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Improving Care for Older People at Newham University Hospital

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Background
This project was initiated following a number of complaints concerning communication between staff and patients on wards caring for older people. A review of the previous years in patient survey data and Essence of Care (Department of Health, 2003) audit results was undertaken and this showed that patients did not feel involved in their care, were given little opportunity to care for themselves when they could and often did not know the name of the nurse looking after them. These findings are supported by recent national reviews.

A New Ambition of Old Age (Department of Health, 2006) commended the progress made in achieving the standards set in the National Service Framework for Older People in 2001 (Department of Health), but also acknowledged that there was still work to be done including improving the skills and competences of the workforce caring for older people and championing change to ensure standards of care improve.

The knowledge and skills of staff involved in the rehabilitation of older people and the care of people with dementia are particularly important to ensure that the independence of older people is maximised so that they can be supported to return to their own homes on discharge from hospital (National Institute for Health and Clinical Excellence, 2006; Royal College of Nursing, 2007).

Good communication is often what makes the difference between a positive hospital experience and a negative one. A review by the Healthcare Commission (2007) identified that older people in particular do not always feel adequately involved in their care. They demonstrated that work is still to be done to ensure that patients feel listened to and are given the information and answers that they want and can understand.

Aims of project
The aims of the project were determined in consultation with members of the Newham Older Peoples Reference Group and the Newham Patients Forum. These included:
- Improving communication between staff and patients
- Increasing the involvement of patients in their care
- Enabling patients to care for themselves

Project outline
The project began in June 2006 when a multidisciplinary project group was established. The group started by reviewing local evidence of care including complaints, critical incidents, surveys and audit data. During the following three months, this information was used to inform the development of the project aims in consultation with user groups and four service user representatives were recruited to the project group.

Three key areas of activity formed the main focus of the project; the development of a rehabilitation skills training programme; the introduction of a named nurse system and the establishment of new multidisciplinary documentation. The implementation and evaluation of these activities will be outlined below.

Developing rehabilitation skills to enable patients to care for themselves
A rehabilitation skills training programme for nurses was established which was facilitated by different therapists within the project group and aimed at nurses on four older peoples wards. The training was complemented by competences to be completed in the clinical areas following the training. This process was facilitated by the therapists who had delivered the programme as they provided one-to-one support to enable staff to use their new skills in practice. The programme began in February 2007 and initial evaluations in March 2007 showed that nurses found the training relevant but not always easy to put into practice. This was because at this stage only a small number of nurses had been trained and the culture of care in their ward environments was not focused on enabling patients and equipment to aid rehabilitation was not available. To overcome this, the frequency of training was increased and ward managers were encouraged to attend so that they could lead a change in the culture of care on the wards. Funding was also sought to purchase perching stools and raised toilet seats.

The training programme continued until January 2008 and then it was evaluated in two ways. An evaluation form and knowledge questionnaire was sent to all fifty two nurses who had taken part and twenty were returned. Whilst all the respondents stated that they felt that the training was relevant to their practice, 73% still felt that it was not always easy to put their new skills into practice. Respondents had retained the knowledge they had been taught with seventeen scoring over 50% and half scoring over 70%.

Observation of practice was carried out over a two week period by the therapists who had taught the programme. This showed that skills taught by the speech and language therapists and physiotherapists were being used in practice 69% of the time; those taught by the occupational therapists 73% of the time; continence care skills 98% of the time and skills relating to the medical care of a rehabilitation patient 88% of the time.

Further ward based sessions are planned to help staff continue to integrate these new skills into practice.

Introducing a named nurse system

To improve communication between patients and nurses a named nurse system was established in January 2007 on one of the older peoples wards. The aim was to encourage staff to involve patients in the planning of their care and to become a point of contact for any questions that the patient or their relatives may have. Notices were produced for each bedside to inform patients of the system and to inform them who their named nurse was. Discussion groups were held with staff to encourage them to share any concerns they had about the new approach and to involve them in identifying different ways of working to sustain this approach. Patient questionnaires were used to undertake an initial evaluation twelve weeks after the introduction of the system. Responses showed that many patients still did not know the name of their nurses or feel able to ask questions. After discussions with the service user representatives, several initiatives to support the new system were implemented. This included further ward based training; staff were encouraged to complete their daily evaluations at the patient's bedside to provide an opportunity for the nurse to review the care plan with the patient and answer any questions that the patient may have.

