Improving patients’ experience of transfer from the Adult Intensive Care Unit (AICU) to the High Dependency Unit (HDU)

Keywords: Discharge, transfer, Intensive Care, patients’ experience, Experience-Based Co-Design

Duration of project: December 2011 to March 2013
Report Submitted: June 2014

Project lead: Surjeet Kaur, Senior Nurse/Service Manager AICU
Contact Details: S.Kaur@rbht.nhs.uk

Author of Report: Dr Sharon Fleming, Head of Research in Nursing
Contact Details: S.Fleming@rbht.nhs.uk

Summary
This project started with a question generated when two team members attended a conference, and a presentation they listened to highlighted the importance of planning and good communication when transferring patients out of intensive care. From this, the project question was developed: ‘How can we improve patients’ experience of transfer from our Adult Intensive Care Unit (AICU) to the High Dependency Unit (HDU)?’ This project used an approach called Experience-Based Co-Design (EBCD) to provide a unique opportunity for staff and patients to work together in improving patients’ experiences of the transfer process from the Adult Intensive Care Unit (AICU) to the High Dependency Unit (HDU). The Adult Intensive Care Unit (AICU) is situated in a Specialist NHS Foundation Trust in Central London. The unit has 20 beds and cares for adults who have cardiothoracic illness and require intensive care. The unit has a special interest in patients with cardiac disease and severe lung failure.

The aim of the project was to explore problems for patients and staff with the transfer process, to act on these problems and to implement solutions. Staff and patients were interviewed to capture their experiences and observation sessions of the transfer process were completed and analysed. The service improvement methodology used was Experience-Based Co-Design (EBCD). Twenty-seven staff and seven patients were interviewed. Staff and patients identified main themes to take forward to a joint patient-staff event. Themes included: communication and information for patients and relatives; person-centred care and timing. Following the joint patient-staff event, action planning groups (with patients and staff) worked to implement solutions to improve the communication of doctors and nurses with patients and relatives. The outcomes of the project were positive changes in the delivery of care to patients and their relatives, as highlighted by the evaluation of staff and patients’ experiences of the transfer process. Findings have been fed back to staff and the importance of good communication is continually highlighted. Changes in the way information is communicated have meant that information about the transfer process is clearer for patients and that relatives are more involved in the process. Staff have also gained confidence in capturing patients’ experiences and an annual patient-staff event to evaluate the sustainability of improvements is planned.

The EBCD approach was ideal to explore and improve patient experiences. However, having good role models to facilitate the process was essential. Our team had funding and facilitation from the Foundation of Nursing Studies (FoNS) and Burdett Trust for Nursing ‘Patients First’ initiative which
provided invaluable support and learning for the team. Organisational, management, clinical units and project team buy-in was also important. Methods such as ‘Claims, Concerns and Issues’ from practice development theory were also invaluable in improving the team’s confidence and ensured the success of the project.

Background
Context of the study site
The Adult Intensive Care Unit (AICU) is situated in a Specialist NHS Foundation Trust in Central London. The unit has 20 beds and cares for adults who have cardiothoracic illness and require intensive care. The unit has a special interest in patients with severe lung failure. Nationally and internationally, the nurses and doctors lead the care of patients with acute respiratory distress syndrome and patients who are on long-term mechanical ventilation. The unit offers innovative therapies such as extra-corporeal membrane oxygenation (ECMO), extracorporeal carbon dioxide removal (using the interventional lung assist device from Novalung) and high frequency oscillation. It is supported in this work by the non-invasive ventilation, physiotherapy, occupational therapy and rehabilitation services. The nursing establishment of 100 (wte) staff 16 funded beds. Patients are generally transferred to the cardiac surgery High Dependency Unit (HDU) or the respiratory HDU.

Previous studies
Many studies have explored adverse events for patients immediately following transfer from intensive care units. Up to 30% (Chaboyer et al., 2008) of patients have been found to suffer adverse events with half of these events seen as being preventable (McLaughlin et al., 2007). Factors involved included staff delay in taking action for abnormal physiological signs and infrequent charting. Most authors call for a review of support systems and discharge processes to improve the transition from intensive care.

Patients with unplanned discharges from AICU are also at risk of a worse outcome (Utzolino et al., 2010). The timing of patients’ discharge seems to impact on outcomes as well with patients discharged in the evening, overnight and at weekends having increased mortality and risk of re-admission to the AICU (Priestap and Martin, 2006; Obel et al., 2007; Pilcher et al., 2007).

