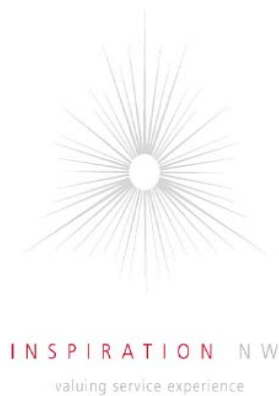

Vital Signs Care Cards

Learning Capture



*Compiled by
ODS for*



*With
contribution
from*



Learning capture

Vital signs care cards

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Foreword

The idea for the Care Cards came from the work of Inspiration NW, a programme dedicated to value service experience across the North West. The cards are a simple but inclusive way to understand and capture the emotional priorities and needs of patients and the concerns of their families and carer.

Supported by a Health Foundation Opportunistic Grant the idea was to find a tool that would help to identify the patient's priorities *in real time*, so care can be personalised to them. The principles behind the cards were how to:

- Foster a meaningful conversation '*in the moment*' about an individual's emotional and preferred service experience
- Enable care providers to tailor responses to clearly signalled patient wishes and direction
- Be user led
- Allow a person to express as many or as few of the 8 statements that apply
- Provide an 'Open Card' – to allow for free expression and interpretation
- Provide consistent evidence based statements to allow for comparative benchmarking over time

Why playing cards?

The playing card design and analogy was used because of the connection to people playing cards; people play their hand and therefore the choices they make are their own choices.

- Familiar and non-threatening
- Choices more likely to be remembered because of the unexpectedness of the method
- Tactile and hygienic (laminated)
- Encourage a more considered reflection on the statement choices
- Encourage a sense of user control
- Low cost
- Allow easy data capture and systematic aggregation

Feasibility study

As part of the NW Advancing Quality incentive programme the cards were tested in five hospitals as a means of capturing patient experience across specific clinical pathways Overall the response to the cards has been very positive for both patients and staff. A more in depth study and evaluation is now needed to explore these early findings but results are very encouraging as patients reported that using the cards helped them to express their preferences, and that the care they received was adapted to meet these preferences most of the time.

Thanks

I would like to personally thank all the staff and patients who volunteered and came with us on this journey. Special thanks to our partners, Organisation Development Services (ODS) and Customer Research Technology (CRT), who worked with us on supporting the implementation process and

capture of the data. David Hynes from Videotile for the capture of the debates and journey on film and Andy Bounds author of the 'Jelly Effect' for his free time to deliver a master class on communications using the cards. It has provided great learning and insight to the challenges of care in today's busy acute settings and it is to everyone's credit that the study was completed on time and has continued to gather wider interest and acclaim.

A handwritten signature in cursive script that reads "Mandy Wearne".

Mandy Wearne
Director Service Experience
Inspiration North West

Executive summary

The vital signs care cards feasibility pilot study was undertaken to help understand and capture the emotional priorities and needs of patients and the concerns of their families and/or carers.

Organisation Development Services LTD were commissioned by Inspiration North West to provide project and change management support and to capture the learning from the pilot sites who participated in the Vital Signs Care Cards feasibility pilot study. The pilot ran from March to October 2009 and began with a launch event where colleagues from across the North West were invited to participate in this study. Five hospital trusts within the North West were identified with each site representing a different care pathway. The five sites and associated pathways were:

- Aintree University Hospitals NHS Foundation Trust: Ward based approach-elderly medicine
- Royal Bolton Hospitals NHS Foundation Trust: Hip and knee
- University Hospitals of Morecambe Bay NHS Trust: Hip and Knee
- Stockport NHS Foundation Trust: Pneumonia
- Wrightington, Wigan and Leigh NHS Foundation Trust: Myocardial infarction and heart failure

The participating sites met throughout the pilot, initially to launch the project and develop implementation and training strategies and subsequently at regular intervals to support the pilot leads and capture learning in a comfortable and safe environment.

The monthly leads meetings addressed key issues, challenges faced and the development of practical solutions. Each lead felt it beneficial to meet regularly and valued having time together. Shared learning was promoted and throughout the journey themes emerged, different change management approaches adopted and practical solutions were implemented.

As part of the learning capture, ODS facilitated a series of focus group discussions. The staff from all sites played a valuable role throughout the project and understanding their experiences together with the views and experiences of the patients and their relatives has provided rich information which will assist in any future roll out of the project.

Findings from the study varied with each pilot site and with each pathway. Overall the process of addressing the emotional needs of patients is seen as highly important and necessary in order to give the best emotional care to patients as per their identified needs. The care cards, for the majority of sites were seen as a useful tool to enter into discussions with patients and their relatives.

There are many recommendations from the feasibility pilot study including,

- to take a whole ward approach instead of a disease specific or condition approach,
- to use the cards from the point of admission to discharge, look at making the documentation used more
- integrated in existing methods and to look at the future use of the cards within different services such as maternity, paediatrics, mental health and community services.

This journey is captured in greater detail within this report.

Introduction

During 2009, Organisation Development Services LTD were commissioned by Inspiration North West to provide support to and capture the learning from the pilot sites who participated in the Vital Signs Care Cards feasibility pilot study. This report details the journey undertaken by the pilot sites, and describes the learning identified during that journey.

The report begins with the launch event in March 2009 and culminates in the Inspiration Live event and final pilot sites meeting in October 2009. Learning has been captured throughout the duration of the pilot through a variety of forums including the pilot site leads meetings, learning capture sessions and staff focus groups. Case studies are presented within this report from each of the pilot sites and findings and recommendations from the feasibility pilot are discussed.

This aim of this report is to capture learning that occurred throughout the pilot feasibility study and highlight some of the softer evidence, comments and discussion that took place along the journey taken by the pilot sites. Although not a formal evaluation paper, this learning capture report considers Donald Kirkpatrick's model of evaluation¹. Kirkpatrick's model was first described in 1959 and this learning and training evaluation framework is a widely used and popular model. The four levels of Kirkpatrick's evaluation are concerned with:

- Level 1- Reaction
- Level 2- Learning
- Level 3- Behaviour
- Level 4 -The effects on the business or environment

This report will therefore examine reaction and attitudes towards the Vital Signs care cards, the learning derived from the feasibility pilot study, the findings regarding the behaviour of staff and patients involved in the study and the longer term impact of using the vital signs care cards for the participating sites.

The report is subjective and contains the opinions of the staff groups from participating pilot sites and should be considered alongside data collected from CRT (Appendix IV) throughout the pilot study which has also contributed to the learning capture.

ODS would like to thank the 5 sites who took part in the pilot for their commitment, contribution and enthusiasm throughout. The 5 sites are:

Aintree University hospitals NHS Foundation Trust
Royal Bolton Hospitals NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Trust
Stockport NHS Foundation Trust
Wrightington, Wigan and Leigh NHS Foundation Trust

Many thanks

Jackie Barringer, Stuart Taylor & Viki Kehoe
Organisation Development Services LTD

¹ Kirkpatrick, D.L. and Kirkpatrick, J.D. (2006) Evaluating training programmes-The Four Levels. Third edition. San Francisco. Berrett-Koehler

Section I

Project beginning

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Initial project meeting – April 2009

Once the 5 pilot sites had been identified they were invited to an initial project meeting at ODS offices. The purpose of this meeting was to understand the specifics of the project; training of staff, reporting mechanisms and to discuss the learning capture possibilities and ideas. The meeting also provided space for the leads to meet each other, discuss their hopes and fears for the pilot, and establish a baseline. At the first meeting there was a real sense of energy and enthusiasm in the room mixed with some scepticism about whether the cards would actually make a difference. However all were keen to find out how the cards would work.

A number of points were addressed at the meeting, these were as follows:

Understand the starting position of each of the sites:-

The sites all provided an overview of their clinical pathways, their approach to the project – whole ward or condition pathway - and the number of staff who would be involved in the project.

Aintree had already undertaken preparatory work for the pilot and were able to share ideas and useful suggestions with the other sites. To help engage staff Aintree had designed a template of each card with a checklist of actions under each heading that acted as a prompt for both patients and staff, which they were also happy to share. Credit must be given to Colin Hont for his enthusiasm and drive throughout the project as his ideas not only helped the other sites but his positive attitude would often help engage sites who would occasionally lose their way.

Wrightington, Wigan and Leigh had also undertaken preliminary work implementing the project with target groups and were keen to begin the project. They too had designed information leaflets and communication briefings which they were happy to share with their colleagues.

The remaining sites were all at the start of the journey, eager to discover more about the pilot and proud that they were part of such an exciting project. There were concerns; the biggest concern was how they would successfully engage their staff with the pilot, a workforce that is already at times overstretched and working to capacity.

Establish support required from ODS:-

The sites agreed that they would like a mixture of support from ODS. Already they valued meeting together to share ideas, concerns and issues and so requested that we had monthly meetings as Leads at ODS offices, the comment being that having the space away from the work environment was really useful in terms of giving full attention to the project.

ODS put forward initial ideas for a Change Management Toolkit that could support the sites during the pilot. The sites were all given the opportunity to request any additional tools or techniques that they would like adding to the toolkit. The feedback from the sites was that they liked the idea of having a tool that had a pick and mix approach which made it versatile and so could be tailored for each site. It was requested that additions to the toolkit could be a competency checklist to assist staff when they were delivering the training along with publicity and marketing materials / suggestions. Besides this request all the Leads were impressed with the content of the Change Management Toolkit.

In line with the ODS approach it was important to engage with each of the sites to understand what their requirements would be, as a whole and also as individual sites as. Whilst there were commonalities across the area there were also some specific individual needs which would need addressing and support.

It was agreed that the support ODS could provide would be split between the monthly Leads meeting, monthly Learning Capture sessions and one to one support for each site. Each of the sites were allocated a Consultant from ODS to support them through the journey.

Training Requirements:-

The sites were all in agreement as to their training requirements. It was agreed that a Train the Trainer type event would be held. This would allow the Leads to invite key members of their team to understand:

- the purpose of the cards
- the requirements of the pilot
- the training requirements
- the implications for staff and patients

The Leads appreciated having a training tool that would allow them to deliver the training in-house as this would provide development opportunities to their staff, provide ownership of the pilot but it would also allow each site to tailor the training to any specific requirements.

Hopes and Fears:-

The Leads were asked about their hopes and fears for the pilot. They then identified risks / challenges and contingencies for these.

Risks / challenges for the Vital Sign Care Card Pilot

- Patient pathway – who do you use?
- How to get buy in from staff groups
- Resources/protected time
- The pilot is a project so there may be issues including applying for AQ monies
- Tight timescales
- Could be complicated- need to not complicate/keep simple
- Poor compliance if not in a state of readiness
- Not having guidance to use /when with patient, piloting applicability
- What if it doesn't meet the needs of the patient? We might use the cards okay, but care not identified (raised expectations)
- Complaints raised due to expectations
- Integral to patient care
- Don't have systems in place
- Negative staff culture/positive impact
- Confidentiality at bedside – need to consider taking patient into another room
- Pilot not acted on – not cascaded/sustained
- Governance Issues
 - Excluding patients

- Design methodology

There is a risk when piloting a clinical condition pathway particularly if patients with that condition are widely spread throughout the hospital on different wards

Contingencies identified

- Individual assessment
- Training, communications, champions, support for leaders, etc.
- Criteria – contract – lead to have the time – executive sponsor agreement
- Keep project, simple, don't complicate
- Being prepared/before launch
- Guidance to be drafted
- Linked to training, process & expectations are clear
- If no 8.² not met complaints may rise
- Making sure part of core pathway/handover etc
- Systems to be developed
- Criteria part of assessment
- Commitment from North West – linked to A2. Assurances/Conferences/National Momentum
- Pilot sites to think through governance applicability, etc. Sample size

Addressing their concerns and thinking of a contingency empowered the Leads and provided ODS with a clear picture which enabled future activities and meetings to be planned in a way that would support the sites to address some of these challenges.

The group were also keen to discuss how they would capture information, learning and the views of the patients and staff that would use the cards. It was agreed that everyone would come to the next meeting prepared with ideas and suggestions.

² Patients "emotional needs" was chosen by Aintree Hospital as an 8th quality indicator as part of their Advancing quality agenda

Train the trainer - 15th April 2009

A joint Leads meeting and Train the Trainer event was held at the De Vere Daresbury Hotel and attended by the leads and colleagues from their teams. At this event there was a number of staff who were completely new to the project and did not have a full understanding of the pilot. This highlighted the differences in the sites as some of the Leads came along with fully briefed staff. This also reinforced to ODS how essential it is to have clear communication, briefings and publicity within the workplace to not only inform staff but to also help engage.

ODS provided a range of training; power point presentation's, role play, answer and a question panel. The choice of training was designed as formal or informal both of which could be tailored to each site. There was also a Change Management Toolkit CD a copy of which was given to each site. An offer was also given to provide in-house training delivered by an ODS consultant. (Stockport later took up this offer).

ODS presented their ideas for the Learning Capture sessions and what this would entail leading on from this a discussion took place about how each of the sites could capture their own learning and experience too. Suggestions such as a comments book for staff and patients, copying the care plans and recording any actions taken or changes made along with measuring comments, compliments and complaints at the start of the pilot and comparing upon completion were just a few of the ideas put forward by the sites.

The Train the Trainer event was well received and evaluated, teams went away confident that they were equipped with the skills and tools needed to cascade the training and awareness building throughout each site.