A review of the outcomes of the staff discussion groups showed that staff were positive about the system and felt that it had enabled them to develop a better rapport with their patients and consequently, this had helped to reduce complaints and improve discharge planning.

A further patient evaluation was carried out in April 2008 and this identified an improvement in communication from the patients' perspective. This involved a survey of twenty patients and the findings are outlined in the table below.

	1st survey result	2nd survey result
% of patients who knew who their named nurse was	0	31
% of patients who knew the name of the nurse looking after them that day	11	63
% of patients whose nurse had talked to them about their care	0	52
% of patients who knew what their plan of care was	0	31
% of patients who felt they could ask nurses questions about their care	44	100
% of patients whose questions were answered satisfactorily when they asked the nurses	11	100

Multidisciplinary documentation

Each discipline in the multidisciplinary team documented their care or treatment in a different place so nursing staff did not always have up to date information to pass on to patients and relatives. The project group produced a multidisciplinary document to be completed at each multidisciplinary team meeting to show the current plans of each discipline and filed this in the patient's notes so it could be accessed by the whole team. A similar document was also produced to be kept at the bedside and contained any information that needed to be passed on to patients or relatives to keep them up to date. The new documentation was initially introduced onto one ward in January 2007, but has subsequently been introduced on two further wards.

A questionnaire was sent to staff from all disciplines working on two older peoples wards to evaluate the new documentation. One of the wards was the pilot ward for the new documentation and the other was using its own documentation. 70% of staff on the pilot ward used the new documentation as their main source of information about the multidisciplinary involvement in patient care. This compared to the other ward where staff used a variety of sources, most of which involved finding the individual therapist and asking them personally. All the staff on the pilot ward felt that the information they wanted was easy to find most or all of the time compared to the other ward where 14% felt that information wasn't easy to find. To evaluate the documentation kept at the bedside, a purposive sample of ten patients who were able to use the documentation and were not acutely unwell were asked if they knew about the form, how often they looked at it and whether the information had been useful to them. 40% of the patients questioned knew about the form and 75% had looked at it once and found it useful. More work needs to be done to determine whether patients want information they can read themselves and the format this should take before progressing with this document.

Conclusion

This two year initiative started in response to local complaints, patient survey and audit data which showed that improvements needed to be made to the older peoples services, particularly in relation to communication, involving patients in their care and enabling patients to care for themselves. It has involved all the members of the multidisciplinary team and service user representatives. Although three key areas of activity have been outlined in this report, in reality, there have been many inter-related spirals of development involving all members of the multidisciplinary team, many of which are still ongoing. Positive patient outcomes have been demonstrated.

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A Proactive Approach to the Prevention of Pressure Ulcers in Nursing Homes

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Background

A pressure ulcer is a localised area of dead tissue resulting from an impaired blood supply. This is usually caused by pressure between an internal bony prominence and an outside resistant force which results in necrosis, but can also be caused by the forces of shear (tissue distortion) and friction (Allman, 1997). They are regarded as serious wounds, potentially causing disability, distress and death. The pressure ulcer is preventable in the most part if the circumstances likely to result in an ulcer are recognised; if those at risk are identified early and appropriate preventative measures are implemented without delay (Department of Health, 2001).

Prevalence of pressure ulcers can be defined as: 'the number of people with a pressure ulcer as a proportion of the entire population over a defined period of time' (European Pressure Ulcer Advisory Panel, 2002).

Aim of project

The overall aim of this project was to reduce the prevalence of pressure ulcers in seven nursing homes within the Heart of Birmingham PCT by 5% annually in line with the Department of Health (1992) recommendations outlined in Health of the Nation.

Project outline

This project was led by the tissue viability service and adopted a proactive approach to reducing the prevalence of pressure ulcers using a combination of detailed audit and support and education for nursing home staff.

Initial audit of the prevalence of pressure ulcers

The tissue viability service developed an audit process consisting of three parts:
1 Examining the tissue viability documentation at each nursing home to ensure that each resident has a risk assessment and that appropriate care planning is in place for prevention and treatment
2 Checking all equipment that can affect the pressure areas of residents to ensure that it is fit for purpose and meets the needs of individuals
3 A skin inspection of all residents to check vulnerable pressure areas and provide clinical advice for prevention

An initial audit of all seven nursing homes within the Heart of Birmingham PCT was undertaken in 2005. This showed that there was a high prevalence of pressure ulcers within each nursing home and an average across the Trust of 38%.