Proactive nurse-led follow-up services following AICU discharge can reduce readmission and improve survival to discharge (Ball et al., 2003). Relatives’ anxiety was found to be reduced if patients are actively followed up and communication practices are improved (Mitchell and Courtney, 2004). However there are other aspects of care which are important to ensure successful patient recovery. For example the impact of organisational and teamwork factors on patient outcomes following discharge from AICU has had limited exploration (Lin et al., 2009). There has been some exploration of patients’ experiences of Intensive Care. However most research focuses on psychosocial recovery after discharge to the community (Maddox et al., 2001); recovery after intensive care with discharge to the ward discussed as one part of the long-term recovery process (Rattray et al., 2010); or a focus on a particular element of the patient’s experience such as their recall of actual events and unreal experiences (Lot et al., 2006). Strahan et al. (2003) explored patients’ experiences 8 to 9 days after discharge from intensive care using a nurse-administered questionnaire. Changes implemented included patient diaries for long-term patients, input from a clinical psychologist and a review of sedation used in AICU.
The project team wanted to build on Strahan et al.’s (2003) work by asking staff and patients to talk about their experiences and to involve patients in introducing improvements to the transfer process from AICU to HDU. An Experience-Based Co-Design (EBCD) approach was used. EBCD was developed by Bate and Robert (2006) in response to the gap between health policy rhetoric of ‘patient involvement’ and practice where healthcare systems still do not put patients first. The authors of this report developed a project plan based on experience based design approaches which are user-focused but added a co-design element where patients work alongside staff in the implementation of improvements. The basis of EBCD is to capture patients’ experiences using a storytelling approach. The potential of doing this is illustrated by Charon (2003) p. 1:

Sickness unfolds in stories. Whether in a patient’s chief complaint, a family member’s saga of surgery, an intern’s presentation at attending rounds, or a death note in a chart, the events of illness unfurl and accrue meaning by being told. Equipping health professionals with the wherewithal to recognize, absorb, and be moved by the stories patients tell – and that professionals tell one another – might go a long way toward fixing what doesn’t yet work in medicine.

Therefore this approach was ideal to explore what we needed ‘to fix’ in order to put our patients first when transferring them from AICU. A successful application to the Foundation of Nursing Studies (FoNS) provided external facilitator support, learning workshops and a small bursary.

Aim
The aim was to explore problems for patients and staff with the transfer process from AICU, to act on these problems and to implement solutions as identified by patients and staff. Staff and patient action groups were to implement identified changes using the EBCD approach.

Objectives of the project
• To capture the experiences of patients and staff during the transfer process from AICU by observing care and asking patients and staff to tell their stories about the transfer process
• To understand these experiences by using EBCD methods (staff interviews and staff event, patient interviews and patient event and a patient and staff co-design event) to plan identified improvements to the delivery of patient care
• To plan for sustainability of the improvements.

Methods and approaches
The EBCD approach was used to capture the experiences of patients and staff. This approach was applied in six stages (see Table 1).
Table 1: Project stages

<table>
<thead>
<tr>
<th>Stages of project</th>
<th>What was done</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dec 2011 to June 2012</td>
<td>Setting up, staff interviews and staff event. AICU and HDU staff experiences of the transfer process were captured by interviewing staff using the storytelling method and the findings were presented at a staff event held on 21st June 2012. Key priorities to be taken forward to the patient-staff co-design event were identified.</td>
</tr>
<tr>
<td>2. April to June 2012</td>
<td>Observation of the transfer process. The transfer process was observed and notes taken to highlight themes to be explored in the patient interviews.</td>
</tr>
<tr>
<td>3. July to October 2012</td>
<td>Patient interviews and patient event. Patients transferred from AICU to HDU were interviewed and the findings presented at a patient event. Key priorities that need action were identified to be taken forward to the patient-staff co-design event.</td>
</tr>
<tr>
<td>4. November 2012</td>
<td>A joint patient/staff co-design event: Final action points were decided and patient and staff action groups formed.</td>
</tr>
<tr>
<td>5. December 2012 to June 2013</td>
<td>Actions implemented.</td>
</tr>
<tr>
<td>6. June 2013 onwards: Sustainability</td>
<td>Implementations evaluated using the PDSA cycle to ensure sustainability.</td>
</tr>
</tbody>
</table>

Project process

The project process was also evaluated by keeping meeting notes, making notes of changes to the project timetable, and keeping action plan documents and notes as to why actions were delayed or changed. Using documented Claims, Concerns and Issues exercises with the team enabled trouble shooting of any problems (Guba and Lincoln, 1989). This exercise took the form of asking each team member about the positive aspects of the project for them, then identifying the negative aspects which were turned into questions so the team could problem solve any concerns. As an example, a concern for a junior member of the team was her lack of interviewing skills, so a solution was for a senior member of the team to mentor her until she felt confident to conduct interviews on her own. The use of ‘Claims, Concerns and Issues’ as ‘Positives, Negatives and Solutions’ meant that each member of the team had a voice in talking about their concerns about the project.

Evaluation Strategy

The evaluation strategy of the project will be outlined by providing description and analysis of the 6 stages of the project and an analysis of the process of getting the project done and the lessons learnt by the team.