Data collection and CRT

Inspiration North West commissioned - Customer Research Technology (CRT) to support the vital signs care card pilot sites throughout the feasibility study.



CRT is the leading provider of research technology in the UK and has a growing international presence. CRT believes the value of patient satisfaction feedback can be significantly improved when the customer's experiences are captured at precisely at the point they occur.

CRT provided each site with a Tablet PC complete with their ViewPoint survey software – these electronic devices were used to capture data for the duration of the pilot.



Data was collected on or around the time of the discharge and the patients were asked the following questions:

- Were you given the care cards?
- Were the care cards helpful in expressing your preferences for your care?
- Were the preferences you expressed using the care cards reflected in the care you received?
- Which of the following statements were most important to you during your stay? : these statements reflected the care card narratives and information. Patients were able to tick all that applied to their stay in hospital but generally picked their top three choices
 - *Confidence in managing my own health*
 - *To feel treated with respect*
 - *To feel reassured*
 - *My treatment to make me feel better*
 - *To feel safe*
 - *To feel physically comfortable*
 - *To understand my treatment and condition*
 - *To feel staff are open and honest with me*

Staff were also asked to register on the tablet:

- Whether they found the care cards helpful in understanding the patients' needs?
- Whether the care given to the patient was adapted to meet their needs?

The pilot sites uploaded the data at regular intervals during the feasibility study and the data findings can be found in **Appendix IV: Page 78**

Section II

Leads meetings and
learning capture
sessions

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Project leads meeting – July 2009

Throughout the pilot ODS facilitated Leads Meetings and Learning Capture events that all the Leads consistently attended. This forum provided a safe environment for the Leads to discuss their learning to date and the challenges that had been faced and how they dealt with and any changes that had been implemented as a result of the pilot. The leads meeting addressed the more practical aspects of the pilot and the learning capture provided the opportunity to discuss the learning to date. The learning capture events were always extremely positive as it was where the discussion took place as to the impact the cards had been making. Having an environment where all 5 sites could discuss what they had experienced generated energy and renewed enthusiasm that would then be taken away. This forum also inspired Leads who, at various times, may have been struggling with the pilot, as well as providing possible solutions to challenges faced. The leads all reported that updating their wards after each meeting had a similar impact of renewed energy and positivity.

The first event was held in July, below is the learning captured at the event. This is what the project leads told us.

What has been the impact of the cards so far?

- There is a sense of improved effectiveness on admission – patient and family appreciate the questions being asked, the patients are not asking for much but appreciate the time taken and the conversation as a result of this.
- Making more conversations happens – providing the opportunity to talk and this has made a feeling of change. Communication is better as well.
- There is a notable rise in confidence in the patient; they are going home with improved understanding.
- The attitude of staff has also been affected by the cards.
- When staff are using the cards it has been impressive watching them have the discussions and seeing how professional it is making them. The cards would be good to use in a ward where attitudes needed to be developed.
- Using the cards hi-light what we should be doing anyway but now we are able to record it and it makes staff feel good too.
- Using the cards is helping improve confidence in care-staff feedback it is helping to promote an early good patient – nurse relationship and helps present a professional approach.

How have staff and patients engaged with the pilot?

- There has been some negativity at the start of the pilot from staff, some of the feedback from the nurses is as follows:-
 - There are too many cards to go through with some patients.
 - We are doing it anyway – The response to this is well lets prove it!
 - Staff had not been doing the cards on the 2nd time – which needs to be challenges

- Patients worrying about insulting us
- It is important to capture the thoughts of staff along the way the first few weeks comments have been recorded in a diary that is on the ward.

Are there any emerging themes?

- Surprisingly the 'safety' card had not been chosen – many thought this would be the top concern for patients and are surprised that it isn't.
- Aintree commented that they have never had a metric before to take to the board and say this mixed ward is affecting the other patients and is having a direct impact – the findings from the pilot is giving the go ahead to do this and it is a BIG PLUS and this has all been a result of using the cards.
- Communication with the family, this too, is having a fantastic impact, there would normally be a queue of family members at Matron hour and I (Aintree) am now seeing a big reduction as we are addressing things through the cards in the beginning of a patients stay.
- It is a busy ward but this is giving protected time to staff, having that permission, knowing it is a priority has made such a difference to staff. We have all agreed that this is important and giving permission to take the time is really taking the pressure off staff and you can see the difference in them. The patients also know staff are busy so the patients having permission to take the time is also really positive

Have there been any challenges or changes as a result of the pilot?

- A problem encountered has been with discharges –not using the tablet and we are sometimes missing patients. To solve this we (Aintree) are going to give this responsibility to the ward clerk to ensure we catch everyone; also we have sticky labels for people taking part with their details on so if they do slip through we are following this up with a telephone call to complete the exit interview.
- Where there is a very good Ward clerk the sites all recommend engaging with them as part of this process as well as the lead consultant
- An impact for WWL has been getting the community health visitors to visit in ward rather than wait a few weeks and get a visit in at home, which by this time they may have had too much salt in their diet for example and had not changed their diet through lack of knowledge and get re-admitted. Answering the cards has highlighted the need for an earlier appointment/talk.
- This pilot has really given priority to the patient's experience - Videoing patients and using this to share with staff will be really beneficial as it does test assumptions and is very moving.
- The pilot has tested our assumptions - we thought we knew best but patients know better!
- In the past there has been anxiety for patients as they may have told one nurse information being told to one nurse but then that nurse might go off for 2 days and then that

information is lost the great thing about this pilot is it provides a way to capture and record what matters to the patients..

- It is important to have the engagement of night staff too.
- Staff found it really interesting and enjoyed it so far. It has been good giving junior staff that learning process, using the cards provides a boost to staff confidence
- In the beginning there was a concern that staff would be negative but actually they haven't been at all.
- It is additional work but it is also extremely worthwhile and it is reducing work in some ways too.
- It could possibly help with complaints – the sites intend to look at the number of complaints throughout the pilot.

Project leads meeting – August 2009

The next Learning capture event took place in August and it is clear to see how everyone has progressed. The sites provided updates on progress, staff thoughts and the patient's experience. The sites had also begun to develop their own processes.

How has the pilot progressed?

- **The more the pilot has gone on the more convinced I have been by it all – I think it is great!**
- Some staff feels that they are putting words into patient's mouth by having prompts so one site is now trialling the cards as one blank and one with the prompts. The blank trial – some people are finding it hard to verbalise, some people feel under pressure to answer. There is something in not having it completely prescriptive but how do you do it? Need a balance.
- The sites used the templates supplied by Aintree originally to get buy in. Now they have a mix and have care plan at the back of the pack to record choices and information.
- It has been noticed that the cards do reduce paperwork. The more time you spend with patient and families – it is lessening the paperwork.
- Not as many patients have been done due to surgery but it has been built into admission and this has been very beneficial.
- Having conversations and with patients and sharing this has only really been effective on day one but day three it is not as successful.
- It has been noted that the choice changes on day three when the patient is ready to go home – this has been interesting. Day one is often around Comfort and day three more about Confidence – feeling equipped with skills and knowledge to successfully be safe and well at home.
- **Kendal** –discovered that this site was using the cards daily. Noticed a difference with this site joining later and not having had direct training, some bits have been lost along the way. Direct training does make a difference.
- In Stockport there have been few patients, the staff are not using it regularly and they still see it as a burden. **Looking at how Aintree have done it – all staff and a whole ward approach you appreciate the benefits doing it that way as it becomes an everyday occurrence.** The learning from Stockport has been that you need to do all patients and all staff – feel very passionate about this. If staff are not on board then it fails – as Stockport have experienced.
- Staffs still require prompting and you need to be present, it requires a lot of input. This has been the learning from many of the sites.
- In Bolton we are finding that doing the cards on day three has little value unless the patient is staying in for six days plus.
- Aintree has been impressed with the way the cards are helping staff to approach family members, sometimes staff have been wary of approaching visitors but through using the

cards they are now more confident and this has made a difference. What has worked well for us is **having the ward based approach, we routinely use the cards and we have had quicker buy in.**

- What Aintree have done is go through 50% of the case notes, if we spot that someone has somehow been missed from the cards then we go and do them.

What have been the response / thoughts of patients?

- At times patients almost feel shocked at being asked – as they expect all things to be a given. Family members ask if they pick three are the others not included – this is more to do with how the cards are being applied and this is something that we need to address with staff.
- Safety – for those patients who are not confused and are sharing a ward with patients who are experiencing confusing moments we now recognise the concerns of those patients and how unsafe they have felt at times. We are now able to put energy in to balance this out.
- One negative is the picking the top 3 cards - patients feeling anxious that the other cards aren't important – this links back to how we train staff with communication skills.
- The biggest buy in has been from the patient's family, through them giving us clues and answers it has enabled us to deal with so many things.
- When we have elderly patients who are confused then it is so valuable to have family members who can provide those subtle details.
- For example falls and safety – we are showing that we have taken a real active interest in the patients care – this pilot has had a big benefit in dementia care – families are happy that we are asking about their family member.
- Aintree are concentrating on the night staff now. Admissions still come in at night time so it is important that these staff are involved. We use the cards on day three and three times during their stay as a minimum however patients are in longer so it is easier for us to do this. Using the cards we are able to look at social and emotional issues, mental health liaison are also becoming more involved.

What have been the thoughts / issues / ideas from staff?

- It has highlighted that we need more formal training for staff – having someone come from outside to deliver training (Stuart ODS) Stockport noticed a difference as it somehow gave it more importance.
- Staffs has continued to make comments that they do this anyway – provide this care – but appreciate that there has never been any way to record this before now and the cards allow us to capture and evidence.
- Pre-op we don't always see patients as they go to another ward – but those wards are taking it on board and having a go. Staffs are not seeing it as a high priority as not everyone is doing

it to everyone. Need to develop the handover process and look to how other sites are doing this. (Aintree are using the electronic handover which works well).

- Junior nurses – the cards are helping them to get to know patients and family members, they are helping to build strong relationships, and there is still a shorter queue at the end of visiting times. Feel there has been a real shift.

What future ideas / thoughts have you had so far?

- Everyone welcomed the idea of Andy Bounds session and their staff attending – think it is an excellent idea. Having this event filmed will be helpful to share with staff as a training resource.
- The group feel it would be useful to understand more about how the cards fit into Advancing Quality and to the Dr Foster tablet? This would also help inform any future roll out.
- Question asked about the style of the cards – does it need to be in a pack of card format, could the sites influence future design?
- Students and health carers are also involved with the cards which is great. Bolton thought trained staff could do the initial patient discussion with the patients but then after that the health carers can do day three.
- **Suggestion – it would be useful if the Vital Sign Care Cards was made part of mandatory training for all staff**
- Presenting the cards to commissioners they questioned the language – non English speaking patients, also those with literacy challenges – but overall they thought it was a great idea.
- Do need champions otherwise it falls off the radar – even if this is an area where it should be part and parcel. There is the challenge to sustain it.
- Would be useful to have monthly PI to see how cards are being used. Aintree are looking at it as the 8th element; empathy. It is providing us with evidence.
- The name of the cards does not give a true reflection of what they do and is a bit off putting. Vital makes you think about blood pressure. The group suggested **Empathy Cards**, thought it was a name that made you warm to it.

Project Leads meeting - September 2009

The learning capture session on 24th September utilised a variation of the evaluation questions originally used in ³*Talking openly: Using 6D cards in clinical consultations to allow patients to talk about trauma* and a series of evaluative questions designed by ODS as the project moves towards its end stage and final evaluation.

How *acceptable* did staff find the Vital signs cards to talk about patient issues and concerns?

Acceptance by the staff moved from a neutral acceptance - in that it was a given that they had to use them as a pilot area. Initially staff thought that it was just more paperwork and just another bit of work to do. This view moved to an increased level of acceptance of the cards by the staff using them to talk about patient issues and concerns.

How *comfortable* were staff using the Vital signs cards when talking about your issues and concerns?

Initially staff were uncomfortable with the cards and both the playing card design and the concept of using cards to discuss issues and concerns were mentioned. There was discussion around the numbering of the cards including the ace card, suits and the joker card. The group did wonder if there were any benefits in the playing card design and some of the focus groups had highlighted that the playing card design was sometimes an issue for some staff and some patients, it could also be interpreted as staff having time to “play games”, It could also be interpreted as encouraging gambling. The group discussed the suits and numbering of the cards and wondered if this had any influence in the patient’s choice for example would the ace card be picked as a priority no matter what the emotional issue was on that card. The group felt that the joker card, whilst allowing the staff to address any additional emotional care issues, was inappropriate and could be interpreted as having fun or not taking the process too seriously.

How *effective* did staff find the Vital signs cards at allowing patients/relatives to talk about issues and concerns?

Once used to the process and cards, staff found the cards to be very effective and allowed them to receive immediate feedback from patients and their relatives. It gave staff very individual information about their patients needs and was effective when speaking to relatives and felt that this encouraged engagement.

Did the Vital signs cards make it *more difficult* or *easier* to talk about issues and concerns?

Overall the group reported that using the cards was a forum that made it easier to talk about patients issues and concerns but when a patient refused to use them, which was remote and occasional, then this made it more difficult to engage in discussing the emotional needs. Also it was

³ Neufeind.J and Hannah.M. Talking openly: Using “6D cards” in clinical consultations to allow patients to talk about trauma. Primary and Community Care Directorate. The Scottish Government

felt that patient diagnosis and the severity of that may well be a factor in whether it is difficult or easy to talk about issues or concerns.