Preventing pressure ulcers through collaborative working

Through the auditing process, the tissue viability nurses were able to identify the needs of residents and staff in relation to the prevention and treatment of pressure ulcers. This informed the development of a preventative strategy which used multiple approaches including:
• Working with nursing home staff to develop positive relationships. Leadership from the nursing home managers is vital to ensure that evidence based advice is implemented and therefore the tissue viability nurses maintain regular telephone contact with home managers to support this process. They also provide clinical support and regular tissue viability updates for staff
• Providing clinical advice for all grades of pressure ulcers that is evidence-based and specific to the individual needs of residents
• Assessing tissue viability equipment and providing guidance to help with the replacement of some equipment
• Providing training courses for qualified staff and health care assistants. These are followed up in the nursing homes by the tissue viability nurses who work along side the staff to help them to make sense of the training in relation to specific residents and therefore to embed changes in practice
• Developing a tissue viability resource file for each nursing home
• Involving the multidisciplinary teams in referrals
• Making adult protection referrals as appropriate

Following the initial audit, a second audit was undertaken in 2006. On average the prevalence of pressure ulcers was reduced by 14% (from 38% to 24%). The Department of Health (1992) set an annual reduction target of 5% and this was achieved in five out of seven homes by the year 2006/07. Whilst these audit results reflect positive achievements, the prevalence remains high and the overall plan is to reduce it to below 10% by ongoing developments.

Ongoing development

With each audit that is completed, the tissue viability nurses highlight areas for possible improvement and development resulting in an evolving process. Following the second audit, further opportunities were identified. These included:
• The continued provision of generic training and the development of advanced training in areas such as the identification of pressure ulcers in residents that have pigmented skin, the identification of clinical infection and documentation and risk assessment
• Enabling reflective practice to learn from issues raised within the homes
• The development of a link nurse scheme to enable the cascading of information in each nursing home

Support for this initiative from the PCT has been vital. This has been achieved by the tissue viability service proactively communicating with them on a regular basis to provide information about audit results and new initiatives.

Conclusion

As a result of this proactive approach, the tissue viability service has been able to provide a specialist service directly to nursing home residents that meet the needs of patients and staff. As a consequence, both hospital outpatient appointments and hospital admissions have been reduced and a health care gap has been reduced thereby reducing the health inequalities that are often associated with older people. This addresses the Department of Health targets set out in the National Service Framework for Older People (2001) and Our NHS, Our Future (2007). Following the successful development of a business plan, the tissue viability service is being expanded to allow this approach to be rolled out across two further PCTs covering fifty seven more nursing homes.

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Baby Bumps

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Background

Teenage pregnancy rates in the UK are the highest in Western Europe and Tayside has the highest rate in Scotland. Tackling teenage pregnancy is central to the government's work to prevent health inequalities, child poverty and social exclusion (Department of Health, 2007a).

Teenage pregnancy and early motherhood are widely recognised to be associated with poor outcomes in terms of both health and social exclusion (Department of Health, 2007b). Poor outcomes do not however have to be inevitable. Many of the health risks associated with teenage pregnancies can be reduced with a comprehensive antenatal programme (NHS Centre for Reviews and Dissemination, 1997), particularly where it is provided as a dedicated teenage service and is part of a multi-disciplinary and multi-sectorial programme to support young people (Ukil and Essen, 2002).

Teenagers are most likely to access care where health care professionals run specially designated programmes and work in liaison with other relevant agencies (Sure Start Plus, 2005). With this in mind, in 2006 a public health link nurse and specialist midwife submitted a proposal to the Local Regeneration Partnership and successfully secured regeneration funding to support the creation of a community group for pregnant teenagers.

Aim of project

This project aimed to improve access to and uptake of antenatal services by pregnant teenage girls living in an area of social deprivation by developing a group specifically to meet their needs.

Project outline

The Baby Bumps group provides support, information and antenatal care for teenage girls in community premises in an area of social deprivation. Local community settings are often more appropriate for young girls as they can be less intimidating and more familiar than hospitals and GP surgeries.

At the initial pregnancy booking visit, pregnant teenagers are given information about the group by the community midwife, who then sends a referral to the specialist midwife. The public health link nurse or the specialist midwife then contacts the teenager to talk to them about the group and to arrange transport to the venue for them. Taxis are used to pick up and drop off the girls as pilot sessions indicated that it is extremely important to make it easy for the girls to attend.

