Improving patients' and staff's experiences of acute care

Wards participating in the Quality Mark programme gather rich data at two stages to help pinpoint what aspects have changed for the better, and reveal possible reasons for this. Rob Chaplin and colleagues explore the results of one such audit

Correspondence
rbchaplin@yahoo.co.uk

Rob Chaplin is research fellow, Royal College of Psychiatrists, London

Jacob Crawshaw was previously employed as project worker, Royal College of Psychiatrists, Centre for Quality Improvement, London

Chloe Hood is programme manager, Royal College of Psychiatrists, London

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Abstract

The aim of this audit was to assess the effect of the Quality Mark programme on the quality of acute care received by older patients by comparing the experiences of staff and older adults before and after the programme. Data from 31 wards in 12 acute hospitals were collected over two stages. Patients and staff completed questionnaires on the perceived quality of care on the ward. Patients rated improved experiences of nutrition, staff availability and dignity. Staff received an increase in training and reported better access to support, increased time and skill to deliver care and improved morale, leadership and teamwork. Problems remained with ward comfort and mealtimes. Overall, results indicated an improvement in ratings of care quality in most domains during Quality Mark data collection. Further audits need to explore ways of improving ward comfort and mealtime experience.

Keywords
Audit cycle, data collection, feedback, inpatient care, quality improvement, questionnaires

PROVISION OF the highest quality of hospital care possible is of critical importance for older people's health and wellbeing. A King's Fund report (Oliver *et al* 2014) highlighted that older patients tend to experience longer hospital admissions and delayed discharges, while emergency readmission within one month is also common. Healthcare professionals working in acute hospitals are treating more patients over the age of 65 than ever before. It is therefore important that hospital staff have the skills, support and confidence to be able to provide the best possible patient-centred care (Aiken *et al* 2012).

Despite the high prevalence of older people being admitted to hospital, there have been many reports of poor quality care. A Care Quality Commission (2013) inspection revealed that 20% of a sample of more than 100 hospitals failed to meet standards for basic nutrition and dignity of older patients and did not adequately involve them in decisions about their care. The findings of the well-publicised Francis Inquiry and other reports demonstrate that care provision can vary in a single organisation, with wards providing high quality care to be found in the same hospital as those who are not (Francis 2010, Tadd *et al* 2011, Royal College of Psychiatrists (RCPsych) 2013). A study of the experience of older adults admitted to hospital revealed that about half recounted poor care including their dignity not being preserved, poor discharge planning and difficulties in communication with staff (Age UK 2012).

Quality Mark programme

The 'Quality Mark for Elder-Friendly Hospital Wards' (Quality Mark) is a quality improvement programme developed to assess care and support improvement using feedback from staff and older patients.

The programme was developed and is managed by the RCPsych, supported by the Royal College of Physicians, the Royal College of Nursing, British Geriatrics Society and Age UK. Individual hospital wards aim to gain the Quality Mark by demonstrating achievements in the quality of care provided to older people. The programme involves data collection through staff and patient questionnaires as well as observations of care and questionnaires for ward leaders, governors, multidisciplinary teams and hospital management. Statements about care quality used in the questionnaires relate to and can be mapped to components of dignified care,

for example, those identified by Help the Aged (2008), such as support to make choices in care, control over individual preferences in decision making, staff attitudes of courtesy and respect, and facilities that are appropriate and clean. The Quality Mark is awarded by a multidisciplinary committee, including service users and carers, nurses, physicians and allied health professionals, to those wards that meet a predetermined score on each assessment taking into account quantitative and qualitative feedback.

Two stages Participating wards undertake a two-stage process. At Stage I, data are gathered to establish a baseline measurement for the wards using patient questionnaires and associated measures, including a staff questionnaire. Wards then receive a detailed local report that includes a summary of the data collected from patients, staff, ward management and governors. The report highlights areas of achievement and areas for improvement. At Stage II, data collection is repeated. The results are summarised in a Stage II report that compares the results with Stage I and is assessed against predetermined criteria, including overall scores and content of patient comments. The two-stage process is designed to ensure that the Quality Mark is not awarded on the basis of a one-off assessment. Commitment is required to engage with the full process and Stage II scores demonstrate that quality of care provision has been maintained or has improved.

In the nine to 12 months between Stages I and II, the ward produces and implements its own individual action plan based on any issues or problems with care that were highlighted in the initial detailed report (see Box 1). The RCPsych does not assess individual action plans, but the effectiveness of these can be inferred from changes in feedback ratings.

For further details on how the programme was developed see Dicks *et al* (2013).

