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An evaluation of a nurse led unit: an action research study

Williamson, T, Rawle, A, Bacon, E, Cooper, E, Davies, N, Eastwood, J, Evans, A, Freeman, S, Green, J, Hindley, G, Jeffreys, J, Johnson, J, Lee, N, Low, J, Martin, J, Rayner, J, Reynolds, P, Richardson, M, Sewell, B, Tickner, D and Whitworth, J

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Salford Centre for Nursing,
Midwifery & Collaborative
Research

An evaluation of a nurse-led unit: an action research study

Tracey Williamson
Alison Rawle
Elaine Bacon
Elma Cooper
Nicola Davies
Janet Eastwood
Alison Evans
Sharon Freeman
Jenny Green
Graham Hindley
John Jeffrey

Joan Johnson
Nancy Lee
Jane Low
John Martin
Janet Rayner
Penny Reynolds
Marion Richardson
Beverley Sewell
David Tickner
June Whitworth

November 2006

Derbyshire County 
Primary Care Trust

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Contact the School of Nursing:

Tel: +44(0)845 234 0184
E-mail: fhsc@salford.ac.uk

Contact the Salford Centre for Nursing, Midwifery and Collaborative Research:

Wendy Moran
Tel: +44(0)161 295 2768
E-mail: w.e.moran@salford.ac.uk

www.ihscr.salford.ac.uk

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An evaluation of a nurse-led unit: an action research study

FINAL REPORT

November 2006

Research Team members and co-authors of this report:

Research Team Member/Co-author Name	Title	Organisation
Tracey Williamson	Research Fellow Co-Project Lead and Lead Researcher	University of Salford
Alison Rawle	Nurse Consultant, Older People and Co-Project Lead	Derbyshire County PCT
Elaine Bacon	Nurse Practitioner	Derbyshire County PCT
Elma Cooper	Member	North East Derbyshire PPI Forum
Nicola Davies	Physiotherapist	Derbyshire County PCT
Janet Eastwood	Occupational Therapist	Derbyshire County PCT
Alison Evans	Occupational Therapist	Derbyshire County PCT
Sharon Freeman	Nursing Assistant	Derbyshire County PCT
Jenny Green	Ward Clerk	Derbyshire County PCT
Graham Hindley	Physiotherapist	Derbyshire County PCT
John Jeffrey	Member	North East Derbyshire PPI Forum
Joan Johnson	Nursing Assistant	Derbyshire County PCT
Jane Low	Care Manager	Derbyshire Social Services
John Martin	Vice Chairman	North East Derbyshire PPI Forum
Janet Rayner	Admission, Discharge and Transfer Liaison Nurse	Derbyshire County PCT
Penny Reynolds	Occupational Therapist	Derbyshire County PCT
Marion Richardson	Ward Manager	Derbyshire County PCT
Beverley Sewell	Admin Support	Derbyshire County PCT
David Tickner	Ex-patient	Derwent Ward
June Whitworth	Chair	North East Derbyshire PPI Forum
Nancy Lee (co-author only)	Programme Leader	University of Salford

CONTENTS

		Page
CONTENTS		I
FOREWORD		V
ACKNOWLEDGEMENTS		Vi
PLAIN ENGLISH SUMMARY		Viii
CHAPTER 1 - INTRODUCTION	Background	1
	Evaluation aims	3
	Literature overview	6
	Summary	11
CHAPTER 2 - STUDY DESIGN	Evaluation approach	12
	Involvement and Partnership working	13
	Preparation and training	15
	Study organisation	16
	Identifying evaluation topics	17
	Prioritizing evaluation topics	19
	Evaluation questions	20
	Developing evaluation research questions, methods and tools	22
	Implementing methods and tools	28

	Summary	28
CHAPTER 3 - METHODS	Methods and data collection tools	29
	Sampling and data collection procedure	31
	Ethical and research governance arrangements	47
	Data preparation, management and storage	49
	Study limitations	50
	Summary	51
CHAPTER 4 - ANALYSIS AND FINDINGS	Analysis	52
	Questionnaires	52
	Interviews	52
	Graffiti board, first impressions questionnaire and comments box	53
	Patient tracking pro-formas	53
	Bed census	53
	Findings	54
	Patient perspectives	54
	1. Questionnaires	54
	2. Interviews	58
	Carer perspectives	62
	1. Questionnaires	62
	2. Interviews	64

	Nurse-led bed staff perspectives	72
	1. Questionnaires	72
	2. Interviews	79
	Referring staff perspectives	88
	1. Questionnaires	88
	<ul style="list-style-type: none"> • Medical consultant questionnaire 	93
	2. Interviews	94
	Audit findings	100
	Patient tracking pro-forma - inpatient journey	100
	Patient tracking pro-forma - non-admitted Patient	103
	Patient tracking pro-forma - readmitted/failed discharge	104
	Bed census pro-forma	105
	Graffiti board, first impressions questionnaire and comments box	108
	Summary	108
CHAPTER 5 - REFLECTION		109
	Summary	116
CHAPTER 6 - CONCLUSIONS AND RECOMMENDATIONS		
	Conclusions	117
	Recommendations	117
	Dissemination	119

GLOSSARY		122
APPENDIX	Responses from comments box, graffiti board and first impressions questionnaires	126
REFERENCES		134
TABLES & CHARTS	Table 1 Evaluation methods	23
	Table 2 Data collection summary	46
	Table 3 Appropriate in-patient bed use	107
	Chart 1 Patient involvement in discharge planning	55
	Chart 2 patient views of staff attitudes to privacy and dignity	56
	Chart 3 Carer ratings of verbal information	63
	Chart 4 Nurse-led staff views of admission criteria being met	73
	Chart 5 Carers engagement in discharge planning	74
	Chart 6 Timeliness and appropriateness of patient discharges	74
	Chart 7 Management of patients whose condition deteriorates slowly	75
	Chart 8 Where district nurses' patients go when not admitted	90
	Chart 9 Where GPs' patients go when not admitted	90
	Chart 10 Where other referrers' patients go when not admitted	91
	Chart 11 GPs' view of the appropriateness of nurse-led care	92
	Figure 1 Themes from Reflection	111

FOREWORD

We are delighted to be sharing the final report of the Evaluation of a Nurse Led Unit study with you. We hope that like us you recognise that the journey we have undergone in doing this study has been as valuable as the findings themselves. Furthermore, we hope you find this report accessible and useful whatever your background or particular interest, perhaps as a health and social care professional, service user or member of the public, academic or participant in the study.

Within our study, we have attempted to promote meaningful engagement of the public and service users as a means of adding to the quality of the work. We believe this has ensured the right research questions have been asked and that the project has been undertaken in the most appropriate way available to us. Involvement of a range of staff as research team members has in our view also added greatly in making the focus of the study relevant to them. We are proud of our achievements as a research team and have put a lot of personal energy and enthusiasm into the process. Much has been learnt along the way, not only in terms of research but about ourselves and each other. We hope the findings are taken forward by those who need to act upon them to reinforce existing good practices and to prompt change in others where improvement is needed.

Few teams within the NHS hold themselves up to the scrutiny that the nurse-led bed team has. They are commended for wanting to take a long hard look in the mirror in pursuit of opportunities for improvement, when they could have chosen to merely carry on as before.

Tracey Williamson

Research Fellow – Older People/User Involvement, University of Salford

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We are grateful to the attendees at the first workshop we held to explore ideas for the study. These people significantly helped to inform our thinking and develop our early ideas.

We would like to acknowledge the support we have received from the Trust Research and Development Department, especially Mick Bond and Roger Simpson.

We would like to thank the Study Advisory Group members for their suggestions and views.

We are grateful to the patients and staff working within the Trust who may have fitted around research team members at times as they attended meetings and collected research data.

Patients, their carers, families and visitors helped us greatly by taking part in the study in a variety of ways for which we offer our sincere thanks.

Dr Nancy Lee at the University of Salford is thanked for facilitating reflection sessions to aid our learning within this study which will in turn help us in future studies.

Statistical support has been gratefully received from Leah Greene at the University of Salford

Special thanks go to Beverley Sewell who has provided excellent administration support throughout and made several useful research suggestions.

Lastly, an acknowledgement to Alison Rawle whose leadership and commitment to improving both staff and patient experiences, made the study possible.

PLAIN ENGLISH SUMMARY

INTRODUCTION

This evaluation study was commissioned by Alison Rawle, Nurse Consultant Older People, Derbyshire County Primary Care Trust (PCT) (formerly Chesterfield PCT). This study took place within Walton Hospital which is a community hospital comprising 120 rehabilitation beds and 56 beds for older adults with mental illness. One of the wards, Derwent Ward, changed focus in 2003 and became the pilot site for 6 nurse-led beds. Nurse-led care is where nurses, commonly but not always in a nurse consultant or specialist nurse role, take leadership of one or more patient services, wards or departments which would traditionally have been led by a consultant doctor. The numbers of nurse-led beds at Walton Hospital have since grown.

Nurse-led care is still relatively new in the UK and is an area in need of greater exploration to see whether it provides safe and effective care for patients compared with traditional approaches. Other concerns are whether patients and their families view nurse-led care as acceptable and comparable with traditional, doctor-led care. A research team of nurse-led ward staff, an ex-patient and patient representatives was set up in early 2005 to plan and undertake an evaluation study that answered questions of interest to the different participants.

EVALUATION AIMS

The evaluation aimed to closely examine the structures, processes and outcomes of nurse-led care.

Objectives were:

- To explore staff, patient and carer understandings of a nurse-led approach to care
- To identify how satisfied patients and carers are with their nurse-led experience
- To identify how satisfied staff are with their experience of utilising the nurse-led bed service
- To examine whether quality of patients'/carers' journeys through nurse-led care could be improved
- To utilise a partnership approach to the study with patients and their representatives
- To develop research skills amongst research team members

EVALUATION APPROACH

The research team adopted a workshop approach in designing the study. Eight workshops and three meetings were held to identify what the focus of the evaluation should be, the research approach and tools to be used, roles of research team members, training needs, training sessions, reflection on the experience of doing research, plans to share study findings and final report content. An action research approach was used as this concerns partnership working with staff and lay people as equally valued members of the research team and has a commitment to using the study findings to improve care where needed. Research team members have been involved in all stages of the research process.

METHODS AND DATA COLLECTION

Data collection concerns the information gathered in order to meet the study objectives. A range of methods was used including:

1. Patient questionnaire (research)
2. Patient interviews (research)
3. Carer questionnaire (research)
4. Carer interviews (research)
5. Staff questionnaire - Derwent Ward staff (research)
6. Staff questionnaire - referrers (research)
7. Staff questionnaire - medical consultants (research)
8. Staff interviews - Derwent Ward staff (research)
9. Staff interviews - referrers (research)
10. Patient tracking - inpatient journey pro-forma (audit)
11. Patient tracking - non-admitted patient pro-forma (audit)
12. Patient tracking - re-admitted/failed discharge pro-forma (audit)
13. Bed census pro-forma (audit)
14. Graffiti board (practice development)
15. First impressions questionnaire (practice development)
16. Comments box (practice development)

To meet research team members' preferences, not all methods were research methods. Some were 'practice development' methods (informal means of exploring patient care and people's views of it) and others were 'audit' (used to gather information available in existing documents such as patient records). Research methods were used to rigorously gather and analyse new information through approaches such as interviews and postal surveys.

Questionnaire surveys were undertaken with patients, carers, staff who admit patients to nurse-led care ('referrers' e.g. GPs and district nurses), medical consultants and nurse-led staff themselves. Individual or group interviews were also held with participants from most of these groups. Data were collected between January 2006 and August 2006.

ANALYSIS

Findings from all sixteen methods were analysed for useful, interesting and important information that could help us to gain an accurate picture of what care was like for patients, carers and staff on the nurse-led ward.

FINDINGS

The over all findings indicate that patients, carers and staff who refer to the nurse-led beds are highly satisfied with the service. It is important to note that whilst participants have indicated a few areas for improvement that we don't focus on these without due regard to the fact that overall they were hugely satisfied. The following summary gives an indication of the balance of participants' views that are detailed fully in the Study Final Report.

Patient Perspectives

These findings are drawn mostly from 32 completed questionnaires received from patients (67 % response rate) and individual interviews with 5 ex-patients.

Findings from the survey show overwhelmingly, that patients were very satisfied with their over all experience on the nurse-led ward, with 90% rating it between excellent and satisfactory. General staff communication with patients was viewed as excellent, very good or satisfactory in 90% of patient responses. A staggering 94% rated their level of involvement as excellent, very good or satisfactory. They were also asked to rate the degree of choice they felt they had concerning their care. Again 90% found it to be excellent, very good or satisfactory. In terms of involvement in discharge planning a further 87% were satisfied or above, although 13% found their involvement in this important area to be poor.

Staff attitudes were rated mostly excellent or satisfactory. In relation to staff attitudes to privacy and dignity in particular, patients were even more impressed rating staff as excellent (25 %), very good (59%) and satisfactory (13%). The majority of patients rated ward social activities highly.

At interview, no participants said they were given any written information prior to admission to the nurse-led beds and only one recalled being advised verbally by their doctors that the service was nurse-led and primarily for rehabilitation. All were happy to trust that professionals were admitting them to the best place for them.

Generally speaking communication with staff was viewed as positive although this at times depended on the individual staff member. There was a tendency for participants to feel they had to ask for information rather than being given it routinely. One participant viewed listening skills as very good indeed. Whilst another believed nurse-led staff would get to know patients better than a doctor would. One comment was that all of the nurses showed kindness, consideration and were friendly.

Participants expressed mixed views about their involvement in discharge planning. For some it was unsatisfactory and felt that they had no involvement in the arrangements, merely being 'told' when it was. Others felt a good degree of involvement. Participants' perceptions of involvement in care were mixed. Some did not recall making any choices and did not seem concerned about this.

Promotion of privacy and dignity was generally viewed favourably.

Carer Perspectives

These findings are primarily drawn from 8 returned questionnaires from carers (24 % response rate) and 4 individual interviews with carers.

Carers were very satisfied with their experience on the nurse-led ward with 100% rating it between very good and satisfactory.

All participants considered verbal information to be very good (63%) or satisfactory (38%). Responses rating written information were also favourable with excellent (17%), very good (67%) and satisfactory (17%). General staff communication with carers was viewed by all seven respondents as very good (57%) or satisfactory (43%). When asked to rate staff response to carers' *own* attempts at communication with *them* (e.g. listening skills), staff were rated highly (very good 86% and satisfactory 14%).

All 100% of respondents (7) rated their involvement in care of their relative as excellent, very good or satisfactory. In terms of involvement in discharge planning all carers were at least satisfied (excellent 25%, very good 63% and satisfactory 13%).

All respondents rated staff attitudes as being between excellent and satisfactory, with 3 of these specifying excellent (43%). In relation to staff attitudes to privacy and dignity in particular, carers rated staff as excellent (14%), very good (71%) and satisfactory (14%), based on seven respondents.

Discharge planning was praised on three occasions. One respondent indicated that communication with and by staff was dependent on the individual, although another comment was that communication was good despite staff being clearly overworked. Staff attitudes were also said to be variable by one respondent who added they saw much caring, humour and compassion.

At interview, participants said that no written information was received by them prior to their relative's admission to the nurse-led beds. Like patients, all were content that the right care was being arranged for them.

Most participants expressed no appreciation as to what 'nurse-led care' was about. The differences between the various staff roles were little understood.

Most communication with staff was considered positive although it again depended on the individual staff member. Participants were generally very satisfied with arrangements to maintain privacy and dignity.

Generally equipment provision and other arrangements for relatives' discharge home were satisfactory.

Referring Staff Perspectives

These findings are drawn from 82 completed questionnaires from referrers to the nurse-led beds (57% response rate). These referrers comprised GPs (41 replies out of 82 sent / 50% response rate), district nurses (25 replies out of 42 sent / 60% response rate) and 'others' e.g. Care Managers, community physiotherapists and practice nurses (16 replies out of 21 sent / 76% response rate). Findings are also from 1 focus group interview with 4 district nurses and 2 individual GP interviews.

Of the district nurses who had referred, 94% found the process of accessing a bed 'easy/quick/responsive', compared with 97% of GPs and 92% of 'others'.

Sometimes no bed was available when a referral was made and referrers were asked where those patients had gone to instead. Of the 9 occasions this happened to district nurses, 3 patients stayed at home, 4 went to the Chesterfield Royal Hospital, 1 went to Red House (a residential rehabilitation facility) and 1 went to 'another' destination. Of the 23 occasions this happened to GPs, 3 patients stayed at home, 11 went to the Chesterfield Royal Hospital, 2 went to Red House and 7 went to 'another' destination. Of the 11 occasions this happened to 'other' referrers, 4 patients stayed at home, 3 went to the Chesterfield Royal Hospital, 3 went to Red House and 1 went to 'another' destination.

When asked if they were aware of the admission criteria for the nurse-led beds, 24% of district nurses (4) said they did not; neither did 32% of GPs (10)

and 17% of 'other' referrers (2). A hundred percent of all district nurses, GPs and 'other' referrers agreed that the nurse-led bed criteria were appropriate.

One question asked if respondents believed that patients admitted to the nurse-led beds would receive a comparable service to those who would normally be admitted to medical-led care. Most district nurse respondents agreed - 31% strongly agreed (5) and 56% agreed (9). GP respondents held varied views - 22% strongly agreed (7), 47% agreed (15), 19% neither agreed nor disagreed (6) and 13% disagreed (4). Most 'other' referrers agreed - 36% strongly agreed (4) and 55% agreed (6).

Respondents made numerous comments to reinforce how valuable and effective they felt the service is. District nurses especially made several comments about the complexity of their patients' needs and the need for a holistic approach to their care. Two GPs suggested a single phone number to access services for patients whose needs are non-medical rather than navigating several phone numbers/services.

Only one participant had ever experienced a bed being unavailable within a suitable time-frame and so the nurse-led beds were viewed as very accessible. All participants thought the service was invaluable.

Drawing on personal views and feedback from their own patients, all participants felt the service had a very positive impact on patient experience and outcomes. Low staffing levels were sometimes commented on by participants' patients.

Participants were asked whether the service was really necessary if some patients could be managed at home for a day or two whilst awaiting a bed. In response it was clarified that the nurse-led beds are not an emergency service and some leeway is permissible, usually because family members have stepped up their input temporarily with the knowledge that admission is imminent.

Nurse-led Bed Staff Perspectives

These findings are drawn from 22 completed questionnaires (56% response rate) and 12 individual interviews with nurse-led bed staff (nurses and therapists).

Respondents' satisfaction at working in nurse-led care was variable. When asked if they felt patients who were admitted met the nurse-led bed admission criteria, 14% agreed (3), 24% neither agreed nor disagreed (5), 38% disagreed (8) and 24% strongly disagreed (5).

When asked if patients and relatives are fully engaged in the assessment and planning of care on the nurse-led ward, 14% strongly agreed (3), 36% agreed (8), 32% neither agreed nor disagreed (7) and 18% disagreed (4).

When asked if patients and relatives are fully engaged in the discharge planning process in particular, 9% strongly agreed (2), 36% agreed (8), 32% neither agreed nor disagreed (7), 14% disagreed (3) and 9% strongly disagreed (2).

A further discharge-related question asked whether respondents felt patient discharges from the nurse-led beds were timely and appropriate. Respondents indicated that 25% agreed (4), 25% neither agreed nor disagreed (4), 44% disagreed (7) and 6% strongly disagreed (1). This was because respondents felt that some discharges were hurried due to perceived pressures to admit new patients.

The next question tried to elicit whether respondents felt the nurse-led beds met a previously unmet need. Thirty-eight percent agreed (8), 29% neither agreed nor disagreed (6), 19% disagreed (4) and 14% strongly disagreed (3).

A further question asked whether respondents felt that patients who deteriorate slowly whilst in a nurse-led bed are managed appropriately and promptly by the multi-disciplinary team. Respondents indicated that 5%

strongly agreed (1), 43% agreed (9), 10% neither agreed nor disagreed (2), 38% disagreed (8) and 5% strongly disagreed (1).

Large numbers of comments were made about respondents' views as to the inappropriateness of some admissions to the nurse-led service. The service was generally believed to work well when the right patient-types were admitted.

Past experience of multiple discharges on a single day were viewed as rushed and stressful. High ward activity in the afternoons when staffing levels were reduced was also noted as a particular problem.

Drawbacks of nurse-led care mentioned pertain to the risks of patients with underlying medical needs which may go unmet. This was particularly noted to put pressure on night staff who were viewed as being 'out on a limb', and weekend staff. A need to improve 'do not resuscitate procedures' and how these are discussed with patients and relatives, was expressed by several respondents. A further drawback was that nurse-led care was viewed by some as having to prove itself, which sometimes prompted patient discharges to make way for new admissions. This is because the nurse-led bed service aims to be very accessible and to meet this expectation, some participants felt a degree of pressure to discharge patients when it was known a potential admission was waiting.

Reasons given as to why patients were admitted who were considered inappropriate commonly included pressure by GPs needing to find a bed for somebody and a view that once in the system it would be easier to transfer patients to the acute hospital if required.

It was felt that a large number of patients were repeat admissions to the nurse-led ward, sometimes because of deteriorating condition and sometimes because they had chosen to go home where it may have been difficult to sustain them. Some would then be readmitted to arrange residential or nursing home care.

A small number of participants expressed not being involved in decisions about who to admit and lacked appreciation of the processes concerned.

Many participants highlighted the pressure of having multiple admissions and discharges as a key concern. Admissions late on a Friday afternoon were considered a risk as on-site medical cover was said to finish at 6pm and there was no nurse consultant to clerk patients in once the weekend started. Getting medical assistance when required out-of-hours, was said to be very difficult by several participants. A lack of notice given of an impending discharge was also highlighted frequently and it was felt a couple of hours notice as had sometimes been the case, was insufficient.

A lack of physiotherapy was suggested as an area that did not impact positively on patient care as some patients had to wait several days for physiotherapy input. Discontinuity of work within teams was highlighted and for some staffing levels were viewed as an unhelpful factor.

Despite its issues, all participants felt the service was working well. It was acknowledged that patients were often in longer than the hoped for 6-8 weeks period and there was a view by some that a number of patients were in too long causing some of their progress to be undone. The balanced approach to meeting both health and social care needs was highly valued.

RECOMMENDATIONS

Whilst the views of study participants were overwhelmingly in support of the nurse-led service the point of the study was to reinforce existing good practice and to identify any areas in need of further improvement. The research team identified 43 recommendations for enhancing their practice. The nurse-led ward staff are now taking forward an action plan to prioritise and address all of these issues.

1. Feed back study findings and develop an action plan/priorities to address study recommendations
2. Explore nurse-led staff preferences in relation to working in a nurse-led setting
3. Explore mechanisms for team building and communication e.g. team-building days
4. Consider involvement of nurse-led staff in pre-admission assessment of referred patients to gain insight into these processes
5. Review admission and discharge activity in comparison to the staffing resource and other ward activity
6. Review organisation of care in relation to team nursing
7. Review discharge processes (including involvement of patients/carers, involvement of therapists, notice given, perception of readiness, provision of services and equipment/medications, ward activity, delays)
8. Review management of poorly patients
9. Review implementation of resuscitation policy and procedures
10. Review out-of-hours medical cover arrangements
11. Review management of patients with dementia and mental health needs
12. Appraise physiotherapy provision and referral processes for the nurse-led beds including out-of-hours cover
13. Develop/refine patient/family information giving (to include who is who, roles, type of ward, uniforms, expectations, purpose of social activities etc)

14. Develop nurse-led bed information material specifically for professionals e.g. referring staff
15. Review processes for involving and communicating with patients and relatives e.g. giving updates/test results, explaining purpose of follow-up appointments, multi-disciplinary meetings (timing, processes, who present)
16. Review processes for involving patients and carers in their care e.g. discharge planning and goal setting
17. Review processes for feeding back to patients/carers who make informal complaints or are dissatisfied
18. Review communication processes between professional groups (including use of the taped handover whereby different staff shifts update each other, multi-disciplinary team meetings)
19. Implement a staff training needs analysis and action plan
20. Explore mechanisms to raise awareness about the service for other professionals e.g. an open day or shadowing/exchange opportunities
21. Consider a single point of referral/phone number for intermediate care referrals
22. Review opportunities for out-of-hours admissions to the nurse-led beds
23. Explore mechanisms to routinely feed back to GPs regarding patient progress/reasons for delays
24. Identify opportunities for project participants to apply research skills in other activities
25. Identify opportunities/preferences of the lay members of the project group to be involved in future research or activities
26. Implement study dissemination plan
27. Consider each specific improvement/recommendation suggested by patients, carers, referring staff and nurse-led staff:
 - a. Provision of patient operated bedside lights
 - b. Provision of ward staff cover during handovers
 - c. Provision of hospital hairdressing service
 - d. Provision of a toenail cutting service
 - e. Provision of support for patients who smoke to give up
 - f. Identify means of introducing new/relocated patients to each other

- g. Provision of mechanism to check walking stick length
- h. Provision of more entertainment in the afternoons/evenings
- i. Consider a visiting Welfare Rights Officer service
- j. Provision of staff training around communicating with patients when handling them
- k. Consider an afternoon rest period for patients
- l. Consider provision of a drinks vending machine for patients
- m. Explore mechanisms to integrate patients at home better
- n. Appraise need for increased clerical support for staff
- o. Consider need for more nurse-led beds and provision for patients with modest nursing needs
- p. Review provision of interpreters

CHAPTER ONE

INTRODUCTION

In this chapter, a brief background is given to set the study in context. The over all evaluation aims and objectives are given. An overview of the literature concerning nurse-led and intermediate care is provided.

