1: Matching report

![Bar chart showing matching report results]

Figure 2: Dashboard

**Results by ward: all data collected so far**

<table>
<thead>
<tr>
<th>Question</th>
<th>Radio ICU</th>
<th>Radio TAC</th>
<th>AECC ICU</th>
<th>AECC TAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. Have staff introduced themselves before treating or caring for you?</td>
<td>71%</td>
<td>73%</td>
<td>63%</td>
<td>61%</td>
</tr>
<tr>
<td>Q2. Have staff taken the opportunity to learn about you as a person?</td>
<td>48%</td>
<td>55%</td>
<td>39%</td>
<td>64%</td>
</tr>
<tr>
<td>Q3. Have staff made you feel at ease by being friendly and warm in General care?</td>
<td>83%</td>
<td>89%</td>
<td>68%</td>
<td>87%</td>
</tr>
<tr>
<td>Q4. Have staff shown you care and compassion?</td>
<td>92%</td>
<td>92%</td>
<td>62%</td>
<td>97%</td>
</tr>
<tr>
<td>Q5. Have staff listened to what you have to say?</td>
<td>75%</td>
<td>83%</td>
<td>68%</td>
<td>82%</td>
</tr>
<tr>
<td>Q6. During your time in hospital, have you had enough contact with staff?</td>
<td>73%</td>
<td>80%</td>
<td>50%</td>
<td>78%</td>
</tr>
<tr>
<td>Q7. If your needs changed, have you been able to get a member of medical or nursing staff to help you?</td>
<td>83%</td>
<td>82%</td>
<td>60%</td>
<td>82%</td>
</tr>
<tr>
<td>Q8. Have staff responded to issues you have raised?</td>
<td>54%</td>
<td>60%</td>
<td>52%</td>
<td>70%</td>
</tr>
<tr>
<td>Q9. If you have raised any concerns with a staff member, have these been followed up?</td>
<td>62%</td>
<td>72%</td>
<td>52%</td>
<td>75%</td>
</tr>
<tr>
<td>Q10. Do staff appear confident and able to perform their tasks when caring for you?</td>
<td>88%</td>
<td>94%</td>
<td>73%</td>
<td>91%</td>
</tr>
<tr>
<td>Q11. Have you had enough time to discuss your health or medical problem with a doctor or nurse?</td>
<td>62%</td>
<td>75%</td>
<td>62%</td>
<td>78%</td>
</tr>
<tr>
<td>Q12. Have your family or friends been informed by the staff about your condition?</td>
<td>94%</td>
<td>79%</td>
<td>59%</td>
<td>63%</td>
</tr>
<tr>
<td>Q13. Have you been informed as much as you want to be in discussions about your care and treatment?</td>
<td>68%</td>
<td>72%</td>
<td>60%</td>
<td>71%</td>
</tr>
<tr>
<td>Q14. Have staff explained your condition and treatment in a way you can understand?</td>
<td>73%</td>
<td>79%</td>
<td>69%</td>
<td>80%</td>
</tr>
<tr>
<td>Q15. Has a member of staff answered your questions in a way that you could easily understand?</td>
<td>82%</td>
<td>84%</td>
<td>72%</td>
<td>87%</td>
</tr>
<tr>
<td>Q16. If you have had any problems or concerns, have a member of staff discussed them with you?</td>
<td>58%</td>
<td>77%</td>
<td>58%</td>
<td>65%</td>
</tr>
<tr>
<td>Q17. Has a member of staff told you about all the dangers associated with your condition or treatment or admission?</td>
<td>43%</td>
<td>46%</td>
<td>43%</td>
<td>63%</td>
</tr>
<tr>
<td>Q18. During your time in hospital, have staff made you feel safe?</td>
<td>93%</td>
<td>94%</td>
<td>76%</td>
<td>94%</td>
</tr>
<tr>
<td>Q19. Have you received as much support as you have required from staff?</td>
<td>83%</td>
<td>85%</td>
<td>64%</td>
<td>85%</td>
</tr>
<tr>
<td>Q20. Overall, do you feel you have been treated with respect and dignity while in hospital?</td>
<td>88%</td>
<td>90%</td>
<td>73%</td>
<td>84%</td>
</tr>
</tbody>
</table>
The following points may guide the evaluation of the success of the near real-time feedback approach to improving relational aspects of care.