Box 1 Examples of action planning items using Quality Mark template

Topic	Actual items (examples) from ward action plans
Personal care and care inputs	Monitor effectiveness of weekend reviews by consultant teams, identify a daily contact to the junior team for discussion if needed and have an identified area that consultants display their leave so medical and nursing colleagues are aware.
	Governors expressed concern about food quality and presentation. Meeting has been arranged with catering manager.
Experience of the ward environment	Lack of raised toilet seats to enable patients to move on and off toilets safely. Ward to identify suitable type and order these for storage in toilet area with advice from occupational therapist.
	The trust has now installed orientation boards in each cubicle and bay – these include date and time. Toilet seats and handrails in the toilet cubicles and bathrooms have been replaced with brightly coloured elder-friendly ones.
Working on the ward	Seniors meeting to be started to enable discussions of team objectives, care requirements on the ward and quality improvement.
	For the ward manager to have supervisory time to support and educate staff.
Other	Acute pain nurse to be requested to provide in-house training to improve pain control/scoring for patients.
	Celebration of completing Stage I and sharing information with staff.

Aim

To assess the effect of the Quality Mark programme on the quality of acute care received by older patients by comparing the experiences of staff and older adults before and after the programme.

Method

Data from 31 wards in 12 acute NHS trusts were included in this audit with participation between September 2012 and June 2014. Types of ward represented included medical, orthopaedic, rehabilitation and stroke wards, with wards focused on older adult care making up about one third (ten). Of the 31 wards that undertook both stages, 17 have gone on to achieve the Quality Mark.

Patients were eligible to complete the questionnaire if they were over the age of 65 and had stayed on the ward for at least two nights. Patients completed questionnaires anonymously and by hand, returning them to the Quality Mark team in pre-paid envelopes. Only clinical and support staff were eligible to complete the online staff questionnaire. Staff responses were anonymised and individual responses were not made available to wards with the exception of anonymised comments provided by patients.

Questionnaires comprised statements for respondents to rate their level of agreement using a five-point Likert scale: strongly agree (SA), agree (A), neither agree nor disagree (NAND), disagree (D), and strongly disagree (SD).

Statements in the staff training domain were an exception as binary responses (Yes/No) were used.

Both questionnaires were split into five separate domains that related to different aspects of patient care. The staff questionnaire had an extra domain about responding to feedback at Stage II.

The five patient questionnaire domains (23 statements at Stage I, 24 at Stage II) were as follows:

- Comfort on the ward, for example, 'The ward is quiet at night-time.'
- Eating and drinking, for example, 'The food is excellent.'
- Staff attitude, for example, 'Staff let me know that they have time for me.'
- Getting help, for example, 'I can always get help from staff when I need it for: using the toilet facilities.'
- Privacy and dignity, for example, 'I always receive care that is considerate and avoids embarrassment.'

The five staff questionnaire domains (25 statements at Stage I, 32 at Stage II) were as follows:

- Morale, leadership and teamwork, for example, 'There is always a colleague to turn to if I need support.'
- Time to care, for example, 'I have enough time to provide patients with reassurance when they need it.'
- Skills to care, for example, 'The training and supervision I have received enable me to: understand how dementia affects patients in hospital.'
- Access to support, for example, 'The ward team has easy access to: walking aids.'
- Training, for example, 'Safeguarding vulnerable adults.'

Statement responses were recoded as: SA = 100, A = 75, NAND = 50, D = 25, SD = 0. Higher scores indicated a more positive opinion about care quality. Shapiro-Wilk and Kolmogorov-Smirnov tests revealed data were not normally distributed. Mann-Whitney U tests were used to compare the mean rank domain scores across stages. Statistical significance was set at $P<0.001$. Data were analysed using SPSS version 21.

During data collection, CH was programme manager, JC was project worker and RC was involved in data analysis and preparation of the manuscript.

Ethical considerations As the Quality Mark was a clinical audit programme that did not involve any research, novel types of care or the process of randomisation, ethics committee approval and consent to participate were not necessary. Internal governance was co-ordinated by the steering group and the award committee at the RCPsych. Each of the participating wards received appropriate sign up by the ward manager and lead consultant before joining the programme.

Results

Table 1 shows an overview of the sample characteristics. A total of 1,514 patient questionnaires were returned at Stage I and 1,515 returned at Stage II, however, an overall response rate cannot be given because the exact number of questionnaires distributed to staff and patients was not recorded. At both stages, patient demographics were similar. Respondents were most likely to be female, aged between 75 and 84, white British and to have completed the questionnaire without assistance from a friend or advocate. A total of 647 and 641 staff questionnaires were returned at Stage I and Stage II respectively. At both stages, most staff responding were either registered nurses or healthcare assistants.

Feedback from patients

Stage comparisons Patient feedback showed modest improvement in the domains 'eating and drinking', 'getting help' and 'privacy and dignity' (Table 2, page 28). There were no between-stage differences for 'comfort on the ward' and 'staff attitude'.