BACKGROUND

Chesterfield Primary Care Trust is in Derbyshire, in the East Midlands, UK. This study took place within Walton Hospital which is a community hospital comprising 120 rehabilitation beds and 56 beds for older adults with mental illness. One of these wards, Derwent Ward, changed focus in 2003 and became the pilot site for 6 nurse-led beds. Nurse-led care is where nurses, commonly but not always in a nurse consultant or specialist nurse role, take leadership of one or more patient services, wards or departments which would traditionally have had substantive clinical leadership from a consultant doctor. Doctors are still available if required, but the day-to-day management of patients is by nurses. Nurse-led care is still relatively new in the UK and is an area in need of greater exploration to see whether it provides safe and effective care for patients compared with traditional approaches. Other concerns are whether patients and their families view nurse-led care as acceptable and comparable with traditional, doctor-led care.

The Derwent Ward nurse-led beds increased in number in 2004 to 12. Throughout most of this study there were also therapy-led beds on Derwent Ward led by a Consultant Physiotherapist. Patients occupying these beds had *primarily* therapy needs such as mobility, as opposed to nursing or medical needs (although some patients may have a mix of these as well as social needs e.g. for home aids and adaptations). These therapy-led beds have **not** been explored within this current study.

The impetus for an evaluation study came from Alison Rawle (Nurse Consultant Older People). An approach was made to Tracey Williamson at the University of Salford to discuss a possible evaluation study. Alison had previously undertaken an evaluation study of her own on Derwent Ward (Rawle 2003) concerning the original six nurse-led beds. This earlier evaluation completed on 31st January 2004. Alison's wish was for a second study from which to make comparisons to the previous study and to evaluate any new aspects not previously explored which would be of value.

Alison's preference was for an action research study and Tracey was an action researcher. An initial meeting was held between the two at which possibilities and resources required were discussed. The preference for a participatory approach was explored further at a second meeting and a request for Trust funding was made. Funding was forthcoming and so a first workshop-style event was planned to engage with and invite the views and ideas of a range of people who may have had a concern or interest in nurse-led care at the Trust.

This first workshop was held in March 2005 and was facilitated by Tracey. The twenty-two attendees were identified and invited by Alison who made efforts to include a range of people including ex-Derwent Ward patients, a carer organisation, Age Concern, staff from health and social care generally, staff from Derwent Ward specifically, Public and Patient Involvement Forum members and the Trust Research and Development Managers. The programme for the day included:

- Welcome, aims and background
- Demystifying research and evaluation and why action research
- Tentative project ideas to date
- The ethical and other approval processes to be followed
- What, where and how to evaluate
- Expectations and how to be involved
- How we would communicate and share learning

- Initial support and development needs
- Who else needed involving
- Agreeing an action plan, initial thoughts about roles and responsibilities
- Timeframes
- Event feedback

The event evaluated well and from that day, 16 attendees agreed to attend a further meeting with a view to becoming members of the research team. All these volunteers went on to choose to be co-researchers as opposed to being involved in other ways e.g. Study Advisory Group member. A research team was formed with Tracey and Alison appointed as joint Co-leads for the project with Tracey as Lead Researcher. During the lifetime of the study, (March 2005 to September 2006), three research team members left due to personal reasons/work commitments and three other people joined the team.

EVALUATION AIMS

The evaluation aimed to provide insight into the structures, processes and outcomes of nurse-led care focussing on aspects of importance to core stakeholders – staff, patients and their carers.

Objectives were:

- To explore staff, patient and carer understandings of a nurse-led approach to care
- To identify how satisfied patients and carers are with their nurse-led experience
- To identify how satisfied staff are with their experience of utilising the nurse-led bed service
- To examine whether quality of patients'/carers' journeys through nurse-led care could be improved

- To utilise a partnership approach to the study with patients and their representatives
- To develop research capability amongst research team members

The remainder of this chapter provides an overview of the relevant literature including nurse-led care and intermediate care written by Alison Rawle.

Chapter 2 outlines the design of the study including ways of working and the journey from ideas to final tool design.

Chapter 3 sets out the study methods and data collection procedures and concludes with an overview of data preparation, management and storage. It also addresses ethics and research governance approval processes and study limitations.

Chapter 4 outlines the analysis procedures used and study findings. This evaluation evolved to become a tapestry of methods including those of research, audit and practice development. Findings from each method are reported on.

Firstly findings are presented from the patient and carers' perspective, then from the nurse-led bed staff's perspective and lastly from non-nurse-led bed staff's perspective. Findings from audits undertaken to complement the research elements of the study are then presented.

Chapter 5 provides an overview of the reflective elements of the study and considers the extent that the research capacity building goal of the study was achieved.

Chapter 6 brings the report to a close with conclusions, key recommendations and dissemination plans.

A glossary of terms, references and appendix can be found at the back of the report.

LITERATURE OVERVIEW

This section provides an overview of the literature concerning intermediate and nurse-led care.

Intermediate Care in Community Hospitals

According to Young and Donaldson (2001) '*community hospitals are experiencing a revival of interest within the overall policy framework of a primary care-led NHS*'. This is evident by the publication of the health white paper (Meade 2001) which sets out the government's vision of more effective health and social services outside hospitals. To deliver this one clear area for change includes investment in community hospitals and shifting care safely away from acute hospitals. The central message of the recent health white paper '*Our health, our care, our say: a new direction for community services*' (Department of Health 2006), reflects a far greater proportion of care and treatment being provided outside hospital and in primary care or community settings. Young *et al* (2003) believe that community hospitals have adapted well to the contemporary NHS and offer a more generic style of intermediate care than for example similar services provided in residential or nursing homes which are likely to require more highly selected patients. Community hospitals are well placed to provide intermediate care particularly in rural areas and can be expected to have a significant role in alleviating the pressures on larger specialist hospitals (Seamark *et al* 2001). However, caution is urged as there is a need to evaluate the effectiveness of any alternative provision in order to determine that it does indeed meet patient need to at least the level currently offered by acute services (Griffiths *et al* 2004). What is questioned is whether community hospitals can provide the level of care traditionally provided within the acute sector to chronically ill, frail elderly. What is of particular interest is whether an equitable level of care can be provided within a *nurse-led* intermediate care unit.

In exploring the concerns raised in relation to intermediate care generally it is perhaps not surprising that concerns are predominantly expressed by medical staff:

“Illness in older people typically presents with non specific symptoms and careful assessment is required if treatment opportunities are not to be delayed or overlooked.” (Young and Sharan 2003)

Similar concerns are shared by Young and Donaldson (2001):

“The presentation of acute illness in older people is non specific, diagnosis more complex and unnecessary delays incur increased complications and worse outcomes. Therefore as a group acutely ill older people are not natural candidates to bypass the DGH (District General Hospital).”

Two of the most vociferous critics of intermediate care developments are the highly respected John Grimley Evans and Raymond Tallis (2001) who state:

“Those geriatricians who have contrived to defend specialist rehabilitation units against the cutbacks of the past 20 years may now have to fight to prevent their being downgraded to intermediate care. Worse yet is the implication for which the text acknowledges there is no justifying evidence that older patients could be sent directly to intermediate care bypassing the skilled diagnostic evaluation that the complexities of disease and disability in old age require.”

Evans and Tallis (2001) are supported in their assertion that there is no justifying evidence to support developments in intermediate care, by a point reinforced in a systematic review (Parker *et al* 2000):

“A national survey of provision for older patients, acute, sub acute, and rehabilitation care accompanied this review and demonstrated considerable recent service development in Britain in just those areas where this systematic review has shown evidence is weakest... If there is a need for evidence-based medicine then there is also a need for evidence-based services.”

It is clear then that the major concerns revolve around the central issue of medical assessment and management of frail elderly by skilled physicians housed within the diagnostic facilities of a district general hospital (which is where traditionally frail elderly with a precipitating illness have been admitted). Geriatricians are clearly alarmed at the prospect of frail elderly being admitted to community hospital facilities where it is felt there are neither the medical expertise nor the diagnostic facilities available. However, the argument almost comes full circle as ultimately the question is whether all frail elderly presenting at the district general hospital need the benefit of a geriatrician and extensive diagnostic facilities? It is suggested that there is an issue of 'appropriateness' in terms of where is it most appropriate to manage frail elderly patients in need of in-patient care? Donald *et al* (2001) stress this point:

“Any resources within the NHS should be used wisely - it would be inefficient to care for patients in a community hospital who could be safely managed at home and unwise to care for patients who would have been better if more appropriately managed in the DGH.”

Whilst Round *et al* (2004) add:

“The GP who can admit to either a community hospital or district general hospital has to decide which facility is better for that patient.”

In accepting the concerns of geriatricians that frail elderly will be disadvantaged by intermediate care developments it is felt useful to examine some of the work that has been done around comparing outcomes between acute and intermediate care. One such study (Round *et al* 2004) compared patient-based outcomes at six months following emergency admission to a district general hospital or community hospital. The quality of life and mortality in the community hospital cohort was similar to those in the district general hospital cohort and it was concluded that community hospital care can be used as an alternative to district general hospital care for a wide range of conditions requiring emergency admission. The patients in this study mirror

the sort of management problem seen regularly in primary care. They were patients with poor underlying health who developed an additional problem such as an infection, making hospital admission necessary. A further study (Martin *et al* 2004) concluded that acute illness combined with a chronic illness represents a significant proportion of patients admitted to acute general hospital. The findings were felt to support the development of better models of managing chronic disease such as admission avoidance schemes. However, in contrast to this a further study (Bowcutt *et al* 2000) demonstrated that unplanned readmission is generally not preventable and often reflects a highly dependent and medically frail group of patients in whom early intervention with readmission is appropriate. These authors suggest:

“Of the readmissions considered to be preventable the most common deficiency in the previous admission was lack of adequate rehabilitation of patients discharged from hospital departments other than the GMU (General Medical Unit).”

Looking again at the study which compared six month outcomes after emergency admission of elderly patients to a community or district general hospital (Round *et al* 2004) it is notable that data suggested that medical staff contact and use of drugs and investigations were major sources of cost differences between the cohorts. It is further concluded that exploration of the benefits and disadvantages of multiple investigations and drug treatments in a frail elderly cohort would also be worthwhile. Furthermore, there is an argument that an increasing number of older patients do not require intensive, diagnostic or invasive procedures; and would be better treated in sub-acute units offering an interdisciplinary approach to treatment. In this model, team members synthesize their efforts to encourage and support an independent and satisfying lifestyle for their older patients (Steiner 2001). This raises yet another question which asks is it appropriate that all older patients receive intensive medical management and investigation, or could their needs be better served within a community hospital where the focus is on interdisciplinary working rather than medical management? Once again we have to return to the issue of appropriateness, and for some frail elderly, in

some circumstances, admission for medical management and investigation may be appropriate and clearly in other cases a community hospital with a specialist rehabilitation team which specialises in older people's rehabilitation services will be appropriate.

There is general agreement within the literature that intermediate care services are supportive rather than directive (Wilson-Barnett *et al* 2003). This model of care is seen to be fitting to nursing rather more than medicine in that patients are viewed holistically and 'care' rather than 'cure' dominates. In practice there seems to be a general recognition that the patients most likely to be referred to intermediate care services are elderly and frail with a mixture of medical and social needs and with highly variable rehabilitative potential (Wilson-Barnett *et al* 2003). Nurse-led intermediate beds therefore are a logical development.

Nurse-led Intermediate Care

Nurse-led beds are not a new development and have been the focus of several previous studies. Ideally significantly shorter stays, better rehabilitation and fewer costs would be associated with nurse-led in-patient care. However, this has not been shown consistently (Wiles *et al* 2003). The distinctive feature of nurse-led intermediate care however is that care is led by nurses. Intermediate care provided in nurse-led beds is based on the premise that although medical diagnosis and treatment is needed at the stage of acute biological crisis, in the post acute phase the need is for education, rehabilitation and supportive interventions which can be appropriately provided and led by nurses (Griffiths *et al* 2000).

The argument for the viability and effectiveness of nurse-led intermediate care is based upon several propositions (Petch 2003):

“There is a therapeutic component for nursing which operates independently of other disciplines and there is a period in recovery where it is nursing not medicine which is the main determinant of recovery.”

At present, the evaluative work which has been done with nurse-led intermediate care has demonstrated significantly longer hospital stays compared to usual care (Petch 2003). Unfortunately, nurse-led intermediate care may be as successful at preparing patients for discharge as usual care but the extended stay is liable to incur considerable additional costs (Petch 2003). It is concluded that future research into intermediate care should consider the nurse-led intermediate care model further. However, no negative outcomes are associated with nurse-led intermediate care (Petch 2003). In their systematic review Parker *et al* (2000) found the quality of trials on nurse-led beds not to be high and all were relatively small in size. There were no firm conclusions in relation to mortality but return home did seem to be more likely for those who had been cared for in this service setting. Clearly more rigorously evaluative studies of nurse-led care are required with a particular emphasis on patients' views as research exploring patients' views of nurse-led in-patient care is viewed as being limited (Griffiths *et al* 2000).

SUMMARY

This chapter has set the scene for the evaluation study and the current knowledge-base concerning nurse-led care has been examined. Its design will now be described fully in Chapter Two.

CHAPTER TWO

STUDY DESIGN

This chapter sets out the overall approach adopted for the evaluation study which was participatory action research with extensive involvement and partnership working. The way that the study was organised and delivered is also set out to illuminate the process for the reader. The approach followed to arrive at a series of evaluation topics is described. How these topics were prioritised and translated into research questions to be answered within the study is further described.

EVALUATION APPROACH – Action Research

As is common in evaluation projects involving organisations, a wide range of potential elements to focus on was evident in this study. Whilst interesting, attention to all may have presented an unwieldy and costly evaluation project and so it has been essential to be clear about what information was needed and how that information would be used once gained, for example, to inform future funding decisions or to make improvements.

An action research approach was requested by the study commissioners and this approach matched well with the preferences of other research team members. Action research was an appropriate umbrella under which to carry out an evaluation for a number of reasons. Action research:

- Is educative
- Deals with individuals as members of social groups
- Is problem-focused, context-specific and future-orientated
- Involves a change intervention
- Aims at improvement and involvement

- Involves a cyclic process in which research, action and evaluation are inter-linked
- Is founded on a research relationship in which those involved are participants in the change process

(Hart and Bond 1995)

Action research is popular in health care as it offers flexibility to respond to the changing local situation e.g. staff moves, local reconfigurations of services and movement of stakeholders.

Within an action research framework, a clearly defined study could not be described from the outset. What to evaluate, by whom and when, was to be the responsibility of a number of research team members to determine. Accordingly, action research designs tend to be loose and fluid to accommodate the evolving nature of action research whereby new avenues of enquiry unfold as the project progresses. This emergent design also allows for meaningful participation in the design of the study especially by non-professionals such as ex-patients and members of the public. This ensures that all co-researcher voices are heard and promotes a sense of ownership of the study, which is important as people are spending valuable time and effort in taking part.

INVOLVEMENT AND PARTNERSHIP WORKING

A crucial component to this study has been the meaningful involvement of ex-patients, patient representatives and staff working with patients who use the nurse-led beds being evaluated. Involvement of users of services in all stages of research is a Government priority (Calnan & Gabe 2001). Users of intermediate care services are predominately over 65 years of age. Despite being the largest consumers of health and social care services, older people do not participate in or have little influence over the shaping or delivery of

those services (Biggs & Powell 2000; Phillipson et al 2000). Findings from the National Listening Exercise (National Co-ordinating Centre for NHS Service Delivery and Organisation - NCCSDO 2000), indicate the importance users place upon involvement in such service planning, as all too often assumptions are made by professionals as to the needs and wants of the public, which are often inaccurate.

The partnership working of staff and the public in this study is consistent with policy drivers for involvement. We intended the study to be an exemplar of how to engage these parties and to ensure they were as fully involved as they wished. Involvement can take many forms and be at any level and the research team members have been encouraged to decide how much or little they wish to participate, recognising that this may fluctuate over time. From the outset it has been continually reinforced that the research team members could take part in any aspect of the research process from design, data collection and analysis to dissemination. It was further reiterated that training and support would be provided by the lead researcher or through external agencies as appropriate. Although less intense involvement was offered, for example to read any drafts as a critical reader or to be consulted for a view on proposals, all research team members wanted to adopt the full partnership approach of being a co-researcher.

The study design was guided by evidence of best practice in involving older people in research (Peace 1999) that offers creative and innovative examples of participatory research with older people. In any partnership working there has to be a process whereby a final decision is made where a consensus decision cannot be made. It was agreed at the study outset that final decision making concerning the conduct of the study rested with the lead researcher although in practice, consensus decision-making was achieved throughout.

PREPARATION AND TRAINING

In this study, all research team members took part in some if not all of the training made available to them. Training needs analysis was undertaken early on and helped to identify people's skills and abilities to some extent, yet training was open to all, regardless of previous experience. Only one of the final four non-staff research team members did not undertake interviewing training and only one of these undertook the analysis training. Several research team members (staff and non-staff) exercised their right to take part in an aspect of training without going on to take part in the activity they were being trained for. For example, some research team members wanted to appreciate interviewing processes but did not want to lead interviews themselves, preferring to observe only. Others were appraised by the lead researcher as competent and went on to lead interviews sometimes after having observed one being undertaken by the lead researcher.

Where training took place this was within a relaxed and conducive workshop environment. The aims of the training and intended learning outcomes were always stated and any other personal expectations identified. The sequencing of workshops meant that previous learning could be seen to be applied in subsequent workshops and earlier learning reinforced or revisited.

Topics included:

Evaluation

Action research

Developing research questions

Questionnaire and audit tool design

Interview guide development

Information leaflet writing

Interviewing

Analysis

Conference abstract development

Several staff research team members undertook training provided by Trent Focus Research and Development Unit, which was invaluable in strengthening their accumulation and application of research skills. Topics included survey design and qualitative research. Research ethics and governance was introduced at the first exploratory meeting about the study by the Trust Research and Development Manager, and reinforced in later workshops.

STUDY ORGANISATION

The overall organisation of the project was not pre-determined but evolved as the study went along. It quickly became clear that a series of regular meetings would be needed and during the lifetime of the study (March 2005 to September 2006), the research team as a whole met eight times. At one stage in the study, the team split into two sub-groups to work on particular issues and so these sub-groups were met with separately on two occasions, totalling twelve meetings altogether. The first seven of these were workshops of approximately 5 hours in length, addressing study design issues and associated training e.g. questionnaire design, interviewing skills. The latter five meetings were business meetings of approximately 3 hours in length, to monitor progress, revise action plans and refine the study's final report. These workshops and business meetings were supplemented by ad-hoc visits to the Trust to meet with individuals or small groupings of the research team members for updates or bespoke training, to liaise with the study's administration support person, to collect data and plan dissemination. Several more meetings were planned for after completion of the study to undertake local dissemination, promote the uptake of findings and to hold a team debriefing meeting and celebratory lunch.

In order to deliver this programme of meetings and activities, the lead researcher adopted a number of roles and responsibilities. It was agreed that her skills as the external researcher would be best employed as co-lead and facilitator of the study and all of the meetings and workshops. This

involved training and support for the research team members and facilitation of the different stages in the study whilst taking a greater or lesser role depending on the wishes and abilities of the research team members. As a commissioned study, the lead researcher was responsible for ensuring the study was carried out to a high standard, to time and funding, whilst safeguarding the wellbeing of herself, the research team members and participants and upholding the best interests of the Trust. As local lead researcher, Alison acted as a 'gatekeeper' to the study and participants, helped navigate local policies and procedures, undertook the role of professional development lead for the staff research team members and was the accountable person within the Trust. Joint responsibilities for both co-leads included the setting up of a Study Advisory Group, ensuring all the necessary ethical and research governance approvals were received and making sure a variety of dissemination activities were undertaken during the project and planned for after its completion.

The next section will follow a meeting-by-meeting account to best describe how the study design evolved and what the activities of the team members were at each stage.

Identifying Evaluation Topics

Workshop 1

Workshop 1 was aimed at a broad audience to gain a variety of perspectives on the proposal for an evaluation of nurse-led beds. It also provided an opportunity to successfully recruit sixteen people to join the research team.

The programme aimed to give participants sufficient insight into evaluation and research to be able to identify what concerns or issues they felt should be investigated. By the end of the workshop the following suggestions had been made:

1. Patient concerns (patients have expressed a wish for information as to why they are in a nurse-led bed, what is wrong with them and what next?)
2. Staff concerns
3. Carers & families concerns (e.g. don't perceive discharge as being well planned - picked up via independent telephone service)
4. Engagement of relatives in discharge planning
5. Existing information (secondary data e.g. from telephone service)
6. Nurse-led *versus* medical led
7. Staff being seen as approachable
8. Team members' roles and team role
9. Transition from hospital to home (suggestions regarding follow up calls, audit of discharges)
10. Patient views at 6 week follow up appointments
11. Do the nurse-led beds meet a previously unmet need, e.g. using beds simply because they are there?
12. Are patient referrals appropriate?
13. Are beds accessible? More than elsewhere (because available)?
14. What are the routes of patients turned away?
15. What is the Chesterfield Royal Hospital's view of the service e.g. bed managers?
16. Nurse-led bed admission criteria – review these and length of stay + staff perception of these
17. Referrals from the nurse-led beds – patient destination when they leave
18. Discharge efficiency – what holds things up?
19. Patient information/use
20. Preparation for moves to other wards etc
21. Patient satisfaction from patients' perspectives
22. Documentation
23. Evaluate goal of nurse-led beds – admission avoidance or facilitating safe discharge
24. Understanding of each other's roles
25. Activities for patients

26. Ward environment e.g. Day Room, wardrobes
27. Staffing and skill mix (numbers and types of staff)
28. Staff skills
29. Psychological issues regarding admission e.g. willingness and motivation to participate

Participants' hopes and fears were also uncovered and revisited by the lead researcher at several points as part of her reflective research practice. Fears included concerns over time, workload, effect on clinical work, own research abilities, meeting group members' expectations and the vagueness of an emergent design. Hopes included improving care, improving the patient experience, desire to learn from patient feedback, personal development, more knowledge of NHS working and transferable knowledge.

The outcomes of the workshop included invites for future involvement being sent to all attendees, identification and invite of other potential research team members, identification of potential Study Advisory Group members and transforming of all the suggested evaluation topics into a user-friendly format for discussion at the following workshop.

Prioritising Evaluation Topics

Workshop 2

When notes of the previous workshop were sent to all attendees, a task was included for them to choose the three 'must dos' and other most important aspects for the evaluation in their view. Replies were collated so that these choices could inform discussions at Workshop 2 and lead to agreement on what topics to include in the study within the limitations of time and funding available. These were narrowed down to five key themes:

- Medical care *versus* nursing care
- Patient satisfaction/issues

- Patient motivation
- Admission
- Discharge

Some discussion was had about things to consider when deciding what should be included in an evaluation. The research team members recognised that a balance was needed between what was **desirable** and what was **possible**. Factors included:

- Time
- Skills
- Clarity & focus
- Impact – difference each part will make
- Interesting
- Relevant
- Passion
- Money
- Are we the best people to do it (each aspect)?

Evaluation Questions

Following group work based on the five topic areas, ideas for the evaluation questions were developed. Following this exercise it was intended that more specific research questions be drawn from the list at the following workshop.

The initial list of general evaluation questions was:

- What factors affect the quality and effectiveness of discharges?
- What is the incidence of failed discharges/re-admissions?
- Is best use made of other teams e.g. Community Rehabilitation Team, Intermediate Care Team including those in neighbouring areas?
- How do we engage relatives and carers in the discharge process?
- What are the discharge destinations of our patients?

