Benchmarking patient privacy to improve essence of care

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Concerned about the privacy offered to patients at a large teaching hospital in the west Midlands, staff established a multidisciplinary group to benchmark privacy and dignity. They have ensured a high standard of care for patients through the benchmarking process. This article details the steps taken by the group and illustrates how *Essence of Care* has successfully provided a framework to support quality improvements.

With the document *Making a Difference* the Department of Health committed itself to improving the quality of care provided to patients through clinical benchmarking (DoH, 1999). Following this, and through consultation with both practitioners and patients, *Essence of Care* (Modernisation Agency, 2003) was designed to provide practitioners with a practical tool kit to explore the quality of nine essential aspects of care.

The process of benchmarking and the benchmarks themselves constitute a formal system for the identification, comparison and sharing of best practice. Once the correct and up-to-date practice has been identified, staff use the benchmarks within *Essence of Care* as a gauge or standard against which to measure themselves. Plans can then be made to improve care.

Privacy and dignity

Back (1998) states that privacy is a basic human right but suggests a patient's privacy may be jeopardised during a hospital stay as caring situations are often intimate. Oxtoby (2003) agrees that the preservation of a patient's privacy and dignity is essential to nursing but that it is more than simply closing curtains around a patient's bed – it also involves respecting the patient's values and beliefs.

The definition of dignity proves more difficult to clarify. Caygill (1990) believes it is 'a socially recognised sense of worth'. When trying to understand the concept of dignity, Haddock (1996) suggests it involves feeling and being treated as a human being in a non-judgemental environment. Leino-Kilpi et al (2002) go on to consider physical and social aspects of privacy in hospitals including physical touch, the need to undress and patients' lack of control over their environment.

Staff in one division of a large acute teaching hospital in the west Midlands felt strongly about the privacy and dignity afforded to patients and so decided to benchmark privacy and dignity using the *Essence of Care* document (Modernisation Agency, 2003). The division incorporates nuclear medicine, imaging, a breast unit, and all oncology and haematology wards and outpatient departments. As ensuring privacy and dignity to patients is essential in all sections of the hospital where patients are seen, no matter how briefly, all clinical areas and departments within the division were invited to participate.

The benchmarking process

In March 2003, a multidisciplinary comparison group was set up. Representatives from each clinical area were invited to attend, alongside allied health professionals and support staff. This included a physiotherapist, a clinical psychologist, a chaplain, a dietitian, infection control and palliative care nurses, domestics, and administrative staff. The clinical governance facilitator and data protection officer also worked with the group.

At the initial meeting the practice development nurse introduced the concept of benchmarking and outlined the privacy and dignity benchmarks from *Essence of Care*. Membership was agreed and terms of reference for the group were produced. The group then looked at available literature before splitting into two groups to list and record everyone's thoughts and ideas regarding the issues faced in relation to privacy and dignity. One group looked at issues concerning the care environment and the other considered individual patient concerns. From the environmental point of view, these issues included:
- The use of side rooms;
- Separate male and female toilets and washing facilities;
- The use of curtains;
- Storage of notes;
- Availability of quiet rooms;
- Discussion of patients' details;
- Use of telephones;
- Visiting times.

The individual patient issues that were raised included:
- Communication;
- Time constraints;
- Religious and cultural needs;
- Hospital clothing including gowns;
- Confidentiality;
- Staff attitudes.

Compiling questionnaires

Information gained from the initial meetings was used to form the basis of three questionnaires – a clinical environment checklist, a patient questionnaire and a staff questionnaire – that would support the benchmarking process. Table 1 (p38) provides examples of the ques-

BOX 1. THEMES OF ANALYSIS

- **CLOTHING**
- **COMMUNICATION**
- **CONFIDENTIALITY**
- **BASIC PRIVACY ISSUES**

tions used within each of the questionnaires.

The clinical environment checklist determined the resources available in the clinical area such as the number of quiet or counselling rooms, the facilities available for patients, which policies and procedures were currently in place for staff, and how patient data was stored and transferred. It looked at what training and support was available for staff, such as data protection education, and how to deal with complaints, and considered the position of computers and faxes in relation to the protection of patient information.

The patient questionnaire looked more specifically at whether patient needs had been met. Patients were asked about staff attitudes and whether they felt their privacy or dignity had been compromised during their stay. They were asked to state whether:

- Staff had shown them respect;
- They were informed of procedures and interventions;
- They had been involved in choices about their care.

Questions also focused on whether the patients' cultural and religious needs had been met.

Finally the staff questionnaire aimed to explore staff knowledge of trust policies and guidelines, data protection, and the translator and chaplaincy services. Staff members were asked to voice any concerns regarding the resources and difficulties they faced when attempting to ensure privacy and dignity for their patients.