**What is the purpose of evaluating our real-time feedback approach?**

» To learn as much as possible about how the real-time patient experience data collections by collecting additional information from those who implemented the data collections.

» An evaluation usually uncovers information about what worked well about the data collections and what could be improved for the future to save resources, such as time and money.

**What does the evaluation involve?**

» The evaluation involves getting together a group of people, to collect and analyse information from different sources.

» This information will allow your team to determine the successes of the approach, and identify areas for improvement.

» Based on the evidence you compiled, any necessary changes can be made to improve your services.

**Who is responsible for the evaluation?**

» It is beneficial to select a small group of interested people who will share the responsibility for the delivery of the evaluation.

» Consider approaching anyone with an interest in the real-time feedback approach, the resulting patient experience feedback and using patient experiences to improve relational aspects of care.

**When should we do the evaluation?**

» Ideally, the evaluation should be done throughout the patient data collection process. Usually, evaluation data are captured before, during and after the patient experience data collections. This provides an overview of how things are before and after the near real-time approach has been introduced. It will also allow you to compare how things have changed over time as the new methodology becomes a part of the hospital culture. Keep in mind that it takes time for staff and volunteers to get used to the new approach of collecting and using patient feedback.

» If the real-time feedback approach will be continued beyond the initially planned implementation period, it will be useful to continue the evaluation data collections to monitor changes over time.

**Who can provide feedback about the success of the approach?**

» Frontline staff.

» Clinical leaders.

» Non-clinical leaders.

» Volunteer coordinator.

» Real-time feedback working group established prior to the questionnaire implementation.

» Volunteers.

» Patients.

» Patient Advice and Liaison Service (PALS).

**What types of evaluation feedback should be collected?**

» Challenges encountered during data collections.

» Challenges encountered when accessing and using patient experience feedback.

» How challenges were resolved.

» Key lessons learnt related to data collections and reporting.

» Types of improvements made as a result of the near real-time patient experience...
feedback.

» Any other information that could help staff to make improvements.

How can this information be collected?

» Formal feedback collected through:
  o Interviews with staff and volunteers.
  o Online/paper questionnaires with staff and volunteers.
  o Volunteer diary.
  o Workshops or focus groups with senior and frontline staff.

» Informal feedback collected in:
  o Meetings.
  o Conversations and communications.
  o Support sessions for volunteers.
Background to case studies: Improving compassionate care

About the research study

Relational aspects of care are considered an important aspect of the overall hospital experience for patients. They include treating the patients with dignity, compassion, and offering emotional support. The Francis Report (2013) highlighted serious problems with the relational aspects of care provided in hospitals, and stated that these deficiencies in care were especially prominent for older patients and those being treated in Accident and Emergency (A&E) departments. The Francis Report also recommended wider use of real-time feedback, or in other words, asking people about their experience of care whilst they are still in hospital, or shortly after discharge.

This study sought to directly address the recommendations of the Francis Report by implementing a real-time feedback approach, using trained volunteers to collect data from elderly patients and those visiting A&E departments. Patient experience data collections focused on relational aspects of care.

Six hospitals participated in the research project as case study sites.

» Hinchingbrooke Health Care NHS Trust
» Milton Keynes Hospital NHS Foundation Trust
» North Cumbria University Hospitals NHS Trust
» Northern Lincolnshire and Goole NHS Foundation Trust
» Poole Hospital NHS Foundation Trust
» Salisbury NHS Foundation Trust

Volunteers were recruited by the hospitals to collect data from patients. Prior to data collections, volunteers were thoroughly trained during a half-day training course. At each site, 1 to 5 wards which provided care primarily to older patients aged 75 years and older were selected to participate, as well as one A&E department.

The process

During the 10 month data collections, ward/department staff simply directed the volunteers to patients they could interview, without needing to spend time collecting patient experience feedback themselves. Staff then received the results on a weekly basis, presented as an interactive report. A printable option was also added weekly, based on staff feedback.

