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Assessing communication on a mental health unit

The Essence of Care benchmarking toolkit provides a systematic framework for assessing practice and identifying improvements in different aspects of healthcare provision (Department of Health, 2001). It is central to the delivery of effective, relevant and person-centred care in all health and social care settings.

The Essence of Care benchmark for improving communication consists of 11 factors addressing how information is processed within and between teams, service users, carers and external agencies (DH, 2010). Good communication is universally regarded as being central to health and social care, while ineffective communication is often identified as the cause of negative treatment (The Patients Association, 2009) and is one of the most frequent subjects of complaints in the NHS (Parliamentary and Health Service Ombudsman, 2011).

Adopting the Essence of Care toolkit to benchmark communication presents opportunities for practice to be assessed, improved and audited by individual teams to suit the specific needs of those using their service. The toolkit also enables teams to focus on the quality of therapeutic interactions, as well as the wider communication networks within and between respective care settings.

Using a team approach

Westbury Ward is a 15-bed, adult, open acute unit that admits individuals from the Bristol area who have severe and enduring mental health problems. As with any ward environment, good communication is vital, and research into nurse–patient relationships suggests that service users value high-quality interactions with staff as much, or more than, other forms of clinical intervention (Redfern and Norman, 1999). We chose to use the communication benchmark to create a framework for information handling and to develop resources for enhancing staff and service-user interactions.

The initial benchmarking process was carried out at ward meetings with staff...
members, service users, carers, external professionals and service-user representatives present. When agreement on scoring individual factors could not be reached, questionnaires were developed and given to participants in order to access a wider spectrum of opinion. Each factor was adapted into an open question with several points for consideration, so individuals could answer in a style and format of their choosing. Initial benchmarking feedback scored “B” for all 11 factors, so we used data from the questionnaires to reappraise scoring (Table 1).

The points on direct communication with service users were highlighted as needing improvement, yet it was clear from an early stage that these problems were primarily linked with communication breakdowns within the staff team. Service users, for example, reported sometimes feeling unsure when they would be able to see their consultant psychiatrist, or at what time their ward review would be. Some were unhappy about the time taken to access basic information about their care, and reported that they did not always know who their named nurse was.

Visiting professionals had concerns about the way information was being inconsistently handed over and circulated among the staff, and some reported instances of arriving on the ward for a meeting that had either been cancelled or rescheduled without some attendees being informed. One carer expressed the importance of the “little things” and recalled a staff member inviting her to make a hot drink but not telling her where the refreshment area was.

The challenge facing the team involved a thorough review of internal communication procedures so the staff team became the primary focus. We agreed that improving individual elements of communication would lead to superficial and short-term change, and that there was a need to integrate sustainable changes into the team’s core functioning through an action plan in order to achieve long-term improvement (Box 1).

After reviewing the benchmarking results, we developed an action plan that focused on three main areas:

- Receiving and handling information;
- Establishing a baseline standard of practice;
- Enhancing skills in interactions with service users.

Receiving and handling information
Taking account of evidence on the Essence of Care ethos, we ensured that our benchmarking team members were selected from all levels of the nursing hierarchy; this ensured that we achieved an integrated approach. Seeking, respecting and assimilating service-user feedback was, in itself, a positive clinical intervention. Personal recovery folders, for example, were given to service users on admission; these contained brief and clearly worded questionnaires on how individuals expect to be spoken to, what they seek in their therapeutic interactions with staff, and how they would like to receive information about their care. This not only fulfilled the needs of the benchmarking process but created a source of direct and constant feedback from service users. Ward community meetings, led by a service-user representative who was also an active member of the benchmarking group, also proved to be useful tools for gathering personal perspectives.

We added evaluation sheets to the recovery folders, which service users could use to comment on the effectiveness of communication on the ward. The completed documents could then be reviewed by the Essence of Care team on a regular basis and uploaded to service users’ care records to keep track of personal experience and preference. This approach allows feedback to be continuously available and useable, despite inevitable staff turnover and changing ward cultures and dynamics (Fig 1).

In order for our work to be person centred, we aimed to localise care delivery. This helped the ward to reflect the priorities of the trust, yet was uniquely orientated to the specific needs and preferences of its service users.

<table>
<thead>
<tr>
<th>TABLE 1. REAPPRAISED BENCHMARKING SCORES</th>
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<td>Factor</td>
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<tr>
<td>Interpersonal skills</td>
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<td>Opportunity for communication</td>
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<td>Assessment of communication needs</td>
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<td>Information sharing</td>
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<td>Resources to aid communication and understanding</td>
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<td>Identification and assessment of principal carer</td>
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<td>Empowerment to perform role</td>
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<td>Coordination of care</td>
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<td>Empowerment to communicate needs</td>
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<tr>
<td>Valuing people’s and carers’ expertise and contributions</td>
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<td>People’s and/or carers’ education needs</td>
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BMS = benchmark meeting score; SUQ1 = service-user questionnaire (before improvement process); SUQ2 = service-user questionnaire (after improvement process); I/S/U = improvement, remained static, unexpected outcome

**BOX 1. COMMUNICATION BENCHMARK ACTION PLAN**

- Ensure on-ward signage is adequate
- Devise core admission care-plan templates
- Store care plans in a quick-reference folder
- Colour code office folders and drawers
- Publish timetables for service-user and carer meetings, and ward rounds
- Appoint staff members to coordinate and timetable activity groups
- Assemble a task team to develop staff induction and training material around interpersonal and interprofessional engagement
- Approach local culture-specific care organisations for multilingual resources
- Organise topic-specific noticeboards, for example: “orientation to ward and hospital site”, “healthy living”, “psychoeducation”, “community support groups”, “carers’ information” and “therapeutic activities”
- Display information around key policies, protected time standards and praise and complaints procedures

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Innovation

**Establishing a baseline standard of practice**

To prevent the improvements being seen as temporary or insubstantial, the team developed an in-house booklet that could be used either as an induction pack for students and new recruits or as a general manifesto of ward operation and good practice. Central to this was the establishment of efficient practice as “baseline acceptable” practice – the aim being to minimise the risk of new team members picking up bad habits and routines.