Baby Bumps recognises that many young women need assistance in resolving crisis issues such as housing, financial support and relationship difficulties and until these issues are resolved, dealing with the pregnancy is not a priority. The teenagers can therefore access information from wider agencies, peer support, parent education as well as routine antenatal checks.

Each of the group sessions is tailored to the needs of the teenagers, based on both formal and informal feedback. This involves talking to the teenagers at each group to help with the planning of future sessions and the use of a questionnaire which is given to the teenagers on a quarterly basis to help the public health link nurse and specialist midwife to evaluate how the group is helping the teenagers to prepare for parenthood.

Outcomes

To date 73 teenagers have attended the group and 60 have given birth. Of the 60 girls who have given birth so far, 33 (55%) have initiated breast feeding at birth and 28 (46%) were breast feeding at 10 days. These figures are favourable when compared with national figures which show that 15.6% of young women aged under twenty years old were breast feeding at 10 days (Information Services Division, 2008).

Nationally, 7.8% of babies are born before 37weeks gestation and 2.7% of term babies are classified as low birth weight (<2499gms). Using these statistics we would expect to see at least four premature babies and one to two low birth weight babies. However, teenage mothers are 25% more likely to give birth prematurely or have a low birth weight baby, which increases the numbers to five and 1.9 respectively. So far, only two low birth weight babies have been born and there have not been any pre term births resulting in fewer admissions to the neonatal unit and significant savings for NHS Tayside.

There has been an increasing uptake of other service such as parent education classes and attendance at hospital clinics. Prior to setting up Baby Bumps, approximately 8% of teenage mothers attended parent education sessions. This figure has now increased to 28%. Local attendance records indicate that there has been a reduction in non-attendance at hospitals and GP clinics. The group members have also accessed a wide range of other services including literacy services, dental services, smoking cessation support, welfare rights services and the Citizen's Advice bureau through direct and indirect referral from Baby Bumps.

Social isolation has been reduced by bringing these girls together and friendships being formed which are often maintained out with the group. Evidence from the evaluation has shown positive outcomes with increased confidence in themselves and in their ability to become a parent being attributed to the support of the group. The teenagers themselves have responded well to the invitation to attend the group and word of mouth has made it an 'OK' group to go to.

Conclusion

The Baby Bumps group aims to address issues raised by teenage pregnancy and the related health inequalities by providing health education and support that is tailored specifically to meets the needs of young mothers. The evaluations suggest that this approach has positive health outcomes and gives the girls increased confidence during pregnancy and in their ability to parent.

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The Carlton Care Homes Project: A Collaborative Approach to Improve the Quality of Care for Older Adults Living within a Care Home Setting

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Background
Not only has the population of older people living within a care setting greatly expanded over the last two decades, the number of residents who are frail, disabled and have complex health issues has also increased (Royal College of Physicians et al, 2000).

There is an increased incidence of depression, dementia and physical impairment amongst older people who live within institutional care (Royal Commission on Long Term Care, 1999) and evidence to suggest that there are unmet health needs amongst older people living in this setting (Worden et al, 2006). These include diabetes, falls and mental health issues.

Older people living within a care home are at an increased risk of inappropriate prescribing (Department of Health, 2004) and whilst national policy aims to ensure that all older people have an annual review of their medication, it has been found that medication reviews are both seldom and inadequately performed by GPs and this activity is often regarded as time consuming and complex (Klepping, 2000).

Local context
Against this background, it was recognised that older people living within a care home setting were offered an inadequate service by the local General Practitioner's (GP) practice for a number of reasons.

GPs visited each care home to address acute health problems only. This was often a frustrating experience for both the GP and care home staff as there was little uniformity about which GP reviewed a patient as it was dependent upon which doctor was on call. From a GP practice of four GPs covering eighteen homes there was little continuity of care or familiarity between GP and patient. This proved detrimental when trying to promote a relationship and rapport with patients and care home staff. In addition, many requests for a home visit were for non-acute issues that could have been more appropriately dealt with by a nurse (e.g. advice about a wound dressing).

As a result of this fragmented care, no GP within the practice had a clear responsibility or lead for a particular care home. This led to a lack of ownership about performing routine blood tests and ensuring regular medication reviews were performed.