To assist staff with quality improvement efforts, members of the research team facilitated an action planning workshops at each site. Planned improvements were discussed by NHS staff members who attended the workshop, and focused primarily on communication with patients and managing patient expectations.
Costs and benefits of a near real-time feedback approach to improving compassionate care: A case study

This case study provides an overview of the short-term impacts or benefits experienced by the six NHS trusts who implemented the near real-time feedback approach over a ten month period. Direct and indirect costs associated with the approach are also described.

Benefits to patients
Patients continuously thanked the volunteers for speaking with them and giving them a chance to “let their voice be heard”. Patients found the interactions with volunteers pleasant and enjoyable. On numerous occasions, patients tried to extend their time with the volunteer by telling stories in between survey questions. If patients reported serious challenges, a volunteer could often address them right away by reporting back to staff. Volunteers saw themselves as “advocates” to patients and let staff know if patients were thirsty, hungry or needed help with other things for which they did not want to press the call bell. Staff at case study sites hypothesised that the interactions with volunteers alone would contribute to more positive patient experiences.

Benefits to volunteers
Volunteers who stayed with the project for three months or longer reported experiencing a variety of benefits. Volunteers who stayed on for a shorter period of time may have also experienced benefits but they were not available to share them with us. Younger volunteers reported gaining a substantial amount of relevant work experience and felt their Curriculum Vitae (CV) benefited greatly from this experience. In some instances, informal mentoring relationships developed, which were beneficial to younger volunteers and supported them with their professional development and career preparation. As a result of their experiences, volunteers reported feeling more confident and comfortable approaching patients and speaking with others. They reported building relationships with the staff who oversaw the volunteer data collections.

Benefits to staff
Staff reported benefiting from ongoing weekly reports of patient experiences. It allowed them to bring up to date feedback to meetings and inform their teams during regular staff meetings. Staff displayed comments on notice boards on the wards to share positive results with staff. In addition, staff found that the new feedback obtained complemented feedback received through other data collection mechanisms. Results from the closed ended patient experience feedback questions could be discussed during action planning meetings and plans for improvements could be made based on recent feedback received. Trends over time could be monitored through the weekly reports.
Positive impacts from the improvement efforts included better communication with other staff, better communication with patients and greater awareness of patient experiences of compassionate care.

Benefits to the trust

Patients continuously thanked the volunteers for speaking with them and giving them a chance to “let their voice be heard.”

The trust overall also benefits greatly from a continued focus on the improvement of compassionate care. For some trusts, this type of work may present a “value-added” service evaluation, for which charitable funds may be used as the ultimate aim is to improve patient experiences. In addition, the approach offers trusts a relatively easy and quick way to understand patient experiences of compassionate care without having to develop a new instrument. The data collections were reported to be well aligned with the trusts’ mission statements and strategic plans. This meant that progress towards objectives could easily be demonstrated with the help of weekly reports. The near-real time feedback approach also fostered collaboration across wards and the Research and Development (R&D) departments. Some trusts reported that the additional way to capture patient experiences fit well within their quality improvement agenda.

Costs

While the instrument is freely available for use, some direct and indirect costs are associated with the near real-time data collection approach. Specifically, electronic devices are required to collect feedback from patients. Tablet computers present an ideal avenue for collecting this feedback due to their large screen size and lack of keyboard. However, if available, existing mobile phones or laptops could also be used for this purpose. Trusts may incur direct cost savings by using available equipment. Costs will also be associated with insuring the devices, obtaining a mobile questionnaire software programme and providing technical support to maintain the devices’ functionality. Finally, indirect costs, such as staff time, may be required to coordinate volunteer activity, create a reporting template and disseminate the weekly reports.
Working with unfamiliar technology and different hospital settings: A case study

This case study focuses on two key areas related to data collection. We describe aspects related to using unfamiliar technology and collecting data in various hospital settings. Challenges as well as key lessons learnt in regards to overcoming challenges in these areas are presented.