- How well do our customers (patients, carers, other staff) understand the service we provide?
- How appropriate are the nurse-led bed criteria?
- How appropriately are the nurse-led beds utilised?
- Are the admission criteria understood AND followed by referrers and nurse-led bed staff?
- Through what processes are patients referred and admitted to the nurse-led beds?
- What happens to patients who are not admitted to the nurse-led beds?
- What are patients' expectations and are these met?
- What are staff expectations of patients and are these understood and met?
- What factors affect patients' participation in their treatment programme?
- What are patients' expectations post-discharge and are these met?
- Are patients satisfied with the process and outcome of their care?
- What are carers' views of the service?
- Do patients receive information appropriate to their needs?
- Are patients satisfied with their degree of choice and involvement concerning their care?
- Are patients satisfied with the activities available during their stay?
- How do patients perceive the communication skills and attitudes of nurse-led staff?
- How well do patients understand staff roles?
- How do the nurse-led beds function in comparison to general rehabilitation beds e.g. discharge processes, client group?
- Is the nurse-led care equivalent to that given on medical wards?
- Are episodes of patient worsening/deterioration being recognised adequately in the nurse-led beds?
- What are patient/carers views of being managed in the nurse-led beds when their condition worsens or deteriorates?
- Do the nurse-led beds meet a previously unmet need?

Early discussion of dissemination was also held at this second workshop as this is often left to the end of a study and becomes rushed. Lists of dissemination audiences and types of media to use e.g. newsletters, journal articles, were identified to return to later in the study.

Developing Evaluation Research Questions, Methods and Tools

Workshop 3

This workshop focused on organising the previously agreed evaluation questions into themes and then matching them with the research methods considered most appropriate to answer them.

There were 27 questions in all and each one was printed onto a single piece of paper. These were spread out on a large table and grouped together by participants into themes.

After a while, the groups/themes that arose were discharge, nurse-led and medical-led care, admissions, patient motivation/participation and patient/carers' perceptions. Grouping them in this way meant that research team members could choose which themes they preferred to work with during the next exercise. The next step was to use sticky post-it notes with a single method written on them and to place these with the evaluation questions that it was thought they would best be used with. More than one method could be used. For example the question "Do patients receive information appropriate to their needs?" had the methods 'questionnaire, comments box, informal feedback' attached to it. Overall, this helped the research team to see which were going to be the main methods, which were going to be the lesser yet still valuable methods, and which methods were not going to be used after all. The purpose of this task was to illustrate to the research team members issues around matching research questions and methods and that different methods can be used to ask the same question. Research team members were encouraged to see if there were any cross-cutting methods that could be used. For example, whether a single questionnaire could be used aimed at answering questions about admission, expectations, discharge planning,

general satisfaction, and so on, rather than have a separate questionnaire for each theme. This turned out to be the case and so evaluation questions were re-grouped according to the method to be used to answer them instead of the topic theme they belonged to. The results of this next stage in the workshop are shown below in Table 1.

Table 1. Evaluation methods

METHODS TO BE USED	EVALUATION QUESTION
Methods that use questions	
Patient questionnaire, individual patient interviews	Are patients satisfied with the process and outcome of their care?
Patient/carer questionnaire, individual patient/carer interviews, comments box, informal feedback	Do patients and carers receive information appropriate to their needs?
Individual & group patient/carer interviews, patient/carer questionnaire	Are patients and carers satisfied with their degree of choice and involvement concerning their care?
Individual & group patient interviews, patient questionnaire, graffiti board, comments box	Are patients satisfied with the activities available during their stay?
Individual & group staff interviews, staff questionnaire, patient tracking, staff skills & training needs analysis	Is patient worsening/deterioration being recognised adequately in the nurse-led beds?
Patient/carer questionnaire, individual & group patient/carer interviews	What are patient/carers' views of being managed in the nurse-led beds when their condition worsens or deteriorates?
Patient/carer questionnaire, individual & group patient, carer and staff interviews, comments box, informal feedback	How do we engage relatives and carers in the discharge process?
Individual & group patient, carer and staff interviews; patient, carer and staff questionnaires	How well do our customers (patients, carers, other staff) understand the service we provide?
Individual & group patient interviews, patient questionnaire	What factors affect patients' participation in their treatment?

Patient/carer questionnaire, individual & group interviews, informal feedback	What are patient and carers' expectations post-discharge and are these met?
First impressions patient/carer questionnaire, individual & group patient/carer interviews	Do patients and carers understand staff expectations of them?
First impressions patient/carer questionnaire, individual & group patient/carer interviews	How well do patients and carers understand staff roles?
Individual patient/carer interviews, comments box	How do patients and carers perceive the communication skills and attitudes of nurse-led staff?
Individual patient/carer interviews, comments box	What are patients and carers' expectations and are these met?
Individual carer interviews, comments box, graffiti board, informal feedback	What are carers' views of the service?
Individual patient/carer interviews, patient/carer group interviews	How do patients and carers feel about nurse-led care?
Individual & group staff interviews, staff questionnaire, secondary data (existing documents)	Are the admission criteria understood AND followed by referrers and nurse-led bed staff?
Individual & group staff interviews, patient and staff questionnaires, comments box, informal feedback	What perceptions do people have of the nurse-led bed criteria?
Individual & group staff interviews	Do the nurse-led beds meet a previously unmet need?
Methods that use facts & figures	
Prospective (future) data collection, secondary data collection (existing documents)	What is the incidence of failed discharges/re-admissions?
Patient tracking	What factors affect the quality and effectiveness of discharges?
Patient tracking, prospective (future) data collection, secondary data collection (existing documents)	What are the discharge destinations of our patients?
Patient tracking, secondary data collection (existing documents), skills & training needs analysis	Is best use made of other teams eg Community Rehabilitation Team, Intermediate Care Team including those in neighbouring areas?

Patient tracking	What happens to patients who are not admitted to the nurse-led beds?
Patient tracking, bed census	How appropriately are the nurse-led beds utilised?

Once research questions were agreed and the most appropriate method/s for answering them had been decided upon, the next stage involved extensive research tool development. These were devised mostly at workshops, developed away from meetings by team members on occasions, and always revised in the light of further feedback from team members. This way, everybody who wanted to be involved in tool development was indeed involved.

An overview of sampling techniques was given so that research team members could start thinking about who to involve as research participants, their numbers and how to reach them.

The scale of the proposed evaluation study was significant. It was made clear to the research team members that to achieve answers to their questions using these methods would be a huge undertaking within the resources available. It was confirmed that this broad focus was desirable and that team members would put in the time and effort required to achieve it. It was also decided to split the research team into two sub-groups. These were the 'Questions Group' (led by a non-staff co-researcher) and the 'Facts and Figures Group' led by a staff co-researcher). This was so that research team members could work more with the kind of research tools they preferred. What followed were two Questions Group workshops and two Facts and Figures Group workshops. The leads of each sub-group provided a single point of contact for the lead researcher as the study grew in complexity. Importantly, all research team members received the notes from both groups' workshop meetings to keep a sense of the whole study.

Workshop 4a (Questions Group)

The primary purpose of this workshop was to agree sampling techniques and draft data collection tools for the 'questions' part of the study. Ethical and research and development procedures and reasons for these were also elements of the day. Time was spent drafting a variety of interview guides, questionnaires, information sheets and consent forms following training on principles for their development. Separate documents were devised for patients, carers, staff who refer to the nurse-led beds e.g. GPs, medical consultants and staff-grade doctors, and Derwent Ward (nurse-led bed) staff.

A non-staff co-researcher took the lead on developing a publicity poster to raise awareness about the study on Derwent Ward. Leads to take forward development of a graffiti board, comments box and first impressions questionnaire were also agreed. All drafted documents were later sent to all research team members for comment, suggestions, amendments and additions.

Workshop 4b (Facts and Figures Group)

The activities in this workshop centred on agreeing sampling approaches and drafting data collection tools for the 'facts and figures' part of the study. A range of tools were drafted and later sent to all research team members for comment followed by further refinement. Tools included a pro-forma for tracking patients' journeys through their hospital stay, a nurse-led bed census, a readmitted patient/failed discharge pro-forma, a non-admitted patient pro-forma. This group was also charged with collating secondary data e.g. previous survey reports in the Trust. Ethical and research and development procedures and reasons for these were also elements of this sub-group's workshop.

Workshop 5a (Questions Group)

This workshop caught up on the many action points from the last one which required research team members to refine data collection tools and sampling approaches. The publicity poster was finalised. Training focused around data preparation, management and storage as well as interviewing. Piloting of tools

was planned for when the required ethical and research governance approvals had been gained.

Workshop 5b (Facts and Figures Group)

This workshop also appraised progress against the action points from the previous one at which research team members had agreed to refine data collection tools and sampling approaches. Training was again focused around data preparation, management and storage. Piloting of tools for this group was similarly planned for when the required ethical and research governance approvals had been gained, despite the activities being classed as audit not research.

Workshop 6

At this workshop, both groups came back together as a whole and the topics covered included conference abstract development in preparation for conferences being applied for by research team members. Anonymous abstracts from other conferences were appraised against the abstract assessment criteria prior to brainstorming the content of an abstract for a local conference by the research team members. Roles and responsibilities for the range of data collection procedures were agreed and the exact detail of those procedures clarified. This workshop included the first reflective session undertaken by an external facilitator to identify the research team members' perceptions of the impact of involvement on the study on them personally (See Chapter 5 Reflection). As Christmas was approaching, it was agreed to start data collection in January 2006.

Meeting 7

Meetings from hereon took on more of a business meeting approach, focusing on updating on progress e.g. ethics approvals and fine tuning of study tools/documentation, as training and design activities had mostly been completed. Any outstanding training was done on an ad-hoc basis outside of these main meetings for those concerned. For example, additional interview training was held for Facts and Figures Group members and a new co-

researcher who had not attended the original training provided, as this had been for Questions Group members.

Implementing Methods and Tools

Meetings 8 – 11

These meetings were primarily progress meetings to monitor data collection processes and to re-think challenges presented during this period such as difficulties experienced around recruiting participants.

Meeting 12

This was the final research team meeting at which the final changes to the final report were agreed. A final reflection session was undertaken by the external facilitator and agreement reached to include a summary of reflective processes in the final report. Dissemination plans were further discussed and planned. Arrangements for a study de-briefing meeting in December were made to allow time to reflect back on the study, appraise how initial dissemination within the Trust had been received and to discuss any action/non-action as a result of the findings.

SUMMARY

This chapter has described the detailed process of designing the evaluation in full partnership with the research team members. Insight has been given into the working relationships and often complex processes followed to end up with the final design. Training and support given to research team members has been described. In the next chapter, the application of those methods and evaluation tools is presented.

CHAPTER THREE

METHODS AND DATA COLLECTION

This chapter describes the methods identified as most appropriate to reach answers to the study questions. Details are given of the many data collection tools devised by the research team to gather sufficient breadth and depth of information to meet their requirements. Sampling strategies and data collection procedures are also set out. The main ethical and research governance issues are outlined.

METHODS AND DATA COLLECTION TOOLS

Several methods have been utilised in this study which have been described here as *research, audit and practice development*. Within these, sixteen data collection tools were employed. (NB: Due to the large quantity of data collection tools - 58 pages - it has not been possible to incorporate these into this report yet copies are available from T.Williamson@salford.ac.uk). These tools comprised:

17. Patient questionnaire (research)
18. Patient interviews (research)
19. Carer questionnaire (research)
20. Carer interviews (research)
21. Staff questionnaire - Derwent Ward staff (research)
22. Staff questionnaire - referrers (research)
23. Staff questionnaire - medical consultants (research)
24. Staff interviews - Derwent Ward staff (research)
25. Staff interviews - referrers (research)
26. Patient tracking - inpatient journey pro-forma (audit)
27. Patient tracking - non-admitted patient pro-forma (audit)
28. Patient tracking - re-admitted/failed discharge pro-forma (audit)

29. Bed census pro-forma (audit)
30. Graffiti board (practice development)
31. First impressions questionnaire (practice development)
32. Comments box (practice development)

The research team members appraised the merits of each method and associated tools in order to make final decisions about which were to be used.

These discussions are summarised below:

- Questionnaires - need carefully structured design, good for specific questions, questions remain the same, quick, cheap, need a clear sample, may need administering, potential help with analysis from audit/research departments, care with length, can be very short e.g. first impressions questionnaire, can reach a large sample group, useful to gain superficial insight into the views of participants yet restricted by the questions asked, no room for prompting and probing
- Interviews - need careful design, scope for adding/changing questions, good for open questions (how, why), need skills to undertake them, need a clear sample, time-consuming, group interviews may reach more people, need rigorous analysis, can be individual or group interviews to meet participants' preferences, useful to gain deep insights into participants' views and experiences, room for prompting and probing
- Patient tracking - need access to databases/patient records, need to develop a framework to follow, need a clear sample, results need inputting, impersonal data collection as data retrieved primarily from documentation, need approvals/confidentiality and anonymity, useful to see what happens to patients on their different journey trajectories - pre-admission, during their stay and post-discharge
- Bed census - ward focused, need to decide timeframe - can be spot checks or monitor over time (audit e.g. length of stay), prospective

(future-oriented), document focussed, needs careful analysing, allows judgements to be made about nurse-led bed utilisation

- Graffiti board - need a big board/wall space, sticky post-it notes, can add prompt questions, need someone to manage it, needs to be visually appealing, can complement responses gained from interviews and surveys, need clear timescales e.g. when to change questions/collect post-its, accessible and informal approach that may appeal to participants, in itself show an interest in quality improvement and patient/visitors' views
- Comments box - will identify suggestions and complaints, easy to make a box of good quality, needs to be lockable and accessed infrequently, clear instructions, tools to write comments, need someone to manage it, accessible place needed to locate it, shows interest in gaining feedback to act upon
- Secondary (existing documents/information) data collection - relies on quality of records, may depend on electronic patient information systems operated locally, risk of inaccuracy unaware of a patient's readmission, little existing Trust information regarding nurse-led beds - previous evaluation and a Trust-wide patient satisfaction survey, can help contextualise a study and provide data for comparison

Use of mixed methods in this way ensured the preferences of all the research team members were included. The combination of methods is recognised as a valuable strategy, as data generated from one method can serve to illuminate the other (Hammersley & Atkinson 1995). It was possible to verify findings from other methods within interviews.

SAMPLING AND DATA COLLECTION PROCEDURE

Following design and tool development during 2005, the six-month data collection period ran from January 1st 2006 to June 30th 2006. Whilst potential participants were identified from within this time period, arrangements to

undertake data collection were at times outside of this period. For example patients discharged in late June were given time to settle in at home before approaching for interview (See Table 2 for a summary of data collection timeframes). Some data collection needed to be after the 30th June because of the nature of the tool. For example, tools to investigate people classed as 'failed discharges' due to being re-admitted within twenty-one days of discharge, could not all be collated until several weeks after the data collection period had officially ended. This was so that patients discharged around the end of data collection period could have their records searched to see if any of them had been readmitted.

In practice, it was between January 1st 2006 and August 13th 2006 that data was collected, although all the samples were drawn from within the stated six-month period.

The procedure used with each data collection tool is described here.

For ease of presentation an overview of each tool, its associated sampling strategy and data collection procedure are grouped together.

1. Patient questionnaire

Tool

This tool (questionnaire) comprised twelve questions aimed at gaining patients' experiences of their hospital stay whilst in a nurse-led bed. Topics covered included communication, privacy, involvement and social activities.

Sampling

All patients discharged from Derwent Ward between January and June 2006, were eligible. Forty-eight ex-patients were identified to send a questionnaire to.

Data collection procedure

The first ten postal questionnaires sent acted as a pilot and no major refinements to the tool were required. At first a small batch of questionnaires were sent and from thereon future ones were sent two weeks after each patient's discharge. Reminder letters approved by the non-staff research team members and repeat questionnaires were sent to all participants 3-4 weeks after the first one was sent. Stamped addressed reply envelopes were included. Return envelopes were addressed to the study administrator as this was considered to be most acceptable to respondents.

2. Patient interviews

Tool

This tool (interview guide) comprised sixteen questions aimed at gaining ex-patients' experiences of their hospital stay whilst in a nurse-led bed. Topics covered included information needs, choices concerning care and discharge plans, involvement in goal setting, and views about the care being nurse-led.

Sampling

A theoretically-guided sample of twenty-three ex-patients was invited for interview in the hope of gaining ten acceptances. This approach to sampling means that participants were chosen who would best be able to give a range of views about the nurse-led service. Participants were chosen to represent the age ranges, males and females, a variety of type and severity of clinical conditions, those who were capable of taking part and those that had sufficient exposure to the nurse-led beds to be able to comment on them.

Data collection procedure

All patients discharged during the data collection period who were eligible for invite had their details checked through computerised patient information systems to ensure they had not been readmitted or passed away. Written study information sheets were sent with invite letters at least two weeks after discharge. Potential participants were advised they could be interviewed at a venue to suit them and that they had choices about who was present from the

research team. Ex-patients completed a reply slip if they wanted to take part. On receipt of these, a research team member contacted them to arrange an interview. On the day of interview, study information was re-iterated, informed, written consent gained and a tape-recorded interview undertaken.

3. Carer questionnaire

Tool

This tool (questionnaire) comprised twelve questions aimed at gaining carer/spouse/family members' experiences of their involvement with the nurse-led beds as a result of their partner/spouse/family member's admission. Topics covered included written and verbal communication, dignity, involvement in discharge planning and overall experience.

Sampling

All carers of patients who were in a nurse-led bed between January and June 2006 were eligible for a questionnaire. Thirty-four carers were identified to whom to send a questionnaire.

Data collection procedure

The first ten postal questionnaires sent acted as a pilot and no major refinements to the tool were required. Although intended to adopt the same approach as patient questionnaires, a procedural error meant that all carer questionnaires were sent out late in the data collection period. Reminder letters approved by the non-staff research team members and repeat questionnaires were sent to all participants 3-4 weeks after the first one was sent. Stamped addressed reply envelopes were included. Return envelopes were addressed to the study administrator as this was considered to be most acceptable to respondents.

4. Carer interviews

Tool

This tool (interview guide) comprised fifteen questions aimed at gaining carer/spouse/family members' experiences of their involvement with the nurse-led beds as a result of their partner/spouse/family member's admission. Topics covered included their views of the clinical care (had their relative become unwell during their stay), expectations, understanding of staff roles and improvements that could be made to the service.

Sampling

A theoretically-guided sample of fifteen carers were invited for interview in the hope of gaining ten acceptances. Participants were chosen to represent a - section of experiences e.g they were carers of short and long stay patients, with variable reasons for admission and contrasting stays and discharge circumstances. Participants were those who had sufficient exposure to the nurse-led beds to be able to comment on them.

Data collection procedure

All selected carers were sent written study information sheets and invite letters. Potential participants were advised they could be interviewed at a venue to suit them and that they had choices about who was present from the research team. Carers completed a reply slip if they wanted to take part. On receipt of these, a research team member contacted them to arrange an interview. On the day of interview, study information was re-iterated, informed, written consent gained and a tape-recorded interview undertaken.

5. Staff questionnaire - Derwent Ward staff

Tool

This tool (questionnaire) comprised nineteen questions aimed at uncovering Derwent Ward staff members' experiences and perceptions of the nurse-led bed service. Topics covered included whether patients fitted ward admission

criteria, patient/family involvement in care and discharge planning, benefits and drawbacks of nurse-led care and timeliness of discharges.

Sampling

All thirty-nine Derwent Ward staff (including research team members) were sent a questionnaire. The research team members decided that they should also be included as they had important views to uncover and formed a large percentage of the ward staff.

Data collection procedure

The first ten postal questionnaires sent acted as a pilot and no refinements to the tool were required. Reminder letters and repeat questionnaires were sent to all participants four weeks after the first one was sent. Internal mail, pre-addressed reply envelopes were included. Return envelopes were addressed to the study administrator as this was considered to be most acceptable to respondents. To protect anonymity, these completed questionnaires were only accessible to the lead researcher who collected them from the study administrator.

6. Staff questionnaire – Referrers

Tool

This tool (questionnaire) comprised eleven questions aimed at uncovering referring staff members' experiences and perceptions of the nurse-led bed service. Referring staff are those who are eligible to refer a patient for admission to a nurse-led bed. Topics covered included appropriateness of admission criteria, their usage of the nurse-led beds, the process of admission and accessibility of the nurse-led beds.

Sampling

A range of 145 staff, eligible for inclusion as they are permitted to refer to the nurse-led beds, was identified. Questionnaires were sent to all eligible district nurses (n=42), GPs (n=82), and Others – physiotherapy, community nursing

posts and Care Managers (n=21), from the two local Primary Care Trusts - North East Derbyshire and Chesterfield.

Data collection procedure

The first ten postal questionnaires sent acted as a pilot and no refinements to the tool were required. Reminder letters and repeat questionnaires were sent to all participants 3-4 weeks after the first one was sent. Stamped addressed reply envelopes were included. Return envelopes were addressed to the study administrator as this was considered to be most acceptable to respondents.

7. Staff questionnaire - Medical consultants

Tool

This tool (questionnaire) comprised three questions aimed at uncovering senior doctors' views of the nurse-led bed service. The tool was kept purposefully short to maximise a response rate. Topics covered were appropriateness of patients admitted to the nurse-led beds, the comparability of nurse-led and medical care and their views on being called to give medical opinions to nurse-led bed patients.

Sampling

These hospital-based staff are also eligible to refer but not included in the Referrers sample group as almost all referrals originate in the community. A convenience sample of five consultant doctors, known to have utilised the nurse-led bed service, were identified to whom to send a questionnaire.

Data collection procedure

Due to small numbers, no pilot was undertaken. No reminder letters were sent due to a satisfactory response rate (80%). Internal mail, pre-addressed reply envelopes were included. Return envelopes were addressed to the study administrator as this was considered to be most acceptable to respondents.

8. Staff interviews - Derwent Ward staff

Tool

This tool (interview guide) comprised seventeen questions aimed at uncovering Derwent Ward staff members' experiences and perceptions of the nurse-led bed service. Topics covered included views of the kinds of patients admitted, improvements needed, general views of the service and effect of nurse-led care on patient outcomes.

Sampling

A theoretically-guided sample of twelve Derwent Ward Staff were approached for interview. The sample embraced the range of professions working with the nurse-led beds and included junior and senior staff, but no research team staff.

Data collection procedure

All twelve interviews were undertaken by the lead researcher. All selected staff were sent written study information sheets and invite letters. Staff could choose a time slot from three full-day visits to the ward by the lead researcher. On the day of interview, study information was re-iterated, informed, written consent gained and a tape-recorded interview undertaken. The venue was a private office in the hospital.

9. Staff interviews - Referrers

Tool

This tool (interview guide) comprised seventeen questions aimed at uncovering referring staff members' experiences and perceptions of the nurse-led bed service. Topics covered included views of the nurse-led bed admission criteria, the benefits and drawbacks of nurse-led care and their understanding of nurse-led care.

Sampling

A theoretically-guided sample of twenty staff who are eligible to refer into the nurse-led beds were invited for interview. The sample comprised district nurses (10) and GPs (10). Participants were selected on the basis of having had sufficient exposure as a referrer to the nurse-led beds to be able to comment on them and were drawn from a cross-section of practices.

Data collection procedure

Various research team members undertook the interviews as agreed with participants. All selected staff were sent written study information sheets and invite letters. On the day of interview, study information was re-iterated, informed, written consent gained and a tape-recorded interview undertaken. Staff specified a preferred venue which was accommodated (GP surgery or hospital meeting room).

10. Patient tracking – Inpatient journey pro-forma

Tool

This tool (audit pro-forma) comprised questions aimed at examining the different stages of a patient's journey during their stay in a nurse-led bed. Questions sought to uncover any factors contributing to the progress or non-progress of patients through their hospital stay. Topics covered included referral reason/source, whether discharge was delayed, discharge destination and support required/in place, and evidence of involvement in discharge planning.

Sampling

Twelve patients were selected for inclusion. These formed a maximum diversity sample. A sampling frame was created listing the most common conditions that nurse-led patients presented with. Patients whose care needs resulted from having one or more of these conditions were selected. This tool aimed to examine the journeys of nurse-led patients with 'typical' presenting conditions. The patient conditions/primary need sampled included:

- Continuation of rehabilitation
- Assessment and rehabilitation
- Falls
- Respiratory care
- Wound care
- Palliative care
- Pain control
- Reduced mobility and coping
- Social reasons
- Confusion
- Parkinson's Disease/neurological needs
- Stroke
- Orthopaedic care
- Medication review/management
- Continence/ostomy management

Data collection procedure

A tool was completed for each patient by a registered member of the research team. This mostly required examination of patient documentation although patients could be approached for supplementary information. The tool also required a professional judgement to be made about the appropriateness/impact of elements of the patient's journey. The first tool administered acted as a pilot and no alterations to the tool were required. Pro-formas were anonymised following completion and collated by the lead researcher.