Because the majority of care home residents are housebound they require a domiciliary visit by a practice nurse (PN) to assist and review the ongoing management plan of any chronic disease. These home visits are time consuming (travel time and ongoing surveillance) and often require the transportation of specialist equipment (for example, spirometry). Practice staff within the GP surgery wrongly assumed that each nursing home had the skills and ability to lead the management of each particular chronic disease for their patients. However, when questioned, these staff reported a lack of knowledge and expertise to perform this task. These factors led to a lack of care home patients receiving a thorough review of their chronic disease by the PN. This demonstrated an inequitable approach to the quality of care delivered to care home residents.

Finally, there was minimal attention afforded to working collaboratively with the care home staff to adopt a proactive approach to health promotion and address common health deficits experienced by older adults in later life. Incentives to improve the quality of life feature within both national and local health targets and were formally incorporated into care provided by the GP practice through being included as specific indicators within the Quality and Outcome Framework register (Department of Health, 2004).

Although residents in care homes represent a minority of the practice population, it was observed that they attracted a disproportionate number of requests for domiciliary visits and were high users of both out-of-hours and accident and emergency (A&E) services. A proposal was therefore accepted by the GP partners for all residents living in care homes to be case managed by the ANP for a period of twelve months.

Aim of project
The aim of the Carlton Care Homes Project was to develop a collaborative case management approach to improve the quality and delivery of care received by older adults living within a care home setting. This development was led by an Advanced Nurse Practitioner (ANP) with a special interest in older people who was based within a GP practice.

Project outline
There was a general consensus amongst GP practice staff that the service provided to care home patients was generally disorganised and reactive. A briefing paper was produced and presented to all practice staff at a clinical meeting to provide a clear description about how an improved method of case management of care home residents could result in several positive outcomes for the GP practice, care home staff and ultimately the patient.

Each home manager involved in the care homes project was visited by the ANP to provide an overview and raise the profile of this development. This also provided an opportunity to learn first hand how care staff felt about the service that they received from the GP practice and any ideas staff had about opportunities to improve this relationship, which could potentially result in benefits for all parties. From the beginning, all care staff described enthusiasm and support for adopting a new way of working. Care staff often reported feeling 'isolated' from the GP practice particularly because they received little communication from various health professionals.

A template was developed to structure an initial health interview with each care home resident based upon a consultation model developed by Bickley (2005). This included a series of prompts for taking a holistic health history with the addition of a section to record baseline measurements of height, weight, pulse, blood pressure and respirations. Past medical history was also retrieved from the electronic GP records. All residents received a holistic health assessment including a review of their medication by the ANP and all information was recorded within documentation that remained with the resident at the care home, so as it could be accessed and added to by other health and social care professionals. Following the initial assessment follow up care was planned and initiated.

Through a process of negotiation between the care homes and practice staff, a new system for requesting domiciliary visits was implemented with specific responsibilities for both the care home staff and GP practice staff. Under the new system, a request for a visit has to be received by the ANP before 10.30am to guarantee a same day visit. This helps both the ANP and care homes to plan their workloads and for the care home to have the resident ready for the ANP to assess at the time of the planned visit. The care home staff are also expected to have taken baseline observations for the ill resident and be available to speak to the ANP at the planned visit time. This approach has enabled the care home staff to take a more proactive role with the reassurance that the ANP will be visiting.

This new approach to case management has enabled the ANP to develop a relationship and rapport with residents and staff. By undertaking two weekly reviews with all residents, familiarity and understanding has been developed between all involved.

Outcomes

During the project a variety of processes were used to identify quantitative and qualitative outcomes for this new approach.

Requests for a domiciliary visit and the number of admissions to the A&E department fell sharply and consistently during the first twelve months of the care homes project. From January to June 2006 there were 25 admissions to A&E whereas from July to December 2006 there were 16 admissions. Similarly, from January to June 2006 requests for domiciliary visits ranged from twenty to fifty per month compared with eleven to twenty requests per month from July to December 2006. These falls are probably attributable to the regular surveillance that care home residents received as this helped to pre-empt and potentially reduce any acute and chronic deterioration in health.