Individually ranked statements Most individual patient statement mean scores (18/22) were higher at Stage II than at Stage I indicating improvements in experience (Table 3, page 29). Patients rated the items in the questionnaire classified as the experience of nursing care – 'getting help' and 'staff

Table 1 Sample characteristics

Patients	**Stage I**	**Stage II**
Number returned, *n*	1,514	1,515
Female, *n* (%)	810 (54)	785 (52)
Aged 75-84, *n* (%)	558 (37)	572 (38)
White British, *n* (%)	1,258 (83)	1,284 (85)
Completed by patient without assistance, *n* (%)	628 (41)	678 (45)
Staff	**Stage I**	**Stage II**
Number returned, *n*	647	641
Registered nurses, *n* (%)	293 (45)	301 (47)
Healthcare assistants, *n* (%)	272 (42)	247 (39)
Doctors, *n* (%)	27 (4)	19 (3)
Other, *n* (%)	55 (9)	74 (12)

Table 2 Comparing patient questionnaire domain scores between stages

Patient questionnaire domain	Stage I		Stage II		Statistics		
	n	Mean	*n*	Mean	Z	*P*	r
Comfort on the ward	1,484	72.97	1,503	74.03	-2.085	0.037	0.038
Eating and drinking	1,473	73.32	1,485	76.11	-4.056	<0.001*	0.074
Staff attitude	1,488	85.19	1,502	85.59	-0.061	0.952	0.001
Getting help	1,362	85.59	1,374	87.64	-3.179	0.001*	0.061
Privacy and dignity	1,486	79.13	1,504	81.34	-3.763	<0.001*	0.069

r = effect size * = $P<0.001$

attitude' – more highly on both occasions than those reflecting the ward environment – 'comfort on the ward' and 'eating and drinking'. Items reflecting 'privacy and dignity' were ranked in between.

Feedback from staff

Stage comparisons There were highly significant improvements in scores at Stage II for all domains including morale, leadership and teamwork, time to care, skills to care and access to support (see Table 4, page 30). The number of staff receiving training improved in all areas including: recognising symptoms of delirium and dementia, person-centred care approaches, cultural competence and diversity, communication about end of life care, risks of sedation and restraint, de-escalation techniques, continence care, safeguarding vulnerable adults, encouraging fluid and food intake, and recognising risk of falling.

Individually ranked statements Scores for all statements (25/25) were higher at Stage II than at Stage I. The four highest ranked statements were the same at both stages, albeit in a slightly different order ('I understand my level of authority', 'access to walking aids', 'there is always a colleague to turn to if I need support', 'we work as a team'). The three lowest ranked statements were the same at both stages ('issues about staffing levels are resolved appropriately', 'I have enough time to discuss and explain care and treatment to patients' families', 'I have enough time to provide practical assistance to patients when they need it').

Training Staff were asked about training received. For the 12 types of training modules received (provided by individual organisations), staff attendance was higher at Stage II than Stage I. On average, there was a 10% increase in staff attending training at Stage II. The biggest improvements in training provision were 'symptoms of delirium' (17%), 'types of dementia' (15%) and 'person-centred care approaches' (15%).

Discussion

It was not possible to determine to what extent the Quality Mark programme was the reason for improvement in ward performance, because action planning implementation includes a number of overlapping local and national initiatives and the programme management team did not appraise action plans in awarding the Quality Mark. The programme collected data from a variety of sources including ward managers, lead consultants and hospital governors. This article only focuses on data collected from patients staying on the ward and staff working on the ward. However, data were collected from multiple centres open to all ward types admitting older people as the majority of their patients, results were based on large sample sizes and minimum target responses were set for each ward based on patient throughput and whole-time equivalent staffing.

The aim of the audit was to compare ratings from patients and staff on the quality of care provided during two stages of Quality Mark data collection. Scores on three of the five patient care domains showed a modest improvement at Stage II in perception of care received: eating and drinking, receiving help when required, promoting privacy and maintaining dignity. Improvements were associated with increased numbers of staff receiving appropriate training especially in delirium, dementia and person-centred care. It could be postulated that improved staff training led to better perceptions of care and areas not addressed by this, notably the ward environment, would not have been expected to have improved because the time scale was likely too short to facilitate organisational planning and investment in facilities. Improvements to patients' perceptions of privacy and dignity were especially

Table 3 Individually ranked patient statements directly comparable at Stages I and II

