Practice changing practice

**KEYWORDS** HIGH DEPENDENCY: WARD ENVIRONMENT | PATIENT EXPERIENCE

**Using NHS resources effectively to improve the ward environment for patients and staff**

How a ward nursing team improved facilities for patients, visitors and staff by using existing resources more effectively and considering others’ viewpoints

**INTRODUCTION**

In January 2008, a new high dependency unit (HDU) opened at St James’ University Hospital in Leeds.

An HDU provides care that cannot be delivered on a general ward, called level 2 care. Level 2 patients are defined as “patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those ‘stepping down’ from higher levels of care” (Department of Health, 2000a).

The move from the old surgical HDU saw a doubling of capacity and enabled us to extend admission criteria to non surgical patients. While the unit had been designed with the latest developments in healthcare in mind, in particular infection control procedures, there were the inevitable teething troubles when it first opened. Over time, these immediate issues were resolved. However, from working on the unit and conversations with patients and relatives, we were aware that some environmental issues remained. This article outlines the process of identifying and assessing the scope of the issues and formulating an improvement plan. It concludes by sharing the lessons the team learnt, particularly in terms of making better use of existing resources and putting patient experience at the centre of the process.

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**BACKGROUND**

The scope of the issues was clarified in four ways, with the aims of gathering as many perspectives as possible and establishing a clear evidence base. We conducted a small non validated questionnaire, used information we had gathered through the trust privacy and dignity audit, conducted a walk round, and looked at the literature.

**Ward questionnaire**

The questionnaire was designed to formalise the anecdotal evidence we were already aware of regarding the ward environment. It was aimed at patients, visitors and staff, and was given out over two days. Some patients were unable to participate because of their condition. We also gave out copies to inpatients on other wards who had been with us previously.

The questionnaire covered:
- First impressions;
- Navigating the ward;
- Experiences of the bedspaces;
- Experiences of day and night;
- Awareness of facilities;
- Receiving information;
- Spending extended periods on the ward;
- Experiences of the staffroom and office.

There were many things that people liked about the unit, for example the space and cleanliness. However, it was also evident they found it threatening, stark and unstimulating. The ward has little natural light and people commented on how disorientated they felt. Visitors struggled to find the ward and lacked information.

**Privacy and dignity audit**

The trust-wide privacy and dignity audit was introduced just as we were considering the environmental issues on the HDU and proved a useful source of information. In relation to this project, it revealed the following areas as points for improvement: meeting and greeting visitors; provision of information in the form of leaflets and noticeboards; storage of patient property; noise levels; availability of clocks; and clear signs.

**Practice Points**

- Through this project, we explicitly put the people who use our environment at the centre.
- The most valuable part of the project has been analysing the environment from patients’ and visitors’ perspectives, to gain an understanding of their viewpoints.
- The project also shows there is much we can do to make the best use of the existing space and resources, which is important given current economic constraints.

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**When the nursing team on the high dependency unit at St James’ Hospital, Leeds, moved to their new unit they discovered that aspects of the environment were not working to the best advantage of patients, visitors and staff. This article outlines the process of identifying and assessing the scope of the issues and formulating an improvement plan. It concludes by sharing the lessons the team learnt, particularly in terms of making better use of existing resources and putting patient experience at the centre of the process.**
Walk round
A walk round of the unit was carried out to try to gain an understanding of how the ward appeared to a person entering from outside the building or to someone sitting in and/or occupying a particular bedspace. The experience of standing in patients’ or visitors’ shoes was invaluable.

Some bedspaces were dark and with blank walls surrounding them (see the patient comment in Box 1); other bedspaces were noisy and confidential conversations at the nurses’ station were clearly audible to patients and visitors. The division of the unit by the link corridor and a lack of signs made access difficult. There was also a lack of information on what was allowed and what was expected of visitors and patients in such a specialist environment.

Literature
The literature showed that space, light, fresh air, cleanliness, a warm and friendly atmosphere, colour, privacy and noise levels were all concerns of visitors and patients (Rowlands and Noble, 2008; Kline et al, 2007; Douglas and Douglas, 2005).

Walk layout, design and appearance has been shown to have a significant impact on the recruitment, retention and performance of nurses in England (Commission for Architecture and the Built Environment, 2004). Daylight, a nice view, somewhere to go to relax away from the clinical area, and reducing clutter were all concerns of nurses. Nurses also said they viewed the appearance of a ward as indicative of its management style (CABE, 2004).

Limitations
The limitations of our assessment process related to completion of the questionnaire.

The staff response rate was low and, on investigation into the reason for this, it emerged there were concerns about the lack of anonymity. It was a surprise that staff raised this as a concern as it had been assumed they would feel able to air their views in an open and honest forum.

It was also not ideal that patients and relatives were given the questionnaire while the former were inpatients on the unit. Patients were often too ill to complete it without help from a member of staff. Patients and visitors may have felt they could not be honest in expressing their views under these circumstances.

An awareness of this limitation led to the decision to follow up patients on the wards to which they had been discharged.

Interestingly, the responses returned from this group did not differ greatly from those of current patients.

IMPROVEMENT PLAN
Improved signage
The first issue we decided to focus on was signage to help people access and navigate through the ward area. From our assessment, it was evident that visitors struggled to locate the ward in the first instance and often became lost between the main unit and the visitors’ facilities on the other side of the link corridor.