Care staff reported improved satisfaction with this revised method of delivering care for a number of reasons. These included:
- having increased confidence about managing patients due to the support from the ANP
- being able to ring the ANP who was familiar with the residents and the care home enabled staff to discuss appropriate solutions to health care issues
- feeling reassured that a same day visit for unwell residents could be arranged through the ANP

Through the process of screening and clinical assessment, a number of insidious health problems were detected. These included hypertension (four residents), chronic kidney disease (six residents), depression (four residents), and hypothyroidism (one resident). This led to the implementation of measures to treat and prevent any deterioration in these conditions.

The medications of all residents were reviewed regularly. As a consequence, many residents had an alteration in their regime. This included the removal of unsuitable medications, alterations in preparations, the introduction of new and more suitable drugs, the review of maintenance dosages and the monitored withdrawal of some unnecessary drugs e.g. benzodiazepines. Overall, this in depth medication review resulted in an annual cost saving of £22,163.

There are many examples of qualitative improvements in the health of care home residents. Some illustrations are provided below.

A male resident, who refused to engage with the ANP during the first few months of visits, eventually came to sit with her and talked about the various activities that he had enjoyed as a younger adult. He admitted to feeling increasingly 'fed up' and despondent about living within the care home and attributed this to his irritation with care staff, who often appeared to spend greater time engaged in task orientated activities with other residents resulting in little time available to talk to him. This led to several discussions with the home manager and eventually an activities coordinator was recruited to improve the quality of life for the residents.

During her visits to one of the care homes, the ANP noticed that a male resident who had no relevant medical problems identified during the initial health assessment, was spending a large amount of time in his room alone and drinking excessive amounts of alcohol. The care staff stated that this was 'normal for him'. The use of a depression screen provided a diagnosis of severe depression and this was confirmed upon discussion. He started taking anti-depressants and within three months he had taken up swimming and entertaining other residents in the day room with amusing stories of his adulthood.

A lady who persistently fell was found to have abnormal blood results. The low sodium contributed towards her falls risk and was attributable to her anti-epilepsy medication. A thorough review of her medical notes cast a doubt on her epilepsy diagnosis. After consultation with a neurologist, her anti-epilepsy medication was reduced and then stopped without any adverse reactions. Her falls have ceased.

Conclusion

This project has demonstrated how a collaborative nurse-led approach to case management within care homes can improve communication and the care delivered to residents. Proactive, organised and holistic care provided to a defined population resulted in positive quantitative and qualitative outcomes for residents, care home staff and the GP practice.

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Using a Hospital Passport: Improving Access for People with Learning Disabilities to Acute Healthcare and Improving Staff Awareness of Learning Disabilities

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Background
This project emerged from previous work at St George's Hospital that aimed to make the hospital friendlier and easier to use for people with learning disabilities (see http://www.fons.org/ns/Dissemination_series_reports/DissSeriesVol3No1.pdf). Following on from the success of this work, the project team wanted to make sure that the increased profile of learning disabilities throughout the organisation was continued and built on and this coincided with policy/practice drivers such as Death by Indifference (Mencap, 2007) and Equal Treatment: Closing the Gap (Disability Rights Commission, 2006).

Patients with learning disabilities have greater healthcare needs than the general population (Foundation for People with Learning Disabilities, 2006). They have the same right to access services as the general population; however, mainstream services have been slow to acknowledge the specific needs of this group of patients and often lack the knowledge and skills to meet these needs (Department of Health, 2001). Godsell and Scarborough (2006, p58) suggest that individualised health action plans, simplified communication styles, accessible facilities and tailored resources are all strategies that can be used to improve healthcare access.

Aim of project
This project aimed to develop, implement and evaluate a patient held hospital passport scheme in an acute hospital setting to raise staff awareness regarding the needs of patients with learning disabilities and to improve communication and the care experience for this group of patients.

Project outline
This project was led by a team including staff working in the acute hospital and community learning disability teams; and has actively involved service users, carers and organisations supporting people with learning disabilities.

In the early stages of the project (early 2007), evidence to inform the development process was collected. This included background data regarding the profile of service users with learning disabilities using the hospital, for example the number of service users with a learning disability, the reasons for referrals to hospital, their co-morbidities and additional demographic data.

Staff awareness of learning disabilities was measured using the nominal group technique to provide a 'before' and 'after' picture of the effectiveness of the passports on improving staff knowledge of learning disabilities. The project team detected a general sense amongst staff of feeling 'audited out' and the selection of the nominal group technique was informed by this. By using this approach, the project team could avoid asking staff to fill out forms/paperwork as it was generally based around group discussion. In January 2008, 23 qualified nurses took part in nominal group one (NG1) and reached consensus of opinion about the most important challenges that they faced when caring for patients with learning disabilities.