11. Patient tracking - Non-admitted patient pro-forma

Tool

This tool (audit pro-forma) comprised questions aimed at exploring what happened to patients for whom there was not a nurse-led bed available when first referred. Questions included reasons why admission was requested,

whether it was a planned or crisis admission, reason for non-admission, patient destination and outcome at six weeks.

Sampling

All non-admitted patients who had been referred to the nurse-led beds during the data collection period were eligible for inclusion. An opportunistic sample of 10 patients was achieved.

Data collection procedure

A tool was completed for each non-admitted patient by a registered nurse member of the research team. This required some investigation work by telephone as not all required information was available through ward or patient information systems/records. The tool also required a professional judgement to be made about the appropriateness/impact of elements of the patient's journey. The first tool administered acted as a pilot and no alterations to the tool were required. Pro-formas were anonymised following completion and collated by the lead researcher.

12. Patient tracking - Readmitted/failed discharge pro-forma

Tool

This tool (audit pro-forma) comprised questions for examining patient and ward records in the event of patients being readmitted after twenty-one days of discharge from Derwent Ward (classed as a 'failed discharge'). The tool aimed to identify whether any readmissions were preventable, attributable to poor discharge planning or due to factors beyond the ward's control e.g. a patient taking their own discharge when unfit for discharge.

Sampling

All discharged Derwent Ward patients readmitted after twenty-one days to the Trust were eligible for inclusion. Sampling could only include those patients identifiable through Trust computer systems and could not identify any patients readmitted to other hospitals. An opportunistic sample of 8 patients was achieved.

Data collection procedure

All discharged Derwent Ward patients readmitted after twenty-one days were identified through Trust computerised patient information systems. A tool was completed for each patient by a registered nurse member of the research team. The tool also required a professional judgement to be made about the appropriateness/impact of elements of the patient's journey. The first tool administered acted as a pilot and no alterations to the tool were required. Pro-formas were anonymised following completion and collated by the lead researcher.

13. Bed census pro-forma

Tool

This tool (audit pro-forma) comprised a series of questions aimed at auditing the nature of patients who were occupying the nurse-led beds. Topics covered included reason for admission, current reason for being an in-patient, whether receiving active treatment or not and a judgement as to whether they were in the most appropriate setting for their needs.

Sampling

The tool was used once-weekly for six weeks. All nurse-led beds were included and the tool was used at differing times and on different days. This sought to reflect fluctuations in ward activity e.g. busy days, rushes of activity following weekly Multi-Disciplinary Meetings (when several discharges may occur). Weekends were not included as any changes in bed occupation were known to almost always take place on weekdays and any changes at a weekend would be picked up at the Monday morning census. Target times/days were:

- 9 00am on a Monday
- 10 00am on a Wednesday
- 12 00pm on a Tuesday
- 14 00pm on a Thursday

- 16 00pm on a random day
- 18 00pm on a Friday

Data collection procedure

The tool was administered jointly by two research team members - the Derwent Ward ward clerk (for patient details, GP name etc) and a registered staff member (to make clinical judgements about the patient's suitability for a nurse-led bed etc). The first tool administered acted as a pilot and no alterations to the tool were required. Information for their completion was available in patient records and routine ward documentation e.g. admissions book. Pro-formas were anonymised following completion and collated by the lead researcher.

14. Graffiti board

Tool

This tool (practice development) comprised a notice board identified for use as a graffiti board positioned behind the Day Room door on Derwent Ward. A notice encouraged participants to place any ideas or suggestions they had on the board, which could be viewed publicly. Maintenance of the graffiti board was managed by research team members based on Derwent Ward. This tool was aimed at gaining feedback in such a way as to be available to all patients and visitors in the hope it may spur ideas from others. Part way through data collection, the board was moved to a more visible and accessible location in the Day Room to encourage greater use.

Sampling

The graffiti board was available to anyone – staff, patients and visitors although mostly aimed at patients and their families. Participants could self-select whether they wanted to take part or not. A self-selecting sample of 7 participants was achieved.

Data collection procedure

Sticky post-it notes and a pen were placed with the graffiti board. On occasion, patients and visitors were verbally encouraged to place completed post-it notes or staff wrote on behalf of patients when asked. The board contents were removed at the end of the data collection period by the lead researcher.

15. First impressions questionnaire

Tool

This tool (practice development) comprised a three-question prompt sheet for use by staff with participants. This aimed to uncover initial reactions to the ward. The questions were:

- What things struck you during your first thirty minutes on the ward?
- What first impressions did you get of the ward?
- How could we make the experience of newcomers to the ward more positive?

Sampling

All new patients and their visitors were potential targets during the data collection period. Recruitment of participants depended on the staff workload on the ward at the time. Forty-six participants took up the opportunity to take part.

Data collection procedure

These informal feedback questionnaires were administered within the first few hours of arrival onto the ward. It was aimed to administer them within an hour. Both patients and visitors were eligible. As a non-research method, both research team members and other ward staff administered them after preparation by the research team members.

16. Comments box

Tool

This tool (practice development) comprised a secure ballot box placed in a prominent position in Derwent Ward Day Room. Alongside it was the study publicity poster asking for views to be placed inside anonymously. This tool aimed at being a confidential means of eliciting informal feedback.

Sampling

The box was available to anyone – staff, patients and visitors although mostly aimed at patients and their families. Participants could self-select whether they wanted to take part or not. Twenty participants took up the opportunity to take part.

Data collection procedure

Pen and paper were placed permanently next to the box. On occasion, patients and visitors were verbally encouraged to comment or staff wrote comments down for patients who asked them to on their behalf. The box was emptied by the lead researcher every few weeks and the padlock replaced.

A summary of data collection timeframes is shown in Table 2 overleaf.

ETHICAL AND RESEARCH GOVERNANCE ARRANGEMENTS

The ethical issues to manage within this type of study pertain to the need to avoid tokenism and involve participants in a meaningful way. Involvement of lay people in research design can be especially difficult to manage but can and should be done, as is advocated by Government policy. What is important is that people have different preferences for research approaches, often based on their beliefs about what is evidence or knowledge and their unique view of the world. No approach is wrong or right. It would be unethical to not give participants a meaningful say in the design of a study or to do research *on* them rather than *with* them when partnership working is a true possibility and appropriate. To merely consult users is insufficient when there is a real opportunity to research topics of importance to them as opposed to those instigated by professionals which sometimes fail to address the concerns of those people we provide a service for.

In action research, as with any research, ethics and other approvals to undertake the research must be gained. Action research and other participatory approaches cannot pre-state exact study design at the outset as these evolve during partnership working. There is a grey area between where preparatory discussions and development end and the research itself commences. Ethical approval could not be given until all data collection tools, information sheets and cover letters and consent forms had been reviewed by the committees. Therefore such approval was gained many months into the study, which is a tension for action researchers wanting to have approvals as early as possible so that ALL stages of the research process have had ethical review. Yet in reality, ethical interest appears to focus mostly on the point from tools and data collection onwards. In our case we sought early research management approval to be undertaking the early stages of the project to design the study, followed by formal research management approval to undertake the main part of the study. The formal application for research management approval coincided with the application for ethical approval as is common practice. In this way we were satisfied that the early design work had the full knowledge and support of the Trust Research and Development

Manager. The lead researcher took responsibility to ensure that any work undertaken prior to ethical approval was done in an ethically sound way.

At the required points in time, approvals were gained from Chesterfield Primary Care Trust Research and Development Department, Nottingham 2 Local Research Ethics Committee and the University of Salford Research Governance and Ethics Committee. A peer review process of the study proposal was undertaken in the Trust and approval gained following a response to queries. A formal honorary contract from the Trust was not received although a research management approval letter and supplementary emails detailing arrangements e.g. copyright, were accepted instead. Work is underway nationally through the NHS Research and Development Forum to standardise an approach to the issuing of honorary research contracts which is known to be a problematic area for researchers and NHS organisations alike. Approval from the Criminal Record Bureau was also gained for the lead researcher prior to interviewing any ex-patients or carers.

Questionnaires and interview transcripts from Derwent Ward staff were only accessible to the lead researcher to protect anonymity and confidentiality. To satisfy ethics committee requirements, no identifiable raw data was available to the lay research team members.

A signed agreement for photographs to be taken of research team members for dissemination purposes was also made with each member. All team members were asked if they were happy to be identified as co-authors/research team members within the report.

A multi-disciplinary Study Advisory Group was set up to give advice and problem-solve, although due to poor attendance only one of the three arranged meetings went ahead.

DATA PREPARATION, MANAGEMENT AND STORAGE

Prior to analysis (described in Chapter Four), a number of considerations and decisions were made around the management of data that had been collected.

Interview data was prepared to facilitate easier retrieval ready for the next stage in their processing. Each individual and focus group interview tape was given an identifying label and kept separately from the corresponding list of interviewees' names and consent forms. Tapes were transcribed by authorised secretarial support and stored in a locked filing cabinet in a locked office when not in use. Once finished with, each tape was given to the lead researcher who stored them in the same secure way. Each transcript was given its identifying label, large margins and line numbers prior to printing.

Questionnaire data was already anonymous as there was no requirement for respondents to give their name or other identifying details. Completed questionnaires were returned to the study secretary who kept these in a folder in a locked office. Completed Derwent Staff questionnaires, whilst completed anonymously, could be identifiable by handwriting. Therefore these questionnaires were locked in a filing cabinet in a locked office and only available to the study secretary and lead researcher. The responses to each question were entered into the statistical computer package SPSS and the analyses from this were then organised in Excel sheets ready for production of bar charts and pie charts.

All other numerical data from the audit tools were transcribed and transferred into tables from which descriptive statistics were calculated. Audit tools had their patient identifying information removed. Remaining free text responses, such as from the First Impressions Questionnaires, were transcribed and listed under each question heading.

STUDY LIMITATIONS

Response rates for the various data collection tools varied. Many were excellent, especially some of the questionnaire surveys. Responses from carers however were low. Wording of the carer questionnaire was very similar to the patient one and these were distributed after most patients had received and replied to theirs (if they wished). We noted that many carers had assisted patients to complete their questionnaires (as we asked for this information) and so their views may have been introduced during this process. It is recognised that many carers may then have found their own questionnaire repetitive, leading to a decision not to reply, despite reminder letters.

We also had a lower participation rate for interviews with patients and carers than had been expected. This was despite carefully worded reminder letters which lay research team members felt were not off-putting in any way. We also thought the offer of a lay research team member or family member being present at the interviews would make them more appealing, which seemed to be the case for some and these were done as paired patient/carers interviews. There is always a risk that people may be reluctant to give their views on a service that they may come back to at a later date, which is often the case with intermediate care. Patient and carer views were supplemented by the findings from the First Impressions Questionnaire and patient survey, which had good response rates.

A further limitation was the unpredictable workload of research team members as both the NHS and Trust underwent a number of changes during the study period leading to changes in team membership and variable input. This will always be the case in health services research. Use of an action research approach meant that the processes we followed could be responsive to any challenges faced along the way. Learning from what works and does not work is an important part of action research. Apart from the lead researcher, time given to the project by research team members was voluntary and not protected. At times data collection procedures were affected by conflicting work pressures and unclear communication, so that these procedures did not

always follow the original plan. Co-ordination of the study from afar by the lead researcher did contribute to this and a stronger physical presence in the Trust, although not possible here, would have reduced the margin for deviation from what was planned. In hindsight, the project administrator should have been invited to earlier data collection planning meetings to be briefed first hand.

Despite a commitment to engage members of the public as co-researchers, it is recognised that even greater efforts were needed to increase the numbers of these, not least to allow for lay members leaving the group as happened twice. Only one of the research team had previously been a patient in the nurse-led beds. Whilst this was very useful, a further one or two ex-patients bringing that perspective would have been more helpful to the project and supportive to that individual. Fortunately, by all accounts, the five lay co-researchers gelled well as team members and felt adequately supported. On only one occasion did a lay research team member express dissatisfaction (at missing a training opportunity) and a repeat training session was offered.

SUMMARY

This chapter has described the process by which participants were selected for use with the data collection tools and the application of these tools during fieldwork. Insight into the ethical and research management issues considered and addressed as part of the study were outlined. In the next chapter, means of analysing the data collected and the findings are presented.

CHAPTER FOUR

ANALYSIS AND FINDINGS

This chapter presents the approach to analysis taken with data from each data collection tool. Findings from all data collection are also presented.

ANALYSIS

Questionnaires

All questionnaires were analysed following input into Excel spreadsheets. Descriptive statistics (ordinal, non-parametric) were mostly used and findings stated as percentages. Comparisons could only be made to identify any statistically significant relationship between a few questions e.g. patients views of the degree of their involvement in care planning and staff views of the degree that patients were involved in their care planning. This is because the questions asked of each group tended to be pertinent to them and were mostly not repeated to the different participant groups, so cross-comparison was not possible. Where such comparison was made it was done using a Mann Whitney U test.

Interviews

The approach to analysis was informed by Lofland and Lofland (1995). Each tape was listened to in its entirety. Interview transcripts were read in full and then examined line by line. Key chunks of text deemed important or significant were selected and given a label so that they could be traced back to their original place in the transcript. Due to the small numbers of transcripts this process was done manually using colour coding. Each labelled segment of text was grouped under emerging headings or themes. As analysis progressed, these themes were merged or broken down into smaller

categories to reach a best fit. Continued examination, reflection and sorting enabled more fine-tuned analysis of this condensed data, leading to an end product of major themes, sub-categories and labels.

Graffiti Board, First Impressions Questionnaire and Comments Box

Free text responses to these data collection tools were transcribed verbatim and loosely grouped into themes. The brevity of these responses limit deep analysis but permit cross-comparison to be made with other findings. All of the responses to these tools can be found in the Appendix.

Patient Tracking Pro-formas – In-patient Journey, Non-admitted Patient, Readmitted/failed Discharge

These were all read in their entirety twice and examined question by question. Analysis sought to identify any patterns or themes that suggested any areas in need of improvement or where untoward events could have been prevented. Patterns between tools have also been sought through a process of cross-comparison. Professional judgement has been a core part of the analytical processes with these tools.

Bed Census Pro-forma

Analysis of these has included a combination of descriptive statistics and use of professional judgement. An overview of nurse-led bed use has been possible with a parallel, critical review of the appropriateness of bed usage during the census period. Analysis sought to identify any patterns or themes that suggested any areas in need of improvement to bed utilization.

FINDINGS

Due to the large number of data sets (information gained from each of the tools), findings have been broken down into *research and practice development findings* and *audit findings*. The first set of findings are organised under the umbrellas of Patient Perspectives, Carer Perspectives, Nurse-led Bed Staff Perspectives and Referring Staff Perspectives. Each section will present findings from each tool separately.

Research and Practice Development Findings

Patient Perspectives

These findings are drawn primarily from 32 completed questionnaires received from patients (67% response rate) and individual interviews with 5 patients. Two thirds of questionnaire respondents were female and the majority of all respondents were over 80 years of age.

Both the patient and carer interview guides and questionnaires asked closely related questions. Asking similar questions in this way was useful at gaining each group's unique perspective of the nurse-led beds. In our findings, views of both groups were in fact very similar. On eighteen occasions questionnaires were completed by carers/family members (15 family members, a home help and two carers) on behalf of patients and so a degree of influence can perhaps be assumed.

1. Questionnaires

Percentages are rounded up to the nearest whole number. Findings from the 32 returned questionnaires show overwhelmingly, that patients were very satisfied with their over all experience on the nurse-led ward, with 90% rating it between excellent and satisfactory.

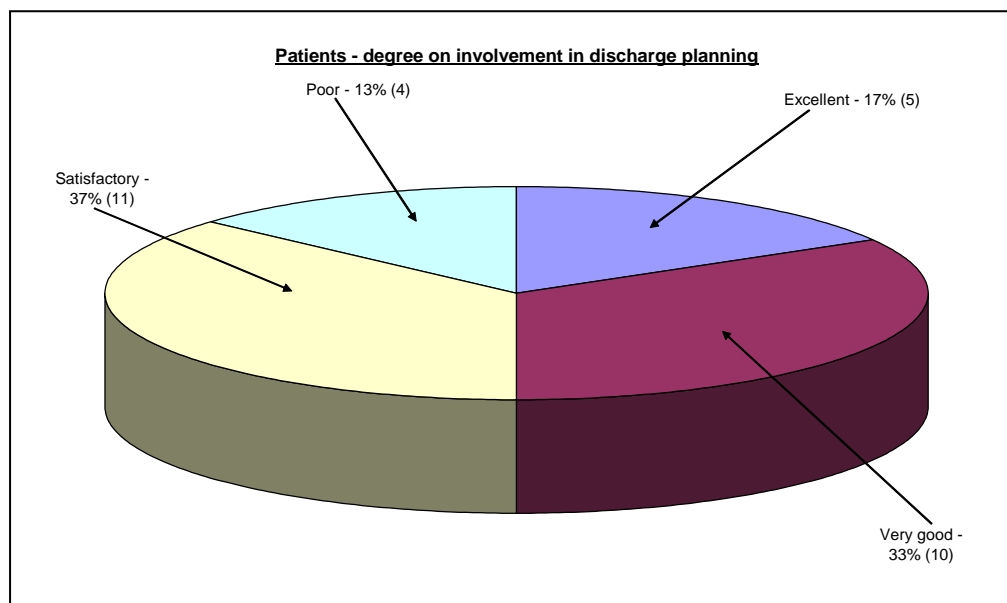
Information

Patients commented highly on the standard of communication on the ward. The majority of patients considered verbal information to be excellent or very good (69%) and matching responses were given about written information (69%). General staff communication with patients was viewed as excellent, very good or satisfactory in 90% of patient responses. When asked to rate staff members' response to patients' *own* attempts at communication with *them* (e.g. listening skills), staff were rated very highly (excellent 24%, very good 45% and satisfactory 21%).

Involvement

Patients were asked how involved they felt in their care. A staggering 94% rated their involvement as excellent, very good or satisfactory. They were also asked to rate the degree of choice they felt they had concerning their care. Again 90% found it to be excellent, very good or satisfactory. In terms of involvement in discharge planning a further 87% were satisfied or above, although 13% found their involvement in this important area to be poor (Chart 1).

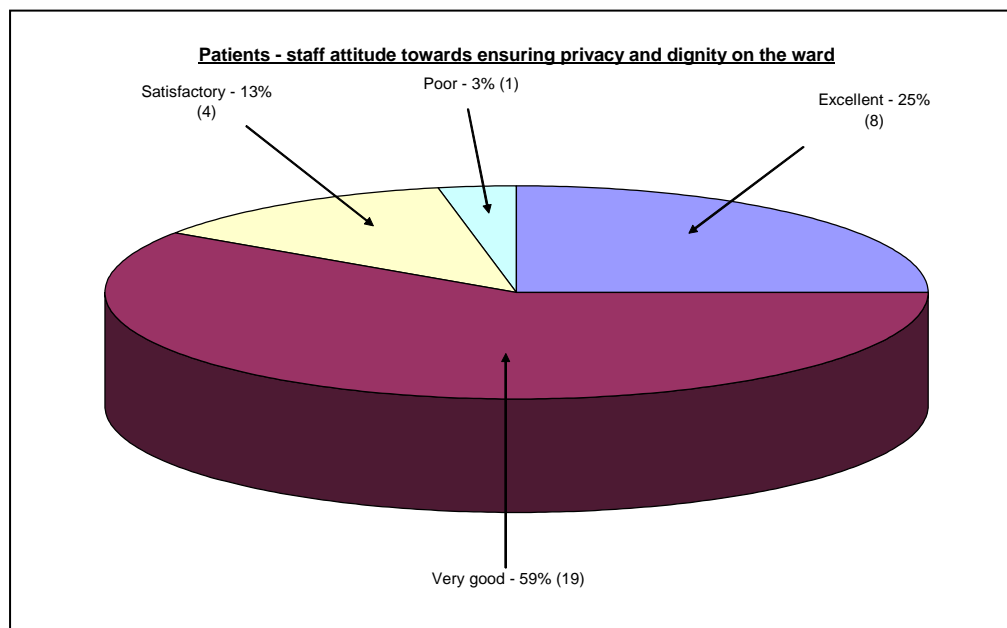
Chart 1.



Attitudes

In terms of patients' rating of staff members' general attitudes, all but one respondent (97%) rated them between excellent and satisfactory, with 5 of these specifying excellent (16%). In relation to staff attitudes to privacy and dignity in particular, patients were even more impressed rating staff as excellent (25%), very good (59%) and satisfactory (13%) (Chart 2).

Chart 2.



Social Activities

The majority of patients rated ward social activities highly with views of excellent (17%), very good (65%) and satisfactory (4%), being expressed. A small number of patients (3) did not look favourably on the activities they did and rated them as poor (9%) and very poor (4%).

Some of the secondary data collected concerned the social activities run by Derwent Ward's Activity Co-ordinator on a daily basis. A wide range of activities were available during the data collection period including card games, chair-based exercises, word games, quizzes and movement to music. From January to June 2006, a total of 111 different nurse-led patients took

part in these activities totalling 934 activity episodes. Of the episodes, most were delivered on a group basis (93%) whilst 7% were on an individual patient basis.

General comments

Parts of the questionnaire encouraged comments and asked open questions to invite written responses. In summary, it was expressed by several respondents that discharge planning could be a lot better. A small number of respondents indicated that they felt they had little choice in discharge planning with one expressing that the occupational therapist's ideas were pushed onto them. Another said they were simply told when they would be discharged. One respondent would have liked information on location of facilities on arrival e.g. Day Room, wash rooms, whereas another respondent highlighted that they received such information and found it very valuable. One respondent said they had received too little information on their progress and condition. A strong theme was how staff were perceived as busy. One respondent said staff were all so busy with little time to spend with the patients. Others felt staff were overworked with too much paperwork. Another respondent said that whilst everything was done the nursing staff were rushed with no extra time and felt quite sorry for the staff at times. Another view was how staff seemed too busy to be sociable and whilst they worked very hard some did not appear cheery. Conversely several other respondents highlighted how sociable staff were, that staff attitudes were very good and could not be faulted and another said how Derwent Ward staff are an asset to the local Health Authority. The high degree of caring and respect was noted by several respondents. A few respondents said how enjoyable the social activities had been on the ward.

Suggestions for improvement

Suggested improvements included less rushing and more time planning jobs, more nurses who could give more time to patients and less paperwork. Others thought the care could not be improved. More physiotherapy was requested by one respondent. Another respondent felt Parkinson's Disease was little understood by the staff. One respondent indicated their discharge had been arranged within the hour with no planning. Whilst questionnaires were

anonymous, several respondents chose to put their names to endorse the comments they had made and to indicate their appreciation of the care they received.

2. Interviews

Findings from interviews have been divided into themes which are presented under sub-headings. Where illustrative quotes are used, an identifying code e.g. P1 for Participant One, is given.

Understanding of the nurse-led bed service

No participants were given any written information prior to admission to the nurse-led beds and only one recalled being advised verbally by their doctors that the service was nurse-led and primarily for rehabilitation. All were happy to trust that professionals were admitting them to the best place for them. One participant recalled getting extensive verbal information about the purpose of the nurse-led service on admission.

Communication with staff

Generally speaking communication with staff was viewed as positive although this at times depended on the individual staff member. There was a tendency for participants to feel they had to ask for information rather than being given it routinely. One participant viewed listening skills as very good indeed, whilst another believed nurse-led staff would get to know patients better than a doctor would. One comment was that all of the nurses showed kindness, consideration and were friendly.

Discharge planning

Participants expressed mixed views about their involvement in discharge planning. For some it was unsatisfactory and felt that they had no involvement in the arrangements, merely being 'told' when it was. Participant 1 said that the response he received when he asked about discharge plans was "*we are working towards it, we hope to get you home as soon as possible*".

Others felt a good degree of involvement. In some cases involvement was extensive e.g. by involvement in more than one multi-disciplinary team meeting and home visits and this was greatly valued. Some participants were not interested in involvement or information about discharge and when asked, did not recall receiving any (P3):

"No I don't think so. All I was interested in was getting better and going home, which is in every patient's mind".

One participant was dissatisfied that three months after discharge, they had received no follow up on their progress and their condition had deteriorated.

Involvement in care

Participants' perceptions of involvement in care were mixed. Some did not recall making any choices and did not seem concerned about this.

