Commitment to Quality

Safeguarding quality of care in long stay psychiatric hospitals

Edited by Helen Smith

Community Living Development Team Discussion Paper

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PREFACE

This document is the result of a working group which met through the latter part of 1986 and most of 1987. Members of the group came together because of our shared commitment — and concern — for the lives of people living in long-stay psychiatric wards. Such people, many of whom are elderly, are particularly vulnerable to receiving low quality care from under-resourced health authorities, who may be focussing more on community services than on the people for whom no discharge is planned. We all know of wards in danger of being "forgotten" as new and exciting services are set up elsewhere; this document is an attempt to ensure that residents and staff on these wards remain visible to their health service colleagues and the community.

It is important to emphasise that the working group, in writing this document, is neither advocating nor supporting institutional forms of care; rather we wish to acknowledge that for some people, a psychiatric hospital will continue to be their home and that the service they receive should be accorded due priority and importance. Our wish is also to draw attention to the complex task of providing "a home" for people with long-term mental health problems. Staff working on these wards have rarely received much credit and recognition, despite the dedication and commitment many have shown in their work.

This document is for all staff working on long-stay wards and for their managers. It was written though with a particular group in mind, that is, those nurses providing *direct care* for residents. We hope that they will find this an interesting and above all, useful document and one which will challenge and change their working practices. To this end we have based our ideas in the practical day-to-day lives of staff working on long-stay wards.

This document is primarily for staff (although relatives and voluntary groups will, hopefully, also find it of interest) but the major focus throughout is the people who initially gave us a common reason for coming together, the residents. We hope that others will see the value of this approach and, like us, find it exciting and rewarding.

Helen Smith
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January 1989

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Thanks are due to Mr **Jim Smith**, formerly Director of the Community Living Development Team, for setting up the working group and starting us on our task. We would also like to thank **Ms Tessa Brooks,** Director of the Quality Assurance Programme, King's Fund Centre, for her helpful comments on the document.

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CHAPTER 1

Principles First

When thinking about quality it seemed to us in the working group that two basic questions needed to be addressed: firstly, how do we know what a high quality service looks like for residents; and, secondly, how can we bring about positive changes in working practices?

Thinking about what makes a high quality service made us quickly realise that we could all "throw in" things, but how were we to organise and make sense of the infinite number of issues that could be considered? It became clear that we needed some statements about what residents should expect from the service they received. This led us to examine our own beliefs about people living on long-stay psychiatric wards. We realised that our ideas about what residents should expect from a service depended upon what we thought about the residents.

It was a challenging task to examine honestly the assumptions and notions we held about the residents with whom we worked. It reinforced, however, our commitment that all people, regardless of disability, were of equal human value and were individuals in their own right. The only way, it seemed to us, that we could progress with any consideration of quality was first to state some principles reflecting our beliefs about people with long-term mental health problems and about the service they had a right to expect.

We were inspired in this task by the publication "Living Well Into Old Age".[1] We found its approach in stating a principle and the implications for the individual and for the service both accessible and useful. We took this format to generate our own principles- these principles and their implications are presented below.

PRINCIPLE 1

People in longstay wards have the same human values as others and have a right to respect and privacy

What it means for the Individual

I want the place I live in to be homely; a place where I can have personal space, access to others and I can have personal possessions, as can any respected person.

I want to be asked about the quality of my life and the service I receive. I can identify my needs and say whether or not they are being met. It should be safe for me to do so without fear of reprisal from staff.

As a respected adult I want to be able to exercise choice. I want to be consulted about my views and be involved in discussions about my home. I want to make decisions about my life.

I want to be acknowledged and appreciated and my contribution to the life of other people on the ward and staff to be recognised.

Implications for Frontline Staff & Service

The environment will be as homely as possible- clean and tidy with normal and comfortable furniture and furnishings. A personal bedroom is essential, as are individual lockers and wardrobes. Large dormitory wards are unacceptable. Medical/nursing equipment should not be on display. People should be encouraged to buy and bring in personal effects and their safe housing should be ensured. Individuals should be informed of security measures and how to file complaints.

Staff should spend time with residents to obtain their views of service provision. Consumers should be part of the consultation process when change is planned. Residents should be encouraged to form groups to express their views and staff should support them. Information should be directed towards residents and not 'filter down'. Advocacy should be explored- any system adopted should be as a result of consultation with residents and advertised widely.

The service must be geared to increasing the choices available to residents. Front-line staff will receive training to encourage decision-making by residents- and the service must ensure a supportive environment for this to take place. Communication links must be established where residents' views are sought and they can receive honest and adult information about change. Front-line staff should help residents to assert their preferences.

Staff will talk to people in a way that recognises and respects that they were once parents, workers, members of organisations, skilled in certain activities, and so on. Staff will look to enjoy the diversity of personalities, backgrounds, interests reflected by the people for whom they are caring.

Prompt Questions for Staff

What steps have I taken to provide a homely environment? Are ordinary household items evident, eg. pictures, ornaments, settees and easy chairs? Do I realise that all individuals need privacy and personal space? Have I responded to this need? Are hospital signs/equipment evident? What facilities are there for residents to display/store their

personal possessions? Can they be compensated for loss/damage and do they know how the complaints machinery operates?

Have I asked the residents about the care they receive? Can residents 'safely' express an opinion, comment on the quality of service received? How do I know that individual needs are being met? Do I involve residents in meetings about change? Is there an independent person available for residents to talk to if they are dissatisfied? How do I feel about the need for a Patient's Advocate?

Does what I do for an individual promote independence? Do I offer the residents choices- and how meaningful are the choices? Have I sought the residents' views? Do I inform residents of changes in environment/ practice. Will the other carers support me in enabling the residents to choose? Will the management support me if I take risks? How do I represent an individual's views to the managers?

Do I appreciate the personality of residents and recognise how much they reflect my own life? Am I interested in finding out what the residents worked as, what hobbies/interests they may have had, and so on?