1. **Staff interviews and the staff event**

Purposive sampling was used in order to gain the perspective of staff with a wide range of experience from the 3 clinical areas (AICU and 2 HDUs).
Table 2: Staff participants

<table>
<thead>
<tr>
<th>Total nurses</th>
<th>29</th>
</tr>
</thead>
<tbody>
<tr>
<td>AICU</td>
<td>14</td>
</tr>
<tr>
<td>HDU</td>
<td>15</td>
</tr>
<tr>
<td>Band 7</td>
<td>2</td>
</tr>
<tr>
<td>Band 6</td>
<td>14</td>
</tr>
<tr>
<td>Band 5</td>
<td>13</td>
</tr>
</tbody>
</table>

Resources used by the team were from the EBCD section on the King’s Fund website (King’s Fund, 2013). After gaining written informed consent, semi-structured interviews were completed using a topic guide (see Appendix 1) which explored staff perceptions of the transfer process (positive and negative); their thoughts on patients’ experiences of the transfer process and what improvements should be made. A story telling approach was used where participants were asked to tell their story using ‘tell me …’ questions. Interviews were audio-recorded and the recording was played back by the interviewer straight after the interview. The themes of the interview were mapped by writing them on paper. Analysis was completed by combining the common themes from each of the thematic mapping sheets from the interviews. The more traditional transcription of data and the coding and categorisation for thematic analysis used in qualitative research projects was not used. Thematic mapping is the preferred methodology for service improvement projects where the resources of clinical staff time are more limited.

Seven members of the team volunteered to undertake the staff interviews. However many team members found using the storytelling telling approach and mapping analysis technique a challenge, therefore the more senior and experienced members of the team mentored team members for two interviews. Mentors listened to the interviews (but sat away from the interviewer and participant) and gave constructive feedback to the interviewer after the interview. Mentors also listened to the interview recording with the interviewer and guided the thematic mapping process. By using this approach the team members gained the confidence and skills to carry out story telling interviews in a supportive environment. The ethical issues of consent and confidentiality were also discussed. As this was a service improvement project, review by an ethics committee was not required.

The main themes arising from the staff interviews were:

- Patient comfort
- Communication and information (with patients)
- Communication and information (with relatives)
- Handover on HDU
- Timing
- Lifts; Meet and Greet on HDU
- Transfer protocol

A staff event was then held on the 21st June 2012 with the provision of a hot lunch using the FoNS bursary. Seventeen nurses attended: 9 project team members, 2 nurse managers (matrons), 1 charge nurse and 5 staff nurses from AICU.

After talking through the project summary, the main themes from the staff interviews were presented to the group. There was then time for discussion to check that themes resonated with the group’s perceptions of patients’ experiences of the transfer process. After this discussion the themes
‘equipment’ and ‘person-centred care’ were added. All of the themes were placed on the wall and all clinical staff present (including the team) voted with stickers for the theme they thought most important. Six stickers were given to each person. The five themes to take forward to the co-design event were: Equipment (13), Communication and information (with patients) (12), Communication and information (with relatives) (10), Person-centred care (9) and Timing (6). The next steps for the project were outlined and staff were informed about the co-design event and were encouraged to attend.

The event was evaluated positively by staff using feedback evaluation forms. All staff attending had ‘good’ to ‘excellent’ overall impressions and feelings about the event and rated the event as a ‘good’ to ‘excellent’ process to reflect on patients’ experiences. When asked about improvements to the event some staff said that more junior staff should attend, the project should be expanded to the medical team, the project should be expanded to include the hospital wards and they would like to see more of these events.

The transfer process was also observed by team members and these findings are reported next.

1. **Observations of the transfer process**

Observation is a powerful tool for the evaluation of service delivery. While observing the transfer process, team members imagined they were a patient, or seeing the service through fresh eyes as a visitor to AICU and HDU. Patients will often not mention the details of their experiences, even though it may have a major effect on their experience of care. Therefore, observers can play a crucial role in exploring patients’ experiences. Observation provides valuable insights into how the service works and what patient and staff perspectives might be.

Seven transfer processes from AICU to the two HDUs were observed (five to the cardiac HDU and two to the respiratory HDU). Team members who were not experienced in observation methods were mentored by more senior team members. Team members used non-participant observation after gaining the AICU staff members’ and patients’ consent. Observation notes were taken from the time of notification of transfer until the patient was settled on HDU. All the observation notes were analysed for common themes. The main themes arising from this analysis were:

- Nurse-patient relationship
- Nurse-relative relationships
- Doctor-patient relationships
- Smooth transfer process: preparation, bed transfer, managing delays, porters
- Transfer in lifts/ambulance
- Transfer in HDU
- Handover on HDU
- Settling patient
- Drugs, equipment, patients’ property
- Communication: keeping patient informed, keeping relatives informed
- Nurse to nurse communication
- Observation process affecting findings (observer effects)

These themes were used to develop the topic guide for the patient interviews which were carried out in stage 3 of the project (see Appendix 2).
2. Patient interviews and patient event

Patient topic guides (see Appendix 2) using the themes from the observation sessions and from the EBCD website were devised by the team. Topics discussed during interviews with patients were:

- the journey from AICU to HDU (care in AICU, journey from AICU to HDU, getting to HDU)
- overall satisfaction with the transfer process
- the information received
- their relationship with doctors and nurses
- crucial touch points
- best and worst bits; improvements needed

Staff who had not undertaken patient interviews before using the story-telling approach, were mentored by the senior members of the team as described in section 1. Patients were chosen to take part where available and if willing to consent to be interviewed. These were undertaken on the day staff had booked time away from their clinical duties.