"I tried to co-operate with everything they did." (P3)

One participant clearly did agree goals (P1):

"Well the physios used to come and ask me what are my goals. One of my goals was obviously being able to walk properly, have more confidence on the stairs ... and my second goal was to be able to use a knife and fork properly, because I can't use it, I can't use my left hand at all."

Privacy and dignity

Promotion of these was generally viewed favourably. One participant suffered incontinence and said that every staff member was faultless in the way they dealt with each incident.

Social activities

Some participants enjoyed the social activities but not all took part. Most highly regarded the activities co-ordinator, although one participant found her

encouragement to take part too strong and they felt pressurised. One participant (P1) felt age differences made them feel out of place:

"I didn't enjoy it at all. I was the youngest there, I know I'm in my 60s but all the other old sods were in their 80s, I felt out of place."

Another misunderstood the rehabilitative aspects of the activities (P2):

"I don't see what it had to do with them being in hospital to be honest. I know they have to have different things to pass people's time but the ones that, to me they were games that kiddies would play at a party, that sort of thing. I was a little bit.., I said to them I didn't particularly like to do them so I'm not going to do them but if they wanted me to fill in I would, which I did."

Organisation of care

One participant did not find the nurse-led bed system of blue and green teams helpful (P4):

"What I couldn't understand with colour coding is if it was a matter of somebody was infectious or some people were infectious - cross infection - yes. But say on a 6 bedded unit and only 5 of them beds were occupied and say for instance it was a Red Team looking after 2 and a Green Team looking after 3 but the 2 people didn't need very much looking after but the 3 did, why they can't help each other, but they can't do it because they're not in that team that day, it just seems silly to me."

All participants were happy to be cared for on a nurse-led ward. Only one participant could recollect clearly who the nurse consultant was, whilst another commented how she was 'unobtrusive' and 'in the background' yet 'very available'. Once reminded of her, all spoke very highly of the nurse consultant. One comment was that without wearing a uniform it was hard to distinguish who she was and a white coat was suggested. Nursing uniforms in general were commented on as being too similar by one participant and others concurred they did not really know what roles people had.

Suggestions for improvement

These included bed-side lights that patients could operate themselves in the night (P4). This participant also expressed concern over the lack of staff at staff changeover time:

“When there’s a changeover of staff I think there should be a couple of floaters, you know that, I know they have to be informed and everything, but at the same time what if somebody desperately needs the nurses? You ring the bell and they can’t come, because they perhaps think oh it’s a toilet call, I think there should be 2 floaters.”

Closure or reduction in hours of the hospital hairdresser was highlighted by two participants as important for nurse-led patients who be may older and/or in hospital for a long time and for whom this service provided a morale boost.

A toe nail cutting service was also needed according to Participant 4:

“I also think there should be some facility where people can have their toenails cut, I don’t mean for free, because my nails were killing me, I could hardly walk because they hadn’t been cut since April, and somebody who shall be nameless did them for me, because I know they’re not supposed to do it, but I couldn’t walk it was hurting me and I couldn’t get down to do it..”

A smoking area for patients was requested by one participant when asked about the impact of his wish to smoke on other patients (P1):

“Well, that’s their decision not to smoke, my decision is that I want to smoke, I like a cigarette and that’s my choice.”

Carer Perspectives

These findings are primarily drawn from 8 returned questionnaires from carers (24 % response rate) and 4 individual interviews with carers.

1. Questionnaires

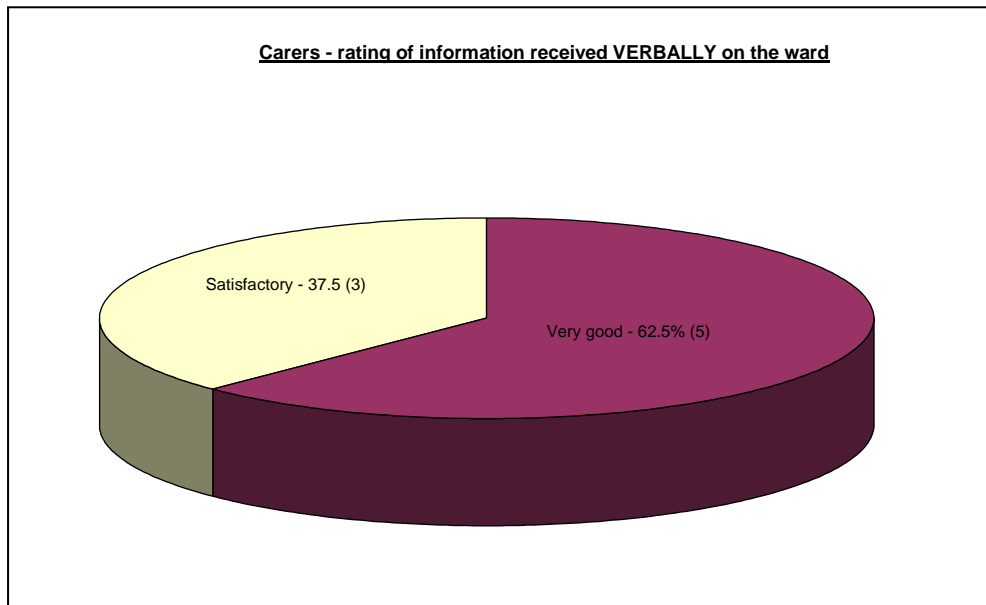
When viewing the percentages, please note that this is a very small response rate. In addition, not all respondents answered every question. Percentages are calculated from the varying number of respondents that answered each specific question not from the number of respondents answering the survey. Percentages are rounded up to the nearest whole number.

Carers were very satisfied with their experience on the nurse-led ward with 100% rating it between very good and satisfactory.

Information

Carers commented highly on the standard of communication on the ward. All eight carers considered verbal information to be very good (63%) or satisfactory (38%) (Chart 3 overleaf). Responses rating written information were also favourable with excellent (17%), very good (67%) and satisfactory (17%) being given by the six respondents. General staff communication with carers was viewed by all seven respondents as very good (57%) or satisfactory (43%). When asked to rate staff response to carers' *own* attempts at communication with *them* (e.g. listening skills), staff were rated highly (very good 86% and satisfactory 14%) by the seven respondents.

Chart 3.



Involvement

Carers were asked how involved they felt in their relative's care. All 100% of respondents (7) rated their involvement as excellent, very good or satisfactory. They were also asked to rate the degree of choice they felt they had concerning their relative's care. Again 100% of respondents (7) found it to be between very good and satisfactory. In terms of involvement in discharge planning all eight carers (100%) were at least satisfied (excellent 25%, very good 63% and satisfactory 13%).

Attitudes

In terms of carers' rating of staff members' general attitudes, all respondents rated them between excellent and satisfactory, with 3 of these specifying excellent (43%). In relation to staff attitudes to privacy and dignity in particular, carers rated staff as excellent (14%), very good (71%) and satisfactory (14%), based on seven respondents.

Social Activities

Only a small number of respondents commented on social activities (3) as the other five had no exposure to these. All three considered the ward social activities to be excellent (33%) or very good (67%).

Parts of the questionnaire encouraged comments and asked open questions to invite written responses. Discharge planning was praised on three occasions. One carer felt very well informed and involved, although there was a several-hour wait over discharge drugs which they were kept fully informed about. One respondent indicated that communication with and by staff was dependent on the individual although another comment was that communication was good despite staff being clearly overworked. Staff attitudes were also said to be variable by one respondent who added they saw much caring, humour and compassion.

The only suggestion for improvement pertained to introducing new patients to each other as when moving out of a side ward or in the dining room as some patients may be shy but lonely.

2. Interviews

Findings from interviews have been divided into themes which are presented under sub-headings. Where illustrative quotes are used, an identifying code e.g. P1 for Participant One, is given.

Understanding of the nurse-led bed service

No written information was received by carers prior to their relative's admission to the nurse-led beds. Like patients, all were content that the right care was being arranged for them. One participant understood from the GP that the nurse-led beds were rehabilitative and that their relative would receive a lot of physiotherapy, which turned out to be the case.

Most participants expressed no appreciation as to what the concept of nurse-led care was about. When asked about their understanding of nurse-led care, one participant's response was (P1):

"There's no doctors. Well, there was a doctor on. I wouldn't have picked out especially that it was nurse led, I just saw them as staff there."

One participant wanted to see more doctors (P3):

"I feel the doctor's not available enough. You know it's nice to come round every day and see the patient and sit and find out how they are going on. So that I can go to them and say 'is she improving, is she getting worse?' and things like that. In fact I didn't know who the doctor was sometimes you know."

Speaking of the nurse consultant once her role had been explained, Participant 3 went on to say:

"(The nurse consultant) seemed to be in a supervisory capacity to me rather than medically involved... If I'd been more aware of (the nurse consultant's) position, I probably would have gone to her more and asked her direct questions about my wife's health and things like that. I didn't know that... if she probably wore a distinctive uniform I would have known who she was and probably gone to her."

Other staff roles were little understood, illustrated by one participant (P2):

"But exactly what the role of Nurse Practitioner is I have no idea."

Participant 3 also struggled with staff roles:

"Well we was both interviewed you know in a room with the... I can't think of the person's name and what her status was but she arranged all the home care for us and she visited us herself and left all the information for us to read through about what was required and what was being laid on."

This same participant added:

"I had difficulty distinguishing between sisters and staff nurses – they wore the same uniform... occupational therapists are the people who do different things aren't they, like basket work and things like that isn't it?"

Communication with staff

Most communication with staff was considered positive although it again depended on the individual staff member. Communication was perceived as mainly coming from nursing staff who were generally viewed as very approachable. Communication by all members of the multi-disciplinary team was well regarded as Participant 2 illustrates:

“They were all excellent, I had no complaints about any of them. None whatsoever. Very kind, very considerate, very pleasant.”

Opportunity for communication after discharge was highlighted by one participant as very valuable (P2):

“I was apprehensive obviously but I mean the attitude when we came away from the ward was extremely helpful, we were told if there was the slightest problem all we’d got to do was pick up the phone and somebody would help and that occurred.”

Privacy and dignity

One participant said they raised a dignity issue as a verbal complaint but never got any feedback despite it being quite upsetting for their relative. Other participants were very satisfied with arrangements to maintain privacy and dignity.

Participant 3 commented:

“Every time that they went to the patient, they drew the curtains and it’s not all the times that they want to use the toilet and things like that. I noticed that they drew the curtains quite a lot and they had the privacy of talking together.”

Social activities

One participant believed that the purpose of the social activities was to occupy patients. When their purpose as part of the rehabilitation process was clarified by the interviewer, this participant made the following suggestion (P2):

“It would have been a lot better to have known one, that (the activity co-ordinator) existed, and two the reasoning behind doing it. If it was explained that it was an important part of the rehabilitation... The idea that you get is that it was just a way of passing some time.”

Another participant felt their relative had greatly welcomed the activities (P4):

“...she did love those yes. She went most mornings I believe. She liked the quizzes, she liked just basically just taking part, I think she liked the company as well... they do some sort of exercises as well ...not strenuous stuff but they do do some which she did take part in as well. So yes, she certainly found it beneficial I think.”

One participant valued the formal social activities and other social opportunities presented by meal time arrangements (P3):

“I thought they were great and the wife did as well. It was something to look forward to for her and she could participate in all the games and the quizzes and things like that. And she thought they were great and another thing, the feeding arrangements, the meal arrangements she thought they was great as well because it was like a family meal together – four or five at the table.”

Organisation of care

One participant found the nurse consultant to be busy in the background and would have liked her to be more visible (P2):

“I don't think that situation really occurred where she necessarily came up and said this is what's going to happen but generally speaking she was very available and she would always talk and discuss things...”

Probably because there was an apparent lack of involvement initially and I say apparent because obviously she was involved but she didn't really seem to be involved initially. That might be something, would help a little bit if she showed a bit more involvement initially. Even though she is involved and involved quite deeply, it didn't seem apparent at the time."

Feedback on test results was an issue for one participant (P3):

"And it was difficult to get to know the results of the X-rays. The staff nurses didn't know and I went to... (a nurse) on the ward and she said 'the doctor will tell you'. But it wasn't very forthcoming, it took quite a few days and the wife kept asking me 'have you seen so and so about my X-rays? What's the results?'. I thought they might have... the doctor probably told her later on but it was quite a considerable time after she'd had the X-rays."

No participants expressed any concerns over the beds being run by nurses as Participant 4 illustrates:

"...it's just a question of old age, needing a hand and running down and basically slowing down and old age catching up with her so she actually wasn't physically ill. Stuff like medication. Nurses perfectly qualified to do that, so I've no problems at all. She got the physios there with what she needed. No I was more than happy with what she'd got and what was available...and I mean obviously I know that if a doctor was needed, they could call a doctor at any time so there was no problem as far as I was concerned at all."

One participant felt strongly that therapy services should be available 7 days a week.

Discharge planning

Generally equipment provision and other arrangements were satisfactory. However one participant had a negative experience when they reportedly had to argue and complain in order to get a much needed commode delivered for the day of discharge. One participant was able to discuss planning for

discharge at length with the staff and discharge went on to be very successful. One view was that an invite to the multi-disciplinary meeting could have been sooner than 3-4 weeks after admission, as prior to that this carer felt like they were simply waiting for referrals to be acted upon.

"I mean obviously the ward staff can only do so much but I think a bit more pressure could have been put on the psychiatric or mental health team to get action a little bit quicker. Once I jumped up and down a little bit things seemed to happen very quickly." (P2).

Another participant (P4) also experienced some disappointment with discharge processes:

"I think I was led to expect that she would probably come home lunchtime, mid afternoon and I think she was certainly home before that, she was home earlier than that. Certain things that had been agreed, one of them I think was 'shall we go home with blister packs for medicine?' That didn't happen so that had to be sorted out the following day. So as for the discharge, I wasn't totally happy with the discharge I'm afraid from the ward."

Whilst a further participant was clearly very satisfied (P3):

"Yes I was satisfied with the dates they gave me and anything like that and I was quite satisfied...you know I was ok at home to receive her and I don't think there were any problems at all there."

Involvement in care

When asked about the value of attendance at multi-disciplinary meetings, Participant 2 said:

"The only thing I found helpful about it was that I could express views. Generally speaking I don't think the meeting as far as we were concerned achieved a great deal. Yes, you've got everybody round a table and you can raise a number of topics all in one go but there didn't

seem to be any decisions made at that meeting, it was just a case of raising points and people taking notes and that was it."

Attendance at a home visit did present an opportunity for one participant to gain information about what was being planned although this was picked up informally rather than communicated direct:

"And I do know certain recommendations were made at the time, some of which I think have happened, but again it wasn't reported to me afterwards, it's just what I picked up during the meeting there."

Suggestions for improvement

A nurse-call system for the Day Room was suggested:

"In the Day Room all the people are sat there, if they need to go to the toilet they've got to shout. There's no way of them being able to call a nurse with a buzzer. I think that somehow the system ought to be set up so that they've got a loop round their neck or something like that. They've got them at the side of the beds but in the Day Room, there are facilities on the wards for plugging buzzers in but they don't necessarily reach everywhere and I think the facility ought to be there for people to be able to call a nurse without having to shout." (P2)

Someone to check walking stick length for all patients using them was suggested.

More entertainment in the afternoons was requested.

One improvement suggested pertained to having a Welfare Rights Officer visit the ward routinely (P1):

"I think people should come round on the wards and make sure that people are getting their benefits. Somebody should make sure that they're in the right age group for getting these benefits. There's probably people in there that don't know these allowances they can get."

More Information about follow up appointments was suggested by one participant (P2):

"We were just told that we'd get an appointment. There'd just be an appointment sent for the Day Hospital... It would have been helpful yes to know who we were seeing and what the object of the follow up was."

A further suggestion was for opportunity for relatives to speak at multidisciplinary meetings alone (P4):

"...the only possible comment I would make is when we went to the multi-disciplinary meeting, I went in with my mother. It can be sometimes very difficult to discuss, plus with my view of my mother, and my mother's view of my mother, when we are both there and I think in some ways it would nice actually if you got the chance to speak on your own."

Staff training around communicating with patients when handling them was suggested (P2):

"(My mother) in particular got comments and there were comments that were made right up until the discharge was that 'you can stand alright for (the physiotherapist) you can stand alright for us', and (my mother) responds very much to encouragement rather than being told you've got to do something and I think from that point of view the nursing staff could do with some training towards that. I mean I'm not saying that they're not caring or whatever, they obviously are, but I think their attitude in some situations could be improved."

An afternoon rest period was advocated by one participant (P3):

"I think from about half past one to half past two the ward should be closed to visitors and people who are able to get on the beds just for an hour for a lie down. Close the curtains and things like that and have a rest. I feel it more in this than the other ward because she's in the wheelchair all day long from 8 to 8 at night which is a long time."

Finally, facilities for people to make their own drinks were suggested (P1):

“Maybe there should be a vender on the ward so you can get yourself a drink if nobody can make you one in between drink times.”

Nurse-led Bed Staff Perspectives

The views of staff who deliver nurse-led care were gained through interview and questionnaires. Interestingly, some staff made use of the Graffiti Board (5 respondents) and Comments Box (6 respondents), and data from these were also drawn upon. These findings are drawn from 22 completed questionnaires (56% response rate) and 12 individual interviews with nurse-led bed staff (nurses and therapists).

1. Questionnaires

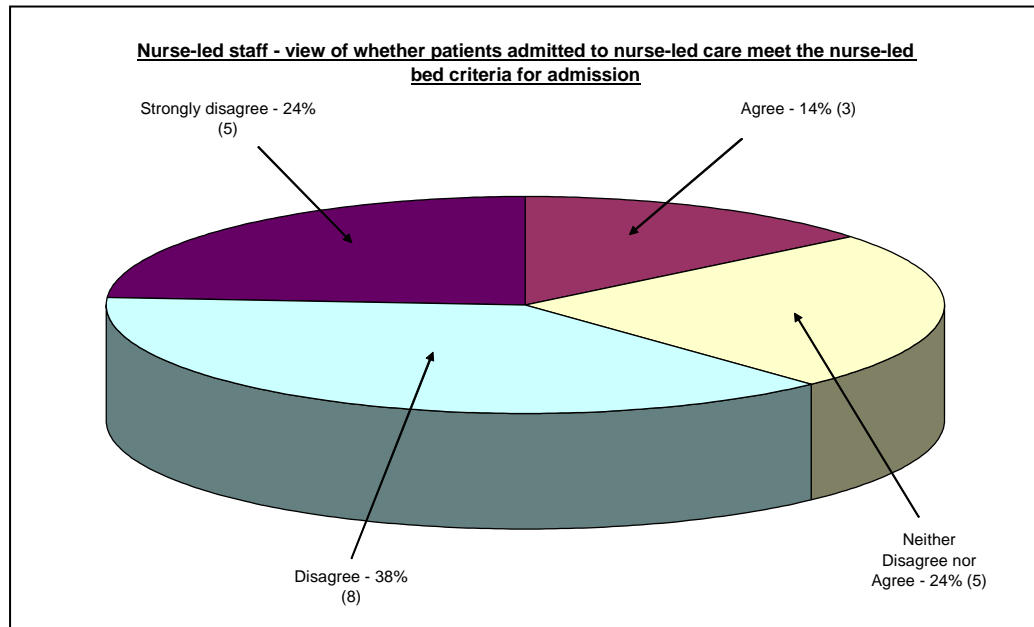
Response rates from nurse-led bed staff were good. Unfortunately, a photocopying error meant several questions were not received by some respondents. Attempts to rectify this failed and so to supplement this data, extensive interviewing has been undertaken. Occasionally other questions were left blank by respondents. Percentages are therefore calculated from the varying number of respondents that answered each specific question not from the number of respondents answering the survey. Percentages are rounded up to the nearest whole number.

The first question asked whether respondents found working with nurse-led patients to be more satisfying than working with medical-led patients. Of the 21 staff who replied to this question, 14% agreed (3), 43% neither agreed nor disagreed (9), 24% disagreed (5) and 19% strongly disagreed (4).

Respondents were asked if they felt patients who were admitted met the nurse-led bed admission criteria. Of the 21 staff who replied to this question,

14% agreed (3), 24% neither agreed nor disagreed (5), 38% disagreed (8) and 24% strongly disagreed (5) (Chart 4).

Chart 4.

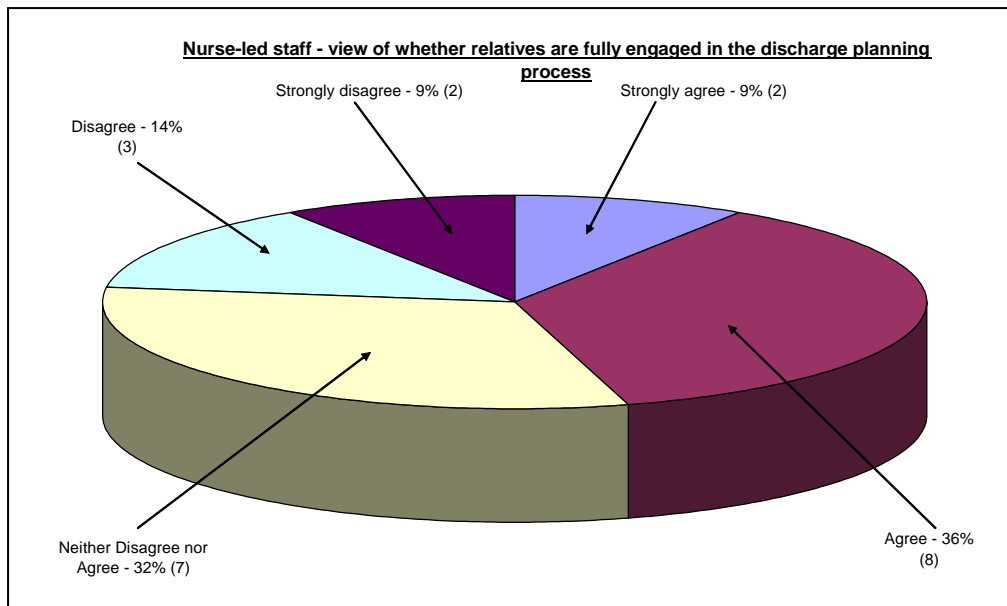


In terms of whether they felt sufficiently clinically skilled to manage patients in nurse-led care, 11% of respondents (2) strongly agreed, 58% agreed (11), 21% neither agreed nor disagreed (4) and 11% disagreed (2). Nineteen survey respondents replied to this question.

When asked if patients and relatives are fully engaged in the assessment and planning of care on the nurse-led ward, 14% strongly agreed (3), 36% agreed (8), 32% neither agreed nor disagreed (7) and 18% disagreed (4). All twenty-two survey respondents answered this question.

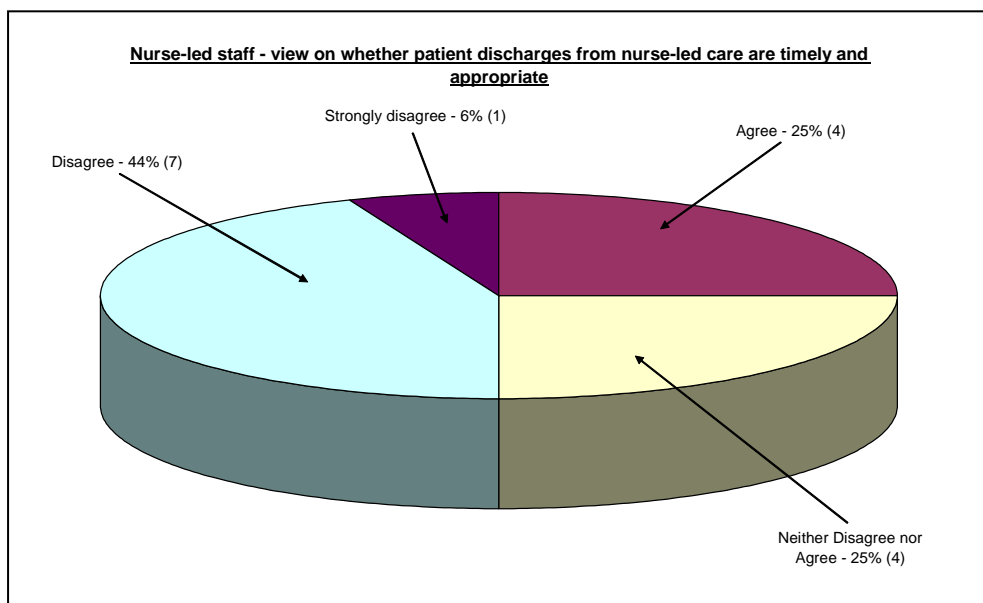
When asked if patients and relatives are fully engaged in the discharge planning process in particular, 9% strongly agreed (2), 36% agreed (8), 32% neither agreed nor disagreed (7), 14% disagreed (3) and 9% strongly disagreed (2). All twenty-two survey respondents answered this question (Chart 5).