PRINCIPLE 2

A person has the right to an individual plan that includes appropriate treatment, a timetable for learning relevant meaningful skills and an agenda for long-term action. Each plan must have clearly stated goals that seek to promote maximum independence for the individual. Plans should be drawn up by the individual, his/her advocate, a small group of relevant staff and the person's family. Plans should be co-ordinated by a resource co-ordinator and regularly reviewed.

What it means for the individual

I need to be involved in agreeing the goals in my personal plan.

I want to do a variety of different things, both within a day and over time, that are useful and meaningful to myself and others. I want the opportunity to learn new skills. I want my existing skills to be used in an active and creative way. I want to be helped to regain the skills I have lost.

I want to learn skills that will enable me to participate more fully in the life of the ward and the wider community. I do not want to be doing the same 'variety' of things month after month (if it's Tuesday, it must be basketwork!)

I need my plan to be regularly reviewed and changed accordingly. I need clear goals, both short-term and long-term.

Implications for Frontline Staff and Service

Individuals (and advocates) will be fully involved in all decisions made about their plan. Residents will be given full information about available options, and support in making an informed choice. Saying 'no' will be seen as a positive reaffirmation of their rights.

The service will seek creative and stimulating solutions to help residents use their time meaningfully. Every effort will be made to discover their individual interests and preferences.

The service will identify for each individual relevant skills that need to be taught (eg literacy skills) and facilitate learning in the most valued way (eg. attending an Adult Literacy Course). Nursing staff will engage families, friends and voluntary groups in the ward's activities. Managers will support nursing staff in their use of community resources for this aim.

The service will have a well-organised monitoring and review process.

Prompt Questions for Staff

Do I take time to explain the options to residents? Do I get cross if they say 'no'? Am I sure that the plan is in the individual's best interests and not mine?

How much do I know about the residents' interests and hobbies? How much effort have I put into finding out? Would I want to be doing the activities they are doing? If not, why not?

How can I help the residents identify the most important skills for them to learn? How can I help them to continue things they can do well or used to be able to do? How would I learn

new things? Do I actively try and involve other people in doing things in the ward? Am I welcoming to relatives, volunteers, advocates? Do I make every effort to help residents leave the ward in the same way I leave my house most days?

Do I keep to the timetable for reviewing an individual's plan? Do I take this task seriously and allocate enough time to do it properly?

PRINCIPLE 3

A service should seek to ensure that people participate as fully as possible in the local community. People from long stay wards are entitled to share community facilities.

What it means for the Individual

I want to be able to go out of the hospital and know that if staff do come with me they will be sensitive in the way they accompany me in public.

I want to spend my money how and when I like.

I don't want to be noticed by other people as being in any way different.

I would like ordinary and normal contacts/relationships within the community and when I do go out I wish to be treated as an individual and out one of a large group from the ward.

Implications for Frontline Staff and Service

The staff will support residents outside the hospital if residents require this- staff will NOT parade their 'staff' identity (ie. by the use of badges, uniform, attitude). The ward will allow for flexibility of working hours. Residents will go out at weekends and evenings.

The staff will be aware that residents may sometimes make financial mistakes (as do we all!) but should foster a friendly relationship which gives the individual necessary and reasonable protection.

Staff will educate the public by showing respect and liking the people they are with; and be concerned with always projecting a positive image of residents. Residents will not look conspicuous in the community.

Efforts will be made to establish links with local centres, clubs and other community orientated activities. Information will be given to the residents about the range of activities available and measures will be taken to ensure that they are accessible and meet the resident's need. 'Mass recruitment' to nearest local club will be avoided. As many of the local amenities as possible will be used by residents- eg. shops, banks, hairdresser, dentist, etc.

Prompt Questions for Staff ?

Do I wear a uniform? If so, why?

How do I face the challenge of helping residents cope with their own money?

How do I help residents to use the local facilities/amenties? How near are they and are there transport difficulties; how can they be overcome? Do residents require special help to make access facilities easier? When trips are planned, are they based on individual interests? Why do we go out in groups of more than 2? What is the reaction of the group, myself, the public when we are out? Do I overprotect; do I exhibit anxiety and prevent true contact? Who manages the money, pays the fare/ for goods etc? Do I know what facilities/amenities/clubs etc. are within the area?

PRINCIPLE 4

A person has a right to sufficient and individualised support so as to respond to their unique and constantly changing needs, and their potential for change.

What it means for the Individual

I want to interact with others who realise I can always learn.

I need to be protected from exploitation, yet want to take reasonable risks.

I do not want to be blamed when things go wrong.

I want sufficient help to do the things I want to do. Knowing there are insufficent resources does not help me. I need staff who don't ever give this as an excuse!

As changes in the ward/hospital take place, I would like to know what the effects would be on myself and my friends. My contribution to the planning process is important.

Implications for Frontline Staff and Service

The service will recognise and act upon the fact that everyone is capable of learning and changing up to the point of death.

The service will safeguard people in a way that prevents abuse yet does not overprotect them.

The service will assess an unmet goal, an accident or unreasonable risk on the grounds of insufficient support or inappropriate goal setting. The severity of an individual's disability will not be used as a justification in itself for not doing something, or for something having gone wrong.

The service will train and support its staff in looking at innovative and creative ways of meeting people's needs within available resources.

A system of consultation will be established whereby information and views can be exchanged and acted upon.

Prompt Questions for Staff

Do I recognise that everyone needs new experiences? This is an essential psychological requirement from cradle to grave.

Am I supported by my managers to face these challenges? Do I support a family's anxiety when their relative takes risks?

What excuses do I use for not doing things that residents want to do? Do I really believe in the residents' ability to do particular tasks?

How do I cope with my frustration at insufficient resources and still find creative solutions?

How and when are residents told of service plans and their effects? What effort do I make to identify the possible choices? What effects will planning have and do I give residents the opportunity/encouragement to give comments/ideas? What do I feel about the plans?

PRINCIPLE 5

People in longstay wards have the right to expect that a positive image of residents will always be projected within and outside of the hospital. A positive image is an essential step towards an effective service.

What it means for the Individual

I want to be allowed to make my own decisions and my own mistakes. In law I am an adult and entitled to vote.