How *willing* were staff to talk about issues and concerns using the vital signs cards?

It was felt that this ranged from staff being unwilling to willing to use the care cards to discuss emotional issues and concerns. The playing card format was again mentioned and this was attributed to the staff that were unwilling to use them. It was also mentioned that there were staff who felt that they addressed the emotional needs and issues of patients already as part of their usual communication with their patients.

How *appropriate* did staff find the Vital signs cards for talking about issues and concerns?

Again the appropriateness of the cards focussed on the playing card design although a great idea to use cards, the playing card aspect was considered not necessary, numbering could be interpreted as leading and the joker card was not a popular design. If the concept is to be rolled out or extended then group recommend that the cards are available in other languages. Further discussions ranged from the cards being cumbersome and hard to use but counter discussed by others who felt that the size of the cards enabled others to use them who may not have been able to do so if they were smaller. Some patients liked to spread the cards out across the bed or bed table in order to make their choices.

Are there any issues that staff consider *relevant* that were not mentioned when using the vital signs cards?

Overall - no there was no issues that staff considered relevant that were not mentioned but the discussion did suggest ways or pose questions in which the cards could be improved. The cards if they looked different they may well raise different issues, they could have prompt questions on the back for use by the staff, could also include individual trust information, as an alternative they could be printed on one side of A4 or one suggestion was that they were printed on bed table sized sheets i.e. disposable lunch mats.

Did the vital signs cards contain any issues that staff might not have previously considered to be relevant or appropriate?

Not but it highlighted for some, the importance of safety issues and concerns and this was not a category that the staff felt would have been considered as a main choice

How *easy* or *difficult* did staff report patients putting the vital signs cards in order of importance?

Some physical reported difficulties for the minority of patients, who found the cards cumbersome, others left the cards with patients so they had time to consider their choice of order, some reported it was difficult as some patients gave equal importance to all cards. Staff reported that overall they felt it was easier for patients to discuss their issues and concerns.

Would staff encourage or discourage colleagues to use the vital signs cards?

There was a neutral response to this question but overall the meeting stated that they would have no hesitation in promoting the concept but not necessarily in the “playing card” format

What the leads would have done differently?

- Commenced the initial training in the use of the cards much earlier and in more depth, allowing staff a longer period of time to practice verbalising and questioning techniques. It was suggested a DVD showing staff examples of how to use or not use the cards would have been a useful tool.
- Highlight champions early on and involve operational members of staff as well as external support is seen as critical. It was felt that this would increase motivation in staff.
- A ward based approach rather than a condition based approach.
- An optional format would be to incorporate the process into care pathways
- More resources
- When used in elective pathways this could be introduced at pre operative stage
- The midpoint assessment could be revised or removed; if this is done on day 3 then patients may feel pressured to pick a new order of concerns
- Consider the timing when the process takes place, for example, a person discussing their emotional issues in a bay may be concerned that others can hear them. Privacy must be considered

Was there successful engagement with staff?

- Now engaged initially difficult to engage staff
- Some sites reported that staff not always engaged, not convinced all staff groups on board i.e. those staff on night duty

Was the training the leads provided to their staff effective?

- Not for all sites, some felt that this was done “on the hoof”
- Highlighted the need for a robust training package – see previous responses
- Felt that they were often training “live” didn’t feel this was fair

How useful was the support and tools provided by ODS?

- Tools and resources were useful
- Used some of the resources but not all, liked the fact that they were downloadable and could be modified
- Liked the sharing of resources from each other coordinated by ODS – forwarding care plans etc...
- Liked ODS style – not in your face but available if and when needed
- Found the vital signs meetings and learning capture sessions very useful
- Liked coming in ODS for these meetings – getting away from site a welcome opportunity for peer networking

What further support could have been provided by ODS?

- Could consider doing all further training for sites. ODS offered flexible approach where sites could use ODS for their staff training if required. Further development of resources, DVD and “how to use...” documents

- Off site support appreciated – leads meetings

How useful was the tablet and the information it provided?

- It arrived late if we had it from the outset this would have been better
- Missed opportunity to use this at times as ambulances arrived to take patients home before the data was captured
- Some felt the tablet was bulky and difficult to use others liked the size and thought it user friendly
- If we received a weekly update from CRT this might have motivated the staff so they could see how they were doing as a site
- Can't see own data so are reliable to CRT to see data
- Some sites had initial IT problems due to the encryption issues within trusts
- Consider ward targets. If set targets then know how many we are aiming to do? This could work both ways it could increase use in order to meet target or it could decrease morale if not achieving target or putting pressure on to achieve it.

How do you envisage the cards impacting on other wards?

- Concept of the cards good format not so good
- Documentation that accompanies care cards- toolkit good resource
- Learning from patient stories and experience of using the cards is valuable and has increased the documentation of patients emotional needs, issues and concerns
- Valuable Audit tool
- Providing soft evidence to support 8th element of advancing quality around compassion and empathy. (see page 11- footnote)

Section III

Focus Groups

Stockport NHS Foundation Trust:
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Aintree University Hospitals NHS
Foundation Trust: *Page 29*

Royal Bolton Hospital NHS
Foundation Trust: *Page 32*

Wrightington, Wigan and Leigh
NHS Foundation Trust: *Page 35*

University Hospitals of Morecambe
Bay NHS Trust: *Page 37*

Stockport NHS Foundation Trust

What was Stockport's experience of the pilot?

Vital signs pilot study is just one of many pilot studies within the trust. Due to this Stockport thought there was a case of "pilot overload" causing confusion for both patient and staff groups. During the pilot phase, ward A15 experienced other issues, including staffing problems and the loss of the card "champion" who had been pre-identified. Together with the requirements of the Vital signs pilot, this was seen as a too time consuming exercise and would be deemed as having a negative impact on patient care.

Practical issues were also raised during the focus group such as the regional variation of ward admissions for pneumonia, which were very low, and the fact that patients are not always direct admissions to this ward but arrive via different routes, therefore the staff felt they would not be capturing accurate "on arrival" information.

The concept and the staff perception of using a deck of cards was raised during this initial question as a barrier to implementing the pilot and an example given from the Matron was that the playing card aspect of the cards were not appropriate, for example the ace of spades means death – *although it should be noted that the ace of spades is not a card that is represented on any of the empathy cards*. The cards are commented on in later questions. It was stated that emotional needs were discussed during informal chats on ward A15 and this was the preference of the staff.

Was it clear from the start that this was about patient's emotional needs?

The focus group stated that this was fully understood.

Was the training sufficient?

There was no problem identified with the training at first. The staff from Ward A15 had received the training from ODS on a one to one basis and this was deemed as satisfactory. It was felt that due to long periods of time between eligible patients arriving on the ward that the staffs understanding of how to use the cards had lessened. They felt a DVD would have been a useful tool to have so staff could watch a "how to use the cards" demonstration where their comfort in using the cards had diminished. This was the first time that the issue regarding the need for "refresher" training had been raised, though the pilot lead had spent further time with a number of staff who had missed the initial training supplied by ODS.

What tools were used and what were most useful i.e questions and answer sheets, change management toolkit, newsletters etc..?

Stockport felt that the paperwork was useful and enabled the lead to develop a comprehensive patient information leaflet

What could have been done differently?

The “playing card” format was described as “childish” and “naff”, a bit deep and they felt that patients were being “done to” as an exercise. Time spent to do this with patients was seen as a “luxury” they did not have. It was felt that staff were reluctant to use the cards with patients overall and when asked if it was any particular level of staff who were reluctant to use the cards with patients, it was said that seniority of staff was not an issue.

Did the cards help engage with patients/family members/other colleagues?

It was noted that the patient information leaflets offered an opportunity to become engaged with patients, their families and fellow colleagues. However as a condition based pilot then only the potential eligible patients and associated staff looking after that patient had an awareness of the pilot.

Was the diary/log useful for capturing learning and reflections?

Although not available at the focus group interview the log was referred to as a useful tool and comments had been entered related to the “playing card” format of the cards

Were they surprised by anything?

There were no surprises articulated though a lack of buy in was mentioned as a result of the “playing card” format which was deemed as trivial.

Did the pilot make them think about their own practice and behaviour?

It was stated that the pilot made no difference to practice and behaviour of the staff which was viewed as very positive.

Did it raise any areas for development and /or further training?

It was stated that no areas for further development or training had been identified with members of staff.

Did the cards impact on quality – what improvements were there?

It could be viewed as a method to improve care but this would need additional resources and investment. Quality was addressed at Stockport through care pathways and by addressing the patients “activities of daily living”, emotional aspects of patients care could be discovered through non-verbal communication with the patient or via informal or indirect discussions with staff of all levels which may include the domestic assistant.

Did the cards make a difference?

It was felt that the cards created stress for the staff which led to frustration and this could have had a negative impact due to other pressures on the ward.

Was the paperwork effective not effective and how user friendly was the tablet?

The paper copies of the vital signs care cards capture, used before the tablet had arrived from CRT, had been filed in patients notes and was not available for the focus group. Staff found the tablet not easy to turn on and off and there were some initial technical issues which meant that information from approximately 5 people had gone amiss. As there had been a total of 15 eligible patients admitted during the pilot phase it was decided that with the 5 sets of missing information and the 3 sets that were captured and uploaded then approximately 50% of eligible patients had been involved in the pilot study.

How would they take this forward?

There would need to be an increase in resources as to roll it out across the organisation could be a huge financial exercise. It may be a useful tool that could be used by the specialist nurses in their services. To do this on a daily basis it is recommended that additional resources were allocated to this project

What was Aintree's experience of the pilot?

It was good but felt they needed more training during the initial introduction of the cards, felt that were learning "live". It works well when patients have the capacity to use the cards. Not sure if when used with the relatives that you are getting the patients views and issues or whether these are the relative's views and issues. All surprised by the priorities chosen but did highlight that safety was very important to patients especially those who shared a bay with a patient who had dementia or was aggressive and as a result patients were moved to more suitable bays as a result. It was felt that participating in the pilot was hard at times and could be time consuming; some patients just didn't want to do it. It got easier as time went along and all staff appeared to adopt their own style and variation using the cards with patients and allowed them an opportunity to communicate with their patients. It wasn't considered any extra work and was easier when able to do this on admission. Felt that it made patients more responsive to staff. One patient only said it was a waste of time as staff do this already.

Was it clear from the start that this was about the patient's emotional needs?

All members of the focus group were in total agreement that this was about the emotional needs of their patients. The term "vital signs" was deemed as not necessary and Aintree referred to them as empathy cards

Was the training sufficient?

Mixed response- staff felt that training had to be done quickly and could have been more structured and other staff reported it to be self explanatory. The focus group recommended that, more training sessions would have been useful especially related to the associated paperwork. A DVD was recommended as a useful resource that would improve the training content showing a good way and a bad way of using the cards as possible examples.

What tools were used and what were most useful?

The patient notice board information and change management resources were seen as useful resources. Liked the introduction to the pilot information available

What could have been done differently?

The group felt that additional packs of care cards would have been helpful and recommended that a central newsletter or email would have assisted the pilot, letting the sites know how they were doing individually and highlighting key findings as they progressed through the pilot phase.

Did the cards help engage with patients/family members and other colleague?

Yes definitely helped, assisted with engagement of relatives. Aintree asked “why just doing this for emotional issues”.

Was a diary/log useful for capturing learning and reflections?

No but issues were shared with the pilot lead staff

Where they surprised by anything?

Yes, surprised by the priorities identified by patients, thought other cards would have been prioritised. It highlighted chances and opportunities and gave permission to go ahead and ask. It enabled staff to get to know the patients a bit better and a different side to the patient

Did the pilot make them think about their own practice and behaviour?

Yes it made staff think more about the emotional needs of their patients and gave them a prompt to address these issues. It also provided evidence that issues around emotional needs had been raised with patients and was documented. This had assisted in a recent response to a complaint. It allowed staff to reflect on care given and change or modify this in response to the patient’s priorities. It enabled informal non-routine information to be exchanged. It was felt there was also a reverse permission situation in that it enabled patients to feel comfortable informing or discussing with staff their emotional needs when these changed.

Has it raised any areas for development and/or further training?

No further areas for development or training was identified as a result of the participating in the pilot

Did the cards impact on quality?

From the managers perspective it improved communication, quality of care and patient engagement. It was felt that this has reduced in-house verbal complaints and reduced the amount of attendances at Matrons surgery. When respect was recently raised as an issue this was related to the medical staff and a solution discussed was to identify the patient’s priorities and have these identified in some way above the patients bed. It also raised some discussion where relatives had expressed that they did not wish for patient’s conditions to be discussed with them for example if a patient was terminally ill.

Did the cards make a difference?

The focus group stated that using the cards did make a difference to the patient’s experience –see above points. It was also noted that staff started to use the cards when entering into discharge discussions

How effective/not effective was the paperwork?

The second draft of the paperwork used by Aintree to capture the patient's choices was much better. This was revised after amendments made by a fellow pilot site, which staff felt made the paperwork easier to complete. We liked the links to existing care plans.

How user friendly was the tablet?

It was felt that the tablet was difficult to turn on and off due to the protective casing. It was reinforced that receiving the data at regular intervals possibly on a weekly basis would help motivate the staff and encourage them when needed.

How would Aintree take this forward?