Chart 5.



A further discharge-related question asked whether respondents felt patient discharges from the nurse-led beds were timely and appropriate. Respondents indicated that 25% agreed (4), 25% neither agreed nor disagreed (4), 44% disagreed (7) and 6% strongly disagreed (1). Sixteen respondents answered this question (Chart 6).

Chart 6.

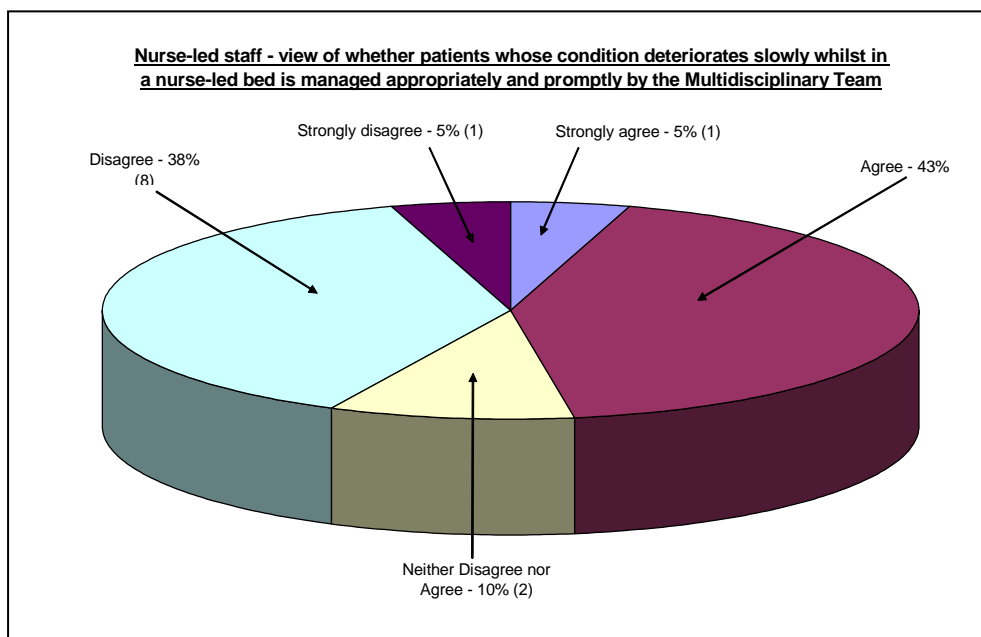


Additionally, respondents were asked whether readmissions to nurse-led care were preventable with better discharge planning. Sixteen respondents answered this question. Respondents indicated that 13% strongly agreed (2), 38% agreed (6), 25% neither agreed nor disagreed (4) and 25% disagreed (4).

Respondents were asked if the nurse-led bed admission criteria were appropriate. Thirty-three percent agreed (7), 38% neither agreed nor disagreed (8), 14% disagreed (3) and 14% strongly disagreed (3). Twenty-one respondents answered this question.

A further question asked whether respondents felt that patients who deteriorate slowly whilst in a nurse-led bed are managed appropriately and promptly by the multi-disciplinary team. Respondents indicated that 5% strongly agreed (1), 43% agreed (9), 10% neither agreed nor disagreed (2), 38% disagreed (8) and 5% strongly disagreed (1). Twenty-one respondents answered this question (Chart 7).

Chart 7.



Conversely, the next question asked whether respondents felt that patients who deteriorate rapidly whilst in a nurse-led bed are managed appropriately and promptly. Respondents indicated that 6% strongly agreed (1), 31% agreed (5), 19% neither agreed nor disagreed (3), 38% disagreed (6) and 6% strongly disagreed (1). Sixteen respondents answered this question.

One question tried to elicit whether respondents felt the nurse-led beds met a previously unmet need. Thirty-eight percent agreed (8), 29% neither agreed nor disagreed (6), 19% disagreed (4) and 14% strongly disagreed (3). Twenty-one respondents answered this question.

Respondents were asked whether they agreed that patients and relatives understood that care would be managed by nursing and therapy staff and that there was limited medical input to the nurse-led beds. Respondents indicated that 38% agreed (6), 19% neither agreed nor disagreed (3) and 44% disagreed (7). Sixteen respondents answered this question.

Respondents were asked to rate their agreement that there were good links with community teams for patients in nurse-led care. Respondents indicated that 53% agreed (8), 40% neither agreed nor disagreed (6) and 7% disagreed (1). Fifteen respondents answered this question.

Furthermore, respondents were asked whether they felt the role of the Care Manager was an integral part of the multi-disciplinary for the nurse-led beds. Respondents indicated that 25% strongly agreed (4), 50% agreed (8), 19% neither agreed nor disagreed (3) and 6% disagreed (1). Sixteen respondents answered this question.

Respondents were also asked whether they fully understood the role of the Care Manager for the nurse-led beds. Respondents indicated that 13% strongly agreed (2), 67% agreed (10), 7% neither agreed nor disagreed (1) and 13% disagreed (2). Fifteen respondents answered this question.

Parts of the questionnaire encouraged comments and asked open questions to invite written responses. Large numbers of comments were made about respondents' views as to the inappropriateness of some admissions to the nurse-led service (e.g. mobile patients with dementia, people with social problems). The service was generally believed to work well when the right patient-types were admitted. Similarly many comments were made about the potential to improve discharge-related processes, which at times were viewed as hurried due to pressure on beds. Past experience of multiple discharges on a single day were viewed as rushed and stressful. High ward activity in the afternoons when staffing levels were reduced was also noted as a particular problem.

Drawbacks of nurse-led care mentioned pertain to the risks of patients with underlying medical needs which may go unmet. This includes some patients who were viewed by respondents to need transfer to an acute bed yet were maintained in a nurse-led bed. This was particularly noted to put pressure on night staff who were viewed as being 'out on a limb', and weekend staff. A need to improve 'do not resuscitate procedures' and how these are discussed with patients and relatives was expressed by several respondents and the procedure adopted by Clay Cross was given as a good example to consider. A further drawback was that nurse-led care was viewed by some as having to prove itself, which sometimes prompted patient discharges to make way for new admissions. This is because the nurse-led bed service aims to be very accessible and to meet this expectation, some participants felt a degree of pressure to discharge patients when it was known a potential admission was waiting. Another view was that many patients had medical needs requiring excessive medical involvement on the ward at times. It was suggested that improved screening pre-admission may lead to more appropriate patients being admitted. This extensive medical involvement was considered to have a negative impact on the satisfaction to be gained from delivering nurse-led care. Clear admission criteria for therapy beds were seen to give more job satisfaction than nurse-led beds with loose criteria. One respondent viewed decisions about which patients are appropriate to be admitted as being swayed by crises such as lack of beds at the acute hospital. Another view was

that it was not always clear what is being aimed for with a patient coinciding with a lack of goals being set. Readmissions were viewed as not cost-effective. This is because some patients had been seen to be repeatedly readmitted following their wish to return home each time where they were unable to cope. One respondent highlighted how some patients with mental illness or dementia can create a threatening environment for other patients. Several staff expressed a preference for a traditional model of care such as a care of older people ward rather than nurse-led care.

Several benefits of nurse-led care were identified which included:

- substantive individual involvement with patients
- non-emergency care for those that need it e.g. not coping
- a bridge for a previously unmet gap between hospital and home
- prevention of inappropriate admission to an acute bed
- strong links with community agencies to facilitate admissions and discharges
- multidisciplinary communication and joint working
- nurse consultant's availability and responsiveness to staff, patients, agencies and families
- strong teamwork and opportunity to make a difference
- patients able to take control of their rehabilitation
- full family and patient involvement
- opportunity to give truly holistic care
- potential for a future, fully autonomous team
- reduced failed discharges

Respondents were asked about any learning needs they had in relation to nurse-led care. One respondent suggested that staff had adequate nurse-led skills but that their ability to cope with some patients was stretched due to these patients needs being beyond the realm of nurse-led care. Also suggested was that staff have the requisite skills but were at times put under too many time pressures to apply these skills efficiently. More support was

requested from the nurse consultant after admission. Training needs identified focused on general updates, cannulation, blood transfusions, syringe drivers, palliative care, heart failure management, leg ulcer management, social care, community services and appraising blood results.

In terms of issues in need of improvement, two respondents highlighted management of situations with dissatisfied relatives as important for them. Several respondents suggested improvement/supply of pre-admission information for patients and families. Others mentioned how patients ask to see the doctor and do not seem to appreciate what nurse-led care is about. The need to further develop the role of the nursing assistants was mentioned, as was the need to develop specialised roles amongst ward staff e.g leg ulcer management. A need was highlighted to address delayed discharges from the nurse-led beds. Regular communication with the nurse consultant and nurse practitioner was requested as although an annual away day was considered good, it was insufficient as infrequent. One respondent suggested that staff feel listened to by the nurse consultant but also needed to have their views acted upon and to receive feedback/joint discussion of concerns. More autonomy for nursing staff was highlighted by a few respondents.

2. Interviews

Findings from interviews have been divided into themes which are presented under sub-headings. Where illustrative quotes are used, an identifying code e.g. P1 for Participant One, is given.

Understanding of the nurse-led bed service

Generally participants viewed the purpose of the nurse-led beds to be the prevention of admission to the acute hospital, often referred to as 'hospital avoidance'.

As a concept, nurse-led care was widely thought to be a good thing yet still developing.

Operation of the service was described succinctly by Participant 11:

“They either come from the hospital because they’re medically stable and it’s the appropriate place for them to be for rehabilitation prior to going home or they’ve been seen by their GP who feels it’s not an appropriate case for an acute bed but they may benefit from rehab to improve their wellbeing so they can basically either stay at home or in residential or nursing care so they’re in the appropriate place. And finally you can have the nurse consultant go out or her colleague, and assess them in the home environment for them to come to us.”

It was a common view that community staff and those at the acute hospital did not understand the purpose of the nurse-led service fully in order to make appropriate use of it.

Participants frequently mentioned patient and family’s lack of understanding of nurse-led care, although a booklet on the subject was said to be given to them on admission:

“Although sometimes the families are not quite sure. They don’t sometimes understand. It takes like two or three days and they realise they’ve not seen the doctor and then they realise that it’s nurse led.” (P4)

Admission criteria

These were generally agreed as appropriate, with a degree of flexibility to make judgements about individual patients. Tensions arose when participants were asked about the suitability of their patients for a nurse-led environment. There were two main areas of concern namely patients who did not fulfil the criteria due to being medically unfit on admission or shortly after or unsuited for other reasons.

Participant 11 illustrates reasons why some patients can be unsuited:

“We’ve had quite a few with dementia who are fully mobile which causes havoc and also coming up, they’re on about reducing numbers of staff at night time where there’s only going to be two members of staff instead of

three and it's going to be chaotic enough with three members, let alone with two."

Another view was that patients who were immobile and needed hoisting or feeding were not fitting of the nurse-led criteria.

Reasons given as to why patients were admitted who were considered inappropriate commonly included pressure by GPs needing to find a bed for somebody and a view that once in the system it would be easier to transfer patients to the acute hospital if required. It was acknowledged that it was not always possible to identify underlying issues until a patient had been assessed and on the ward for some time at which point issues came to light.

It was felt that a large number of patients were repeat admissions to the nurse-led ward, sometimes because of deteriorating condition and sometimes because they had chosen to go home where it may have been difficult to sustain them. Some would then be readmitted to arrange residential or nursing home care.

A small number of participants expressed not being involved in decisions about who to admit and lacked appreciation of the processes concerned.

"I'd not read these before (admission criteria), about the criteria and it does... I suppose it's something we should know really but you sort of just take it for granted. You know, it's like I'm not involved obviously in admissions or anything like that but it's interesting to see why certain people, you know, why people come in." (P2)

"And it would be nice if we could go out as well if we've got the staff available at that time to go out and assess sometimes with them. You know if you're sort of like going out with (the nurse consultant or nurse practitioner), when you go out to assess it would be nice if we could go." (P4)

"I would dearly love to be involved with assessing the patient, under the guidance of (the nurse consultant or nurse practitioner). I would dearly love to see that patient

in their own environment and hopefully have an input into the care that they get on the ward.” (P5)

Organisation of care

Many participants highlighted the pressure of having multiple admissions and discharges as a key concern:

“Yes, I think it should be more spaced out. Mornings are very hectic anyway, perhaps if they had like an early afternoon discharge rather than in the morning. And timing as well; I mean, I think they’re better off being discharged sort of mid-week rather than them going home on a Friday and sometimes the services aren’t there on the Saturday and Sunday for them, as well.” (P11)

“...but like when there’s two or three discharges in a day, I know it causes real problems on the ward because they’ve then got two or three discharges then they’ve got two or three admissions and it’s just manic and then I think that problems can happen. You know, things are likely to go wrong. I mean they don’t but it just really causes a fractious atmosphere on the ward, you know, amongst staff. You can feel it, you can feel they’re getting stressed and it’s not good for patients.” (P2)

“We’re having maybe sometimes two discharges and two admissions in one day as well as just the run of the ward. It’s too much and that’s something else that really gets on my nerves. And I understand that they need to get the patients in, they obviously can’t be left at home and they can’t go to the Royal because it’s not an acute problem but you just find sometimes you’re just spinning round and spinning round and you just can’t keep up with paperwork. So again, therefore, the patient who’s going out doesn’t get the best discharge because you’re worrying about the patient coming in. The patient who comes in doesn’t necessarily get a good admission because you’ve also got another discharge and another two admissions to do at the same time... if we maybe had a bit more time between discharges and somebody else coming in, that would be so much better.” (P9)

Admissions late on a Friday afternoon were considered a risk as on-site medical cover was said to finish at 6pm and there was no nurse consultant to

clerk patients in once the weekend started. Getting medical assistance when required out-of-hours, was said to be very difficult by several participants.

Other-out-of hours systems were generally a concern as illustrated by Participant 6:

“If we have patients admitted once the nurse consultant’s gone home, we’ve got no doctors to check drug cards, if there’s any queries, you know, we’ve got to call GPs. GPs are not always... you know, it’s like, you’re a hospital, why can’t you sort things out? We have a lot of that sometimes. They’re not always understanding. And I think Pharmacy get fed up because sometimes they’ll come and they haven’t got drugs so we have to then fax the Royal and it’s all the cost of that and you know, I think it’s not this that’s the problem, it’s the whole system of how community hospitals are run that’s probably the problem.”

A lack of notice given of an impending discharge was also highlighted frequently and it was felt a couple of hours notice was insufficient. One participant stated (P1):

“I think personally it’s the sudden changes when the nurse consultant decides the people are going home, to get all the equipment and TTOs (discharge medications) and everything else sorted out and to make sure that they are quickly cared for at home is quite difficult and it’s got to be done quickly.”

The sometimes pressured choice of who to discharge was seen as an issue.

“.....sometimes the discharge, you know, they’ve got three on the list that are waiting to come in so they just pick the person who’s more or less ready for discharge and say, we’ll discharge them and you think well, is this right? We’re rushing them out in a way to get somebody else back in because you’ve got a waiting list and it gets frustrating.” (P9)

Others felt they had had insufficient input into discharge decisions:

"I've found here that patients have been discharged without my opinion being sought or without an apparent multi-disciplinary opinion being sought, or a point in the planning having been reached to a conclusion. I feel that sometimes they've been discharged simply because of need of beds and when I'm not personally satisfied that I've reached the end of what I want to do."

A lack of physiotherapy was suggested as an area that did not impact positively on patient care as some patients had to wait several days for physiotherapy input.

Discontinuity of work within teams was highlighted and for some staffing levels were viewed as a contributing factor. As one participant stated:

"I think they need to have the staff for it (working in teams) to work and we're just changing into primary nursing as well and I think for that to work properly they need to have the staff but it sounds like they're cutting back rather than adding on." (P11)

Whilst another added:

"But like with me, I'm on a nurse team, but this morning, because they're short, I'm on a therapy team. So there's no consistency, you know. We're having to float between teams. So once you're off that team, there's the embarrassing part of not knowing the other team's patients. But it's just the way things are at the moment with the staffing levels on the ward." (P5)

The award-winning taped handover system between shifts was considered very helpful. Therapy staff indicated the tapes concentrated on nursing issues and would prefer more content about such issues as mobility. Greater detail needed from some staff using the tape recorder was also mentioned. A view shared by several participants was that occupational therapy staff did not take part in the handover system as much as other professionals.

"Well it's just that we can't carry on, you know, we haven't got an idea of what they want us to do, you know, with them patients... They use their own

paperwork, you see, and it's hard... whereas we have ours at the bottom of the bed, it's easily accessible."
(P12)

Whilst valuable as a communication process, multi-disciplinary team meetings were viewed as unwieldy and in need of review. Over all communication between staff was generally considered to be very good.

Another common view was that staffing levels were insufficient including nurses and physiotherapists. Management of staff turnover was also highlighted (P1):

"And it's the time as well taken to fill posts because they never interview for new posts until the person's actually left and that leaves a gap, sometimes of up to, it can be up to four months because if you have to serve two months notice and then the other person who gets the job has to serve two months notice, that's four months down the line when you're without anyone."

Fluctuations in patient needs were also noted to affect staffing requirements:

"You get people that are quite demanding and need a lot of input and then you get other people that are quite mobile and don't need as much input but you've got the same staffing levels all the time."

There was a common view that patients who had become poorly were sometimes held onto for too long prior to transfer to the acute hospital. Yet other participants viewed medical input and or transfer to acute care to be prompt.

There was a view that auxiliary nurses had something to contribute to multi-disciplinary team meetings and should have involvement.

Involvement in care

Several participants highlighted resuscitation and discussions about resuscitation status as an important area in need of addressing with patients and their families.

Opportunity to engage patients and relatives in care planning was frequently mentioned as being during multi-disciplinary meetings.

“Well we usually try and bring the new patients in with their families which of course that takes longer, because you can’t be ignorant and when they’re off-loading and what have you, and some are quite chatty so that takes a lot longer than usual.” (P12)

Whilst communication with patients and families was generally felt to be very good, several respondents did not feel patients and families knew who the nurse consultant was and felt ways needed to be found to make her more identifiable.

Staff development needs

It was clear that several staff had not chosen to work in a nurse-led environment having already worked on the ward previously prior to it changing to nurse-led care. Training in taking blood was indicated by one participant. Electronic documentation training was requested by two participants. Others felt they had no training or development needs. Finding mentors and supervisors for nurse prescribing was reportedly a challenge.

Impact of the nurse-led service

Despite its issues, all participants felt the service was working well. It was acknowledged that patients were often in longer than the hoped for 6-8 weeks period and there was a view by some that a number of patients were in too long causing some of their progress to be undone. The balanced approach to meeting both health and social care needs was highly valued.

“I think it is more person led. I think they are more closely watched and more closely supervised. It’s also

quite a social improvement as well because people can come in from a very isolated background and as I say people drop through the net and then when they come into hospital they realise that there is a better way of doing things and I think the nurse-led care is good in that respect and because we all work as part of a team.” (P1)

Relationships with patients were considered better in nurse-led care.

“I think it’s more personal. I think, you know, sort of like nurse led beds you get to know patients a bit more, where a doctor... you’re just sort of a number really, they don’t have the time because they’re that busy rushing about from one ward to another, whereas (the nurse consultant) does take more time with the patients which is better. I think it’s much more personal. And she’s always willing to speak to family members as well, you know, and be involved and listen to their viewpoints as well. She’s quite accessible.” (P2)

A common view was that the nurse-led client group differed little from those in acute settings as so many patients were viewed as having medical needs.

Improving the service

More thorough assessment and admission of more medically-stable patients was frequently indicated as a needed improvement.

Better management of admission and discharge activity was also a very strong suggestion, with all admissions being during office hours as another.

“Because the patients themselves and families get frustrated if they come on a Friday evening, nobody’s seeing them ‘til Monday morning and they get frustrated with us because it’s a hospital and they expect there to be doctors and consultants and things, so, you know, and it would reduce the anxiety and frustration for them as well. So I think that’s probably one of the main things. Unless they were so well organised that they were coming and the GP had admitted them and we knew that the drugs were up to date and they brought all the drugs with them and there was no reason that they couldn’t wait ‘til the Monday then fair enough. But quite often people come and there’s...we’ve got no backup. If

there's no drugs there and stuff, it just makes the job that much harder." (P6)

One idea was for better integration of patients at home following discharge.

"Where you could perhaps overlap and go and visit them. So that then they've got used to you, even if it's only for like a week or ten days, that you can go home with them and do things with them and go and visit them, and then I think that way they might just slip in a bit easier, with their own carers, because they do do things different and they might not have as much time as what we do to deal with them."

Another suggestion was for more clerical support for all staff groups. (P4)

Referring Staff Perspectives

These findings are drawn from 82 completed questionnaires from referrers to the nurse-led beds (57% response rate). These referrers comprised GPs (41 replies out of 82 sent / 50% response rate), district nurses (25 replies out of 42 sent / 60% response rate) and 'others' e.g. Care Managers, community physiotherapists and practice nurses (16 replies out of 21 sent / 76% response rate). Findings are also from 1 focus group interview with 4 district nurses and 2 individual GP interviews.

1. Questionnaires

Response rates from all referrers were very good. The first question asked whether respondents had ever referred to the nurse-led beds. If not, the remainder of the questionnaire was not relevant to them. Eight district nurse respondents had never referred, nor had 8 GPs and 4 'others'. Occasionally questions were left blank by respondents. Percentages are therefore calculated from the varying number of respondents that answered each specific question. Percentages are rounded up to the nearest whole number. Of the district nurses who had referred, 94% found the process of accessing a bed 'easy/quick/responsive', compared with 97% of GPs and 92% of 'others'.

A small number of comments related to the smoothness of the telephone referral process being dependant on the nurse they were liaising with.

Of the district nurses who had referred, 93% found the process of facilitating admission into a nurse-led bed 'easy/quick/responsive', compared with 97% of GPs and 92% of 'others'.

Sometimes no bed was available when a referral was made and referrers were asked where those patients had gone to instead. Of the 9 occasions this happened to district nurses, 3 patients stayed at home, 4 went to the Chesterfield Royal Hospital, 1 went to Red House (residential rehabilitation facility) and 1 went to 'another' destination (Chart 8 overleaf).

Of the 23 occasions no bed was available for GPs' patients, 3 patients stayed at home, 11 went to the Chesterfield Royal Hospital, 2 went to Red House and 7 went to 'another' destination (Chart 9 overleaf). Of the 11 occasions this happened to 'other' referrers, 4 patients stayed at home, 3 went to the Chesterfield Royal Hospital, 3 went to Red House and 1 went to 'another' destination (Chart 10 overleaf).

When asked if they were aware of the admission criteria for the nurse-led beds, 24% of district nurses (4) said they did not; neither did 32% of GPs (10) and 17% of 'other' referrers (2).

A hundred percent of all district nurses, GPs and 'other' referrers agreed that the nurse-led bed criteria were appropriate.

Chart 8.

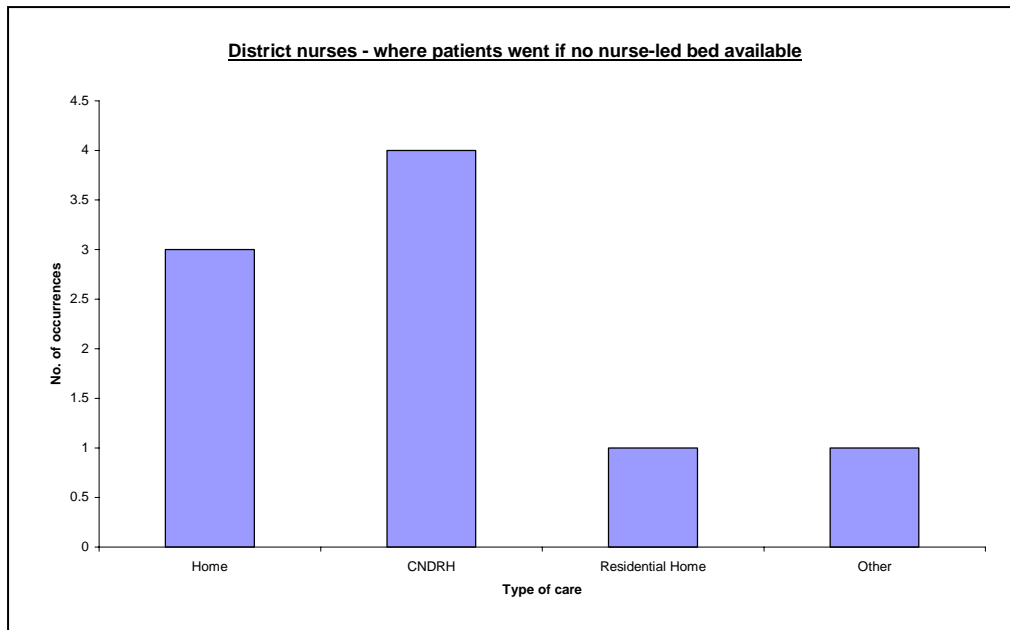


Chart 9.