I do not want to be labelled as helpless, dangerous or useless and therefore when spoken of in the media/local publications I would like to be represented as an intelligent adult, able to contribute to the community and not as a child or in derogatory terms or labels.

I would like my environment to project a positive image at all times and to reflect that it is my home.

Implications for Frontline Staff and Service

The service will actively support residents' rights to decision-making without imposing its own values or moralities. Where necessary, support will be given to promote independence and self-assertion.

Words and ideas will reflect a positive image of residents. Use of jargon will be avoided and client groups will not be identified or categorised by derogatory labels.

The service will ensure that the environment is homely, safe and clean and that the images portrayed are appropriate to the age and culture of residents. The environment and grounds will reflect a homely, non-threatening appearance. Any barriers that may reduce access or cause alarm will be removed. Greater attention will be paid to how the public view the service.

Prompt Questions for Staff

How are decisions about individuals made and who has the last say? What management support will be needed to facilitate self-decision and how will I help achieve it?

What do I think of the residents? What words, terminology or jargon do I use in my recording or discussions with professional groups? What do I say about my job outside of the work situation? Do I imply negative values and reinforce attitudes of helplessness or danger? Are my views evident to the residents? What "messages" am I giving to residents, their relatives, other professionals and the community?

Is the environment welcoming, and is it accessible to the local community, friends and relatives? Is the decor positive and age appropriate or does it appear run down and neglected? Are service areas sited away and out of sight of residential areas? What are the first impressions upon entering the grounds? Are appearances marked by institutional features? Who decides how the environment is to be decorated? Would I like to live here?

CHAPTER 2

The Quality Action Process

We have discussed principles of care that we feel should guide residential services for people with long term mental health problems. As can be seen the principles defined in Chapter 1 are grounded in fundamental human principles stating that people with disabilities have the same human value and the same rights and responsibilities as other non-disabled people. Principles about service delivery reflected these fundamental values. These principles can be used as part of a quality assessment process. We would like to emphasise our belief that all staff must view quality assessment as a philosophy or attitude that is an integral part of providing a service. What follows is a suggested framework for putting this philosophy into practice.

Setting up a Quality Action Group

This model is drawn heavily from "Pursuing Quality",(2) a document concerned with assessing quality in services for people with learning difficulties (mental handicap). The process however, seems directly relevant to all caring services. The stages are as follows:

A group of stakeholders[1] are identified who are directly involved in a particular ward in the hospital and who are enthusiastic about providing high quality services. Direct care staff will be well represented in this group. Managers should also be members, as should relevant voluntary organisations who may be involved with the hospital. **People living on the ward have most to gain from a high quality service and have a vital input as members of the group.** Relatives are also important members.There may be a relatives group in the hospital or ward who could send a representative.

Obviously the group should be a workable size, 8-10 members may be large enough to represent the different interests, yet small enough to tackle the work effectively. Careful consideration should be given to the composition of the group. A comprehensive and representative membership will ensure that the issues chosen are not skewed in a particular direction.

2 **The Quality Action Group will need to spend a significant period of time working out and agreeing upon principles of care.** It is essential that this ground work is done if the group is to accomplish its task. In the first chapter we have produced principles generated by our working group. These principles are similar to those stated in "Pursuing Quality" and "Living Well Into Old Age". Quality Groups could adopt these principles directly, or could generate their own. It is important to emphasise that principles should be about residents' *lives,* not about the service process.

1. Stakeholders refers to anyone who is significantly involved in the service.

3 **The next step is for the Group to define what it means to put these principles into practice.** This step is important in orienting the Group to the daily lives of people on the ward, translating abstract principles into "what it means for me". This can be a challenging task, but equally can stimulate creative ways of working. In Chapter 1 we did this by thinking about:

i) what it means for the individual;
ii) what are the implications for staff; and
iii) what questions do we need to ask about the service in terms of this principle.

4 **Taking a small number of issues at any one time, perhaps those generated by a single principle, the Group collects data on these issues.** The task here is to record current working practices. This evidence will then be fed back to the Group who will decide what action needs to be taken.

5 **Action goals should be set in accordance with the original principle.** These goals should be clear, understood by everyone and, most importantly, described in a way which makes it clear how they are to be achieved.

6 **Regular monitoring of progress on these goals is necessary to ensure that changes do happen.** With each issue tackled in this way, the ward will move one step nearer to a high quality service.

We would now like to look in more detail at assessing quality in services where residents, due to their disability, are unable themselves to be actively involved in the quality action group.

Assessing Quality in Services for People with Severe Disabilities

When thinking of improving the quality of care for people with severe disabilities (elderly people with dementia, people with serious learning disabilities, those with a long history of institutionalisation and so on) it is worth going back to the basic questions that need to be answered. Firstly, how do we know what to change? Secondly, how are working practices actually changed at the point of service delivery?

Knowing what to change, as we have stated above, clearly involves seeking the views of those who receive the service. However, how can we communicate with someone who is unable to articulate their views, may have very limited expectations and limited understanding of the service or may feel in too vulnerable a position to make criticisms (for example, people in long-stay hospitals)? This poses a real challenge to staff; yet unless faced we cannot assume that we are correctly identifying important factors of quality in people's lives, or that changes in care actually affect their lives for the better. So, how do we find out what are relevant factors of quality? The following suggestions might be helpful.

- Never underestimate an individual's ability to communicate. Be creative in ways of approaching dialogue. Ask people how the service they receive can be improved and learn to "listen" in different ways; e.g. through expression, gesture or other behaviour.

- A "Getting to Know You" (G.T.K.Y)[3] exercise with a representative sample of people can help generate what are relevant quality issues for a larger group of service users. By "shadowing" an individual over long periods, covering a 24-hour day, it is possible

to develop a sense of the person's day. The aim is to develop some understanding of how they experience the service. This information can be used to highlight issues for change. G.T.K.Y. can be particularly valuable for planners and managers who may not often come into direct contact with service users.