This is for further discussion and may adapt this process into the patient assessment documentation. There were some questions from staff asking "why?" the playing card format was used and whether this was necessary. Patients did not find this an issue but it was identified that this may be a generation related point, in that the elderly generation are more familiar with playing cards in a sociable context. If the pilot is rolled out a suggestion was to lose the "playing card" format but maybe use pictures on the cards instead. The group stated that if anything improves patient care then it is beneficial and worthwhile and the more you use the cards the easier it becomes.

What has gone *well* in the pilot for Bolton?

The cards really helped give staff awareness in the care planning process. Patients feel that they were given the opportunity (permission) to speak to staff and this also provided the opportunity for more in depth information about the patient's feelings/priorities. Giving staff an opportunity to spend time with patients and able to get an understanding of patient's feelings was really useful. Not only did it make the nurse more self aware about approaching patients and interacting with patients, it highlighted what is important to the patient and improved rapport and staff opinion.

What could have been done *differently*?

It would have been useful to have more care givers involved - support workers – students – AHP's – MDT and to also have C4 admission ward be involved from the beginning. More preparation – formal sessions for the staff – more briefings – talking through the process would have helped as well as formal training – staff to have time out – role play/demonstration in training. Having the full ward involved would have been better.

Was it clear that the pilot was about allowing the patient to outline their *needs* and *emotional* requirements?

The pilot allowed patients to talk about their emotional needs and this made the nurse more aware of the patient's emotional needs. As a consequence of the cards more personalised patients care was delivered.

Not all staff have appreciated the concept of the pilot or felt that they have changed their care as a result (more briefing required)

What *benefits* do you think there has been for patients/staff?

For the patient it has made care more personal around patients need. It has built up rapport between patients and staff.

Some patients may not have fully understood – may not have wanted to participate – there were approximately 4 patients at Bolton who did not wish to participate.

For staff it has reinforced what we should be doing anyway. It helps us to evidence that emotional care is catered for. We have noticed that it has improved nurse communication skills. It also provided the permission to take time to discuss needs with patients when the ward is busy/chaotic.

Did the Vital Signs Care cards help staff *engage* with patients/family members/other colleagues?

We had good feedback from relatives as it gives the family reassurance and security that patients emotional needs are looked after. When the cards have been left with the patients it has allowed them to discuss with their relatives their emotional needs.

What have been the *barriers*?

Time on discharge to undertake exit interview has been a challenge. If the patient has transferred to another ward we have not been able to continue.

Staffing levels has been a challenge, how busy the ward can be and how the cards are then not a priority when other things are happening on the ward. Often it is the same nurses who have been the ones using the cards.

Symbols on the cards - the joker was offensive to a few patients and the number on the cards also caused confusion. We do not like the name Vital Sign Care Cards – we would prefer Emotional Care Cards.

Did the pilot make you think about your own *behaviour and practice*?

Definitely yes (x4 staff). The cards made you more aware of your patient's feelings; they helped you to put yourself in the patient's shoes and appreciate how vulnerable and frightened patients are. It also makes you aware of using jargon –many patients chose understanding as do not understand what is being said to them, makes you think about the jargon that is used by the staff.

What improvements were made to patient care?

It made it more personalise and individualised. It also made patients feel more involved and their emotional needs are being addressed.

Do you have any *recommendations/suggestions*?

For this particular site it would have been better to use with Patients to be involved pre op. Better preparation of staff pre commencing – however this was our issue- ODS had prepared us well.

How are you going to take it *forward*?

We are going to involve more staff – students – support workers – HCA – MDT etc. We will also be taking an all ward all patients approach. We will also be looking at guidance for short stay patients (only in for 24 – 48 hours) and will ensure integrated information into the care plan.

If you were asked to tell someone about the project what would you say?

The pilot scheme provided a chance to look at emotional needs as well as physical needs; trying to capture holistic needs of patients. It was a combined project with 5 other Trusts. It was a project to help in documenting the patient's needs and not just hearsay. Looking at and measuring patient emotional needs and improving the patient journey.

What could have been done *differently*?

We learnt that it is really important to make sure you understand what is needed for the pilot before you begin. It has been difficult introducing because we weren't fully prepared – we needed more formal training.

What did you find *helpful* from ODS?

ODS have supported us throughout the pilot, they have been there when needed and contactable. ODS enabled us to refresh the project and get it back on track- without their support the project would have not happened. They helped in the early stages to understand what was required- it is complex project that requires a lot of time and skill in change management, support helped us in getting rid of the “weeds”. The leads monthly meeting provided by ODS where essential, helped us learn from others and provided a support

What wasn't helpful?

Nothing! Except the tool kit – provided at time when I was new to the project- did utilise it and on reflection now know what I should have utilised- e.g. templates

Should similar support be offered in cascading the project, what could be changed for the next stage?

The train the trainer to brief staff was good- we did not do the formal training with all staff due to time constraints. Next time it would be helpful if ODS did the training in the sites with us .

How did you find using the Vital Sign Care Cards?

They were really easy to use, simple and easy for patients to pick up on. They were straight to the point of what is core. We liked that there weren't too many. We only had one patient who did not participate

The cards provides an opening to start the discussion which allows the patient to express how they are feeling and this assists in finding out additional information.

We noticed that they are points of conversation and also encourages patients to chat to each other! Using a questionnaire with patients is quite cold but this is very good method of engaging with the patient and hearing what is important to them.

Using the Tablet was alright but sometimes had trouble sending it

Do you feel that the cards have made a *difference* and if so how?

We leave cards with patient at the start of the day and give them time to look through, the patient is not rushed and can think about what matters.

If a patient has been seen by a consultant and has questions about their treatment sometimes they may be too embarrassed to ask as it may be that they have forgotten what was said or didn't understand, the cards are a prompt to aid that discussion

The cards definitely made a difference - it would be good to roll out to different wards

We put all the information on the handover sheet which is a really useful way to record information and ensure it is passed on.

What *benefits* do you think there has been for patients/staff?

The patients have also enjoyed using the cards – there was quite an excitement on the ward when they found out about the video

The cards have made people feel more valued and personalised.

The cards help you to ask the question rather than just do it

Family members might be worried about their next of kin but perhaps don't feel confident enough to say anything; these cards are a prompt to start the discussion. This is especially true when the cards have been left with the patient as it is a way to involve them in that person's care.

The patient will often change their mind throughout day so it is good to have a few hours to think about things.

Did participating in the pilot hi-light any training or development needs?

The training using the cards was useful– talking through what we should do and say.

You would take something away from it if you made it too formal

Not being formal you can personalise more which has been really effective. It has taken time for staff to use the cards and get used to using them but the more they use the cards the better it is.

Key people were needed initially to oversee the project and keep encouraging staff. Once the training has been delivered it is more a case of practising.

Team work has been key to this project being successful.

What improvements were made to patient care?

The cards helped the family to also get involved – some wait to do it with their family.

The cards have helped the family to express their concerns too.

Communication is not always good between families; this has been a tool that has helped improve communication.

Understanding and honesty have been popular choices. Initially it was thought that safety would be the most picked but staff have been surprised but people primarily want to be re-assured and to understand their condition.

The cards had given patients a prompt – sometimes they wouldn't want to mither so sitting with them, giving this time helps and the patient appreciates us making the time. It has helped them to discuss things that are bothering them.

The information provided is kept recorded in the back of sheets so that others who have dealings with the patient can see.

What could have been done differently?

Couldn't have done it on whole ward, it would be useful to start smaller then spread it out. Training – staffing need to look at how to educate every member of staff / bank staff – training staff so they are all informed. Need to do this in a way that it didn't become a task.

Would need a nominated person to do it otherwise would never get finished.

Were you surprised by anything?

The paperwork was good – easy to use. It made a difference with handovers being able to pass this information on. It made a real difference to have individualised rather than whole ward charges. Staffing levels and time biggest issue and fitting it in as you can't always predict what will happen in a day but we always managed through. We managed to capture the majority, it has personalised the care and we have all been happy with it. Beginning and leaving – we found that the choices didn't really change. Understanding has been the most popular choice on both entering and leaving the ward.

It is different on our ward than for people who had planned to come in as it is different for people with heart complaints as it is a sudden problem. Obviously it is not always appropriate to give the cards straight away due to the nature of the condition.

General consensus that this idea would sell to people; look at how training used to be it used to be care focused and then it went more clinical. This pilot has brought the focus back to the care element which is often the reason people enter this profession. The cards give the patient ownership of their care and it helps to make them feel more in control. This has made a real difference to the patient's experience.

What was your experience of the Vital Sign Care Card Pilot?

The cards initiated a more in-depth conversation on admission, encouraging patients to say more in detail how they were feeling. Issues were discussed which may well have not been brought up if the cards had not been prompts. For example patients talking about relatives who had died in hospital and their issues of anxiety – we are not fully convinced this would have been brought up without the using the cards.

Using the cards does provide that time to allow patients to express themselves more fully. Often you may ask a patient if they have any concerns and accept very easily when they say no.

There is a strong feeling from staff that due to the size of the unit and the ethos that we have created from day one (we have been open for 18 months) the emotional needs of our patients are already being met and we would prefer to pursue the idea of a more practical, integrated and natural approach.

Day three was often awkward, patients were not as keen on day three and it felt like it was a nuisance to them. Patients most often felt that all their emotional needs were being met and to suggest anything less would be an insult to the nurses.

Almost felt that by picking “top 3” other aspect of care would be somehow less important. Nurses kept on reinforcing that all areas of emotional needs would be met. Comments from patients were as follows

“This care should be covered by all good nurses any way in a natural way”

“The cards almost makes the issues being discussed less important and of less value”

“Don’t like the way emotional needs are addressed in a staged way”. Staff should not need props.

The cards were easy to use, however most patients (especially male) thought they were a waste of time. The cards were really beneficial to use however it was sometimes difficult to fit them in along with all the other paperwork. It was really useful to learn more about the patients needs.

Although the cards were a lot of extra work they did highlight the particular needs of the individual patient and it gave the patient the chance to express themselves and the cards gave them the opportunity to do that and it helped them.

Has it made a difference?

It has made time to sit with the patients however the actual difference was minimal, if anything the “staged” way of addressing patients emotional needs did not feel as genuine and in some ways detracted from the nurse / patient relationship as it looked as if you may not provide the care without the pilot.

It may be that the pilot makes the patient feel you are interested in how they feel, but the general feeling was that we do that anyway.

For EOU FGH we are in a privileged position as a 10 bedded dedicated arthroplasty unit – the falseness of the card procedure detracts from our natural approach. We would be happy to adopt the concept but would prefer to integrate into practice. We want to provide evidence of what we feel we do very well and are hoping to use the concept to do just this. We want to provide evidence that we do communicate and address patient’s emotional needs. In 18 months we have not had a complaint – the overload of lots, questionnaires etc feels like patients may get fed up.

It did make a difference as it flagged up issues that maybe we would not have known about if we had not used the cards, the patients also found the cards helpful in expressing their needs. It was really interesting to see which cards were more important to patients. However it was difficult to see which card was most preferred; the cards did seem to help improve respect towards staff too and helped develop a rapport.

One patient said that she liked the cards as she normally

found it difficult to express her feelings and the cards made it easier to do so.

Did the Vital Sign Care Card pilot highlight any training or development needs?

There is potential for staff development in this area by using the care plan in some way. For our team a lot has been done on customer care and confidence in care which has worked well. We would like to develop the care plan in some way as a result of this pilot.

It raised the point that staff need to be more aware of the patient as a whole rather than, for example hip knee replacement, as some patients mentioned that they felt their other problems / difficulties weren't always acknowledged. The pilot promoted holistic care.

The cards reminded me of the importance to communicate about feelings and anxiety, and made me aware of explaining things more thoroughly.

Was the training for staff sufficient prior to the start of the pilot?

We had no concerns regarding the training. Perhaps staff would have felt it was more "official" if an outside person had delivered the training but we felt we did a fairly good job in the short time we had.

Yes! It was explained well and in detail. The training was very good and it had supporting documentation to refer to if we needed to remind ourselves about anything. The training was excellent.

What *benefits* do you think there has been for patients/staff?

Staff felt that in our situation the staged approach detracted in some ways from our care. But there was a definitely a general feeling that having a more focused or guided approach to emotional care needs does provide the evidence of what we do.

Staff felt that although issues were flagged up they would very likely have been addressed any way. What we don't normally have is evidence of all the little ways we address emotional needs for example; phone patients families to reassure them, stop patients worries by reassuring about social support etc.

Day three was not welcomed by patients on the whole, generally they did not refuse but the general feeling was that it was unnecessary and patients were happy with their care – but we should capture this as well.

Section IV

Project closing events

Inspiration North West Live:

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Final leads event: *Page 41*

Inspiration Live event 9th October 2009

The Inspiration Live event was held in The Monastery Manchester, an overview of the project was presented by Jackie Barringer from ODS and each of the pilot sites presented a snapshot of their individual journeys. Each pilot site lead was then available in the market place for further discussions with the event delegates. Each pilot site had prepared a case study which was given to all delegates within their delegate packs. The pilot sites case studies can be found in Appendix II.



Pilot sites- Final leads meeting 15th October

Was held at the Village Hotel Bury and included an inspirational presentation and workshop from Andy Bounds author and communication guru. The pilot sites participated in the final evaluation



Comments about ODS and recommendations should the pilot be cascaded.