Technology

The use of tablets presented some challenges during the initial phase of data collection. For instance, older patients and prospective volunteers were, at times, uncomfortable with using tablets because they were considered to be ‘new technology’, which wasn’t familiar to them for the purpose of data collection. One volunteer described their experiences collecting data on an elderly care ward in the following statement. “No-one seems interested in using [the tablet] themselves on elderly care – it isn’t familiar or easy for patients who are not lying very comfortably in bed”

Stationary devices in the A&E departments, such as kiosks, were found to be not as successful at collecting patient feedback in comparison to a trained volunteer carrying a tablet. As there were fewer personal interactions motivating the patients to complete the survey on the kiosks, they were less likely to be used.

In addition, tablets required maintenance throughout the ten month data collection period. This included updates to the software, as well as repairs to the hardware. For example, the questionnaire software automatically completed updates, as they became available. One volunteer reported, the “tablet froze on several occasions.” Therefore, ongoing questionnaires were at times interrupted although the data were not lost. Also, through frequent and continued use, the charging ports of tablets could become damaged and require repairs to maintain their functionality.

Key lessons learnt

In order to minimise disturbance to the data collection due to technological and setting disruptions, hospitals described the following lessons learnt over the course of the data collections.

Once recruited, volunteers were thoroughly trained and comfortable with using the tablets so they could help patients fill in the questionnaire. The training included a practical component and volunteers knew whom to approach for assistance.

Initially, hospitals used kiosks in their A&E departments instead of volunteers. After several consecutive weeks of obtaining only few responses, both trusts independently decided to remove the tablet from the kiosk and instead have a trained volunteer collect patient feedback within the A&E department.

Ongoing technical support offered both locally and remotely was considered to be another
key to success. For example, in-house trust IT staff set up all wireless connection, and kiosks. They were also to hand if any problems with the tablets arose. However, if the tablets needed replacing or deeper investigation was required into why a tablet wasn’t working, then the trusts contacted the research team to investigate.

It was noted by all trusts that it was beneficial to have additional tablets to hand. This meant that spare tablets were always available and data collections were not negatively affected by faulty technology and multiple volunteers could collect data simultaneously.

Setting

A&E departments and elderly care wards were perceived to be challenging environments for data collections. Volunteers reported a “sense of frustration” when no or few patients were able to be questioned when they visited the area. Volunteers explained, “Sometimes there have been very few patients, when some are asleep it can be a wasted time!”

A&E departments were generally found to be challenging environments for data collections. As despite their high patient turnover, there was less opportunity to survey patients. Also, patients were often waiting to be seen and so were unable to comment on their care, or were in severe pain or distress. Upon discharge, patients were keen to return home and often did not want to complete a questionnaire.

On the other hand, elderly care wards were found to be difficult for data collections because there was lower patient turnover, which meant fewer patients could be approached. Patients on elderly care wards were less likely to have this capacity to consent or sufficient energy to participate in the questionnaire.

One volunteer described, “[Department/Ward] was very quiet and I was not able to get patients to complete the survey”.

Protected times on wards also meant that volunteers were unable to collect data from patients at certain times of the day, which could reduce the number of questionnaires collected during a shift. One volunteer shared, “Still a problem getting on to some wards before 10.00 am due to patient care time and have to get out for meal times, which causes a bit of a panic”.

Key lessons learnt

Various challenges related to the hospital setting were experienced during data collections. Volunteers also brought different life and work experiences with them, which could facilitate or hinder their engagement with the data collections. Volunteers were a heterogeneous group, where each individual interpreted and managed challenges in a unique way. Therefore, it was important to provide ongoing opportunities for volunteers to discuss and learn from their experiences and challenges. This way, challenges were identified as they arose. It was key for the site lead or volunteer coordinator to review the volunteer feedback weekly resolve local challenges right away. Examples of challenges experienced by the case study sites, which could be resolved immediately were consultants querying volunteers about the purpose of the data collections or consultants telling volunteers that they were not allowed to collect data on their ward/department.
Volunteer and staff engagement to enhance quality improvements: A case study

This case study focuses on two key aspects related to the data collections and reporting. Specifically, volunteer and staff engagement are discussed, and how the experienced challenges around engagement were overcome. Issues surrounding volunteer engagement, generally focused on their recruitment and retention, whilst challenges surrounding staff engagement, focused on their use of the real-time feedback results.