Patient questionnaire statement (ranked at Stage I)	Domain	Stage I	Rank	Stage II	Rank
The ward makes mealtimes a sociable experience.	Eating and drinking	63.49	22	70.05	19
The ward is quiet at night-time.	Comfort on the ward	67.83	21	69.25	20
The ward is quiet throughout the day.	Comfort on the ward	68.35	20	67.21	22
The food is excellent.	Eating and drinking	69.48	19	69.08	21
I can always talk to staff without being overheard.	Privacy and dignity	70.81	18	78	16
The temperature is just right.	Comfort on the ward	71.31	17	72.21	18
The menu always offers me an attractive option.	Eating and drinking	71.72	16	73.37	17
It is easy to find my way around the ward.	Comfort on the ward	78.06	15	79.79	15
My views are respected when decisions are made about my care.	Privacy and dignity	81.29	14	83.1	13
At mealtimes, staff always make sure everything I need is in reach.	Eating and drinking	82.25	13	83.51	12
I have enough to drink at all times.	Eating and drinking	82.42	12	84.95	7
The toilets are clean.	Comfort on the ward	82.46	11	83.57	11
I always receive care that is considerate and avoids embarrassment.	Privacy and dignity	82.91	10	80.14	14
Staff let me know that they have time for me.	Staff attitude	83.25	9	84.18	10
Help when I need to eat and drink.	Getting help	83.47	8	84.51	8
I have never been talked down to by staff.	Privacy and dignity	83.63	7	84.36	9
Getting up and moving around the ward.	Getting help	84.5	6	86.69	5
Using the toilet facilities.	Getting help	84.99	5	87.28	4
Staff welcome visits from my family and friends.	Staff attitude	86.24	4	85.71	6
Personal care such as getting washed or dressed.	Getting help	86.46	3	87.87	3
Getting relief from pain and discomfort.	Getting help	87.05	2	87.91	2
Staff always seem caring.	Staff attitude	87.59	1	88.46	1

important, because these have been highlighted as problematic (Age UK 2012). The lowest-ranked items relating to comfort on the ward (noise, temperature, orientation) did not improve. Staff attitudes did not improve but were initially ranked highly. It is possible that this may have been related to a 'ceiling effect' of audit: it is most effective when staff are performing poorly (Ivers *et al* 2012).

By Stage II scores on all staff questionnaire domains had significantly improved. The greatest change was related to staff having better access to resources, for example, walking aids, hearing aids, adapted cutlery and patient advocacy services. Staff scores in the 'time to care' domain were the lowest initially but substantially improved by Stage II. Staff indicated that they had improved skills and that the morale and leadership of the ward had improved. It follows that the programme may have had an effect on staff's view of their ability to care. It is, of course, unclear if this is a result of their increased training attendance, the presence of the Quality Mark programme, their action plans or other factors.

Higher scores at Stage II may reflect better ward management in terms of provision of peer

Table 4 Comparing staff questionnaire domain scores between stages

Staff questionnaire domain	Stage I		Stage II		Statistics		
	n	Mean	*n*	Mean	Z	*P*	r
Morale, leadership and teamwork	647	74.55	641	80.98	-6.402	<0.001*	0.179
Time to care	647	64.87	641	72.97	-6.933	<0.001*	0.193
Skills to care	647	75.94	641	81.64	-6.303	<0.001*	0.176
Access to support	647	73.87	641	82.27	-9.129	<0.001*	0.254

r = effect size * = $P<0.001$

support, reorganisation of rotas or confidence due to training. A review of the effectiveness of audit on professional practice and healthcare outcomes found that it can lead to small but potentially important improvements (Ivers *et al* 2012). This has been shown to be linked, among other factors, to clear targets and action planning, which is a requirement for achieving a Quality Mark. Finally, one of the main benefits of the Quality Mark programme is to support staff to reflect on their practice.

Conclusion

The findings from the audit suggest the Quality Mark programme was associated with modest improvements in some patient-rated areas of care experience and highly significant improvements in all staff-rated areas. A report for NHS England found 'a substantial amount of recent evidence that the experiences of staff... are associated with the care provided to patients, in the form of patient satisfaction, health outcomes, and ratings of quality of care' (Dawson 2014). On this basis, we would expect that improved staff experience will lead to more consistent care delivery and sustainable improvement. Although we cannot conclude that the Quality Mark programme is the sole driver of improvement since many other factors could have influenced practice, it provides a measure that is sensitive to change as perceived by patients and staff.

It is appropriate to consider the implications of these results for practice on wards that did not participate in the audit. First, as the principles of care are universally applicable across all inpatient settings, wards could examine the areas of care that were found to be most problematic as there may be similarities with their wards. Second, examining one's own practices or participating in an audit may lead to improvements in the care delivered. All wards could focus on issues of comfort, and privacy and dignity and share any solutions found to improve these areas of care.

Online archive

For related information, visit our online archive and search using the keywords

Conflict of interest
All authors worked for the Royal College of Psychiatrists who run the Quality Mark programme

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