As the patient interviews were done over the summer period of 2012 when the London Olympics took place, many staff were on leave and the clinical units were exceptionally busy, as a consequence only seven patient interviews were undertaken. It was hoped more interviews could have been completed but rich data were gathered from these interviews, which gave the project team insight into their patients’ experiences. The main themes arising from the patient interviews were:

- Communication between doctors and patients
- Communication between nurses and patients
- Information giving
- Conflicting information
- Delays
- Lifts
- Transfer process
- Property
- Environment
- Visiting
- Noise
- Anxiety about transfer
- Relatives
- Person centred care
- Car parking

These findings were presented at a patient event held on 10th October 2012 at the study site. Patients were invited using professionally printed invitations, a hot lunch was provided and patients’ travel expenses were paid; all financed by the FoNS bursary. Five patients and four relatives attended. One relative left early as she became upset while talking about her experiences. The Head of the Patient Advice and Liaison Service (PALS) left with her to support her and to talk through her experiences.

The format of the day was introduced and the team and patients introduced themselves to each other. The work done so far and the summary of the staff event were presented and a discussion identified any other themes important to the patients and relatives present. Further themes added were ‘equipment’ and ‘medication’. The person-centred care theme was split into two separate
themes of person centred care: AICU and person centred care: HDU, as patients felt their experiences were different in each unit.

Patients then ranked each theme along a scale with a good experience at the top and a bad experience at the bottom. The results are presented in graphical form below:

**Figure 1: Patient experience themes**

![Graphical representation of patient experience themes]

An emotion mapping exercise, where patients were asked to add ‘emotion’ words to describe how they felt about each theme, was completed. This exercise was done by asking patients to think of the emotions they felt about each theme and to write these emotion words on a sticky note and attach them to the theme. A few patients did this well but most patients wrote phrases about their experiences, not emotion words. On reflection a better way to do this exercises would be to use picture cards or evoke cards ([http://www.evokecards.com](http://www.evokecards.com)) to enable the group to discuss their emotions.

Patients then voted for the themes they wanted to take forward to the joint patient-staff event by placing stickers on each theme. Each patient-relative was given six stickers. Numbers of votes are in brackets. A summary of the themes, the numbers of stickers and the emotional mapping is given below:

- Communication between doctors and patients (9): ‘exasperation (sometimes)’ ‘patient confused, speak in different languages’ ‘not given enough information on going home on leave for 3 days’ ‘reassured - doctor explained my husband’s op well’
- Information giving (6): ‘good’ ‘blunt to the point - made me relax’
- Communication between nurses and patients (5): ‘excellent’, ‘nurses helpful, one or two could have been more helpful’ ‘day nurses excellent, night nurses always too busy or doing other
things’ ‘just 2 nurses on night duty, terrible experience, just awful, very upset, both patient and wife’

- Delays (4): ‘Did not explain delays on operation, therefore did not ask’ ‘irritation: uncertainty about transfer to HDU; Discharge’
- Equipment (4): ‘commode better than bedpan’ ‘more equipment for larger people’
- Conflicting information (3): ‘no conflict’ ‘very good, all tablets were explained’
- Environment (3): ‘air-conditioning was not working’ ‘nice environment’
- Anxiety about transfer (3): ‘None - told us about area’
- Noise (3): ‘put up with it’ ‘Nurses were not noisy’
- Transfer journey (2): ‘was not told where I was’
- Visiting (1): ‘sympathetic’ ‘helpful’
- Relatives (1): ‘terrible very upset’ ‘helpful’
- Lifts (0)
- Property (0)
- Person centred care: AICU (0): ‘exceptional’ ‘not too happy with it. Asked for things but it didn’t happen’
- Car parking (0): ‘had to drive around the block to find a space’
- Medication (0): ‘queries’

As discussed above, most patients and relatives chose not to use ‘emotion words’ and not all participants put ‘emotion’ stickers on the map, so some positive views may not be represented.

Therefore, the themes taken forward to the joint patient-staff event were: Communication between doctors and patients (9); Information giving (6); Communication between nurses and patients (5); Person-centred care (HDU) (4); Delays (4) (Timing); Equipment (4). Some of the issues raised were discussed in person with participants as the team members felt these issues needed immediate action and could not wait until the action planning event. For example, exploring the negative experience of a patient during one night shift and communicating this to the clinical matron and buying commodes for larger patients.

From the evaluation forms, patients thought the patient event was a positive experience with all ratings being ‘good’ or ‘excellent’. Some of the comments were: ‘a unique opportunity to discuss your experiences’, ‘you think you are the only one but others are worse off than you’, ‘able to bring personal concerns’.

3. **Joint patient-staff co-design event**

Patients and staff were invited to attend a patient-staff co-design event held on 28th November 2012 to decide on actions needed to improve the transfer process from AICU to HDU. Project team members facilitated the event. The aims of this event were to feedback and agree the themes identified at the staff event in June and the patient event in October 2012. As at the separate staff and patient events, themes were then ‘voted upon’ by attendees to identify three main priorities that need improvement. Action groups were formed with staff and patients to work on these improvements together.
Six patients (two had attended the patient event), one patient’s relative and 19 nurses attended (seven nurse managers, one nurse consultant, nine staff nurses and two practice educators). The Head of Patient Advisory and Liaison Service (PALS) also attended to support patients who might become upset while talking about their experiences. After introductions, the work done so far and a summary of the staff event and patients’ events were presented. As many patients and staff had not attended previous events, a discussion was held in case any new themes need to be added. However, the existing findings encompassed the patients’ and staff experiences.