Volunteer engagement

Volunteer availability was considered a difficulty with regards to data collections. Some volunteers left the research after the training day due to other interests or being moved to other tasks of a higher priority to the hospital, by the volunteer coordinator. Student volunteers were also commonly found to be unavailable during the summer months due to holidays, and older volunteers were found to be more likely to become unavailable at a short notice due to appointments or illnesses during the winter months.

One staff member explained:

Volunteers are unpaid. You can’t expect them always to be there, on a certain day and a certain time. You hope that they are and you can ask them to have a commitment, but that’s something that you can never guarantee.

Another staff member stated, “[...] We had problems maintaining volunteer engagement with the project.”

Volunteers reported a perceived pressure to complete a certain number of interviews per shift. While the research team only provided recruitment targets for the whole ward or department per month, volunteers still held clear expectations of how many questionnaires they would complete per shift. This resulted in volunteers feeling a sense of pressure when these self-appointed targets were not met.

Key lessons learnt

In order to minimise disturbance to the data collections due to limited volunteer resources, trusts implemented the following strategies to increase volunteer recruitment and retention.

A purposive and ongoing volunteer recruitment method was put into effect at some trusts, and was found to be successful in attracting volunteers who were engaged in the research for longer. A person specification was used, which outlined the desired volunteer characteristics to support tablet-based data collections.

To reduce the pressures of meeting questionnaire targets, some staff endeavored to set realistic expectations about the number of instruments that volunteers could expect to complete during a shift and continued to emphasise that patient experience feedback recruitment levels were always dependent on the nature of the ward/department that day.

To provide volunteers with support throughout the data collection period, the volunteers filled in a weekly diary, which asked questions regarding their week’s data collection. The research team monitored the diary, and made trusts aware of any complications that arose. Support calls were also scheduled throughout the 10 month period, to give volunteers and staff members an opportunity to speak with the research team and have any questions they might have answered. These support mechanisms served to identify and mitigate any challenges experienced by staff and volunteers, and increase volunteer motivation.
Volunteers were also provided with certificates of research participation at the end of the data collection to show that their contribution to the research was recognised and valued. Student volunteers and volunteers who were looking to develop their skills for career purposes were particularly interested in receiving the certificates as proof of their involvement.

**Staff engagement**

As staff were generally not involved with data collections, their engagement with the research centered primarily on the use of the patient-reported experiences. Staff reported that they had limited time to engage with the weekly patient feedback results that were sent to them. Staff also often did not have access to a computer, making it harder for them to look at the reports and make use of them. Staff reported reviewing the weekly reports during their break times, which required a printable report as computers were not available. Those who were able to view the electronic reports requested an easier to view and understand format, such as a one page reporting dashboard. Staff explained their request with the statements: “Ward staff are not trained to understand the results” and “the results need to be quick and punchy”.

**Key lessons learnt**

To increase staff engagement with the patient feedback results, a printable, static dashboard displaying results and summarizing progress and areas for improvement was incorporated into the weekly reports. This printable ‘at-a-glance’ version provided staff with the information they needed in an easier to view format, allowing them to quickly view what areas had improved so far and which areas of care still needed intervention. As staff were provided with a printable sheet, staff could view the data at a time that was convenient to them without the need to access a computer.

Buy-in from a senior clinical staff member, e.g. director of nursing, or matron, was found to be key to identifying and prioritising actions for improvement and encouraging frontline staff to engage with the patient feedback results. The involvement of senior staff helped to develop and initiate action plans to target areas of improvement. For example, in order to improve communication between staff, and patients and their families, one trust implemented a ‘coffee hour with matron’, where patients and their family members could meet with the matron over refreshments, and discuss any questions or concerns the may have about their treatment or after care. As the matron was the driver to this initiative, she was involved in all aspects of developing the coffee hour, and was seen to encourage patients to talk to her during this time.

**Volunteer training presentation**

This presentation gives an example of content from a volunteer training session

www.picker.org/volunteertraining
Questionnaire -
Patient experiences of
compassionate care

Introduction
This questionnaire is designed to understand your experiences of relational care whilst being a patient in this hospital. Relational aspects of care refer to the emotional care received as a patient in addition to the physical treatment or care. This includes the relationships formed with the hospital staff that cared for you.