Feedback

Once compiled, the next step was to pilot the questionnaires. This revealed that although the main issues were very similar within the inpatient and outpatient areas, they did require different questions to be asked in order to gain useful information, and this resulted in the production of two sets of questionnaires: one for the ward areas and a second for the outpatient departments.

The next task was to identify possible evidence for each factor from the *Essence of Care* document. The group spent one meeting listing examples of evidence in order to ensure all group members felt confident enough to go away and start scoring their individual areas.

The *Essence of Care* highlights the importance of gaining patient input and involving patients in the benchmarking process. Staff gained feedback from patients and evidence for scoring against the benchmarks, not simply through the questionnaires but also by using visitors' books, complaints received and compliments made. Observations of practice, where a staff member quietly

observes the activity in a ward or department, were also an invaluable source of evidence for the scoring process.

Staff found that the process of scoring and collecting evidence was quite time-consuming and group members decided to set up a 'buddy' system to support the clinical staff. Each clinical representative was provided with a buddy, or partner, from the section of group members who were not affiliated with a particular ward or department. It was often the buddy who completed an observation of practice, which had the added bonus of affording a new perspective on current practice and allowing an objective view of the area.

The many pressures on clinical areas meant that some areas had scored against the benchmarks before others had completed their questionnaires, but whenever staff reached the stage where they had scored their areas, they shared and compared these scores with the rest of the group. We found that staff often scored themselves quite severely and in many cases further discussion with the rest of the comparison group provided a more objective score. The focus was not the score itself, but instead the staff decided that the planned changes were more significant. This was taken very literally by some staff with changes being implemented as soon as issues were identified and before formally scoring. For example, one area realised that their patients' notes were stored in an overly accessible area and immediately arranged for the storage racks to be moved to an area where patient data could not be viewed from the reception desk.

It was essential to maintain momentum once staff started to individually assess and score their areas and the group arranged for the trust's clinical standards facilitator to provide regional and national feedback regarding benchmarking activity. This ensured that all staff remained confident that the work they were doing was valued and that they were making a difference. Groups from other divisions within the trust were also invited to present their implemented changes and ideas and this resulted in the sharing of examples of good practice at a local level within the trust.

Results

Having analysed the results of the questionnaires, patient feedback and observations of practice, a number of common themes were identified (Box 1).

Clothing

Patients and staff highlighted the difficulties faced with hospital gowns. These were often the wrong size and patients found them confusing and difficult to fasten. There were similar concerns about hospital nightwear especially the risk of possible exposure when patients were moving around.

Communication

There was a general lack of understanding regarding the translator and chaplaincy services available within the trust and staff did not know how to access them when required, or exactly what services were available. It

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TABLE 1. EXAMPLE QUESTIONS FROM THE QUESTIONNAIRES USED

CLINICAL ENVIRONMENT CHECKLIST

	Does not comply	Some action required	Complies well
Facilities for screening patients			
Guidelines for transport of patients' notes			
Separate female and male toilet facilities, correctly signed translation services			Interpretation/

PATIENT QUESTIONNAIRE

	Yes	No	Comments
Have you been spoken to in an inappropriate way by any member of staff?			
Did the staff call you by the name you would wish to be addressed by?			
Have you ever felt that your dignity, privacy, and modesty have been compromised during your stay/visit?			
Were you examined by students during your stay? If yes, were you asked permission?			

STAFF QUESTIONNAIRE

	Yes	No	Comments
Do you know where trust policies are kept?			
Do you know what action to take if a patient complains?			
Do you know how to help someone with communication needs?			
Have you a basic awareness of Christian, Sikh, Muslim and Hindu practices?			

became clear that the position of nurses' stations and the use of telephones there meant that patient information was often overheard.

Patient telephones were often found to be attached to walls, which meant that they could only be accessed by mobile patients, who could also be overheard by others.

In outpatient areas, the layout of the buildings often made it difficult to welcome patients. Also, the patient information leaflets provided within wards and departments were found to be disorganised.

Confidentiality

Staff in outpatient areas discovered that patients could hear information about other patients while waiting at the reception desk and some departments used hatches between the reception and the waiting areas. Patient feedback highlighted that counselling rooms were often believed to be 'bad news rooms' so consideration was given to when and how these rooms should be used. Another large problem identified was the storage of notes within clinical areas and the safe and confidential transfer of notes between departments.

Electronic nursing handover sheets used to improve the information gained at handover provide legible information about patients. The benchmarking identified that, in some circumstances, they were being disposed of carelessly. Computer terminals were also highlighted as providing access to patient data, and nurses, doctors and administrators were also found to be leaving themselves logged onto accessible computers.