- Inferences about what constitutes a high quality service, developed from clear values and principles, can help overcome difficulties if people are unable to express their needs and preferences. For example, a principle which states that people with dementia have the same human value as anyone else implies for the individual, contact with a service which acknowledges the fact that they have a history as a worker, parent, member of political or other groups, interests, skills in (for example) photography, sport, and so on.A person may be unable to say clearly that they want staff to know and be interested in their past, yet staff doing this could be inferred as being highly relevant to an individual's quality of life. A high quality service therefore would be one which actively trains staff to promote a positive, respectful view of people with dementia.

  The use of independent advocates is another way of obtaining information about residents' lives. Advocacy services are rare, but if we are serious about improving quality then an independent voice is essential for those who cannot speak for themselves.

Once knowing what to change, how are actual changes made in caring for this group of people? We would like to restate our belief that quality assessment must be concerned with *empowerment* of both residents and staff. Giving the results of a survey or checklist to a group of demoralised staff will probably not bring about much positive change. If, however, as we have suggested above, staff are themselves intimately involved in collecting data, suggesting changes and evaluating their work, they are far more likely to "own" quality assessment as their responsibility.

At the risk of repetition, we would briefly outline the model proposed above whereby:

1 A group of stakeholders (users, workers, managers, etc.) decide what are the issues to be addressed; again issues and goals must be clearly defined and based within the day-to-day lives of service users.

2 Measure the current situation with regard to an issue and collect evidence through, for instance, time-sampling; carefully recorded observation; straightforward monitoring.

3 Suggest changes in practice.

4 Re-evaluate changes on each issue over time, possibly using techniques in 2. This is only a brief resume of the steps outlined at the beginning of the chapter, it is suggested that readers return to these steps for a fuller description of the Quality Action process.

Use of Role Play

Role play is another way of becoming aware of issues that might affect the quality of life of residents. It can be a useful way of understanding what it is like to live on a ward.

The experience of being dependent and under the control of nursing staff can provide valuable insights into what it is like to be a resident. The person or people designated as "the resident" or "residents" should decide themselves on the length of time for the role play, and the level of dependency, withdrawal and so on, they wish to enact. Staff involved in the role play should be aware of factors such as staff's own communication skills, do staff talk at — or with — the "residents"? How are the petty restrictions of institutional living experienced? What, for example, do the "residents" feel when the night nurse comes on duty and tells them to go to bed? Question established practices. For instance, how does the "resident" feel at wearing the same style clothes as everyone else; at having to return to the ward by 8.00 p.m.; at sometimes wearing someone else's knickers! Those staff observing the role play might like to reflect on who benefits from the practices they see and would they accept these rules if applied to the nurse's home? Staff discussions could focus on the basic psychological needs for dignity, respect and privacy and contrast these to the situation on the ward. If nurses feel certain practices would be unacceptable for themselves, then why should this be different for residents?

Such discussions would be greatly aided by including the residents who live on the ward. When this happens it may be useful to have an outside facilitator to ensure that residents are truly listened to by staff and have equal chance to contribute to the discussions. It may take time for some residents to develop the confidence to express their feelings about hospital. Staff should avoid general questions such as "what do you like/dislike about the ward?" as these can be difficult for anyone to answer and may, initially, be received cautiously by residents. Rather staff and residents should focus on particular issues, such as mealtimes, and discuss small steps to improving quality.

CHAPTER 3

"Excuses, excuses....."- and how they might be challenged!

Before we proceed to look in more detail at assessing quality it might be useful to look at excuses that may arise for not looking at quality — and how these can be challenged effectively!

Excuse:

"We are too busy to take time out to look at quality".

Challenge:

* What are the nurses' daily activities?
* What percentage of time is spent on direct nursing care?
* What percentage on non-nursing duties?
* Is the most effective use being made of spans of duty?

Excuse:

"We are too short of staff to spend time assessing quality".

Challenge:

* If there were more staff, how would they be used?
* What is not being done now that would be if there were more staff?
* Have you tried to improve quality of care and found the lack of staff prevents this being implemented — or has no attempt actually been made?

Excuse:

"We are short of facilities and equipment for improving quality".

Challenge:

* What facilities do you require that you have not received?
* What attempts have been made to obtain these items?
* Are there alternatives, have they been tried?
* Has management been involved in attempts to obtain these facilities?
* What response has been received from management?

Excuse:

"Why should we look at improving quality, our standard of care is very good?"

Challenge:

* What measurements have been used to ensure standards of care are as high as claimed?
* How often has quality been assessed? Without regular monitoring at prescribed intervals, claims that standards of care are high can only be subjective.
* Is there any facility for user feedback?
* The quality of care should be constantly assessed and evaluated.
* Standards of care should be as high as possible with both residents and staff working in equal partnership.

Excuse:

"We can't be more flexible — the patients need routine"

Challenge:

* On what do you base this statement? Have you asked the residents how they feel about the ward routine? If not, why not?

* Have you asked the staff how they feel about the ward routine?

* Does the service dictate the routine e.g. arrival of meals, domestics to wash up, arrival/collection of linen? If it does, and this affects your delivery of care, what have you done about it?

* Do you feel responsible for "absorbing" this effect and if so — why?

* Can you vary your workload so that delivery of care is more flexible? Individualised care is more flexible than task-orientated nursing; how is care delivered on your ward? Are tasks allocated to the nursing staff and are they related to resident care?

If you are delivering individual care your workload is flexible and there is only limited routine e.g. arrival of meals, drug rounds, etc.

Excuses:

"These residents will never be any different — they're institutionalized".

Challenge:

* Have you assessed the residents' strengths as well as weaknesses?
* Are you aware of their abilities as well as their limitations?
* Does each resident have a personalised care plan?
* Have they participated in their care plan?
* What choices can they make about their care and their daily life?
* Are they encouraged to make decisions about their life?
* Are there opportunities to participate in ordinary activities such as shopping, social outings, holidays?
* What recreational activities exist?
* Are the residents assisted to join in activities on/off the ward?
* How can more choices be offered?
* How can decision-making be encouraged?
* Do staff promote institutionalisation?
* How can staff promote individuality?
* How much do you know about the resident's background, employment history, likes and dislikes?