Staff and patients then voted on the priorities most important to them. Each person was given 6 stickers. The priorities to take forward were identified by the highest votes. The numbers of votes were:

- Communication and information (between healthcare professionals and relatives): 26 votes
- Communication between doctors and patients: 24 votes
- Communication between nurses and patients: 23 votes
- Information giving: 20 votes
- Person centred care (HDU): 17 votes
- Lifts: 13 votes
- Delays (Timing): 4 votes
- Equipment: 2 votes

Therefore the three top priorities were: communication between healthcare professionals and relatives; communication between doctors and patients; and communication between nurses and patients. Patients and staff formed 3 action groups to have an initial discussion of improvements needed for their themes. Initial actions were discussed in each group.
Table 3: Action planning for better communication

<table>
<thead>
<tr>
<th>Communication between nurses and patients</th>
<th>Communication between doctors and patients</th>
<th>Communication between healthcare professionals and relatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient-centred care: nurse to put themselves in shoes of patient (empathy)</td>
<td>1. The use of patient-centred language/terminology</td>
<td>1. Patients rely on relatives for information giving</td>
</tr>
<tr>
<td>2. Respond to patient’s requests</td>
<td>2. Introducing themselves: Who is who?</td>
<td>2. More information needed about what to expect when a patient is in AICU and HDU</td>
</tr>
<tr>
<td>3. Consideration for others</td>
<td>3. Asking if patients understand</td>
<td>3. Information about who can help with discharge difficulties and arrangements</td>
</tr>
<tr>
<td>4. Attention to basic nursing care</td>
<td>4. Explain the plan of care</td>
<td>4. Arrange meetings with medical staff for an update</td>
</tr>
<tr>
<td>5. Recognise patients’ needs and re-arrange priorities</td>
<td>5. Nurse to go with doctor to be patient’s advocate</td>
<td>5. Improve communication between hospitals: patients transferred from other hospitals were sometimes sent with little information</td>
</tr>
<tr>
<td>6. Keeping patients informed</td>
<td>6. Include patients in conversations ‘Doctors talk over me’</td>
<td>6. Have point of contact for relatives to speak to including contact phone numbers</td>
</tr>
<tr>
<td>7. Importance of professional conduct</td>
<td>7. Allowing opportunities to answer patient’s questions</td>
<td>7. Some information needed to be clearer</td>
</tr>
<tr>
<td>8. Information giving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Show commitment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The normal process using the EBCD approach is to have regular action planning meetings with patients and staff. However as many of the patients lived some distance from the project site, correspondence was by email, telephone and mail (one patient did not have email access).

4. Actions implemented

After the patient-staff event it was decided at a project team meeting to reduce the number of action groups to two, with the ‘communication with relatives’ group joining the other two groups. There were two reasons for this decision:
• Many of the actions for improvements to care for relatives needed action by nurses and doctors so it was easier to include the actions into these groups
• Team members were finding it increasingly difficult to find time to work on the action planning phase and the project was more likely to succeed with two action planning groups

This change was made in consultation with patients and staff. At the time of this report, action plans had been finalised and have been implemented. The effectiveness of these actions will be measured by a patient event planned for October 2014 to capture patients’ and relatives’ experiences of communication with healthcare professionals.
a) Action plans for the communication between nurses and patients/relatives group

During action planning the team discussed patients’ comments about nurses’ communication in the patient events and the patient interviews. Again, most of their comments were positive:

“Everything you wondered about (in AICU) you didn’t even have to ask, it was explained. Nurses were particularly good with my wife and children coming in. They had these conversations I had no idea about.”

“I asked 10 times the same thing but nobody ever got annoyed at me, they just answered my questions.”

“Nurses were very professional, but at the same time personal. I felt cared for, and supported throughout. I was treated as an individual, and as an important person.”

However there were areas for improvement:

- **Language**

  Many staff spoke English as a second language and this resulted in communication problems for some patients:

  “Good English. A couple of nurses that I found difficult to understand. Their accent is so strong.”

  “I think there is a bit of a language problem.”

- **Communication**

  Communication about the move to HDU:

  “No idea what the difference between AICU and HDU was.”

Documentation is important but it is important to communicate well with patients:

“No complaints but the nurses seem to spend a lot of time on the computer. Then they forgot what you have asked them.”

“Nurses have to talk to patients more instead of just delivering the care”

Action Plans were presented at meetings with nursing staff and communication between nurses and patients/relatives was discussed. They agreed to the following changes/improvements:

- AICU service manager will take up one page of the AICU staff newsletter to raise awareness regarding the importance of high quality basic nursing care and Trust Core Behaviours amongst all AICU staff. The importance of the 6Cs (NHS England, 2012) will also be highlighted in this monthly newsletter, due to the recent Francis Report [http://www.midstaffspublicinquiry.com/report](http://www.midstaffspublicinquiry.com/report)

- The above subjects will have a raised profile during AICU Team Days (staff meetings held every 4 months) led by a Service Manager and a Matron

- ‘Compassion in Practice’ has been added as a teaching topic on an AICU junior staff study day held in May 2013

- Patients’ views and experiences will be discussed during daily morning briefing meetings on AICU