Basic privacy issues

Within the outpatient X-ray department all patients used the same changing cubicles and the old cramped hospital buildings posed many difficulties for ensuring privacy for patients due to lack of space. Patients receiving information and treatment were often sitting very close to the next patient. Within ward areas, curtain rails were broken and curtains did not always fit the space required. It was highlighted that staff were often interrupting care, which was taking place behind curtains.

Changes to practice

A number of changes in practice occurred as a direct result of the benchmarking process.

Clothing

To overcome the difficulties with gowns and hospital clothing, one area set up a welcoming service where the reception staff checked the patient in before supporting them with any difficulties they faced with gowns. Outpatient appointment letters were altered to suggest

that patients could bring a dressing gown with them for increased comfort. The group facilitator fed these problems back to the trust's *Essence of Care* steering group, which is currently looking at trustwide options for hospital clothing and gowns.

Communication

To improve awareness of the staff regarding the translator and chaplaincy services, we have produced posters that give up-to-date information for staff immediately when they need it.

Many clinical areas have introduced mobile phones so that staff and patients alike may take the phone to a quiet section of the department to make confidential calls. Wards and departments have also worked to display the available patient information leaflets effectively.

Evidence gained through the benchmarking process has been used by the trust's patient council to acquire resources to fund alterations to outpatient reception areas.

Confidentiality

As checking of patient information is often paramount to the safety of patients, certain outpatient areas introduced privacy zones at the reception desk, and these are strictly enforced by all staff. A freestanding wooden sign states that a privacy zone is in place and asks waiting patients or staff to queue behind a line.

The practice of using hatches from the reception area into the waiting room has been stopped. Departments that are not manned over a full 24-hour period now ensure that all confidential information is locked within the department at night.

The realisation that patients saw counselling rooms as 'bad news rooms' came as quite a shock to the nurses who had not stopped to think about the circumstances in which a certain room was used. Now instead of only taking patients into the quiet rooms to discuss their diagnosis or prognosis, the rooms are utilised for more general discussions and nursing interventions.

The data protection officer played an important role in supporting the assessment of the clinical areas and the action planning process. Ward areas have liaised with the portering services to ensure that porters are aware of their role in the transfer and storage of notes. During regular away days staff have been shown relevant scenarios, explaining the significance of these issues and thus raising their awareness.

To avoid the discovery of patient information and nurse handover sheets in public areas, shredders have been bought to dispose of these documents appropriately. Group members have also placed obvious signs on computers to remind staff to log out correctly and protect patient data.

Basic privacy issues

Staff in the outpatient X-ray department have now altered changing facilities to provide male and female areas and a cubicle large enough to facilitate a wheelchair. Within other outpatient departments furniture has been moved to improve the space available for patients so they do not have to sit too closely together.

Within the ward areas, any curtain rails that did not work have been mended and curtains that did not fit have been replaced. Laminated 'engaged' signs can now be pinned to the curtains around patients' beds. Engaged signs have also been ordered for other areas such as counselling and consultation rooms, and toilets. These have successfully stopped unnecessary interruptions and ward staff have received very positive feedback from patients since their implementation.

In one area, the privacy and dignity of the staff themselves was considered to be just as significant as that of the patients and a privacy zone was set up and marked on the floor outside the staff room itself. This has also provided a quieter and more secure area for the staff to use during their breaks.

Conclusion

Feedback from staff and their continued enthusiasm and commitment to meetings indicate that they remain very positive about the changes they have already made and the value of the benchmarking process.

Staff are keen to continue the process, striving to improve the care and service provided at the trust. Staff have also received very positive feedback from patients and have been motivated and empowered to provide a high standard of care.

The success of the implemented changes has varied among clinical areas depending on the commitment of staff involved and the level of managerial support. The senior nurse and head of nursing have guaranteed commitment to the benchmarking process. On a wider scale, the trust steering group and clinical standards facilitator have ensured trust support and the necessary feedback to the decision-makers.

The experience of the benchmarking process itself has brought together sections of the division that would not normally meet. This has resulted in a greater awareness of the particular pressures that different departments face, which in turn encourages team working.

The work of the group has already been acknowledged and valued with one clinical area receiving the trust chairperson's award for improvements in care.

The general attitude to privacy, dignity and confidentiality has increased across the division even among staff who were not directly involved with the process. The use of posters, leaflets, education and feedback at staff meetings has supported the changes made following benchmarking. The *Essence of Care* has even made it on to the medical agenda as staff presented the significant issues relating to privacy and dignity on medical induction programmes.

In conclusion, the privacy and dignity benchmarking group have discovered that very small changes to the way they approach the care of patients may turn out to have a great improvement on the quality of the care they provide. Many of the implemented changes have been inexpensive and yet have ensured that patients feel safe and valued within the organisation. ■

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