- Supportive
- Understand the NHS
- Co-operation
- Partnership
- Effective training
- Understand our concerns
- Couldn't have done it without them

Issues and solutions

- "Playing Cards" – get rid
- "Vital Signs" terminology
- Rename – empathy
- Liked "care delivered your way"

Training

- Andy's bit today at beginning
- DVD – possible tool –
 - right way
 - wrong way

- examples
- Integrated into care pathways all have it – not condition specific
- Actions
- Terminology – descriptors and prayers (broad spectrum) on back of cards.
- Pilots – happy to give advice for redesign
- Refer to pilot success – champions / buy in
- Consider launch/ idea
- How to engage other staff, groups? – Integrate
- Symbols/
- Elect handovers
- Link to productive ward
- How is it introduced?
- Morecambe Bay – Roll out to all GP's
- Wigan – Roll out across trust
- Bolton – Discussing options to proceed
- Stockport – Improve integrated care pathways to reflect empathy / emotional need
- Aintree – Preparing a paper –benefits realisation, then launch within organisation. Recognise empathy in standardised admission process.

Support

- Clear launch- training tool kit
- Team approach
- Cascade training package
- Senior commitment time given
- Support with time to implement training – problem solving
- Training
- National authorisation – a must do
- Champions
- Executive drive
- time management to train/ implement
- Support from 'the top' -time out to do
- Time to help train others

Top Tips

- Have a full standardised document to use “off the shelf”
- Positive communication
- Patient Centred
- Keep it simple
- Embedded into practise
- Time to train
- Embrace project as beneficial to you and your patient
- Not an “Add on”
- Need champions
- Give the right training before launch and time
- Feedback from patients
- Audit
- Feedback- let staff know positive as well as negative

- Champion and mini champions
- Communication
- Information Board for all staff
- Team work
- Preparation of staff 'selling it'
- Support
- Share enthusiasm
- Get the documentation right
- Needs to be part of nursing process
- Make effort to collect patient stories
- Regular feedback/ suggestions
- Use a champion to promote project

Section V

Conclusion and Recommendations

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Conclusion

From the launch of the feasibility pilot, the site leads have all been extremely motivated and committed to the project. Practically, when back in their organisations they have experienced different levels of staff behaviour towards the empathy cards ranging from a high level of commitment to low level engagement. This has been attributed to a number of factors, the approach taken, whether the pilot study was ward or condition based, whether the pilot involved elective or non-elective pathways and whether it was influenced by other factors such as whether there was a ward champion driving the pilot or whether there was enough patients eligible to participate in the pilot to maintain momentum. The behaviour of patients and relatives who participated in the pilot also varied, there were those who welcomed the cards as a means of discussing emotional needs in greater depth than they traditionally would through the admission process, those who appreciated that emotional needs were readdressed throughout their stay and those who felt their emotional needs were addressed routinely already without use of the cards.

Bringing the pilot sites together on a monthly basis allowed learning to be shared in a safe environment, it enabled a means of peer support where discussion was promoted and solutions, tips and advised shared. It was found that sites had their own individual experiences and learning as each approach and pathway was individual. Some sites had made certain assumptions about the emotional needs of patients and their relatives which were different from the findings from the data collected. This allowed care to be modified to meet patient's needs.

The reaction of staff and patients in relation to the use of the care cards differed with some sites experiencing negativity towards having to enter into discussions about issues which were already seen as part of routine basic nursing care and others positively promoting the use of the care cards as a means of capturing and recording evidence that emotional needs of patients had been addressed. Additional daily pressures on services and staff were highlighted as potential obstacles where the study was not particularly embraced amongst staff though that also varied amongst sites as pressures were evident in most pilot areas. The playing card format of the cards was often verbalised as having a negative impact amongst staff and a slight number of patients. It was felt generally that the playing card format and design was unnecessary and did cause confusion for some patient groups, it was deemed as looking like a "game" by some staff and had received some strong feedback from the majority sites who recommend that if there is a roll out study of the care cards that the playing card format, icons and design are removed leaving just the statements for patients to consider.

The "effects on business" or whether care altered as a result of using the care cards again differed from site to site, there was clear effects for some sites indicated by reductions in

complaints at matrons surgery sessions and a change in behaviour of staff seeing the cards as a means of permission to sit and talk to patients in greater depth regarding their emotional needs and issues and to capture that information and modify care accordingly. It was seen as a way to engage early on during the patient journey with relatives where patients lacked the capacity or capability to use the cards themselves, reassuring those relatives that emotional issues were as important to staff. There were also sites who said it made little difference to business as emotional issues, as mentioned earlier, were addressed routinely as part of the nursing process.

Richard Gamble, Business development director, CRT Ltd, further highlights differences from the data collected by the pilot sites

“For those patients who took part in the pilot the Vital Signs Care Cards clearly made an impact. 95% of patients found the cards useful for expressing their preferences and more importantly 95% perceived that using the cards influenced the care they received. In a small pilot, numbers do not allow many overview conclusions statistically. However one trend is clear. There is a significant difference between patient responses at each pilot in each care pathway. For example whereas at the Royal Albert patients are most concerned about physical comfort (70.4%) they are least concerned about honesty (4.1%). Compare this to Royal Lancaster where physical comfort is 5th in importance (36.2%) and honesty is the 2nd most important ((52.2%). This finding further emphasizes the need to ensure that personal patient preferences are captured during their care journey.”

In summary, the learning captured throughout the feasibility pilot study varies in its findings with each pilot site and with each pathway. Overall the process of addressing the emotional needs of patients is seen as highly important and necessary in order to give the best emotional care to patients as per their needs. The care cards for the majority of sites are seen as a useful tool to enter into discussions with patients and their relatives, though not always viewed as a necessary tool in order to have those discussions. The information captured and recorded provides evidence that the emotional aspects of patient care is personalised as to the patients needs.

Recommendations

Throughout the pilot there have been a number of suggestions put forward from each of the sites. These suggestions have come from the leads, the staff and patients who have taken part in the pilot, staff and patients who were excluded from the pilot along with ideas that came from the discussions held during the learning capture sessions.

The recommendations are as follows:

- To take a whole ward approach instead of a disease specific or condition approach
- For the training to be mandatory for all multi-professional staff involved in the patient pathway
- The name Vital Signs to be 'reconsidered' – the suggestion put forward by the group was Empathy Cards
- Training DVD to show example of “how to” and “how not to” use the cards
- To look at the use of the cards at the point of admission (as part of the admission)
- To look at how the cards could be used prior to admission (pre-op clinic)
- To look at the use of the cards with a wider remit i.e. Maternity, Care Homes, Children's Wards, Mental Health, Community Services
- To think about the design of the cards – majority of the sites would prefer the cards without the playing card design, one alternative suggestion was to use photograph's or blank cards
- To have supporting materials to use with the cards – symbols to put above the patient beds to represent the choices, key rings for staff with the symbols and meanings on, prompt questions on the reverse of the card
- Look at making the documentation more integrated to existing methods
- To have a Champion to oversee each ward and be ward based and to allow time within the role to do this

In addition to the above ODS have identified points that they would recommend to be considered for a future successful next stage roll out:

- The role of the project lead is time consuming, particularly for those who have a clinical management position, for example Matrons, future consideration should be given to this
- The project leads should be supported and may require additional support in the human dimension of change
- Having a project sponsor is crucial and the support from the sponsor should be consistent throughout in order to best support project leads and champion the work
- A ward based champion is recommended for continuity and to maintain motivation and drive throughout

Appendices

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Vital signs care cards project – Launch and information workshop 2nd March

Barriers to initiative

Barriers Patients may feel

- Patient understanding of cards? Literacy complex language
- Patient time
- Pt understanding
- Pt confidentiality may be breeched
- Lack of Pts being open early on
- Some Pts confused
- Can an advocate be used?
- Pt resistance
- Right person
- Medication can affect Pt perception i.e. analgesia
- Equity

Barriers staff may feel

- Staff time
- Time
- Benefits
- Staff levels
- Poor attitude
- Staff attitudes to this
- Too hard
- Care planning!
- Staff resource
- Clinical buy-in
- What is this going to achieve
- Scepticism
- ? benefits
- Consultation overload
- Staff training (customer services)
- Card name “vital sign”
- So what!
- How long will it take to do
- Style Change overload
- Apathy
- Infection control
- Staff commitment
- Right time
- Cynical
- Include E&D

- Is this flavour of the month?
- What's the point?
- Attitude
- Lack of interest
- Real time v. Retrospective
- Lack of medical engagement
- Same old same old.

Issues with the cards

- Redesign cards locally
- When? (elective)
- How do you translate cards to data
- Language
- Language barriers
- Joker card! Trivial
- Visually impaired
- Flashcard not playing
- Card statements

Data evaluation barriers

- Report mech.
- Who collects data?
- Score
- What to do with info?
- Who collects
- Another net promoter score? No metrics
- Do you re assess and when?
- This measures aspiration not experience
- Qualitative data – how to interpret.
- Data
- How do MDT understand patient outputs

Other Barriers

- Communication
- Culture
- EQIA informer
- Ward based not condition
- How to act on info? Process/time
- Trauma vs. Elective
- Re visit patient

Solutions to barriers

Learning capture

- Reduction in complaints
- Adjust as necessary (approach)
- Run as a project and regular audit
- Benefits analysis
- Evaluate care plan by applying a metric
- Benchmark scaled at a ward basis to build trends

Implementing cards

- Ward approach for consistency
- Include as 8th indicator on Pt sensitive indicators
- Bring process into initial assessment phase
- On admission daily review
- Early implementation
- Ward nurse does pre-op
- Use core care plans to help
- Pct pressure
- Daily MDT to cover this, include in handover
- Reassess based on los (rules to be built)
- Whole ward would implement care cards
- Use core care plans to help

Staff resistance

- Changing the culture
- Staff training and involvement change management
- Training
- Resources: training – money – communication
- Education of multi-disciplinary team
- Change in culture
- Employ quality matrons

Cards Specific

- Redesign cards
- Infection control checked cards
- Flash cards not playing cards
- Laminated cards
- Interpreted into foreign languages

Resources

- Increase resources – staff -> education

- Resources
- Money
- Withdraw funding from ODS – transfer to trusts

Communications Solutions

- Share good news RE: project
- Share feedback from compassion cards
- Working smart by addressing issues before a problem
- Staff and public involvement i.e. media trust website
- Sell the concept in a positive way
- Share project with patients relatives
- Share project on public notice are
- Engage all members of team
- Communication of the initiative internally
- Explanation – be clear why it is being used
- Share vision positively
- Involvement of agencies associated with visual, hearing difficulties

Project/ change management

- Scope
- Champions
- Steering group
- Support. IT. Data
- Simplicity – easier to implement
- Project lead
- Board level commitment
- Objectives
- Project lead ‘champion’ plan
- Clinical buy-in
- Exec lead
- Appropriate implementation of actions
- Executive profile: to ensure people understand why.

What is required from ODS?

What do the organisations require?

- Effective and enthusiastic project management team
- Good understanding of pilot aims
- Standard or benchmark
- Clear expectations/outcomes
- Project lead
- How-feed into business plan and strategic planning

- What happens to info-comparison with other trusts
- Champion
- Involvement of patient experience lead
- Financial incentive
- Project plan
- Fresh eyes
- Facilitation
- Metrics
- Understanding of the expertise that ODS can offer
- Measure sets
- Implementation plan
- Support transferring qualitative data-quantitative data
- Clear framework
- Time scale

What is required for the teams who will be involved?

- Communication
- Commitment
- Protected time
- Board level action
- Contact person
- Feedback
- Information and guidance
- Motivation
- Skills
- Open communication at all levels
- Time
- Training
- Never ending supply of cards
- Education/information
- Awareness of impact on patient care
- Clear defined roles
- Opportunity to feedback and celebrate success

What will the lead require?

- Progress reports
- Time
- Resources
- Plan
- Good data collection tools
- Admin/audit person
- Space

- MDT input
- Action plan to implement with discussion with ward staff
- Project manager
- Support (board, senior managers)
- Resources
- Clinical engagement
- PR
- Networking with other pilots
- 24 hour support
- Regular meetings
- Networking opportunities
- Feedback-board and staff
- Admin-data analysis support
- Network support
- “Tool kit”

Learning capture

What we will capture and measure, how do we keep it simple?

- Patient emotional experience
- Areas for improvement/bad practice
- Current good practice
- Lessons learnt
- Patient experience in terms of quality provided
- Relatives experience
- Are we the best at what we do?
- Learning from feedback to improve patient experience
- Patients receptiveness
- Learn by mistakes – implementing
- Find out what you’re good at
- Areas for change
- Hopefully improvement –metrics
- Numbers of patients
- Time frames
- Trends: usability
- Benchmarking with other sites
- Sharing practice
- Feedback

Vital Signs Care Cards **Case study – Aintree University** **Hospitals NHS Foundation Trust** **Local background**



Aintree University Hospitals NHS Foundation Trust applied to take part in this regional pilot to promote a greater understanding of the patient's emotional needs, whilst having care delivered at Aintree.

This was launched on one particular ward within the Department of Medicine for the Elderly and all patients were included in the project so as to promote nurse / patient interaction and to provide clinicians with a tool to record the emotional needs of patients within an acute clinical environment.

Approach taken

The project was discussed with the Ward Team and placed as an agenda item on the Ward Meeting. Staff training was undertaken prior to launch and posters were placed at the front entrance of the ward explaining the cards to patients and their relatives to outline what they could expect. Staff were encouraged to discuss the use of cards with their peers on an informal basis so as to discuss findings and share the strategies used.