The booklet, *Working on Westbury Ward: Information for Students and New Staff Members*, was designed to supplement the trust’s induction material, which applies to all inpatient settings. Having a localised induction tool helped the team to highlight what was specific to the ward and its demographic, in addition to its style of service provision. The booklet continues to be updated, taking into account service-user questionnaires alongside other amendments necessitated by changing policy, evolving attitudes and the introduction of new recording and reporting systems.

**Enhancing skills in interactions**

Enhancing skills when interacting with service users was also addressed by developing in-house documentation and was principally based on service-user feedback. While opportunities for one-to-one interaction are a mandatory component of inpatient mental health care, our focus was on the quality of these interactions as well as their frequency.

The team was already using a valuable resource on clinical interaction by Janner and Page (2009), but we had no consistent means of monitoring what our own service users expected from one-to-one engagement with staff. Our aim was to:

- Integrate service users’ needs and expectations into the ward’s approach to engagement;
- Offer a developmental tool for staff needing to improve or demonstrate their communication skills; and
- Create a forum through which service users could feed back directly and immediately inform clinical practice.

The resource we developed, *A Westbury Ward Guide to Talking and Listening*, covered the following areas:

- An explanation of “one-to-one” and how and when to offer it;
- Appropriate language and terminology to use during interactions, including a glossary of clinical terms with evidence-based points for ethical consideration (Hamilton and Manias, 2006);
- Feedback from the one-to-one service-user questionnaires (Table 2);
- Assessing individuals’ mental state during one-to-one sessions, supported by a seminal study on staff members’ vulnerability to making poor mental-state assessments based on environmental contexts (Rosenhan, 1973);
- Advice on professional boundaries and handling disclosure;
- *Westbury Words*, a service-user representative’s account of being an inpatient on Westbury Ward. This describes how tone of voice, mode of address and body language are central to making an interaction meaningful, and gives a personal perspective on the link between therapeutic engagement and managing the frustration service users can experience.

The questionnaires are continually being completed and collected, so the Essence of Care team can update the booklet every 4-6 months; service users are also invited to review it and suggest improvements.

With information-gathering systems in place, new Essence of Care workers inherit the ongoing benefits of this activity without having to start again from the beginning. All our work on Essence of Care is shared with other mental health wards across the trust and is discussed in a local acute care forum. As our work on Essence of Care is part of a trust-wide strategy in which communication is a priority benchmark, we have disseminated practice developments to other teams by presenting them at trust-wide workshops.

**Outcomes and evaluation**

Assessing the direct impact of the benchmarking process was challenging due to the high turnover of staff and service users. We adopted five qualitative approaches to monitor improvement:

- Service-user feedback forms;
- Ward-community meetings;
- Staff meetings;
- A carers’ drop-in session;
- Student supervision groups.

Information gathered from the service-user feedback forms was used to rescure each of the n factors, enabling us to evaluate improvement or unexpected outcomes (Table 1).

General feedback, both via the feedback form and in ward-community meetings, suggested therapeutic interaction had improved and service users felt staff listened to them; however, it was made clear that this applied to “most”, but not all, staff. Visitors to the ward acknowledged the improved signage and availability of carer information. Introducing a clinicbooking system specifically for carers to discuss their needs and experiences was also welcomed.

Since we started benchmarking for communication, the team has adopted a culture of reflective practice, wherein our methods for receiving, processing and conveying information are an agenda item at each team meeting and other members of the multidisciplinary team are invited to staff handovers. In student supervision groups, pre-registration nurses reported finding both booklets invaluable. First-year students, with no previous experience of mental health care, reported that the one-to-one booklet compensated for a perceived deficit in their theoretical training; student groups continue to value it as both a localised tool and a skills-development resource.

**Conclusion**

Essence of Care offers an opportunity to review practice and improve care for individuals. We have demonstrated that service-user involvement in benchmarking, scoring and action planning ensures improvements are patient focused and relevant, and that listening to the individual perspectives of changing service-user groups means improvements continue beyond the benchmarking process.

The two staff development documents described are both relevant to health professionals in mental health and other fields. Communication presents similar...
Thanks to Dr Anthony Harrison, Lou Winstone, Allison Teagle, Sam Coutu-Oughton and Roxanne Jacobs for their input, and to all of the service users and carers who contributed to this Essence of Care project.

References


challenges to acute physical-care settings; the one-to-one booklet in particular could be transferred to any environment in which staff–patient and carer interactions occur.

Ensuring these improvements were consistently integrated into everyday practice was our main challenge. Addressing staff in terms of their own clinical strengths and interests, ensuring input came from service users, and openly exploring the rationale for altering practice helped the improvement process to benefit staff as well as service users and carers. Throughout our work we emphasised that Essence of Care centralises the core nursing principles that some staff members felt were being increasingly undervalued in their day-to-day work. This was helpful in reassuring staff members who were concerned the project would be purely a “paperwork” exercise. The reward for early planning and information gathering has been a model of inpatient communication that allows individual perspectives to influence a wide spectrum of care. NT