- Trust Core Behaviours and the 6Cs will have a raised profile during staff recruitment processes and staff appraisals

- A page explaining Trust Core Behaviours has been added to AICU New Staff Induction Booklet (given out to all new staff)

- ‘ICU steps’ booklets are now available on AICU for relatives and patients to read and keep [http://icusteps.org/professionals/booklet](http://icusteps.org/professionals/booklet)
b) Action plans for the communication between doctors and patients/relatives group

During action planning, the team revisited patients’ comments about doctors’ communication in the patient events and the patient interviews. Most of their comments were positive:

“I received very good information pre-operatively. ‘The Itinerary’ was well explained pre-op … what they (surgeons) were going to do, where I was going to go, and what I would look like …”

“It was obvious that there was good communication (between staff groups) behind closed doors … Asked to see Mr Xxxxx and he came to see us … and he phoned my mum (pre-op).”

However, there were some problems:

- **Conflicting information:**
  “They do not give you the straight information. One doctor says one thing and the other one says something else.”
  “All doctors tell you different stories.”

- **Introductions:**
  “The doctors seem to come out in 3s and they were talking. I did not know which one was Mr….. (who actually operated on me).”

- **‘Talking over’ patients:**
  “The doctors talked over me, they did ask me questions but they carried on talking amongst themselves. I was beyond caring as I was feeling so ill.”

- **Relatives:**
  “Doctors should communicate more with immediate family.”
  “It would be good to have a process where meetings could be arranged with the medical staff for an update.”

The findings were presented at a meeting with key medical staff and communication between patients and relatives and doctors team was discussed. Medical staff agreed to the following changes/improvements:

- **Doctors** will introduce themselves to patients and relatives during ward rounds. Identification badges will be worn at all times.
- **HDU** – There is now a daily evening handover where the team discuss critical patients’ care and plan of treatment. The day teams will make sure that there is a clear plan for overnight. Team consultants and Senior Registrar will enforce this.
- **AICU** – The consultants will aim if possible to finish the ward round on time so that it does not impinge on relatives’ visiting time.
  - Immediate family will be made aware of ward round time so that they can be present when patient care is discussed. However, it will be best to make appointments for family and consultants.
  - An appropriate time can be negotiated so that a member of the team is present to discuss issues or give information to relatives in the afternoon if visiting time is an issue.
  - A simple daily action plan explained to the patient every day, and also a detailed medium term (over the next week) twice a week for longer term patients, and a weekly long-term plan.
- **Discuss patients’ and doctors’ expectations of outcomes:**
  a) A nurse should be present for the round and act as patients’ advocate
  b) Immediate relatives can communicate with nurse in charge for information
- Doctors will keep medical terminologies to simple and layman terms
- Adequate time will be given to patients and relatives so that they fully understand what has been said, explain the course of action and expectation. Doctors will confirm that information has been understood before leaving the patient’s bedside, or give the option to ask questions later
- Patients’ perception should be taken into consideration when commenting with patients and relatives. This should be done in a sensitive manner
- A Respiratory HDU booklet has been written (the cardiac HDU already has one). These booklets will be handed to patients/relatives prior to transfer to the HDU to give them adequate information prior to transfer and to alleviate anxieties

Project process
Project team meetings were held every 6 to 8 weeks. Meetings were held even if no progress had been made in order to action plan and discuss problems using the Claims, Concerns and Issues exercise (Guba and Lincoln, 1989). Meeting notes were kept with actions noted. These were circulated to team members. Project documents, such as consent forms and information sheets for the interviews, were put on a server that all team members could access.

Short and long term objectives were noted on action plans usually completed at FoNS workshops (see Appendix 3). Whether objectives were being met was discussed at team meetings and timescales adjusted as needed. Old action plans were kept as a record of the project’s progress and the changes made.

Discussion
What went well - and why?
The main elements of this project that worked well were teamwork and the facilitation from FoNS.

Team work
There were ten members in the project team and although there could have been difficulties in maintaining good communication and interaction with such a large group, the enthusiasm and commitment team members showed was inspiring. Meeting the aims and objectives of the project were challenging and courage and commitment was needed for team members to learn new skills, to listen to problems in their care delivery to patients, and for some members to work closely with senior colleagues. It was the skills and qualities of the team members that allowed the project to move forward and for improvements to be planned and actioned. The clinical lead enabled staff time and mentorship to collect the observation and interview data and led the difficult task of implementing improvements. Another senior team member is an expert in leadership training and practice development and was a valued mentor for nurses new to storytelling interview and observation techniques. The Head of Research in Nursing provided training in the EBCD approach, provided analytical skills, did the data analysis and managed the project. The team also benefited from the participation of nurses from AICU and the HDUs, both senior and junior. This meant the team had diverse experience and skills which contributed to the success of the project. Attendance at team meetings was never below 60%. Some members attended team meetings in their own time which is not ideal, but due to shift rosters it was difficult to arrange meetings at a time convenient to the whole team.
Facilitation and funding from FoNS

The support and facilitation from FoNS was also key to the project meeting its aims. The five workshop days provided by FoNS introduced new concepts in practice development to many of the team members. The creative activities also provided opportunities to try new ways of working in a non-threatening environment. Our team approached the workshops in a different way to other teams. The project manager attended all the workshops to provide continuity but brought two different team members each time. In this way all the team members were exposed to the workshop activities and learning opportunities. This is reinforced by a quote from a team member who was asked her thoughts about the workshops:

“This is a very good forum for us to meet and share our experiences and also learn from each other.”