Care Plan documentation was formulated to assist nursing staff once a patient's needs were identified and an evaluation document was utilised to evaluate any interventions carried out on a daily basis. All patients were issued cards on admission to the ward and then these were re-issued at day three. Where patients lacked capacity to select cards, family members were asked to contribute.

Patient and staff feedback was sought by using a hand held device which asked key questions relating to the use of cards and the care delivered.

The ward was involved in filming some of the patient/staff/relative experiences further to using the cards.

Findings and challenges

All patients were issued with cards as part of the admission process and their specific needs identified. However, many patients during the pilot lacked capacity to independently choose their preferences. As a result of this, family members/next of kin were encouraged to become involved in the process so as to ensure the correct actions were undertaken as a result of the emotional needs identified.

Many relatives reported that they found this a positive experience, providing appropriate reassurance.

Patient safety presents challenges in all hospitals, however, the Vital Signs Care Cards highlighted how patients themselves considered safety as a priority when assessing their emotional needs and how this impacted on the way they felt.

A key message taken from this project highlighted that within an acute medical ward within the department of medicine for the elderly, patients identified safety being a priority. Patients without dementia and their relatives often mentioned how sharing a six bedded bay with a confused patient or a group of confused patients, caused some anxiety yet they had felt it difficult to raise these concerns due to the sensitive nature.

Equally, the relatives of those patients without capacity stated that the cards provided them with an opportunity to discuss their concerns about the safety of their family member and the impact that their behaviour could potentially have on other patients within the ward environment. Reassurances could then be offered by adjusting the nursing approach by considering individual preferences and information.

Lessons learnt

Committed champions are key in ensuring this process becomes embedded within the clinical environment. Otherwise there is a risk that the process discontinues due to other perceived conflicting priorities.

Assumptions are often made when delivering care – Vital Sign Care Cards provides a tool to distinguish individual care needs and to plan care effectively

Vital Sign Care Cards promoted effective communication not only with patients but with their relatives too. Often, the cards promoted discussion between the patient and nursing staff, where further needs were identified, aside from the actual headings used on each of the care cards

Staff stated that the cards provided them with a tool to appropriately assess the emotional needs of patients.

The use of cards provided reassurances very early on in the patient stay that emotional needs were important to the team and that staff were committed to delivering care which incorporated these needs

Next steps

Clearly, staff found it beneficial to use a tool which assesses the patient's emotional needs and one which allows for effective evaluation of these. We are now looking to incorporate this approach into the standardised ward admission process.

Vital Signs Care Cards

Case Study- Royal Bolton Hospital NHS Foundation Trust

Local Background

At the Royal Bolton Hospital we had previously undertaken some work on the elective orthopaedic ward (F4) looking at patients' experiences whilst in hospital. We recognised that we were not always meeting our patients' emotional needs and when we were, we had little evidence to support this. Joining the Vital Signs Care Cards Pilot seemed an ideal opportunity to explore and evaluate our practice

Approach Taken

The ward manager was enthusiastic about the challenge as were 2 staff nurses from F4.

In order to launch the Pilot we set up formal training sessions on the ward and tried to capture as many staff as possible prior to the cards going live.

It was agreed that the patients would be shown the cards on the ward and asked to choose which were most appropriate to their individual needs. Their choices and any specific needs would then be recorded in the care plan that had been developed using a combination of work produced by Aintree and our own documentation. It was also agreed that staff would review these choices with the patient's mid-way through their hospital stay to see if their needs had changed

Both staff and patients were also given an information leaflet explaining the background and purpose of the Pilot.

Challenges

The patients liked the cards and felt it gave them the opportunity to talk to the ward staff about their feelings and concerns. The staff themselves felt the cards helped to initiate this conversation with their patients and gain a better understanding of their individual needs which in turn meant their care became more personalised. This also helped some members of staff to build upon their communication skills and therefore gain more confidence in talking to patients and relatives.

However in hindsight, we feel the cards would have become more embedded and accepted by the staff had they been used for every patient on the ward rather than just those having a hip or knee replacement. The fragmented nature of using only this client group meant staff did not get enough opportunity in using the cards for them to become familiarised and comfortable with them.

Findings:

- Patients liked the cards and the time it afforded them to discuss their needs with the staff and as a result felt more involved in their care
- Staff gained more in-depth information about patients feelings and their priorities and therefore care was more personalised
- As patients were naturally anxious about their forthcoming surgery some found it difficult to focus their attention on the cards.
- The patients also found that using the cards on their own without any written prompts made it difficult for them to express their individual needs
- Using the cards as a prompt enabled the nurses to become more confident in discussing their patients' emotional needs.

Lessons Learnt:

- The Project needs to be owned and driven by the staff on the ward with sufficient time to dedicate to it
- There needs to be in depth preparation for staff prior to going live with the project to ensure they have fully understood its purpose and their role within it.
- Patients and staff felt it would have been more beneficial for the patients to be given information about the cards prior to admission. This would have enabled them to think more about their choices and discuss them with their relatives
- The patients found the written prompts explaining the cards enabled them to better express their needs
- Nurses became more self aware about how to approach patients and discuss their needs

Next Steps:

The Trust is considering the outcome of this pilot alongside existing options to gauge our patient's experience.

Vital Signs Care Cards

Case Study - University Hospitals of Morecambe Bay NHS Trust

Local background

The University Hospital of Morecambe Bay ran the vital signs care cards pilot over a period of 2 months. Our aim was to include every patient admitted for hip or knee replacement surgery.

We have 3 Elective Orthopaedic Wards, one on each of our three main sites. The sites are approximately 25 miles apart and each has different working environments and nursing challenges. However the same care pathway is followed and we chose to adopt a consistent approach to the pilot. The Lead nurses from each site worked together on a structured approach aiming to provide data which could be easily analysed and presented.

A key objective of our recently developed Nursing Strategy is: *“To look for new ways of actively listening to the needs and wishes of our patients so we can improve services and make changes for the better”*.

We applied to be a part of this unique pilot programme hoping it would enable us to capture patient’s emotional needs as they progress through our service and act upon these needs in real time.

Approach Taken

- Staff Training:- one to one teaching, presentations and role play. Publicized across the trust.
- A Care Plan was developed to capture quantitative and qualitative data.
- Each patient was given the Vital Sign Care Cards on the day of admission and the third post operative day and the order of all 8 cards noted.
- Patients top 3 cards discussed fully. Individual concerns and actions planned to address these concerns were documented. Daily evaluation of the care plan was undertaken
- Exit Questionnaire for patients and staff.

Challenges

- Time. Particularly when patients admitted one or two hours prior to surgery.

- A tight timescale to introduce the pilot across three sites with lots of nurses to train.
- Clinical area relied heavily on nurse champions to ensure success of the pilot.
- Nurses felt they were “doing it anyway”.

Findings

- Effectiveness, Reassurance and Comfort most commonly chosen cards on admission.
- Effectiveness and Self Confidence most frequently chosen cards on 3rd post operative day.
- Most nurses were surprised at how little the Respect and Safety cards were chosen.
- Making time for meaningful conversation was valued by patients and staff.
- Pre operative assessment has reduced the amount of time nurses need to spend with patients on admission.
- A lot of emotional support is provided which we do not normally document.
- A significant number of patients were not keen or refused to use the cards on the 3rd post operative day, commenting that we were meeting their needs fully.
- After the pilot nurses said they were thinking of the card topics when admitting patients.

Lessons Learnt

- Often patients say they have no concerns and nurses accept this. The cards encourage patients to discuss how they are feeling and explore what is important to them.
- Nurses did have preconceived ideas about what would be important to patients.
- We realised that although we do normally work hard to meet our patients emotional needs, during the pilot we had a lot more documented evidence.
- The cards were well received on admission but less so on the third post operative day.

Next Steps

We are currently developing a new section for our Integrated Care Pathway which will incorporate the vital sign care cards. By embedding the concept in practice we hope to prompt patients and nurses to spend a little more time considering emotional care needs. For this patient group we recommend the cards are introduced at pre operative assessment and then used once on the day of admission, followed by daily evaluation.

Case Study – Stockport NHS Foundation Trust

Local background

Like most Trusts we regularly measure patient experience and satisfaction with the services we provide using surveys and other methodologies. We were keen to take part in this innovative pilot in order to test whether the Vital Signs Care Cards could provide a standardised and systematic process that would explore and capture patients 'emotional' needs and care preferences in a qualitative way and in real time, become easily embedded into existing nursing processes and procedures, be acceptable to patients and their relatives and have a positive impact on their stay and provide a standard measure of patient experience which would enable us to benchmark performance in this area.

Approach taken

We were asked to pilot the cards on patients with a diagnosis of pneumonia, admitted to our respiratory ward during July and August 2009.

Articles promoting the pilot were written for the Trust Team Brief and 'Take 5 ...' staff newsletter prior to its launch. Before the pilot began, ODS visited Stepping Hill Hospital to train ward staff in how to use the cards and provided background to the pilot and the principles behind using the cards.

In order for the pilot to succeed it was critical that staff had the correct documentation and therefore the following standard documents were produced to support staff taking part in the pilot:

- Patient Information Leaflet
- Vital Sign Care Cards Process Flow-Chart
- Vital Sign Care Card data capture sheet
- Vital Sign Care Card monitoring sheet
- Patient Exclusion Criteria

The cards were used within 24 hours of being admitted to patients who were eligible and wanted to take part. Patients were shown all 8 cards and asked to place them in their order of priority, their top 3 cards were then used to plan care in more detail to meet their specific emotional needs. As part of the patients care, staff checked on a daily basis that emotional needs were being met. Patients were asked to review their priorities at about the mid-point of their hospital stay and provide a final review of the experience of using the cards before discharge.

Findings

The numbers of patients taking part were very low due to the fact that we piloted an acute condition and had no control over the number of pneumonia patients being admitted to the ward. During the

timescale of the pilot a total of 38 pneumonia patients were admitted to the Trust; no patients with a diagnosis of pneumonia were admitted during August.

15 patients were cared for on the ward taking part in the pilot and of these 12 patients were eligible and agreed to take part. Of these 8 completed the exit questionnaire prior to discharge however, due to technical difficulties results for only 3 patients were able to be used in the final study.

- Patients reported that they took for granted that staff would automatically look after their emotional needs
- Using the Vital Sign Care Cards was not easy for acutely ill patients
- Patients appreciated the time staff spent with them to discuss their needs in this way
- Staff felt the documentation supporting the pilot made it easy to undertake and record findings
- Staff took care of patients emotional needs on a daily basis through the integrated care pathways and questioned whether the cards were necessary
- Staff documented psychological needs in the ICPs but acknowledged that documenting patients emotional needs was not supported by documented evidence which the pilot did provide
- Some staff had strong negative views about using “playing cards”
- Using the cards with this group of patients, who can be very poorly, and on a ward with acutely unwell and terminally ill patients was very difficult for staff

Challenges

The low numbers of patients taking part meant that staff did not get a chance to embed this into practice, become proficient in administering the cards or appreciate any positive effect on patient care

- On average staff used the cards approx 2 – 3 times over the course of the two month pilot and this was insufficient for it to become a routine process
- Initial assessment took a long time to complete
- Staff shortages during the pilot meant that the ward did not have a champion to drive it forward and this resulted in patients not being asked to take part or complete the exit questionnaire, reducing numbers ever further

Lessons Learnt

A number of key lessons were learnt as a result of taking part in this pilot:

- A ward based “champion”, driving the use of the cards on a daily basis is critical for success
- Using the cards on a “whole ward” basis is better than on a “condition” basis
- Staff did not think that the cards changed their practice when asking about patients emotional needs as this is already embedded in ICPs
- Staff were not convinced that this was the best method to collect this type of patients emotional needs

Next steps

The trust is reflecting on the pilot results and process used and this will be further considered when making improvements to existing integrated care pathways in order to address patient’s emotional needs.

Case Study- Wrightington, Wigan and Leigh NHS Foundation Trust

Local background

We participated in the pilot scheme to test out the impact of objectively measuring 'how organisations make their customers feel'. Wigan Heart Centre views patient feedback as paramount in improving and individualising care provided during their hospital stay. We ask patients to complete our questionnaire 'Lets 'get to the heart of the matter', normally when they are due to be discharged. We recognised that this approach meant we only learnt of issues after the patients had been discharged meaning we missed an opportunity to address needs.

The chance to participate in the pilot study provided an opportunity to capture in real time the emotional needs and care preferences of patients in the acute setting.

Approach taken

Patients were selected to participate in the pilot who had a diagnosis of myocardial infarction and patients already on the Advancing Quality Acute Myocardial Infarction Pathway. The matron for cardiology, Coronary Care Unit, cardiac specialist nurses and the cardiology ward embraced the challenge and adopted a team approach. A briefing session was held for all staff. Patients who agreed to participate were given an information leaflet and issued the cards at the most appropriate time for that individual, this supported early identification of priorities that could then be addressed. Patient priorities were reviewed on day two and three of their hospital stay, choices, priorities and any specific needs were recorded in the case notes and handed over during shift change.

Challenges

- As acute myocardial Infarction is not a planned event, cards could not always be started during admission, as this could some times be during the night
- Vital Sign Care Cards offered an opportunity to emphasis to the patient that their individual thoughts and needs about their treatment were always addressed and were a priority.
- The cards allowed the patients to feel that they are actively participating in the care that is delivered and provided.
- Some patients find it difficult to express their emotional needs; the use of cards broke down that barrier in many cases as the cards were user friendly.
- Staff gained more in-depth information about patients feelings and their priorities and therefore care was more personalised
- Using the cards as a prompt enabled the nurses to become more confident in discussing their patients' emotional needs.