The passports were developed in partnership with service users with learning disabilities. It evolved through multiple draft stages with the service users being involved at each stage commenting on both wording and layout. A final version was achieved when no further amendments were suggested by any of the service users. The passports adopt a traffic light communication system and are based on similar tools developed by other services; in particular one developed by a learning disability team in Gloucestershire (Corbett, 2007). The traffic light system is very visual; red covers essential need to know information (such as name, address, next of kin details), amber describes information that would be very useful when caring for the patient (such as diet preferences) and green provides information that could be useful for nurses to read though not necessarily urgent on admission (such as likes and dislikes). The passports are printed in full colour and have a laminated front cover to make them as striking and identifiable as possible.

Implementation of the passports involved the identification of service users with learning disabilities who had forthcoming elective admissions, from the caseloads of the learning disability nurses on the project team. The service users were asked if they would like to use the passports and if so, were supported (if necessary) to complete one in preparation for their admission.

Outcomes
Staff awareness of learning disabilities
In June 2008, when learning disabled patients had started to use the passport, nominal group two (NG2) was conducted involving twenty eight experienced nurses. The consensus suggested that the passport had made a difference to caring for patients with learning disabilities. Of the seven challenges identified in NG1, the hospital passport was considered to have addressed five. Ten previously unidentified challenges also emerged from NG2 suggesting that staff awareness had increased about caring for patients with learning disabilities.

Patient experiences
Patient experience regarding experiences of using the hospital was collated from June 2008 using semi-structured interviews based on eight questions formulated by the project overview team. Although the numbers of patients who have used the passport are still relatively small and therefore firm conclusions cannot yet be drawn, positive feedback has been received. The following case example demonstrates this:

Recently a service user was admitted to XX ward…I helped carers to fill in a hospital passport and shared it with the ward sister…, as well as the nurse who was caring for the service user at the time…When carers from her home went to visit they were really pleased to learn that the staff…had read the hospital passport and were using the information inside.

For example, staff knew that the service user is a fan of [a pop singer] and that she is scared to sleep in the dark. Because of this, her light had been left on at night and people had chatted to her about [a pop singer]! The carers felt she would find this especially comforting as it was her birthday yesterday and staff noted that too.

The carers have asked if they can have some hospital passports in the home. This is so that they can fill in sections with service users, so that the just need to be brought up to date if someone needs to attend hospital on an emergency basis or as a planned admission, and so that service users feel they have ownership.

(Community Learning Disability Nurse who was not part of project team)

Continued development

The project overview team are continuing to meet to enable the continued development of the passports in response to ongoing evaluation feedback from service users and staff. Based on patient feedback, a few amendments need to be made to the passports such as replacing the diagrams with photographs of medical staff and parts of the body.

A training session for new staff has been introduced on the nurse induction programme which will reach about 500 nurses per year. These sessions are being delivered by a rotating member of staff from the community learning disability teams and cover awareness of communication issues, how to support people with learning disabilities and how to recognise/use the hospital passport. Ideally, service user involvement will be part of these sessions.

It is intended that a hospital passport will be patient-specific rather than organisation-specific and that the passports will be accepted across agency/organisational boundaries. Therefore a wider working group incorporating leaders from neighbouring hospital and primary care trusts has just been established, with a vision to develop one passport that will be implemented across healthcare organisations in south west London.

An underpinning perspective (based on a quote from a service user involved in the previous project) was that getting things right for people with learning disabilities means that you get things right for a lot of people. By improving access for people with learning disabilities, it is also likely that access for other groups of patients such as those with other disabilities, people who do not speak English as their first language and people with expressive or receptive communication difficulties. In fact, an example of transferability of findings has lead to a pilot study of a communication tool for patients of the Multiple Sclerosis Service.

Conclusion

This project involved the development and implementation of patient held hospital passports in an acute hospital. The passport was developed in partnership with service users, carers and other organisations supporting people with learning disabilities. A passport, like a health action plan, is completed by/with a person with disabilities and it contains information considered necessary for a hospital appointment/admission. Ultimately it is intended that the passport will form part of the patient's health action plan once that has been completed but it is also designed as a stand alone document. The patients involved in this project who used the passports felt that they had supported communication during their hospital admission and improved their overall care experience.

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