Excuse:

"This patient group doesn't want change"

Challenge:

* How do you feel about change,are you projecting your feelings onto residents?
* When change is taking place are the residents informed and consulted?
* Are they part of the decision-making process? If not, how can you involve them?
* Can you increase their involvement by assisting them to participate?
* Can you make others aware of the residents' right to be consulted?
* How often do you consult the residents?
* What communication network exists for residents to express their views?
* What happens to these views after they are expressed?
* Do you encourage the residents to express their views on change?
* How much information do residents receive and is information witheld? It is a false assumption that residents don't want to change - they need information and assistance to express their views and have a right to be consulted.

CHAPTER 4

Other Considerations on Quality

Good Ward Atmosphere

A "good ward atmosphere" emerges time and again in the relevant literature as being crucial in influencing the relationships between staff and residents, and in being an important determinant of quality of care. The working party had all had personal experiences where ward atmosphere was not good ; residents looked apathetic, bored, didn't communicate much, and generally looked unhappy. Staff equally felt like that when working on those wards. In wards described as having a "good" ward atmosphere, residents behaved very differently, even if similar in terms of age and disability. There was more communication, interest and activity. The staff on these wards tended to work more as a team, despite staffing shortages, and poor facilities.

Below is the list of factors which the working party felt were important in creating a good ward atmosphere. The point was strongly made that a good ward atmosphere doesn't just "happen", but has to be actively worked at.

1. A Statement of Philosophy of Care

A philosophy of care needs to be developed which directs the way care is delivered. This should be a statement of shared beliefs and aims held by all staff— not just those in senior positions. Commitment to high standards starts at this basic level and the statement remains as a point for negotiation/bargaining/re-evaluation when and if conflict arises about working practices. All staff need to be involved in making this statement, otherwise junior staff may feel they are delivering care "to order", and not feel full members of a team.

When a group of individuals come together to make a statement of this kind there should be an agreement that the philosophy represents a common aim or "mission". The mission statement can be used as a basis for future service developments. It should be seen as a *working* principle;that is, the statement should be phrased in a way which makes it clear what the service is about and which all staff can understand. Junior staff should have their views and beliefs recognised and incorporated into the statement. The statement can also be used to abolish the "two shift system" whereby the style and quality of the service changes as one nursing shift goes off duty and the other commences. Inevitably there are individual differences in the way that care is delivered but a stated philosophy, or mission statement, shared by all means that the overall ward culture is preserved, ensuring consistency in all aspects of care. It is essential that the mission statement is about *residents* and the way the service enhances their lives, and not simply about *how* the service is delivered.

2. Setting Objectives

Once the philosophy of care is established, ward objectives can be set. There are two types of objective that need to be considered; firstly, those concerning the residents, (these

objectives will be established through the quality action group discussed in chapter 2). Secondly, objectives need to be set concerning the staff group. For example, a charge nurse may set personal objectives for his/her own performance. This could be to appraise junior staff yearly and assist them to form their own personal development plan for the next year. Equally, it may also be to initiate weekly communication meetings for ward staff. Staff should be involved in drawing up those objectives which affect the working life of the ward.

It would seem good practice to appraise all staff regularly, setting personal objectives for their performance. Any such personal objectives should be clearly measurable with clearly defined ways of meeting the defined targets. Ongoing interest and evaluation by the charge nurse is essential otherwise there is no measure of whether improvements are happening.

3. Communication and Teamwork

Working in a team and feeling a sense of belonging is an important part of nurses' satisfaction with their work. Team building should be given priority as an activity which needs resourcing and training.

The essential component of teamwork is not just "talking to each other" but a belief in the importance of listening to others. If the nurse in charge is perceived as a listener he or she is also perceived as approachable; that is, someone interested in new ideas and open to suggestions, as well as a problem solver. This personal quality needs to be perceived by both staff and residents. There should be a climate where possessiveness is discouraged, residents should not be seen as "my patient" or "my group". Nurses who are possessive about their work may find it difficult to encourage people from outside the ward to become involved in care. However, where staff are working as a team with other disciplines and are clear about their roles it is likely that they will acknowledge and invite others to be involved in the care of residents.

Where there are good staff-resident relationships and good *in*formal communication there is a tendency to feel that *formal* communication meetings are not necessary. However, regular formalised meetings need to be held where issues and problems are raised for proper discussion. The informal style of communication can break down precisely because it can become too casual an approach. Certain topics of discussion will require all members of the team to be part of the decision-making, including residents on the ward. Absent parties may have difficulty accepting decisions in which they have not been involved and this could lead to discontinuity of care. Flexibility of agendas for meetings is important and everyone should be able to table items for discussion. The communication in multi-disciplinary meetings should be an opportunity to re-evaluate the care being provided and reaffirm the ward's objectives.

Communication of information to residents— and communication between residents— are equally important issues to consider. Resident's meetings should be held where information is passed both ways between staff and residents. Often residents get third-hand, last-minute information about major changes in their lives. A switch to greater consultation enables residents to be more involved in the running of the ward and this in turn may lead to them being seen as more valued people by staff and others with whom they come into contact.

Excuse:

"We've got 8 baths to do this morning- how can we organise social activities for the residents"?

Challenge:

* Is bath-time only a task? IT SHOULDN'T BE!

* Is bath—time a learning experience for the resident?

* Are they getting feedback about their hygiene and presentation to others?

* Is the residents' ability being assessed in order to determine the level of nursing intervention?

* Do residents have a daily bath because you bathe daily, or is it part of a planned programme of care?

* Have they asked for a bath, do they need one, or have you decided to bath them because Tuesday morning is bath-time?

If you're assisting residents to bathe as part of a care plan then you will be communicating with them— bath-time is a social activity

SO— do they really need or want to bathe? If the answer is NO what can be offered instead?