Findings

- Vital sign care cards offer a unique opportunity to identify priorities which are pertinent to individual patients and addressing these early on to ensure that care is always tailored and delivered in ways which ensures the patients needs are met whilst they are being cared for
- The Vital sign care cards overcome communication barriers allowing patients to communicate their needs in a 'safe & non intrusive way'
- The use of the cards stress the importance of good communication with patients, many patients identified understanding as a priority. This made us ensure patients fully understood events and procedures.
- The cards have identified to patients that their needs and priorities are important and will be addressed at all times were ever possible

Lessons learnt.

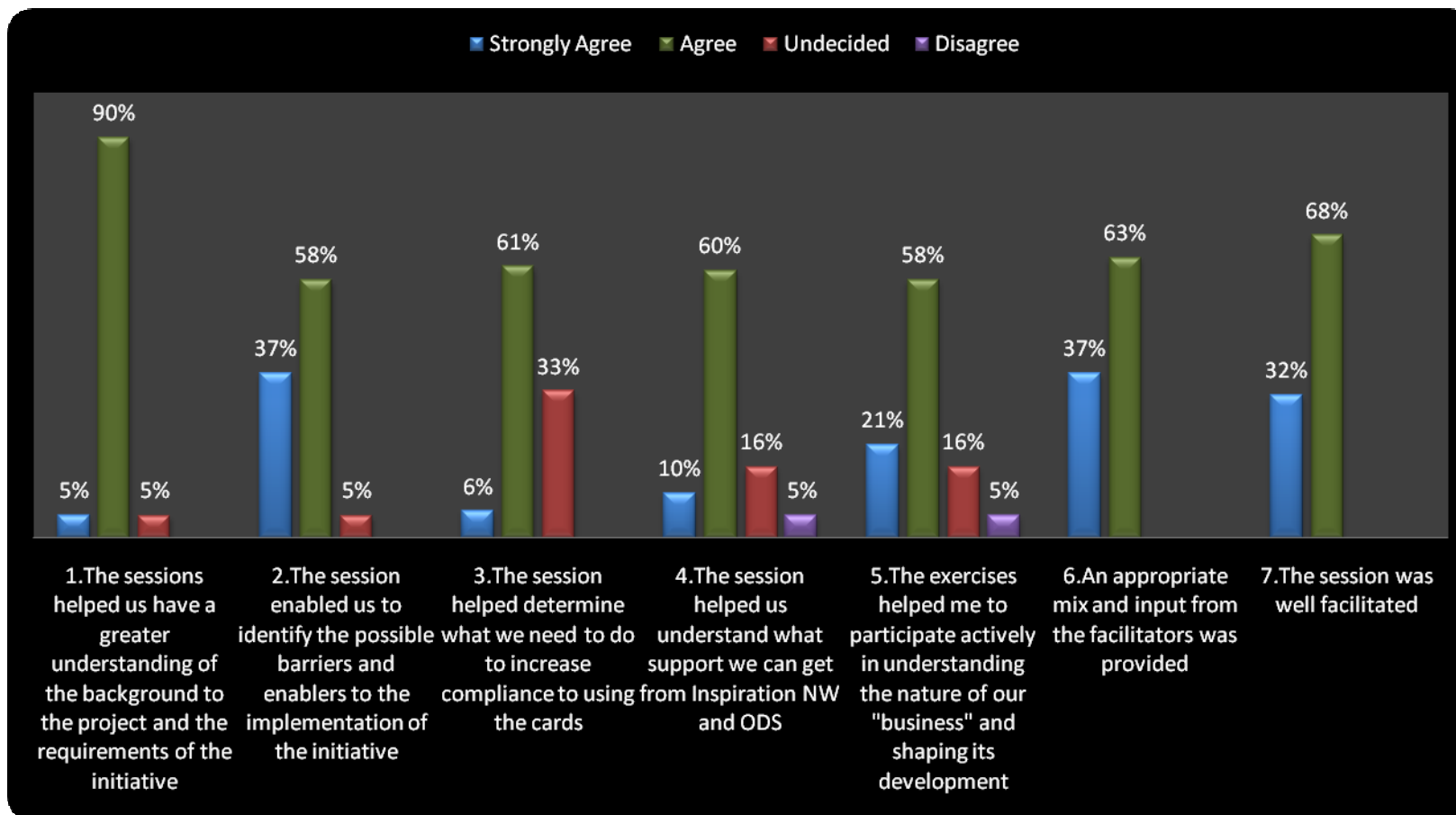
As health care providers we can sometimes make assumptions as to the priorities of patient needs as we can at times, concentrate on delivering treatment protocols at the detriment of the patient's psychological needs. The pilot identified to the clinical team how important effective individualised communication with both the patient and the patient's carers/relatives is.

The pilot gave the staff the opportunity to engage with the patients at all levels of care delivery, improving the staffs relationship and understanding of the patient and their needs.

Next steps

The pilot will be presented internally for consideration as part of the nursing strategy, and will be used in forums to engage with all multidisciplinary staff and patient representatives. We will continue to monitor complaints for themes and trends specifically targets issues around lack of patient communication and engagement of patient care.

Launch workshop evaluation March 2009



8. What was the most important thing you learned during this session?

- How pilot will be run and supported.
- How it fits with AQ measures in the short term.
- The concept of Vital Signs cards.
- Communication tools.
- Importance of patient experience + how we can shape it.
- The barriers to implementations.
- Aims and barriers of project and how the ambulance service could contribute.
- About the use of the cards and how they will be used.
- All of the above.
- How these cards are to work, how we can adapt to our trust.
- What resources are needed to implement and the difficulties that could occur.
- The amount of resources required to implement this project.
- Where this tool sits in AQ, how it may be used.
- About the project, how we could implement it, the problems.
- New way of looking at patient's emotional experience.
- That no organisation is different.
- How to implement and start the project, how to overcome the potential barriers.

9. What did you like best about the session?

- Informative, enjoyable, contribution from all.
- Opportunity to talk to other trusts & learn from each other.
- The barriers and solutions exercises
- Interaction with other groups.

- Group work/discussions.
- Networking, discussion.
- Lots of opportunity for discussion
- The information provided.
- Group work and the exercises
- Networking, history to others points of view.
- Venue, room layout, participation, speakers, made clear and took on board our opinions.
- Highlighting fears and thinking about solutions.
- Brainstorming and discussing issues with other organisations.
- Table discussion and exercises
- Discussion around capturing patients experience and how to measure P.E.
- Well staged, logical approach, clear instructions.
- The solutions tree post-it note sessions and ideas generated.
- Networking/ idea sharing/ problem sharing.

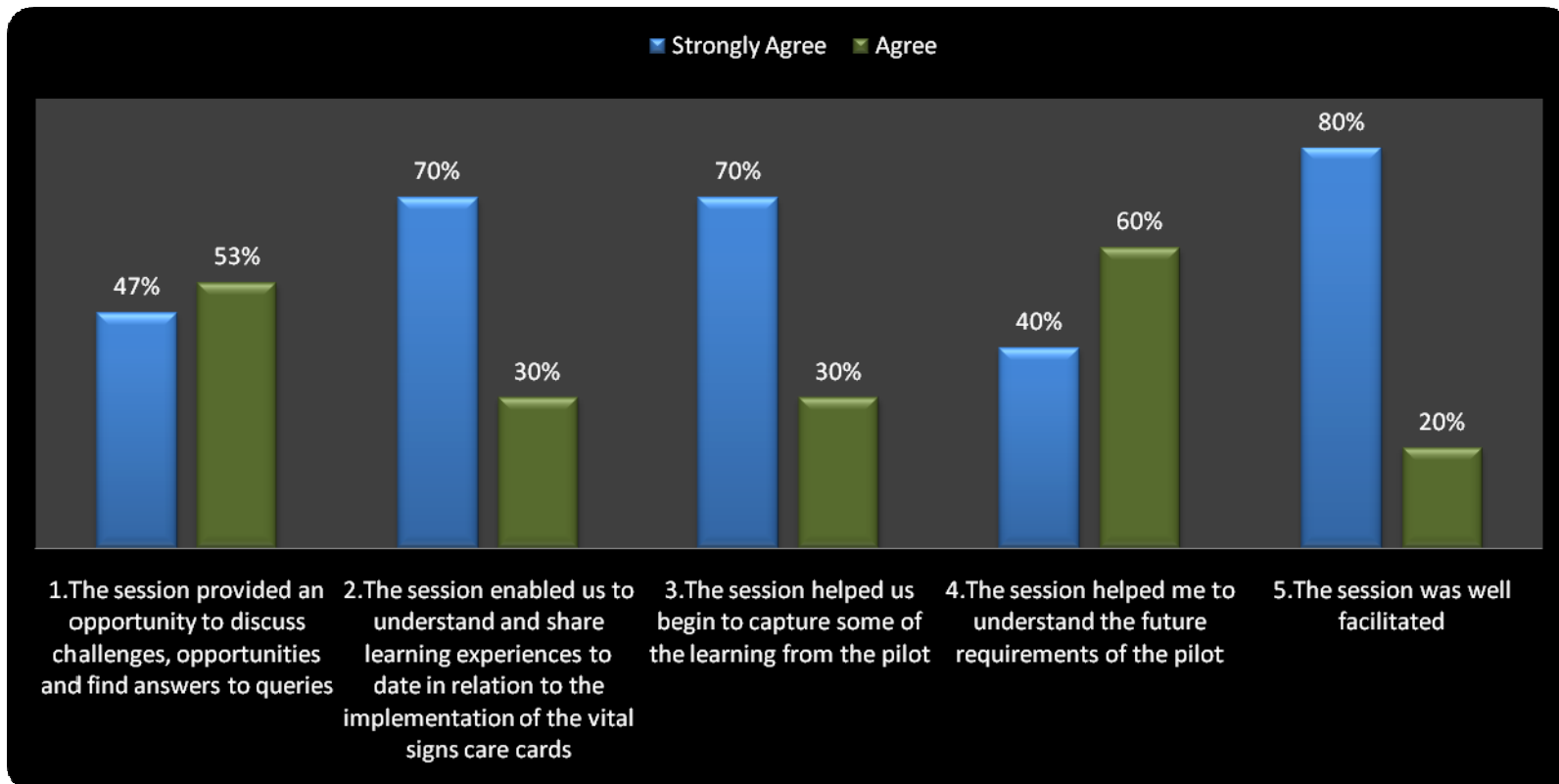
10. What did you like least about the session?

- Some negativity, bit flat at times (participation) from trusts.
- Pace was a bit slow at times.
- The time element, (short) therefore limited discussion.
- That there were only two ward base nurses present.
- Change management wasn't really discussed apart from 'shoes'
- Nil, very informal session.
- Not much to dislike, some people a bit negative on my table – a bit annoying.
- n/a, well organised.

11. What suggestions do you have to improve this session?

- Full day
- Invitation to be extended to Ward managers as well.
- Room was cold.
- Invite nurses
- Introductions at the beginning
- Session was great!
- Perhaps a step back is required as document/basic information varies and therefore this needs to be addressed before we can move on to engaging in patient experience/discuss.
- Slides of initial presentation and ODS team names.
- Morning session.
- PT strategies for example.

Learning capture/leads meeting: May 2009



6. What was the most important thing you gained from the session?

- Practical tips – discussing implementation with other pilot sites
- Further knowledge of the project
- Training package for staff
- Better understanding
- More knowledge of the pilot
- Knowledge of the care cards
- A better understanding of the practicalities, how to reassure staff at ward level could be sold the concept – i.e. Tools to use
- Well explained presentation that was easy to understand
- Knowledge about the pilot
- Knowledge felt supported

7. What did you like best about the session?

- Discussing the “how” to do
- Liked all of it- was great thanks
- Getting together including other sites
- Just learning more from ODS
- Integrating with other sites
- Time was allocated to determinate knowledge
- Informality – yet professional – liked the changing of agenda to suit our needs
- Informative
- Informality and experience of the facilitators