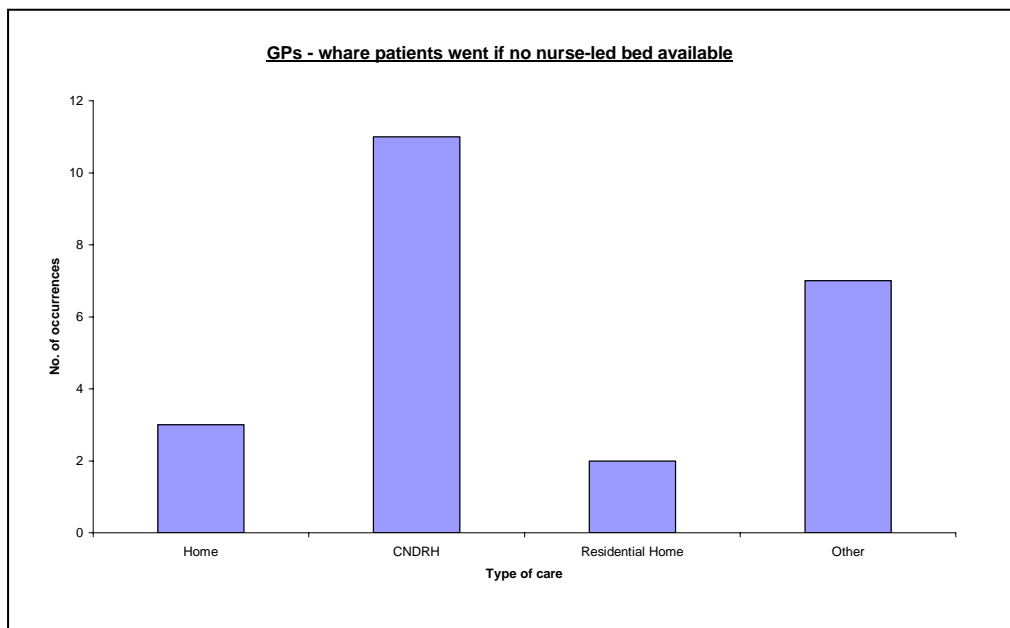
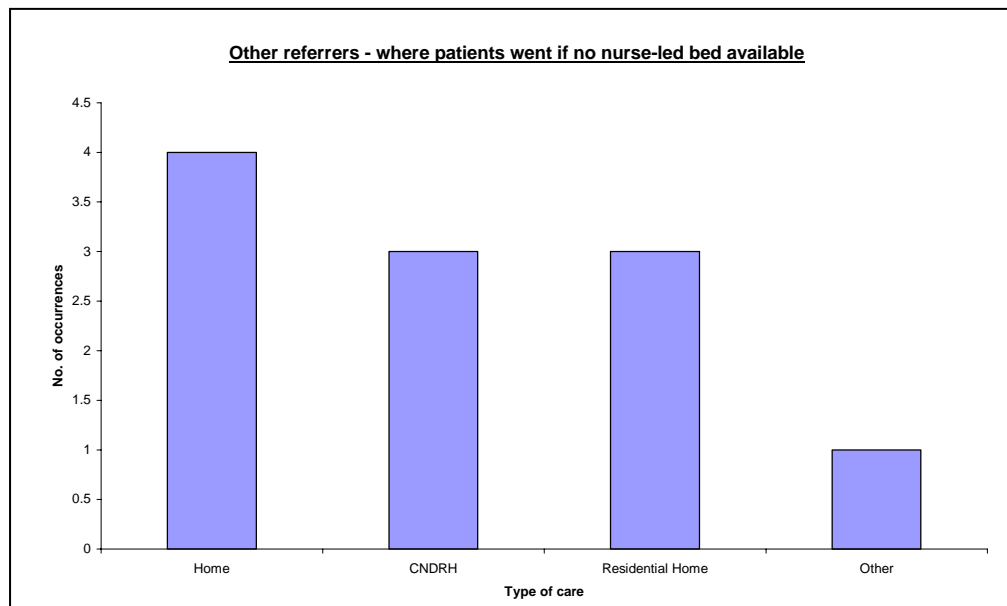


Chart 10.



Similarly, 100% of all district nurses, GPs and 'other' referrers felt clinically able to make a referral to the nurse-led beds.

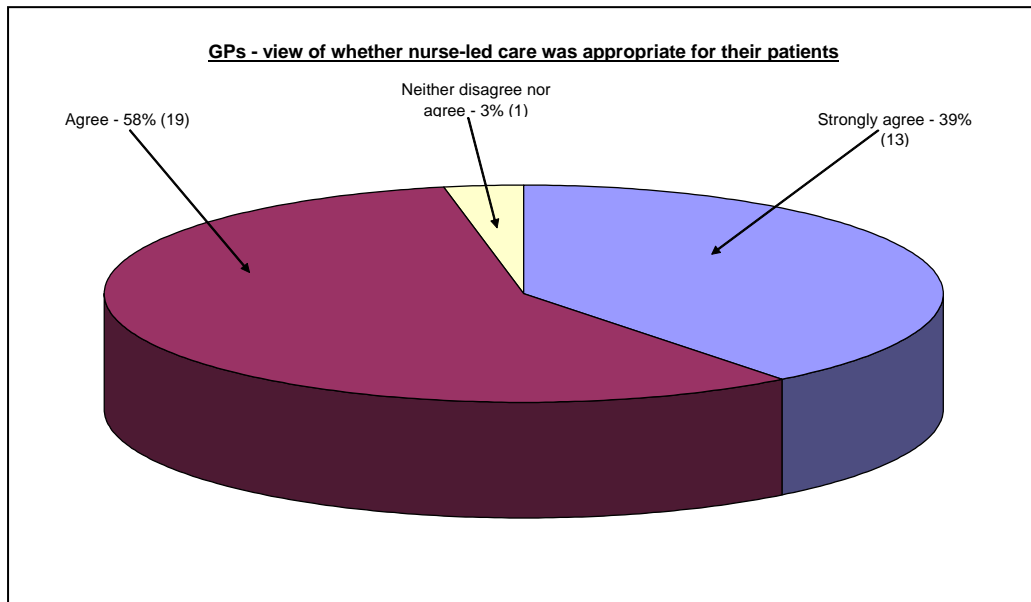
When asked if they would use the nurse-led beds again, 100% of district nurses, GPs and 'other' referrers said yes.

The next question asked if respondents believed that patients admitted to the nurse-led beds would receive a comparable service to those who would normally be admitted to medical-led care. Most district nurse respondents agreed - 31% strongly agreed (5), 56% agreed (9) and 13% of respondents (2) neither agreed nor disagreed. GP respondents held varied views - 22% strongly agreed (7), 47% agreed (15), 19% neither agreed nor disagreed (6) and 13% disagreed (4). Most 'other' referrers agreed - 36% strongly agreed (4), 55% agreed (6) and 9% of respondents (1) neither agreed nor disagreed.

Lastly, referrers were asked if on reflection they felt that nurse-led care was appropriate for their patients. Most district nurse respondents agreed - 31% strongly agreed (5), 56% agreed (9) and 13% neither agreed nor disagreed

(2). Most GP respondents agreed - 39% strongly agreed (13), 58% agreed (19), 3% neither agreed nor disagreed (1) (Chart 11). All 'other' referrers agreed - 67% strongly agreed (8) and 33% agreed (4).

Chart 11.



Respondents made numerous comments to reinforce how valuable and effective they felt the service is. District nurses especially made several comments about the complexity of their patients' needs and the need for a holistic approach to their care. Also highlighted was that the service provided something that the acute hospital did not and was a much needed service for community staff. Respondents had received positive feedback from their patients about their stay in a nurse-led bed and felt they had received comprehensive assessment and rehabilitation which had enabled them to return home. Several comments highlighted how communicative the nurse-led bed staff were. Several 'other' referrers suggested that some patients were discharged too early before they were fully prepared and on occasion sent without take-home drugs. Also that some physiotherapy referrals were unhelpfully last minute. It was suggested that community patients are prioritised over acute hospital ones which had led to several cancelled transfers in the past and frustration. Several GPs pointed out that comparing

medical-led and nurse-led care was not possible as not comparing like-for-like. Others responded by saying that patients with certain needs e.g. rehabilitation, received better care in the more appropriate setting of a nurse-led bed. Finally two GPs suggested a single phone number to access services for patients whose needs are non-medical rather than navigating several phone numbers/services.

Medical Consultant Questionnaire

Only five medical consultants were sent a questionnaire and a response rate of 80% was elicited.

Firstly, respondents were asked if they believed appropriate patients were being admitted to the nurse-led beds. Twenty-five percent agreed whilst the remaining 75% neither agreed nor disagreed.

Secondly, respondents were asked to consider whether patients in nurse-led care receive care comparable to that of patients in medically-led care. The three respondents to this question all indicated that they neither agreed nor disagreed.

Lastly, respondents were asked how they felt about giving a medical opinion on a patient who is in nurse-led care. All three who replied indicated being very happy to give an opinion.

One consultant felt that sometimes patients were admitted to the nurse-led service, for various reasons, who would be better suited to a medical bed. Another concurred that some patients would better suit a more acute/investigative environment. It was also suggested that it may be difficult to anticipate the best place for a patient with needs such as falls, urine infection, which could indicate minor or major illness.

2. Interviews

Findings from interviews have been divided into themes which are presented under sub-headings. Where illustrative quotes are used, an identifying code e.g. P1 for Participant One, is given.

District Nurses

All four district nurses had referred to the nurse-led beds on numerous occasions and had a good amount of exposure to the service on which to base their views.

Understanding of the nurse-led bed service

All participants demonstrated a good appreciation of the service offered including palliative care, terminal care, 'off-legs' syndrome, leg ulcer management, rehabilitation, nursing diagnostics and pain relief. Management of blood transfusions was highlighted by one participant but not all participants were aware of this aspect of the service. There was some disagreement as to whether the nurse-led beds provided respite care or not.

When explaining the purpose of the nurse-led beds to patients, participants acknowledged this was not always possible in a crisis situation. Where participants did explain the service they said it was:

"A five star hotel!" (P1)

"A place they will be cared for 24 hours a day physically and mentally." (P4)

"I usually tell them its a nurse-led unit and I usually say she's a very expert nurse who knows a lot about it because obviously you do worry that they might feel less confident." (P1)

Referring to the service

Participants all said that they personally decided whether or not to refer and almost always did this independently or with other district nurses and only rarely sought the view of a GP. Only one had ever experienced a bed being unavailable within a suitable time-frame and so the nurse-led beds were viewed as very accessible. The process of referral was viewed as smooth as patients' needs could be discussed with the nurse consultant or nurse practitioner who had also been helpful when alternatives to admission were agreed upon such as the Rapid Response Service. Whilst all participants were aware of the admission criteria for the nurse-led beds, all admitted to having read these once and never having referred back to them. This was because they viewed any non-acutely ill patients as possibly suited to nurse-led care which they would explore with the nurse consultant or nurse practitioner on a case-by-case basis. One respondent (P1) clarified:

"I think we just change them (the admission criteria) as we go along unfortunately because we tend to think that they are our patients so therefore we do change the guidelines a bit."

Another participant (P2) added:

"Yeah and to be fair, it's very hard to change it on the criteria because each case is so individual that you almost can't."

Arranging admission tended to be focused on week days and before 3pm as patients in need could usually be identified within these time-frames so avoiding out-of-hours admissions. All participants viewed themselves as deliverers of nurse-led care and believed this helped the close working and 'mutual respect' necessary to liaise effectively with the service.

Value of the service

All participants thought the service was invaluable. Participants expressed that the nurse-led bed staff were perceived to work particularly well with social services and in getting services put in place for patients for when they go

home. They appreciated the high level of communication and updates they received on their patients' progress whilst in a nurse-led bed. Participants felt the level of detail in arranging discharge resources was excellent e.g. ensuring patients have blister packs for medication and commodes, seat raisers etc. It was felt that nurse-led staff better understood supportive services that could provide such equipment compared with acute hospital staff.

It was viewed that patients valued the service as they felt better able to talk to nurses as opposed to doctors. Nurse-led bed nurses were felt better able to deliver holistic care and considered to be more knowledgeable about the patients. Nurse-led staff's ability to look at a patients' functioning was particularly highlighted as excellent (P4):

“They’re looking at function, actual day to day function of your patient and how they can function as opposed to a medical situation, you know? If you sort somebody’s cardiac oedema out it is going help function but you’ve actually got to look at as ‘we’ve sorted it out a bit, can they walk now?’ Can they actually cope with taking the medication once they get home and all those things that won’t ever get done in a medical-led system because prescribing the Frusemide will be seen as enough in a medical system. Whereas the nurses will have looked at ‘how does that affect their continence?’”

The nurse-led bed service was likened to another model of GP-led care that was said to have not been successful locally when previously implemented. The nurse-led bed service has a close working relationship with a particular doctor and so one participant suggested that this meant that the service was in fact medical-led but with a more appropriate ethos. Participant 1 said:

“So it is similar really yeah and so really in a sense it’s almost like a small cottage hospital. Because the GP led beds in Chesterfield didn’t work because the GPs wouldn’t serve them in the way that they needed serving, they were withdrawn and in a way (the nurse consultant) stepped into that gap.”

Impact of the service

Drawing on personal views and feedback from their own patients, all participants felt the service had a very positive impact on patient experience and outcomes. Low staffing levels were sometimes commented on by participants' patients. Comment was passed on several patients who had used the nurse-led bed service and gone on to return home successfully. One participant (P3) said:

"She loved it there, I saw a big difference in her – confidence, mixing, looking after the rest of the women on the ward. I came to see her a couple of times and she was a different woman."

The nurse-led bed policy of six-week follow-up appointments for patients was praised. It was further clarified that although the leadership qualities of the nurse consultant were key, the other nurse-led staff were also well-trained and responsible for the perceived success of the nurse-led beds.

Participants were asked whether the service was really necessary if some patients could be managed at home for a day or two whilst awaiting a bed. In response it was clarified that the nurse-led beds are not an emergency service and some leeway is permissible, usually because family members have stepped up their input temporarily with the knowledge that admission is imminent.

Improving the service

A need for a dimension to the nurse-led bed service for patients with less nursing needs e.g. convalescence was widely recognised by participants.

All participants believed that more nurse-led beds were needed and that they would have no problem filling them with appropriate patients.

One participant felt that the rehabilitation component of the ward had 'slipped' recently. This view was in response to patients who had reported a lack of

physiotherapy contact and physiotherapy staffing levels were mentioned as a contributing factor.

Participants felt that for some patients a written information leaflet about the service would be useful.

Participants felt a visit to the nurse-led service would be valuable personal development for them. To-date much of their knowledge was said to come from students who had enjoyed their placement there. Said one participant (P3):

“It would be nice just to have a day there and just to see how the day runs.”

Whilst an isolated case, one participant viewed the service providing interpreters for patients whose first language is not English, as in need of improving in terms of availability and/or information as to what is available.

GPs

Both GPs had referred to the nurse-led beds previously in order to be able to comment on it.

Understanding of the nurse-led bed service

Both participants appreciated that the nurse-led bed service offered general rehabilitation although one was unaware that they were also admission-avoidance beds. Typical patients included those who had had falls or a chest infection. Both indicated that they believed the beds offered a comprehensive, holistic assessment by members of the multi-disciplinary team which one felt was not always the case at the acute hospital. One view was that the service was protocol driven and like in any job, different staff have different knowledge of these protocols. When explaining the purpose of the nurse-led service to patients, one participant explains that it is a ward which is managed by nursing and therapy staff.

Referring to the service

One GP was unaware of the nurse-led bed admission criteria. The other recognised them as a valuable guide with flexibility to accommodate individual patients as negotiated with the admitting nurse consultant or nurse practitioner. For geographical reasons, one GP would use another service first and the nurse-led beds second if a bed was not available. One participant said that if there was no bed then the acute hospital was the place of choice if additional services at home and other measures were not sufficiently available. One participant reported being faced with a list of phone numbers when trying to find an alternative service for a patient which presented a significant deterrent to busy GPs.

Value of the service

The experiences of both GPs when using the nurse-led beds were positive ones. Key benefits were viewed as the comprehensive assessments of patients and thorough discharge planning. During office hours, the beds were found to be very accessible. One GP highlighted the nurse-led bed staffs' attention to patient function as being well-managed compared with acute care colleagues.

Nurse-led care was viewed as a useful dimension of primary care, resulting in GPs focusing on the more difficult patient cases. One participant highlighted the value of discussing the best place for a patient with the nurse consultant or nurse practitioner. If in doubt the nurse-led staff would go and assess the patient. The only drawback mentioned was that some patients seemed to stay longer than planned although it was acknowledged this was not necessarily a fault of the service. Examination of the reasons for this and associated learning was encouraged. Patients had fed back positive accounts of their experiences of the service, although it was recognised that the hospital itself had a stigma attached to it from years gone by.

Impact of the service

One participant believed that some patients may be admitted for nurse-led care who would not necessarily have been admitted to acute care at that

point, but who could be expected to deteriorate sufficiently to require acute care in the absence of such nurse-led involvement.

Improving the service

One participant felt that the nurse-led beds should be available for admission at weekends and out-of-hours and believed beds had been available on one occasion, when a request for a bed had been turned down. To do this the ambulance system would need to be accommodating and recognise the preventative importance of transfer in non-medical emergency situations.

Both participants recognised value in having written information for patients although one acknowledged that in crises, this information may be more important for relatives.

A strong request was made for information about patient's progress, especially if in hospital for longer than anticipated, either in writing, fax or verbally. This pertained not only to knowing how the patient was getting along but also what had worked/not worked as part of the pre-admission management/admission process. It was suggested that such feedback would be interesting as well as something to learn from.

A further request was for opportunity to see the nurse-led bed service first-hand, having not visited it for some time.

Audit Findings

Patient Tracking Pro-forma – Inpatient Journey

Twelve patients had their inpatient journeys tracked. These gave a good cross-section of the kind of conditions patients would commonly have on the nurse-led ward. Most referrals came from GPs whilst the Community Rehabilitation Team were involved on three occasions (twice alongside GPs), district nurses co-referred with GPs on three other occasions and the

Emergency Admissions Unit at Chesterfield Royal Hospital referred one patient. The average length of stay was 37.3 days (range 6 to 97). Discharge destination was usually to the patient's home whilst one patient died, two went to residential intermediate care facilities and two were admitted to residential homes.

The actual care needs that led to their referral to nurse-led care, bearing in mind that more than one could be specified) were: falls (2), respiratory care (2), palliative care (2), pain control (5), reduced mobility and coping (3), Parkinson's Disease/neurological needs (1), orthopaedic care (1) and 'other' (3) including urine infection, safety and general deterioration. However the actual reasons for admission identified following assessment were: falls (3), respiratory care (1), palliative care (3), pain control (7), reduced mobility and coping (5), Parkinson's Disease/neurological needs (1), assessment and rehabilitation (1), and 'other' including safety (1) and general deterioration(1).

A range of 4 to 7 professionals were identified as involved in each patient's care whilst on the ward. These were the nurse consultant, physiotherapist, occupational therapist and nurse for all patients and commonly the Care Manager and doctor. Occasionally others were involved including McMillan Nurse, Respiratory Specialist Nurse, Social Services Manager, psychiatrist and dietician. The goals of all these professionals were recorded as being met with the exception of one patient whose disorientation/clinical condition prevented this. Evidence of goal setting tended to focus on records of discussions in the weekly multi-disciplinary team meetings, records of discussions with the patients, professionals' own records and notes case notes. It was not clear whether goals are routinely set out in nursing care plans (stated in one case only) or are retained within the personal records of other members of the multi-disciplinary team.

The audit sought to identify any patient/carer involvement in discharge planning, including whether their preferences were met. On a small number of occasions there was no evidence of involvement and whilst it may have happened, it was not documented. On other occasions, there is extensive

evidence of involvement and accommodation of discharge preferences. Generally speaking, findings suggest consultation and involvement was very good although it is difficult to know if evidence of these discussions was documented or recollected by the auditors during the audit e.g. “patients were invited to a multi-disciplinary team meeting” (6 occasions).

Professionals involved in post-discharge support for each patient ranged from 4 to 6 in number and commonly included the GP, Community Rehabilitation Team, domiciliary physiotherapist, domiciliary occupational therapist, Domiciliary Services Organiser/agency, district nurse and infrequently the police, Respiratory Specialist Nurse, Emergency Care Team and Visual Impairment Team. Evidence of patient goal setting for use in the community was evident on six occasions only. There may have been goal setting but it was not evident to the auditors. Communication of goals to patients and community agencies does not appear to be routine.

As well as looking at a breakdown of elements of the patient’s journey, a key purpose of the audit was to identify any areas for improvements such as preventable delays in the over all patients’ journeys. From the information gathered here, delayed discharges (according to the Social Services definition) were evident on three occasions as patients awaited placement (1) and a care package/home adaptations (2) One of these patients incurred a delay of 2 months whilst awaiting a bed, adaptations, social services 4 times daily and the continence pad service. Other delaying factors were to accommodate patient/carer preferences e.g. their initial refusal to be discharged whilst awaiting surgery, and patients’ lack of motivation and insight into the need to rehabilitate slowing their potential progress e.g. *“I’ll manage when I get home”*. In a further case, a patient’s preference to smoke whilst being treated for recurrent chest infections could reasonably be expected to have hindered their progress.

Patient Tracking Pro-forma – Non-admitted Patient

The records of 10 patients, who were referred to the nurse-led beds but were unable to be admitted, have been examined. All patients were referred in the afternoon by a mixture of GPs (5), district nurses (2), care managers (2) and a nurse practitioner (1). Reasons given for the other non-admissions include no beds (5) and low staffing levels (3). All but two patients met the nurse-led bed admission criteria and these two comprised a patient with no nursing needs and another who had no evidence of the reason given for referral (dizziness). Instead, these patients respectively went for respite care the following day and to Red House for assessment.

The other 8 patients who were unable to be admitted went to Red House for assessment (2), CDU (1 - a day later then admitted to nurse-led bed the same day), remained at home without need of any support (1 - admitted to nurse-led bed 4 days later), remained at home with increased services (4 - one went to nurse-led ward 4 days later, one got admitted to Chesterfield Royal Hospital four days later, one stayed at home throughout and one died). Where needed, increased services/input was provided by the Rapid Response Team, tissue viability nurse, district nurse, GP, family, domiciliary occupational therapy, DSO/agency and a hospital doctor (for advice).

Patient outcomes at six weeks were managing at home well (6), died (2 – one patient the same night as originally referred and another two weeks later after Red House, Emergency Admissions Unit and Chesterfield Royal Hospital admissions). It is beyond the scope of this audit to appraise whether either of these deaths was preventable and at best it can only identify what alternative arrangements were made for non-admitted patients.

The audit indicates that patients unable to be admitted are found alternative arrangements to meet their needs which are usually in the form of increased services/input and not through unnecessary admission to the acute hospital. Wherever possible, waiting patients are then brought into a nurse-led bed at a later date.

Patient Tracking Pro-forma – Readmitted/failed discharge

The records of 8 patients, who were readmitted following discharge from a nurse-led bed, were examined to see if readmission was due to a poorly planned or executed discharge, known as a 'failed discharge'. Discharges are considered to have failed if a patient is readmitted within twenty-one days. Of these eight re-admissions, four were considered difficult to avoid. These involved a patient with cellulitis of the legs whose condition is a chronic one that is known to require regular hospitalisation, a patient whose family had not wanted any services but could then not manage, a patient who fell outside of their house and a patient whose mental health had deteriorated. These of course beg the question whether services or other steps could have been taken to prevent these occurrences, so maintaining the patients at home. The other four re-admissions do appear to have some preventable elements to them in hindsight. One patient 'did not feel right' on the day of discharge, had received no home visit assessment, and went on to have a fall. A second patient went home without the cause of their diarrhoea being fully resolved and this re-started. A third patient had insufficient support in place at home to manage their disorientation and hallucinations (although support levels put in place had accommodated family members' preferences). Lastly, a patient was discharged whilst feeling unwell and prior to awaiting a urine test result. This was positive for infection and the patient was treated with antibiotics.