It would seem to us that if

nurses are	**residents**
skilful	feel safe
discreet	have dignity
communicative	feel trusted
genuine	feel trust
warm	feel warmth
a team	feel secure
respectful	feel respected
respected	feel respectful
informative	feel informed
consultative	feel powerful
ordinary people	are ordinary people
understanding	feel understood
teachers	can learn
listeners	feel like talking
share decision-making	have control
risk-takers	have freedom
not possessive	have self-esteem
approachable	less isolated
democratic	can have autonomy
confident	feel safe

4. Leadership

In order to develop a good ward atmosphere the person in charge of the ward has to institute a democratic but responsible style of leadership. They should demonstrate their confidence in staff by sharing responsibilities and decision making. Leaders who are not confident in their own abilities can hold onto their job description, insisting "they are the boss" and adopt an aggressive, directive style.If charge nurses are to do their job well, they will need the support of their seniors- it is unlikely that charge nurses will support their team if they themselves are unsupported when mistakes are made. Honesty is an essential quality in a good leader, "everyone makes mistakes" is a statement that needs to be believed at all levels of the service. Admitting that charge nurses do not have all the answers and are sometimes themselves unsure or inexperienced in certain situations may be seen as a positive statement by the rest of the team. Junior staff however, may sometimes feel they want the charge nurse to know everything so they themselves can feel "safe". If this is the case, then the situation should be talked about openly. Sharing problems and difficulties honestly can help junior staff feel less in awe, more competent and possibly become more capable. It is up to the charge nurse to create a climate where others can say "I am not sure, can you help"?

5. Risk Taking

Leadership involves charge nurses taking risks in allowing their staff to take the initiative. Risk taking applies to residents also. Residents who have spent many years in hospital may have become disabled and dependent through the very care they have received. We all know of staff who, for the best of reasons, treat the residents as if wrapped in cotton wool. Supporting residents in taking risks is part of a clearly stated philosophy of care that has been communicated to all who work in the service- and some who don't, such as relatives. It involves staff helping residents to develop their own ability to make decisions. The results may mean that staff receive criticism or that others do not understand the staffs' new role. For example, if staff say that residents can choose when they take a bath and one resident bathed less often than their relatives wished, relatives may criticise the nurses for not caring. Senior staff equally may walk on the ward and criticise the resident looking dishevelled. Nurses themselves may find it difficult to withdraw and be less active, in order to facilitate the residents becoming more active.

Risk taking then, affects everyone, but the charge nurse is the crucial person to influence and support the process within the ward, at management levels, and with relatives. It is their job to negotiate managerial support of the ward and assist relatives to understand the philosophy.

What makes for a good ward atmosphere is difficult to define, we have indicated some factors that seem, in practice, to be important. Achieving a good ward atmosphere is often the start of a quality action process, fostering an environment where staff can look critically at their working practices and use the mission statement and ward objectives to improve the service.

Implications for Managers- Support For Staff

We have not specifically referred to issues of staff support in assessing quality, but predict that involving staff in this process will, for some, raise problems for which they will need support.

The staff of a mental health service are its most valuable resource. There may be a general supposition that because the Health Service is in the business of caring, there is a natural extension whereby staff are themselves cared for and supported. Regrettably this is not always the case and action needs to be taken to ensure that staff are valued and supported in the work they do.

Support systems are generally considered to exist within line management or through relationships with colleagues. These networks are vague and it is not sufficient to suggest simply that a member of staff experiencing problems should approach a colleague or supervisor for advice and assistance. The individual might not feel comfortable and it may not be appropriate to approach another individual who works for the organisation (especially if a line manager) to discuss either work-related or personal problems which may be affecting a person's work performance.

Most people will build their own personal support networks, however, it is important that other ways are considered in which staff might receive additional support. The following are some suggestions:-

* daily informal meetings of team members.
* weekly (more formal) meetings chaired by the charge nurse.
* confidential counselling services (by senior staff or professional organisations).
* access to chaplaincy services.
* access to self-referral occupational health services.
* availability of a "quandary" procedure guiding staff when experiencing problems.
* development of staff support groups.

A service which looks to improve the quality of care offered to residents will not succeed in this task unless it also looks at the quality of staff support mechanisms. In seeking to offer individualised care to residents, staff most feel that they are also seen as individuals and that reasonable account will be taken of their needs, interests and personal circumstances.

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APPENDIX I

A Case Study in Assessing Quality by Claire McKeen, St Nicholas Hospital, Newcastle Health Authority

Introduction

In October 1986 I was invited to join the King's Fund working group to look at standards of care in long-stay psychiatric wards. The first few meetings were enlightening and also very confusing — words like 'standards' and 'quality' were debated and definitions sought. It was our belief that 'quality' did exist in long-stay wards, but that there was a need for continuous assessment and evaluation in order for care to remain responsive and appropriate to the residents' needs. The great difficulty we perceived was in the area of quality measurement, but that did not deter us from attempting to find ways of bringing about and measuring change.

At the time of joining the group I was sister of Appleby ward, a long stay ward for elderly female residents in the Continuing Care sector of St Nicholas Hospital. The ward staffing establishment was 2 charge nurse/sisters, 3 enrolled nurses and 7 nursing assistants, it was not a training ward for learners. I realised that the assessment of quality was part of my job as sister, but was unsure about how to start and who to involve. In going on to explain the ways in which I went about looking at quality, I hope to be helpful to others who are keen to examine the care they deliver, but am not suggesting that this is the only way— this is how we did it!

There were some changes that seemed necessary before implementing any assessment of quality of care on the ward, these included:

* being involved in all future appointments of staff to the ward; the senior nurse for the Continuing Care sector supported this idea, (and gave much professional and personal support throughout the assessment period);

* involving the clinical nurse specialist for the Continuing Care sector, she was responsible for teaching/training input during the assessment process;

* commencing weekly formal meetings on nursing care— all ward nursing staff as well as senior nurses attended and took responsibility for leading discussions/introducing topics. On-going informal communication also took place with individual staff to discuss the ideas of looking at 'quality',

* advising the general manager for the Continuing Care sector of our plans to explore quality on the ward. He provided support for many developments, including authorising a 'day-out' of the ward to look at producing a statement about our philosophy of care. It was decided to embark upon this particular task as a project from which other wards in the hospital could learn.

Appleby ward has a Befriending Scheme where members of the local community befriend some of the residents, these befrienders were part of the project discussions. Few residents have family who visit or keep in touch, but those relatives who visited the ward were kept informed of changes/developments which took place, and were consulted for feedback where practicable. The ward consultant and hospital practitioner were also informed of the project and gave their support.