The questionnaire will take approximately ten minutes to complete. Your results will be completely anonymous and will be used to improve future patient experiences of care. Family or carers may provide feedback on behalf of the patient. However, all questions should be answered from the patient’s point of view.

You are free to leave any questions unanswered and to stop taking the questionnaire at any time, without giving a reason.

Informed consent
I have been informed about the purpose of this questionnaire by a hospital volunteer and/or have read the information sheet.
» Yes
» No
I agree to participate:
» Yes
» No

What ward are you currently on?
» [insert ward name]
» [insert ward name]
» [insert ward name]

Patient questionnaire on relational aspects of care
Q1. Have staff introduced themselves before treating or caring for you?
☑ Yes, all staff have introduced themselves
☑ Yes, some staff have introduced themselves
☑ No, staff have not introduced themselves

Q2. Have staff taken the opportunity to learn about you as a person?
☑ Yes, definitely
☑ Yes, to some extent
☑ No
☑ Don’t know

Q3. Have staff made you feel at ease by being friendly and warm in conversations?
☑ Yes, always
☑ Yes, to some extent
☑ No

Q4. Have staff showed you care and compassion?
☑ Yes, all of the time
☑ Yes, some of the time
☑ No
☑ Don’t know

Q5. Have staff listened to what you have to say?
☑ Yes, definitely
☑ Yes, to some extent
☑ No
Q6. During your time in hospital, have you had enough contact with staff?
- Yes, definitely
- Yes, to some extent
- No
- Don’t know

Q7. Do staff appear confident and able to perform their tasks when caring for you?
- Yes, always
- Yes, to some extent
- No
- Don’t know

Q8. Have you had enough time to discuss your health or medical problem with a doctor or nurse?
- Yes, definitely
- Yes, to some extent
- No
- Don’t know

Q9. Have you been involved as much as you want to be in decisions about your care and treatment?
- Yes, definitely
- Yes, to some extent
- No
- Don’t know

Q10. During your time in hospital, have staff made you feel safe?
- Yes, completely
- Yes, to some extent
- No
- Don’t know

Q11. Have you received as much support as you have needed from staff?
- Yes, definitely
- Yes, to some extent
- No
- Don’t know

Q12. Overall, do you feel you have been treated with respect and dignity while in hospital?
- Yes, all of the time
- Yes, some of the time
- No
- Don’t know

Q13. Who was the main person or people that filled in this questionnaire?
- The patient
- A friend or relative of the patient
- Both patient and friend/relative together
- The patient and the volunteer together

Q14. Are you male or female?
- Male
- Female

Q15. What was your year of birth?

Q16. Do you have any of the following long-standing conditions? (select all that apply)
- Deafness or severe hearing impairment, blindness or partially sighted
- A long-standing physical condition
- A learning disability
- A mental health condition
- Dementia
- A long-standing illness, such as cancer, HIV, diabetes, chronic heart disease, or epilepsy
- No, I do not have a long-standing condition

Q17. Does this condition(s) cause you difficulty with any of the following? (Select all that apply)
- Everyday activities that people your age can usually do
- At work, in education or training
- Access to buildings, streets or vehicles
- Reading or writing
- People’s attitudes to you because of your condition
- Communicating, mixing with others or socialising
☐ Any other activity
☐ No difficulty with any of these

Q18. To which of these ethnic groups would you say you belong? (select ONE only)
☐ English/Welsh/Scottish/Northern Irish
☐ British Irish
☐ Gypsy or Irish Traveller
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Chinese
☐ African
☐ Caribbean
☐ Arab
☐ Any other ethnic group, write in...

Q19. Please use the space below to provide any additional comments you may wish to share about the staff caring for you and your time in hospital.
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Case study site contacts

They may be able to provide insight in the following areas:

» Set up of the questionnaire on wards
» Recruiting and maintaining a volunteer workforce
» Using the tablets to collect data
» Using the patient feedback to highlight areas for improvement
» Action planning
» Developing innovative, low cost ways to improve patient experiences of care

Contact details for three of the case sites involved in the research are provided.

Please note: A response may not be immediate, as we are unable to determine the number of communication requests that they may receive.

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If you have any questions, or wish to learn from the case study sites which took part in the research, the listed contacts welcome you to get in touch.

References


Further reading