We ordered signs to indicate the ward entrance and to clearly mark facilities for visitors, for example toilets. We also ordered greeting signs to improve the atmosphere of the ward entrance so that visitors felt welcomed and valued. We met an estates manager to look at how we could make the route between the waiting area and the main unit more obvious for visitors.

In our questionnaire, patients and visitors had suggested coloured lines on the floor. However, hospitals are moving away from this way of marking routes so we needed to find an alternative. We decided to consider artwork to act as route markers.

Improved information
The next issue we decided to focus on was improved information and this was divided into two subgroups: information for patients and visitors; and information for staff.

Information for patients and visitors
Patients and visitors mainly received information verbally from staff or through noticeboards in the waiting area. While it is mandatory to display certain pieces of infection control information on these boards, it was not necessary for every board to be occupied with this information, as had been the case.

It was decided that one board should be allocated for infection control and the remaining one should be used for a rolling programme of information prepared by ward link nurses on relevant topics.

A suggestion sheet was pinned up in the waiting area where visitors could write down what they would like to see on the information boards.

A computerised interactive noticeboard was also planned for the waiting room to cut down on what needed to be displayed on the walls. As some visitors did not use the waiting room at all, it was decided to supplement this with two lockable display cases on the main unit.

In addition, from our assessment it was evident that visitors and patients were not being given basic ward information – such as that on visiting times – in a consistent manner. It was also evident that some information, such as how long surgery may take, was not getting through at all. As a
result, visitors were expecting to visit a patient at lunchtime who would be unlikely to leave recovery until the evening.

Two senior nurses were asked to develop a leaflet that could be given out on the pre-assessment unit and also be available to be given out on HDU. It was decided to repeat this information on two noticeboards, one at the waiting room entrance and one at the main unit entrance for those who may have missed the leaflet.

**Artwork**

From our assessment it was clear that artwork on the walls would make a dramatic difference to everyone on the unit. It was felt that some bright pictures would help diffuse the unstimulating, clinical nature of the ward while also improving the working atmosphere for staff.

Initially, we contacted local schools and colleges to involve children and young people as a positive and inexpensive way of producing artwork. We were fortunate to gain the input of the hospital arts development team (TONIC), who felt this would not be the appropriate place for non-professional artwork to be used and offered to draw up a proposal of work for us.

We also planned to install projectors in the side rooms so that long term patients could select their own pictures for the walls.

**Light boxes and clocks**

HDU has little natural daylight and several bedspaces were particularly dark and enclosed. We looked at research involving the use of light boxes as a way of helping to differentiate between day and night and intend to apply this to HDU.

The issue regarding the size of clocks on the unit had been a difficult one for us. In order for some patients to see a clock, other bedspaces had to display a very large clock that reinforced the length of the patient’s stay in that bedspace. Smaller bedside clocks posed other problems in terms of leads and visible displays. This issue was identified as another area in which TONIC could help.

**Good housekeeping**

While our assessment raised many physical alterations and improvements that needed to be made, it was also evident that we could improve the unit’s atmosphere by better use of the existing space.

It was noted that curtains should be pulled back, blinds fully opened, and lights put on. Patients and visitors appreciated some appropriate and subtle music or radio to distract them from clinical sounds, such as alarms and oxygen systems. While the ward was generally clean and tidy, it was noted that it was important to keep nurses’ easels and desks clear of clutter as well.

A photographic poster campaign was planned to improve awareness of how the bedspace can appear to a patient when housekeeping by staff is poor.

**EVALUATION**

We are hoping to evaluate the effectiveness of what we have put in place in April 2010, taking into account the limitations highlighted in our initial assessment process. We would like to start a formal follow up clinic of patients once they have returned home and use this to gather patient and visitor views. We are also exploring options for conducting research into the use of light boxes on the unit.

We intend to rerun the questionnaire and the privacy and dignity audit. We intend to conduct a second walk round and will also consider any new literature that may have been added to the evidence base.

Much of the assessment work that has been carried out for this project would integrate well into the annual Patient Environment Action Team (PEAT) audit in line with *Standards for Better Health* (DH, 2004). This would enable local information gathered by those in this environment on a daily basis to be fed into and used by the wider trust. A good example of this is the recent PEAT audit of the Royal Marsden Hospital in which similar work by staff highlighted signage as an area for improvement within the organisation (National Reporting and Learning Service, 2009).

**REFERENCES**


**BACKGROUND**

- This project fits in with the priorities laid out in *Improving Working Lives* (DH, 2000b), *The NHS Plan* (DH, 2000c) and *Standards for Better Health* (DH, 2004).
- It also complements the emphasis on patient dignity, and the new DH guidance on using patient feedback to improve care (Hairon, 2009).

**VALUABLE LESSONS**

While this is a project that is still very much at the implementation stage, we feel we have already learnt lessons that are worth disseminating to the wider nursing community.

The most valuable part of this project has been the process of standing in patients’ and visitors’ shoes to gain insight and understanding of their viewpoints.

It has been good to hear that most patients and visitors are deeply appreciative of and happy with the care they receive on the HDU. Discussion with patients who have been confused or frightened on our unit has been humbling, and sitting in a vacant bedspace, watching what they see, has been eye opening.

While it is clear there is much we hope to achieve in terms of physical changes to the ward environment, this process has revealed that there are many things we can do to improve the space we already have by using it more effectively and by considering others’ viewpoints.

These are useful lessons to learn in the current economic climate, which makes us even more aware of how we should use health service resources.