All nursing personnel on Appleby were invited to a team-building day held off the ward and facilitated by the senior nurse for the area. The aim was to produce an operational policy for Appleby ward. This was an opportunity for us to spend time as a team in order to:

* get to know each other better as individuals;

* discuss our beliefs and values about the care we deliver in a friendly and open environment;

* most importantly, agree upon the philosophy and principles of care that would underpin the operational policy.

The ward group used the principles at the start of this Paper, not as a blanket prescription, but as a catalyst for the generation of our own principles. We came up with different implications and prompt questions personalised to our area of work and field of responsibility. The operational policy contained a statement of agreed values and beliefs as well as some agreed standards which the group negotiated with the help/facilitation of the senior nurse. This draft document was widely circulated; opinions were sought, communication encouraged and support elicited.

Results and Outcomes

1. Structural Changes

I became actively involved in the interview and appointment of new staff for Appleby and was able to appoint a staff nurse committed to the concept of 'quality of care' and to nurse training. I changed my pattern of working from shift work to 9- 5 Monday to Friday; this was in order to work with all of the staff and support them through the project and ensuing changes. This ensured consistency and continuity of communication and consultation with all staff.

The notion of 'quality' and 'evaluation of care' was introduced in the ward meetings and this stimulated the new staff nurse to produce a paper for discussion ('Appleby- A Plan for Action') which was distributed to the ward team. Responses to this paper were widely debated and used by the team as a further basis for change.

2. Identifying work targets

Specific targets that arose out of the "day-out" included:

* Identification of education needs and planned input from specialist trainers to meet these needs. There continues to be an ongoing evaluation of training needs.

* Selecting a model of nursing based on prior work done by team members (who had researched different models and held discussions about their suitability).

* Adopting a key worker system.

* A commitment to review the residents' average day and the staff's working day, with a view to improving both 'days'. This issue is explored continuously in the weekly communication meeting and many aspects of delivery of care have changed as a result. The average day is now more flexible for residents and more relaxing for the staff, as well as supportive of individualised care.

* Exploring individual staff needs through appraisal and feedback. Ward sister and charge nurse attended a course on Individual Performance Review which looked at a positive approach to staff appraisal.

3 . Quality Action Group

From a short paper produced after the team day - out we have identified a group of people who will continue to look at standards of care for the residents. This group will meet monthly and their aim is to assess, evaluate and advise on quality of care. Clearly defined standards will be generated in conjunction with the clinical team and will be "owned" by all the team as desirable standards to achieve.

The members of the group:

Ward sister and charge nurse

Senior nurse (Continuing Care)

1 volunteer from the Befriending Scheme

Mrs X- a resident's daughter

This is an exciting and challenging prospect and we are hopeful of working together to evaluate and improve the care we deliver.

4. Training Status

The ward attained training status in summer 1987 and is the only Continuing Care ward in St. Nicholas Hospital to be included in the training circuit. Sixth formers from local schools and colleges have also spent time with us with the aim of being introduced to careers in mental health.

5. Other Changes

The team considered every aspect of their work and beliefs about their work - their thoughts and comments were translated into a paper entitled 'A Good Ward Atmosphere'; the paper also contained comments which had already been heard, or we expected to hear when introducing newcomers to the idea of changing patterns of care - these comments were used as 'excuse' statements and we proceeded to challenge them.

A new charge nurse was appointed to the ward upon the retirement of the previous post-holder. We discussed our roles in relation to each other and assumed different areas of responsibility, dividing certain areas between us such as supervision of the key worker system; staff appraisal; co-ordination of meetings; responsibility for staffing requirements, number on duty etc. There is little duplication of roles and more consistency than with the previous system where we would work opposite shifts doing the same job.

Conclusion

No-one can ignore, or be ignored, when 'quality of care' is the issue for debate. A top-down approach is inadequate and can be seen as insulting, even punitive, for example, if a Health Authority were to generate a set of standards for all the wards in their area without consulting staff or others. I realise now that many people need to be involved in the discussion— all ward staff, managers of the service, friends, relatives, ancillary workers, education staff and, most importantly, residents if successful changes are to take place.

People's feelings must be considered. Looking at 'quality' involved many different emotions. At times we felt disillusionment and sadness when we identified our shortcomings or inability to change certain areas, tempered with pride and satisfaction at realising our strengths and gains. Some of us were unsure about risk-taking or exploring our actions and presented negative (blocking) arguments as a defence, although stopped when we realised that this anxiety was usually shared. Often the institutional climate dictates that individual staff should not disclose their weaknesses for fear that this information be used 'against' them in some way- however we each received managerial support for the honesty of our statements and praise for our achievements to date.

The residents' feelings are primary- change for change's sake is always negative and we realised that residents in long-stay wards are often anxious about change and feel vulnerable - an understandable feeling given their past experiences.

Throughout the process of change, residents and their families must be supported by information— consulting and counselling where necessary. The greater their particiaption the more successful change will be. Ask how they feel! It's probably a more accurate measurement than most tools- the crucial element is the strength of the resident/staff relationship in assisting the resident to state opinions and express views in a supported setting. I think in Appleby we have achieved real dialogue based on mutual trust.

Discussing quality has no mystique to it now— nor should it have. Many models exist and can be helpful and the ideas must be accessible to everyone. 'Quality' is my responsibility as a nurse not just as a ward sister. I have a duty to promote high standards of care, and to support my colleagues in doing the same.

Claire McKeen
Appleby Ward
St Nicholas Hospital
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Appendix 2

Quality- Past and Present

One of the major statements of this Discussion Document is that people who have experience of being resident in hospital can- and should- contribute to the discussion on standards of care in hospitals. In this section we will look at previous work in this area, focussing particularly on the results of surveys concerned with patient satisfaction. It is interesting to note that these studies have mostly been carried out in a general hospital setting, psychiatric hospitals are rarely represented.