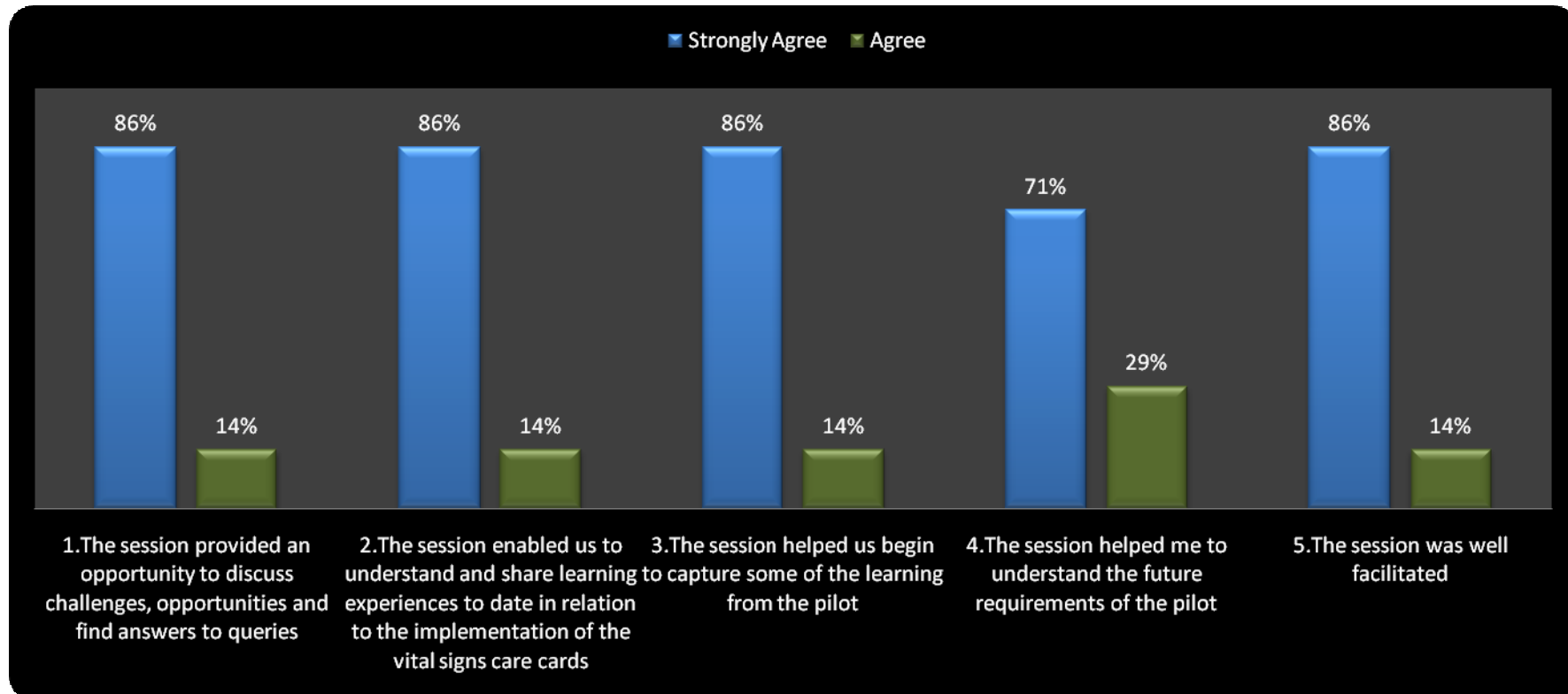
8. What did you like least about the training session?

- It was a lot to take onboard – found myself wandering at times

9. What suggestions do you have to improve this and future sessions that are scheduled?

- Perhaps all bring documents/tools to the next meeting to share ideas/best ways forward. Be interested to see what organisations are using.
- Thanks for an interactive, pleasant afternoon
- Nothing

Learning capture/leads meeting: July 2009



6. What was the most important thing you gained during this session?

- Having group discussion
- Knowledge of how others are doing
- Sharing experiences/ideas with others
- Sharing of approaches to the pilot
- Feeling disappointed prior as some negativity from ward, but now feel better
- Discussing how different organisations capture this data
- Sharing progress and different approaches

7. What did you like best about the session?

- Sharing experiences
- Openness/honesty/friendliness
- Same as above
- Just the open discussion
- Networking
- Informal, extremely interesting to hear others' progress
- Very relaxed

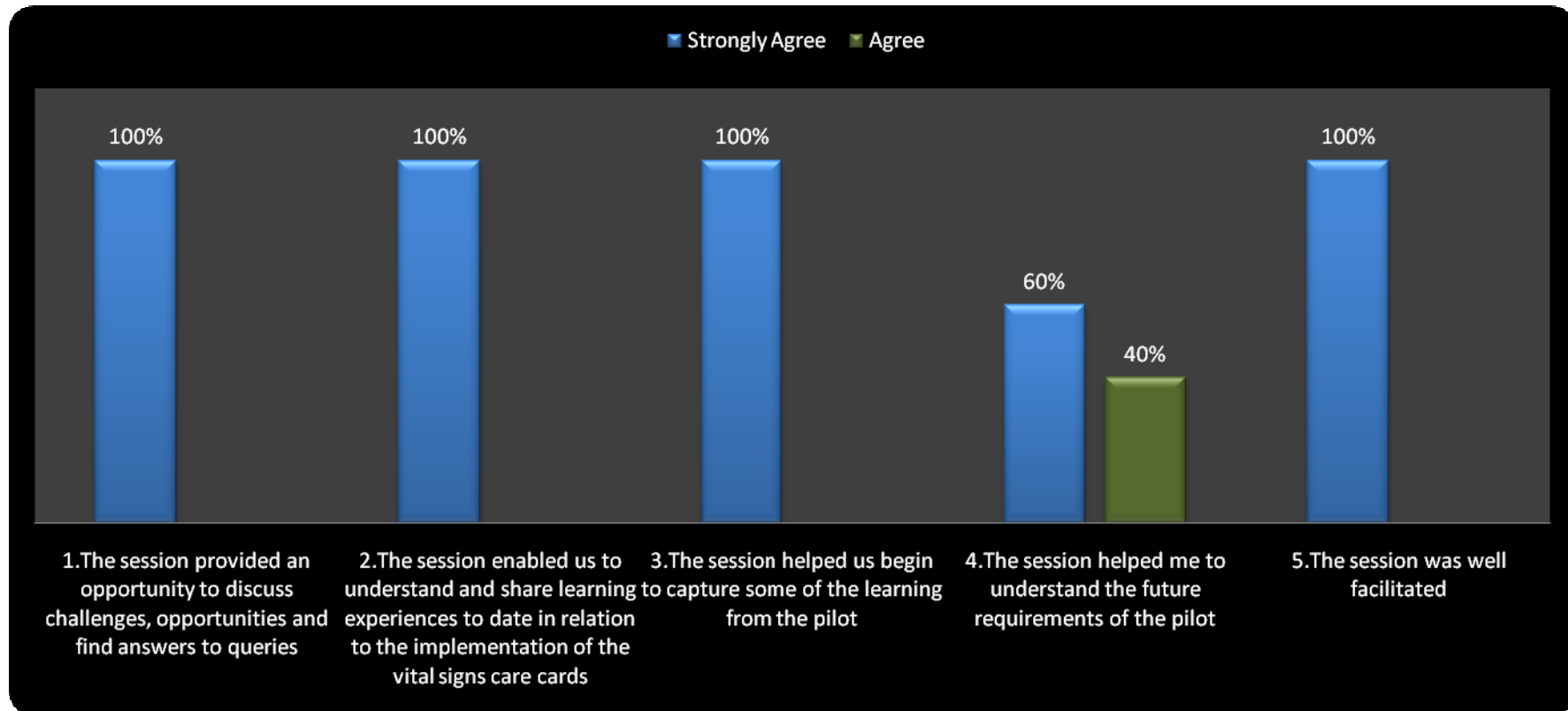
8. What did you like least about the session?

- Nothing

9. What suggestions do you have to improve this and future sessions that are scheduled?

- Nothing
- As discussed encourage staff to attend workshop
- Continue as today

Learning capture/leads meeting: August 2009



6. What was the most important thing you gained during this session?

- Sharing experience x2
- Group discussion

- Touching base and listening to experiences of other sites
- Sharing our successes and our looking at how to rectify any areas of concern

7. What did you like best about the session?

- Very relaxed
- Good group
- Positive feedback

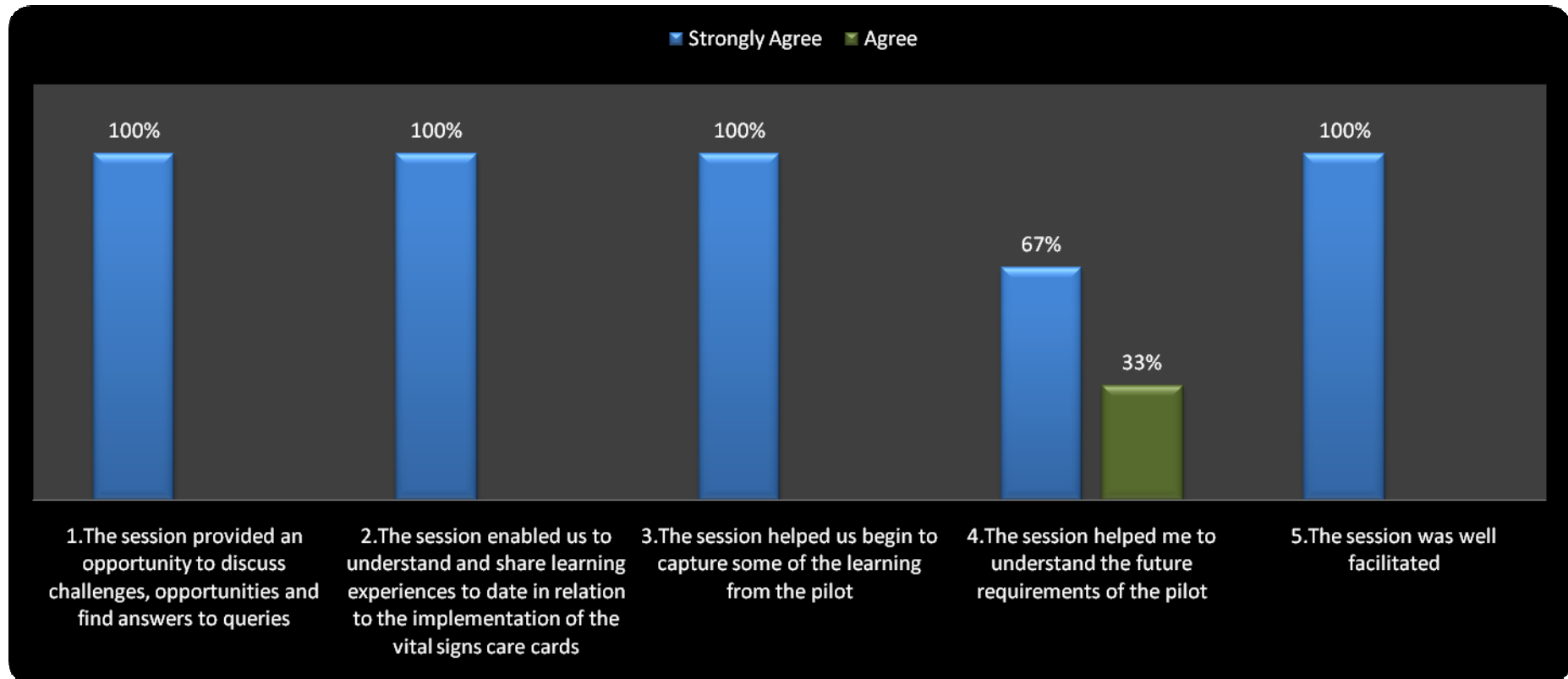
8. What did you like least about the session?

- The heat
- Hot room

9. What suggestions do you have to improve this and future session that are scheduled?

- Thank you this was really beneficial

Learning capture/leads meeting: September 2009



6. What was the most important thing you gained during this session?

- As with the previous sessions the opportunity to talk through issues with the other sites

- Clarification of 9th October
- Consultation of experiences
- Further knowledge of other trusts, issues and concerns
- Understanding of other sites situations/problems
- Data from Card Choices valuable (CRT)
- Networking
- Honesty from group and helping each other

7. What did you like best about the session?

- Sharing problems and working together
- Open discussion
- The people, the openness x 2
- Liked all of it, getting the figures was good
- As with the previous sessions the opportunity to talk through issues with the other sites

8. What did you like least about the session?

- Difficult sometimes when a lot of people talking at the same time

9. What suggestions do you have to improve this session?

- Doing a good job

NHS North West (Pilot)



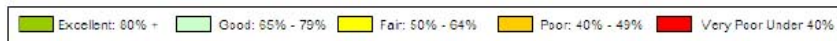
	Royal Albert Edward Infirmary	Royal Bolton Hospital NHS Foundation Trust	Royal Lancaster Infirmary	University Hospital Aintree	Stepping Hill Hospital	Overall
Response Rate	152	110	96	87	3	448

Were you given the 'Care Cards'?	99.1%	95.0%	100.0%	94.2%	100.0%	97.6%
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Patient						
The 'Care Cards' were helpful in expressing my preferences for my care	99.1%	90.0%	94.4%	92.3%	100.0%	94.8%
The preferences I expressed using the cards was reflected in the care I received	99.0%	91.3%	98.6%	90.4%	100.0%	95.8%

Which of these were most important to you during you stay? (tick all that apply)						
"Confidence in managing my own health"	30.6%	62.3%	11.6%	33.3%	100.0%	33.0%
"To feel treated with respect"	12.2%	73.6%	21.7%	58.8%	100.0%	35.9%
"To feel reassured"	29.6%	73.6%	44.9%	43.1%	100.0%	45.1%
"My treatment to make me feel better"	67.3%	73.6%	92.8%	43.1%	100.0%	70.7%
"To feel safe"	13.3%	71.7%	27.5%	66.7%	100.0%	38.8%
"To feel physically comfortable"	70.4%	71.7%	36.2%	45.1%	100.0%	57.5%
"To understand my treatment and condition"	88.8%	79.2%	44.9%	29.4%	100.0%	64.8%
"To feel staff are open and honest with me"	4.1%	77.4%	52.2%	49.0%	100.0%	39.6%

Member of staff						
I found the 'Care Cards' helpful in understanding the patients needs	100.0%	62.0%	80.0%	80.0%	0.0%	79.6%
The care given to the patient was adapted to meet their needs	100.0%	62.0%	84.0%	91.4%	0.0%	82.8%



Net promoter score	99.0%	80.8%	89.9%	61.7%	100.0%	86.5%
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