The key practice development activity learnt at the workshops and used for our team was the ‘Claims, Concerns and Issues’ exercise (Guba and Lincoln, 1989). This exercise was done at the end of every team meeting and provided a means for all team members to have a say about the positives, negatives and a vehicle for problem-solving.

Our FoNS facilitator also provided knowledge, support and her regular meetings kept the project team on track.

Since starting this project, which has demonstrated the value of EBCD to explore patients’ experiences, another two projects using the same methodology have commenced: one exploring the journey of families on the paediatric surgery ward and another exploring the experiences of pulmonary rehabilitation for patients with Chronic Obstructive Pulmonary Disease (COPD). The experience of funding and support from the FoNS facilitator and the FoNS workshops has given the Head of Research in Nursing confidence to start these projects. The development of the team members, particularly the more junior clinical staff has also ‘spread’ to other staff resulting in less resistance to staff participating in future project teams.

The FoNS bursary meant the scope of the project could be expanded to include patient and staff events with lunches provided; payment for staff time and costs for dissemination at three conferences:
1) The CARN/IPDC conference in Canterbury, UK in November 2012
2) The Health Care Innovation Expo in London March 2013
3) The International Congress of Nursing Quadrennial Conference in Melbourne, Australia in May 2013.

The support the funding provided also increased the credibility of the project due to the competitive application for funding.
**What didn’t go well and why?**

**Recruitment of team members at the start of the project**

When planning the project, it was considered important to have team members from AICU and both HDUs. However one of the team members missed team meetings and could not contribute to the actions needed for the project. It was only when staff interview data needed to be collected that it was decided to replace the team member with another staff member from the same unit. The new team member was engaged with the project’s aims and caught up with the project work needed in a short time.

**Finding time to do project work**

Finding time to carry out project tasks was the most consistent concern raised in ‘Claims, Concerns and Issues’ sessions at the team meetings. Some time out was funded by FoNS and the manager was supportive of staff taking time out to do project work, however it was still difficult for team members to juggle competing priorities. The team discussed how to find more time in the clinical day and although the team did not come up with concrete solutions about how to find more time on a busy clinical unit, team members said allowing time to discuss their problems and frustrations helped to maintain their focus on getting tasks done.

**Keeping to timescales**

Action plans were kept by the team for each stage of the project, however timescales did need to be flexible because of unpredictable nature of clinical activity in the AICU and HDU. This meant that when interviews or observation sessions were planned, sometimes staff were called away because of emergencies or other events.

For example, originally the team had planned to complete staff interviews by February 2012 as this excerpt from the action plan completed at the December 2011 FoNS workshop shows:

<table>
<thead>
<tr>
<th>Objective</th>
<th>What action is required</th>
<th>Who</th>
<th>By when</th>
<th>Resources/support needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete staff interviews</td>
<td>Complete staff interviews and analyse common themes for staff event. Prepare presentation</td>
<td>Whole team</td>
<td>18/02/2012</td>
<td>Consent forms, Topic guide, thematic analysis sheets, tape recorder</td>
</tr>
</tbody>
</table>

This objective was completed by June 2012 showing that flexibility and commitment is needed when doing service improvement work.

**What would you do differently and why?**

**Recruitment of team members to foster engagement**

The project managers should have had more discussion with individual team members about the aims of the project and the amount of work it would entail at the first project meeting. This was discussed but briefly and it was assumed that team members were part of the team because they wanted to be involved. However one team member had been told by the ward manager to join the project. The team member already had a heavy workload but did not feel empowered to discuss this with the team. It meant that project work wasn’t done and a new team member had to be recruited.
at short notice. If this problem had been discussed sooner, it would have resulted in less frustration for the first team member.

**Better delegation of action planning**
Because of work commitments the project manager found it difficult to work on the project from January to March 2013. This meant that much of the action planning activity was delayed until April and May 2013. The work should have been delegated to another team member to lead so that action planning groups could implement the changes identified sooner.

**Conclusion**
This project started with a question generated when two team members attended a conference, and a presentation they listened to highlighted the importance of planning and good communication when transferring patients out of intensive care. From this the project question was developed: ‘How can we improve patients’ experience of transfer from our Adult Intensive Care Unit (AICU) to the High Dependency Unit (HDU)?’ The funding from FoNS and the enthusiasm and hard work of the team members enabled improvements to be made to patient care, focusing on communication with patients and relatives by doctors and nurses.

The team did this by using the EBCD approach to listen to patients’ and staff stories; to present these stories at staff and patient events; to decide priorities for action and to drive forward action planning and implementation of changes at the patient-staff co-design event. Actions for changes in communication behaviour for doctors and nurses to provide person-centred care to patients and relatives have been implemented. Ensuring these changes are sustained is the team’s next challenge.