The studies date from the 196O's, when some 2OO surveys were carried out. Typically the subjects in these studies were short-stay patients from medical or surgical wards, followed up after discharge by questionnaire and/or interview. Certain categories of patient were excluded from most surveys on the grounds of unsuitability for questioning, e.g. paediactic, geriatric, psychiatric and mentally-handicapped patients.

Surveys in General Hospitals

Recurrent Themes

Certain common themes recur in these surveys which appear to be important factors in determining quality of care; a number of these are summarised below. Their order is not significant as they are interrelated. They make some useful and stimulating points when thinking about quality.

1 **Hospital and Ward Atmosphere**
The people who work in a hospital generate an atmosphere unique to that institution. Each ward also has its own particular atmosphere or climate. This is a product of the staff's characteristics, their personalities, attitudes, relationships, communication network, morale and stability. There is also a relationship between the ward atmosphere and patient satisfaction (as, incidentally, there is between the atmosphere and a student nurse's progress). This important theme is discussed in chapter 4.

2 **Informal Channels of Communication**
There is a ward "underlife" of which the staff know very little. It uses informal communication channels along which patient passes information to patient. Admission to hospital generates much anxiety and the first-time patient has much to learn. "Veteran" patients help and support a newcomer by teaching them the rules, telling them what to expect from meals through to surgery, and identifying the ward hierarchy. Thus patients are socialised by, and develop a degree of solidarity with, fellow-patients.

3 **Authority of Nurses**
Staff in a hospital carry about with them the insignia of their place in the hierarchy, this is a constant reminder to patients of <u>their</u> place in the hierarchy. Such insignia include uniform, a badge of office, a bunch of keys, or other tools of the trade. In some settings personal clothing and ornaments are worn by staff; this, by its very

individuality, is a conspicuous status symbol for those with few personal possessions. Nurses are also invested with power by controlling access to doctors, providing or with-holding information, delaying or hastening events.

4 **The Popular Patient**
Some patients receive more attention from nurses than do others. Patients are in competition with each other for a relatively scarce resource, causing resentment in some and despair in others. The popular patient is able to initiate interaction with nurses and to act as intermediary for another who is unable to gain access.

5 **Patient-Nurse Interaction**
Nurses and patients in hospital have been found to use physical care needs to initiate and maintain interaction with each other. Communication for its own sake was found to be lacking.

6 **People, not Conditions**
Former patients tend to recall the people they met rather than the physical conditions of life in hospital. They value highly the support given by fellow patients and the kindness and skill of nurses. Criticism of hospitals is directed as much against people as against the facilities provided.

7 **Companionship and Privacy**
Hospital patients value the companionship of other patients as a buffer against loneliness and anxiety. Yet equally there is a need to be able to withdraw from the noise, ceaseless activity and presence of others. A further significant finding is the continuing boredom for patients in the midst of perpetual ward "busyness".

8 **Insulation of Hospital Life**
Patients in hospital have to live there, whereas the staff only work there. The residents are insulated from the world outside. The hospital routine and moods take the place of weather and time. Immediately they enter hospital, new patients take on a role that puts aside all the roles they may have outside, roles in which the staff may then have great difficulty in visualising for individuals.

9 **Whose Standard of Care?**
People enter hospital primarily to seek relief of their symptoms and this colours their evaluation of the hospital experience, making it difficult to draw uniform conclusions from the surveys. Also, one person's standard of care is not another's. Patients who have spent many years in hospital may no longer be able to compare their situation with that of people living outside hospital. Different and imaginative forms of evaluation are needed, if patients are to really assess their hospital experiences, and not just respond in the way they think staff or the interviewer wants them too.

Surveys in Psychiatric Hospitals

Very few surveys have been undertaken that look at residents opinions of psychiatric hospitals. "Psychiatric Hospitals Viewed by Their Patients". [4], published in 1972, is the landmark in this field and challenged the usual assumption that hospital residents diagnosed as being mentally ill are too disabled to take part in opinion surveys. Raphael developed a simple questionnaire, to be administered by hospital staff, which posed questions on nineteen topics identified as being of interest to residents in hospital. The topics related to ward environment, physical care, treatment from staff and life in the hospital. She analysed

responses of 2,148 short-and long-stay residents from nine psychiatric hospitals in Britain. Only 2% of replies were considered "irrational".

The Responses

As one would expect, the residents' views varied from hospital to hospital and from ward to ward within a hospital.

1 **Physical Care and the Ward Environment**
Residents were generally satisfied with the dormitories and day rooms in which they spent much of their time yet, paradoxically, complained particularly of the noise that came from the radio, television and communal living. Related to this was a lack of privacy. There was nowhere to withdraw from the mixed group of residents (and staff) with whom they had to live.

2 **Care and Treatment from Staff**
As in most surveys of hospital residents, the nurses received much praise, though some patients reacted to what they perceived as excessive discipline and regimentation. Raphael commented that "most psychiatric patients had a great dependence on their doctor"; they were very concerned with how often, or how seldom, they were able to see the doctor and complained that doctors withheld information from them. Raphael found "an immense variety of views expressed about freedom and control".

3 **Life in the Hospital**
People who had been resident for a long time were especially concerned about the lack of social activity- hospital boredom was one of their major complaints. There were never enough facilities to exercise the hands or minds of the residents. Evenings and Sundays were dullest of all. "Some people felt that boredom arose of excessive care by the staff rather than by lack of recreation".

Raphael's work was the first major contribution from psychiatric hospital residents to a survey on life in hospital. Her aim was to develop a means for psychiatric hospital staff to evaluate the conditions in which the residents lived. She consistently notes that short-stay patients were far more critical of care and conditions than those deemed long-stay. This finding may be due to the vulnerability of long-stay residents and possible fear of reprisal if they were known to have been critical. Equally, it may have been that a long stay in hospital dulls people's critical perceptions of their environment and the residents in the survey no longer had an outside point of comparison with hospital life. Raphael's concluding observation was that "the contentment of patients in psychiatric hospitals depends far more on kindness, skill and organising ability than on the physical factors that are often considered first when trying to ameliorate conditions".

This study, and others carried out since, highlight the need for staff to consider of quality of care. It is hoped that these ideas might give some indications of how a high quality service might be achieved.

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