There were many challenges to achieving the aims of this project including: finding the time to collect the patient and staff data in order to evaluate patient experiences; analysing the interviews; managing changes in the team and increased clinical work load. However the opportunity to learn and use the practice development approaches introduced by the ‘Patients First’ programme meant the team were supported and the project aims were achieved.

**Recommendations**
The EBCD approach proved invaluable for the team to capture patients’ experiences of the transfer process from AICU to HDU and to involve patients in making changes to the delivery of patient care. It is an approach that will be used again but planning and support are needed to ensure EBCD projects succeed:

- Team support from an organisation such as FoNS ensures that project targets are met and help is provided to overcome cultural and organisational barriers
- Tools are available for teams to use EBCD but novices in the approach will need support from nurses experienced in practice development and in using interviews and observation to capture patients’ experiences
- A project manager is essential to co-ordinate the different stages of the approach
- Regular team meetings, action planning and good communication within the team and with colleagues about the project’s aims ensure challenges can be overcome.
The project team:
Surjeet Kaur, Senior Nurse/Service Manager AICU
Michele Hiscock, Deputy Director of Nursing
Dr Sharon Fleming, Head of Research in Nursing
Joy Anderson, Senior Nurse/Matron AICU
Rita Peters, Nurse Consultant in Critical Care
Sari Sundin, Senior Staff Nurse, Anaesthetic and Critical Care
Julie Hedger, AICU/Critical Care Outreach Sister
Vijay Lutchmee, Practice Educator, Respiratory Medicine
Vicky Powell, HDU Clinical Practice Educator, Surgery
Kieran McManamy, Staff Nurse, HD

References


Appendix 1

Topic guide for Staff Interviews

1. **Introduction**
Tell me about your nursing experience and how long you have worked here

Tell me what your role is

2. **Transfer process**
What are your perceptions of the service you are providing to patients at time of transfer to HDU?

Tell me about the decision making process of where to transfer the patients and the actual transfer process

Tell me about the preparation to transfer a patient

Tell me about the confidence you have in transferring patients from AICU to HDU

Tell me if you feel you have enough knowledge to care for these patients

Tell me your learning needs in regards to transferring patients from AICU to HDU

Tell me about the support you have to care for the patient during the transfer process

Tell me about a positive transfer experience

Tell me about a negative transfer experience

*(If staff talk about politics within the service)* How does this issue impact on patient experience?

[Interviewer to summarise list of positive aspects and problems]*

3. **Perceptions of patients’ experiences**
What do you think it is like being a patient when being transferred from AICU?

What do you think the patients perceive about the service you are providing when patients are transferred?

Which patient needs are met? Not met?

What could be improved for patients and their families during the transfer process?

In your opinion, what are the major ‘touch points’ or critical moments in the patient journey at transfer from AICU to the HDU (the things or events that really shaped their overall experience)?

[Interviewer to summarise list of positive aspects and problems]*
4. **Improving the service**

What do you see are the main priorities for improving the transfer process from the staff point of view? What changes should be made?

What other things do you feel would help to improve your experience and the experience of other staff during the transfer process?

What do you think patients and family would identify as things that would help to improve their experiences of transfer to the HDU?

In your opinion, where might we begin to improve the patient transfer experience?

[Interviewer to summarise list of priorities]

Ask the interviewee which HDU they were discussing in their interview

Any questions for me?

Thank you for your time
Appendix 2

Patient interview topic guide
The story of your journey from AICU to HDU

Introduction

1. Your journey from AICU to HDU
Tell me about your journey in general. How was it for you?
Tell me about your care in AICU before the transfer. (prompts: feelings; information given to patient and family; patient comfort (person-centred care, were they washed, given drinks or food before transfer, dressings done, was transfer rushed?); were there delays; were family with them).
Tell me about the journey to HDU (feelings; lifts, was it a smooth journey, porters, bumpy, ambulance if respiratory HDU)
Tell me about getting to HDU (feelings; greeting; settling in, nurses talking to each other; belongings and right equipment; meeting staff; seeing family)

2. Issues
Overall satisfaction
Broadly speaking, how satisfied have you been so far with the care and treatment you have received for the transfer from AICU to HDU?
What are the best bits and worst bits of the transfer process?
The information you received
Did you find it difficult or awkward to communicate with the doctors or nurses?
What would you have liked more information about?
What information would your family have liked?
Have there been times when you have been given conflicting or contradictory information?
Were you clear about what was going to happen to you while you were being transferred?
Were you clear about your care on HDU?
Your relationships with the doctors and nurses you met
Tell me about your relationships with staff.
Tell how much staff supported you during the transfer process?
Tell me about the relationship of staff with your family?
Tell me whether you think staff knew you as an individual

3. Best and worst bits

Where would you say are the crucial points in the transfer process – moments of truth?
Are there crucial touch points? The parts we should focus on in the design process?
What were the best and worst parts of your whole experience?
Based on your first-hand experience, if you were looking to improve the services for patients being transferred from AICU to HDU where would you begin? Imagine we were setting it all up from scratch. (This question includes physical environment, the process itself, staff attitudes and behaviour, etc)?

THANK YOU
Any questions for me?
### Action plan

<table>
<thead>
<tr>
<th>Objective</th>
<th>What action is required</th>
<th>Who</th>
<th>By when</th>
<th>Resources/support needed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>