Again, it is difficult to predict patient outcomes with any certainty as support considered satisfactory pre-discharge, may not be adequate in reality and so on. Identifying what did not work can only be done retrospectively with hindsight. What this audit does show is that there is room to take a closer look at discharge planning and ward organisation around test results, support packages, patients' views on their readiness for discharge and collaboration to prevent admission through increased services as soon as existing services are seen to be insufficient.

Bed Census Pro-forma

This point prevalence audit was undertaken on six occasions:

Week 1 - Friday 31st March 18 00

Week 2 - Monday 3rd April 09 00

Week 3 - Wednesday 12th April 10 00

Week 4 - Thursday 20th April 16 00

Week 5 - Tuesday 24th April 12 00

Week 6 - Thursday 4th May 14 00

It is important to note that this audit does not count patients but beds. This is because patients may be occupying beds on one or more weeks of the audit and risk being counted up to six times. A longitudinal audit, examining bed use over several weeks on a daily basis, would best be used to identify numbers of patients occupying nurse-led beds inappropriately. This audit only provides a 'snap-shot' which is why it has been done on several occasions. Whilst some beds may have had patients in who were not appropriate on the day of audit, this was not necessarily the case between bed census dates. These findings are necessarily subjective as clinical judgement was used by the auditors when considering the attributes of patients occupying the beds.

Throughout the audit period, the number of beds available for nurse-led patients was above the normal allocation of fourteen. This was with the co-operation of the Therapy Consultant who allowed therapy beds to be allocated to nurse-led patients when there were no therapy patients requiring beds. One occupied bed space was not included as the patient had only recently been admitted that day and had not yet been clerked in by the nurse consultant. Bed occupancy of the normal allocation of 14 nurse-led beds on the audit days was high (97%). Note that the three percent of beds unoccupied by nurse-led patients were not empty, but were instead occupied by therapy patients.

The patients occupying the beds during the census originated from a total of twenty different local GPs. Most patients were admitted from home whilst only two had come from an acute care setting at Chesterfield Royal Hospital. Their length of stay at the time of audit ranged from one to sixty-five days.

A number of primary reasons were given as to why patients occupying the beds had been admitted. More than one reason could be given but these were substantial reasons and not merely a list of all conditions being experienced by these patients. The numbers in brackets represent the number of mentions. On admission these were: assessment and rehabilitation (51), reduced mobility and coping (24), falls (17), pain control (6), continuing rehabilitation (3), respiratory care (1), palliative care (1), confusion (1) and 'other' (25). The 'other' options frequently included discharge planning and infrequent cases such as Charles Bonnet Syndrome, a trial in the ward flat and clinical conditions (e.g. urine infections, leg oedema, end stage heart failure, acute physical deterioration).

The primary need for maintaining a bed on the nurse-led ward either evolved or remained the same. Most common care needs at the time of audit were given as: respiratory care (10), pain control (8), confusion (8), assessment and rehabilitation (6), continuing rehabilitation (5), reduced mobility and coping (5), falls (2), palliative care (1) and 'other' (56). The 'other' options frequently specified included awaiting social services arrangements e.g. calls and equipment, planning home visits, discharge planning as well as infrequent instances of awaiting psychiatric review, awaiting care home placement, diarrhoea and vomiting, collapse, full nursing care required, anaemia treatment, depression, safety, constipation, chest infection, PEG feeding and awaiting surgical review.

Of the 84 bed spaces audited during the census period, 55 (66%) of these were considered to be occupied by an appropriate patient needing nurse-led care, whilst 28 (34%) were not. See Table 3 overleaf.

Table 3. Appropriate in-patient bed use

Appropriate for Nurse Led Bed?	Week 1		Week 2		Week 3		Week 4		Week 5		Week 6	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Bed 1		N		N	Y			N		N	Y	
Bed 2	Y		Y		Y			N	Y			N
Bed 3	Y		Y		Y			N		N		N
Bed 4	Y		Y		Y		Y		Y		Y	
Bed 5	Y		Y			N	Y		Y		Y	
Bed 6	Y		Y		Y		Y			N		N
Bed 7	Y			N	Y		Y		Y		Y	
Bed 8	Y		Y		Y		Y			V		N
Bed 9	Y		Y		Y		Y		Y		Y	
Bed 10	Y		Y			N	Y		Y		Y	
Bed 11	Y		Y			N		N	Y			N
Bed 12	Y		Y		Y			N		N		N
Bed 13	Y			N		N		N		N	Y	
Bed 14	Y			N		N	R	R		N	R	R
Bed 15	Y		Y		R	R	R	R	R	R	R	R
R = reverted to a therapy bed												
V = void new patient not included												
TOTALS	14	1	11	4	9	5	7	6	7	6	7	6

A number of reasons were given as to why these bed spaces were being used by patients not considered to be in the best place for them. These were generally because the patients were fit for discharge and awaiting arrangements to be put in place e.g. equipment or outcome of a case conference, some were being discharged later that day, one was better suited to a therapy environment and for one a ward for people who are elderly with mental illness, was preferable.

Of the 84 bed spaces audited, 18 of these were occupied by patients who it was thought did not require in-patient care. Twenty-three of the bed spaces

had patients in them who it was considered were not receiving active treatment. These corresponded with the patients who were awaiting discharge, placement and such like.

Graffiti Board, Comments Box and First Impressions Questionnaires

These findings are presented in the Appendix and comprise Graffiti Board (2 patient/carer respondents), Comments Box (14 patient/carer respondents) and First Impressions Questionnaires (46 patient/carer respondents).

SUMMARY

This chapter has given an overview of approaches to analysis. Findings giving a comprehensive view of the perspectives of patients, carers, nurse-led bed staff and other staff who use the service, have been detailed. Considering findings grouped in this way has ensured a deeper and more holistic representation of viewpoints gained.

CHAPTER FIVE

REFLECTION

This chapter presents an overview of the reflection mechanisms used within the study and the issues raised by research team members during reflective processes.

Introduction to Reflection

Group reflection has been used within the evaluation study to explore research team members' expectations; their involvement in study planning and their experiences and views during the study process. To remain neutral the reflection was facilitated by an independent academic not connected with the evaluation study or the hospital unit concerned.

Schön (1983) described reflection as helping professionals explore and improve knowledge and attitudes; to enhance their professional practice, through a process of structured thinking. Reflection can also be used in some research. This is to make visible the role of the researcher in relation to the process of research, to explore attitudes, values, decisions and thoughts during the research process (Alvesson and Skoldberg 2000, Holloway 2005). This approach has been utilised within the evaluation study.

The Reflection Process

Reflection principles and reasons for its use in the evaluation study were presented to research team members at a meeting in March 2006. This was also an opportunity for the reflection facilitator to meet research team members for the first time. After some discussion there was agreement that tape-recorded group discussion was best for equal participation by the research team members; professionals and lay members. The first group

reflection took place that same day which was early on in the evaluation study's data collection period and the other was held at the end of the study. The first group reflections started with simple questions, for example, 'tell me how things are with the study?' The second group reflection used a structured approach to discuss all parts of the evaluation.

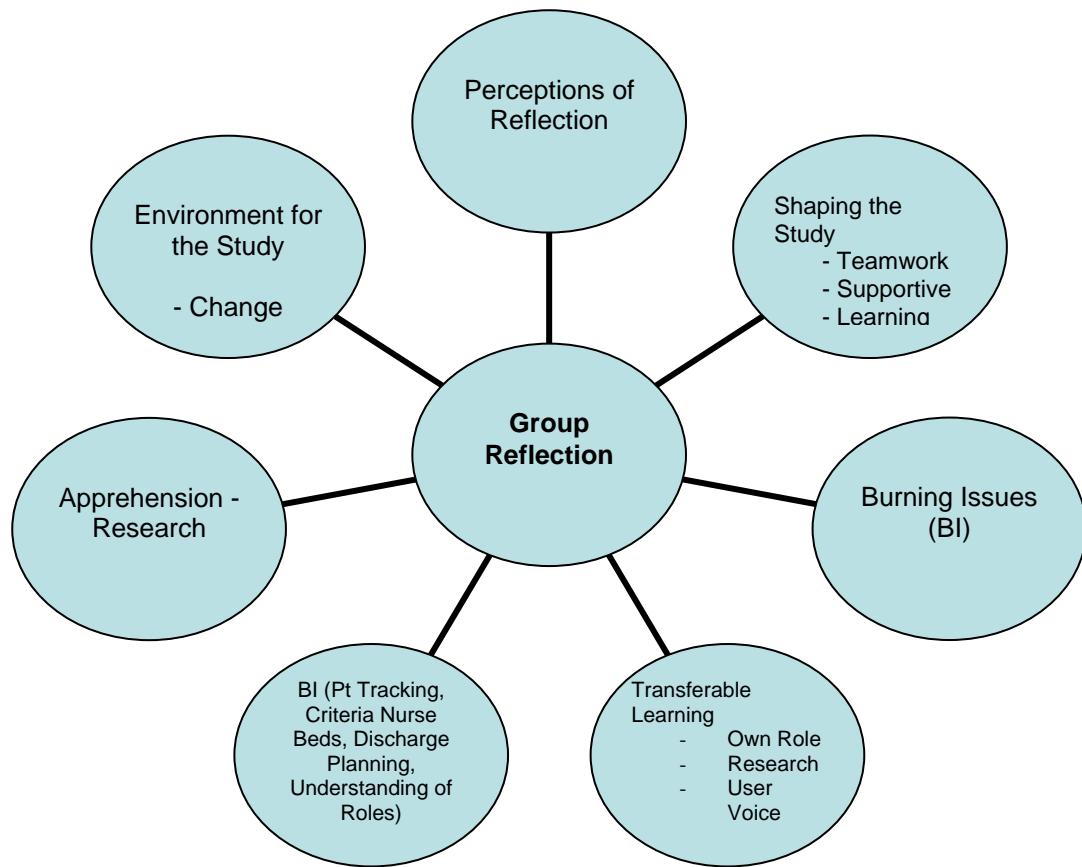
The tape-recorded reflections were transcribed and analysed to find the significant points emerging. The principles of Graneheim and Lundman (2004) informed this process. For example, visible and obvious responses were highlighted, as opposed to hidden or implied comments about the evaluation study. Findings from the first group reflection were discussed with research team members after the second group reflection in September 2006. The research team members agreed that the lead researcher could receive copies of the transcripts.

Careful attention was paid to the reflection process to make sure it was credible, authentic and reliable, in keeping with Cutcliffe and McKenna (1999). Transcripts from the reflections along with facilitator notes and content analysis will be archived along with the evaluation study data. Information that can identify participants will be removed at this stage.

Perceptions of Reflection

Some research team members felt guarded about the reflection, not knowing if they would like it. In the first group reflection, some of the research team members present were slightly hesitant in discussion. In the second group reflection by contrast research team members present appeared more confident in reflection and able to detail the various aspects of the study. It was interesting that part of the second reflection was used to 'think aloud' about outstanding study issues, things to be followed up or explored in more detail (refer to theme below, Burning Issues for examples). There was also some discussion of staff participation in reflection itself as the nurse-led beds had been temporarily closed to admissions due to an infection control issue at one point during the study period.

Figure 1. Themes from the group reflection



Shaping the Study

Comments identified research team involvement in shaping the study, deciding questionnaire content, discussing key issues and emerging ideas:

"...there was a lot of rejigging wasn't there?"

"...you felt you could say anything...we were all in the same boat."

"...we threw ideas of what sort of information we wanted to be in it (the study)... how we were going to get that information."

Teamwork and a supportive, non-threatening atmosphere for learning and development of the study were identified. These were reflected in comments about brainstorming, developing ideas, and the ability to ask any question at all within the study. In summary there was a strong sense of involvement shaping the study:

"Ideas have blossomed"

"I am on my feet and running now"

There was evidence of coaching and encouraging among the research team members.

Shaping the study was also seen as a way of learning about respective professional roles within the nurse-led ward itself. Inter-professional working, understanding of roles and responsibilities featured strongly in this theme and in the burning issues uncovered within the study itself.

Burning Issues

Research team members used group reflection to think about the study itself, outstanding issues and puzzles. These were:

- Patient tracking systems
- The criteria for nurse-led beds and understanding of them
- Discharge planning
- Understanding of respective roles in the health and social care team

The above led to some lively debate about what work was still to be done, how the study had uncovered issues which had perhaps been simmering away for some time:

"That's something we need to learn from it, something that could be done."

“There’s no ignoring of facts that we have an issue...it would be a complete and utter waste of time if we were to ignore this... we have to address it as a team.”

This discussion was interesting as research team members used the time to explore, discuss and forward plan; reflection for future action.

Transferable Learning

Several examples of research team learning were identifiable; particularly research skills and other professional development. Skills for conference presentation, writing abstracts, having the confidence to speak were discussed, along with self and professional presentation. Improved knowledge of the research process was discussed, particularly in relation to requirements for ethical approval. Another key aspect of learning concerned understanding of professional roles within the team and recognition of strengths and weaknesses. This was a key element here along with an expressed need to develop inter-professional working and understanding.

“I think you learn a lot about yourself and about other people as well.”

Some of the research team expressed professional skills such as improved ability to delegate and to communicate more effectively from research team involvement.

Improved knowledge about quality within the research process was expressed:

“It’s very difficult not to have a view based on what you do...”

“It’s important to write down whatever they said and make sure it was totally unbiased.”

“I went on a couple of courses to try and help with this... there was (also) less formal learning in that Person A and Person B led sessions on various things specifically

to develop skills... but you also develop skills and everybody fills in the gaps just as the process goes on."

The above reflects the importance of practical research experience - hands on, getting involved, to improve confidence - instead of reading about research as a distance activity. There is some overlap here with the theme apprehensions of research. There was also a link between the evaluation study and ownership of improved clinical practice:

"...getting ownership beyond people here (in the research team) so they (other staff and service users) see that things do change and maybe in a year or two's time something else comes up they think, well yes, it was worth it."

One striking aspect of transferable learning was about the user voice, not only in research but in nursing and wider health care practice. This was recognition that professional views on service delivery and user experiences could be very different:

"Some of those things patients aren't willing to express whilst in that environment because they feel vulnerable... where they believe it is confidential, things do come to light."

"I think I didn't see the significance of some of that sort of thing until now..."

"...more about what was important to them (service users) rather than my perception of what might be important to them, or what was important to me..."

"The richest part of this is the patient experience and their perceptions... what is really important is what the patients think about what is happening."

Some research team members returned to the user experience and reality, compared with the professional's experience and reality several times, perhaps illustrating some adjustment of professional values and beliefs about service users and their experience.

Apprehensions of Research

Current policies in health and social care have emphasised the need for research to develop evidence-based practice. However it is possible that research itself has perhaps been seen as a difficult, academic activity conducted by 'others' not connected to the practice setting. Given this background, apprehension about research was not surprising:

"You tend to think of research as done by boffins not like people like us."

"I had my arm twisted a shade... to come in the first place... I've found this style of research isn't as scary as all that and it is quite user friendly and the one thing I would have liked to have been more involved in."

Other comments suggest that research was initially an intrusion into other aspects of professional role, especially care delivery:

"...well haven't I got enough to do?"

"I'm glad I did get involved."

"I questioned whether I wanted to be involved in it."

The taking apart of the nurse-led ward's activities and developing study ideas, whilst initially seen as irritating was welcomed later on in the evaluation. There was a change in perception, particularly voiced in the second group reflection, where initial apprehension about the study and research involvement, moved towards involvement, and later analysis of the research method itself. For example:

"My style of doing things, it probably would have been a shambles... it's been a good learning thing but I could easily have missed out on it by thinking this isn't for me or the way I work... it's a waste of time."

"You don't always see the relevance... as it's all come together you do see the importance of that... I've found it fascinating."

“Then you read an article it’s got a bit of research findings, sometimes it’s pretty alien language... this wasn’t like that.”

“I felt like God, what am I doing here? (laughter) but it started to fit together a bit like a puzzle really.”

What came out of the reflection, and there is some overlap with the theme of Shaping the Study here, is that the study did have the principles of action research, shaping ideas, trying things out and re-working:

“I remember that huge table and I know Tracey took photos and I wondered how she was going to sort out this... we spent a lot of time in that big group thrashing it out.”

Environment for the Study

The group reflection gave research team members the chance to explore wider health-related issues concerning change, for example, changes that affect health as a whole and specific changes in the ward itself:

“You start to stock take and things... it’s undergone the most enormous change.”

“Change is inevitable isn’t it in anything, in life, in work, probably how we react to that that’s important I think.”

SUMMARY

This chapter has given a descriptive account of the research team’s group reflection during the evaluation process. It suggests participation helped the development of personal and professional skills, particularly in relation to research and professional practice. It also helped clarify and explore values and beliefs about practice, especially about the user experience during health care.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

Whilst the views of study participants were overwhelmingly in support of the nurse-led service the point of the study was to reinforce existing good practice and to identify any areas in need of further improvement. Many examples are given which illustrate how the service is considered to be of a high standard by the vast majority of people who use it, particularly in relation to assessment/admission, discharge planning, communication, privacy and dignity. Conversely, discharge planning and communication are particular areas for which there was evidence that suggested some variability in standards and so these will need to be focused on in particular in the response to these findings. Some suggestions for improvement were made by a minority of participants, sometimes individual participants, yet the research team is equally committed to working on these issues as it is on more general themes. As a result, the research team members have identified 43 recommendations for enhancing their practice. The nurse-led ward staff are now taking forward an action plan to prioritise and address all of these issues.

28. Feed back study findings and develop an action plan/priorities to address study recommendations
29. Explore nurse-led staff preferences in relation to working in a nurse-led setting
30. Explore mechanisms for team building and communication e.g. team-building days
31. Consider involvement of nurse-led staff in pre-admission assessment of referred patients to gain insight into these processes
32. Review admission and discharge activity in comparison to the staffing resource and other ward activity
33. Review organisation of care in relation to team nursing

34. Review discharge processes (including involvement of patients/carers, involvement of therapists, notice given, perception of readiness, provision of services and equipment/medications, ward activity, delays)
35. Review management of poorly patients
36. Review implementation of resuscitation policy and procedures
37. Review out-of-hours medical cover arrangements
38. Review management of patients with dementia and mental health needs
39. Appraise physiotherapy provision and referral processes for the nurse-led beds including out-of-hours cover
40. Develop/refine patient/family information giving (to include who is who, roles, type of ward, uniforms, expectations, purpose of social activities etc)
41. Develop nurse-led bed information material specifically for professionals e.g. referring staff
42. Review processes for involving and communicating with patients and relatives e.g. giving updates/test results, explaining purpose of follow-up appointments, multi-disciplinary meetings (timing, processes, who present)
43. Review processes for involving patients and carers in their care e.g. discharge planning and goal setting
44. Review processes for feeding back to patients/carers who make informal complaints or are dissatisfied
45. Review communication processes between professional groups (including use of the taped handover whereby different staff shifts update each other, multi-disciplinary team meetings)
46. Implement a staff training needs analysis and action plan
47. Explore mechanisms to raise awareness about the service for other professionals e.g. open day or shadowing/exchange opportunities
48. Consider a single point of referral/phone number for intermediate care referrals
49. Review opportunities for out-of-hours admissions to the nurse-led beds
50. Explore mechanisms to routinely feed back to GPs regarding patient progress/reasons for delays

51. Identify opportunities for project participants to apply research skills in other activities
52. Identify opportunities/preferences of the lay members of the project group to be involved in future research or activities
53. Implement study dissemination plan
54. Consider each specific improvement/recommendation suggested by patients, carers, referring staff and nurse-led staff:
 - a. Provision of patient operated bedside lights
 - b. Provision of ward staff cover during handovers
 - c. Provision of hospital hairdressing service
 - d. Provision of a toenail cutting service
 - e. Provision of support for patients who smoke
 - f. Identify means of introducing new/relocated patients to each other
 - g. Provision of mechanism to check walking stick length
 - h. Provision of more entertainment in the afternoons/evenings
 - i. Consider a visiting Welfare Rights Officer service
 - j. Provision of staff training around communicating with patients when physically handling them
 - k. Consider an afternoon rest period for patients
 - l. Consider provision of a drinks vending machine for patients
 - m. Explore mechanisms to integrate patients at home better
 - n. Appraise need for increased clerical support for staff
 - o. Consider need for more nurse-led beds and provision for patients with modest nursing needs
 - p. Review provision of interpreters

DISSEMINATION

At the second study workshop, ideas for dissemination and dissemination audiences were considered. The research team were made aware that this can often be a hurried part of the research processes and needed planning well in advance. These suggestions were revisited at the study end and now form the bulk of the dissemination plan for the study.

Dissemination audiences include:

- Staff using the service e.g. those who refer in and are referred to
- Other wards/departments at Walton Hospital and local NHS/social care staff
- Council Overview & Scrutiny Committee
- Volunteer organisations
- Over 50s group
- PCT patients and staff
- GP practices
- Other PCTs
- Universities
- The Law Centre
- Women's Guild
- Expert Patient Programmes
- Patient Forum
- The Public
- Local Research Ethics Committee
- All participants

Dissemination ideas included:

- Intranet – the Trust and University of Salford web pages
- PCT presentations – nurse-led staff, Trust Board, staff awareness sessions, research network
- Popular press/wide readership e.g. Nursing Times
- Nursing & Medical journals e.g. Journal of Clinical Nursing, Health Service Journal
- Other professions' journals
- Therapy Weekly magazine
- Royal College of Nursing Bulletin
- Free local newspapers

- Leaflets
- PCT newsletter
- Plain English Summary for distribution at conferences etc
- Poster

During the study, a small number of dissemination activities have already taken place:

Bacon, E and Low, J Developing research capability through the evaluation of a nurse led unit. Inspiring Success conference (**Regional/poster**), Derbyshire, April 2006

Rawle, A and Williamson, T Good research but by whose definition? Involving users and other stakeholders in the design of an evaluation of a nurse-led unit, UK Evaluation Society conference (**National/paper**), Manchester, December 2005

Williamson, T and Cooper, E Uncharted territory: designing an evaluation of a nurse-led unit with meaningful user involvement, Health R&DNoW Sharing Success conference (**Regional/paper**), Chorley, February 2006

Williamson, T and Rawle, A A to B via PPI: the non-linear path to study design with Public and Patient Involvement, RCN International Nursing Research conference (**International/paper**), York, April 2006

An abstract has been submitted to present the study findings:

Rawle, A and Williamson, T Findings from a participatory evaluation study of nurse-led intermediate care, RCN International Nursing Research conference (**International/paper**), Dundee, May 2007

GLOSSARY

Action research

An approach to research that is participatory, has change and improvement as goals, and can embrace a range of methods.

Audit

A process of examining current practice by comparing it with what is known to be desirable practice e.g auditing infection control practice against accepted standards

Away day

A workshop-style event for teams of staff, usually for team building purposes or to work on a shared issue

Canulation

A clinical procedure that inserts a fine plastic tube covering a needle into a vein in the hand or arm usually, for administration of fluids or drugs

Care managers

Social Services staff who manage caseloads of patients requiring their services

Convenience sampling

Samples of populations who are readily available e.g. patients on a ward

Data

Information

Data collection

Gathering of information, commonly through surveys, interviews, laboratory tests, examining documents etc

Descriptive statistics

Simple statistics where findings are usually presented as numbers and percentages that have not been subjected to complex statistical testing

DSO/agency

Domiciliary Services Organiser who provides home care services

Dissemination

The process of sharing findings and learning from a study usually with a variety of audiences and using various media to meet their needs e.g. posters, plain English summaries, reports, conference presentations, publications

Evaluation

The process of identifying the value placed on something e.g a service can be evaluated against the reasons given for setting it up in the first place or a job role can be evaluated to see if it met the job-holder's expectations

Handover

The process whereby ward staff feed back to the next staff shift about what happened whilst they were on duty e.g patients' progress, tasks outstanding

Holistic

Usually in reference to holistic patient care i.e. care that considers a person as a whole and respects their social, spiritual, mental and physical health needs rather than focusing on one or some aspect/s

Domiciliary

Home care in the community

Intermediate care

Care between hospital and home. Usually aimed at keeping patients out of acute hospital care when admission there is unnecessary, preventing

premature admission to long-term care such as in a nursing home and ensuring a safe and timely discharge from hospital

Maximum diversity/theoretical sampling

A research sample from a population aimed at selecting those individuals or groups that will likely yield most information. Often seeks a diverse sample so that opposites can be compared e.g. younger and older people, males and females etc

Multidisciplinary team meeting

A regular meeting of professionals caring for a group of patients e.g. physiotherapists, nurses, occupational therapists, speech and language therapists, care managers etc. Often patients and carers attend. The focus is generally on planning care, monitoring progress and discharge planning

Nurse-led care

Is where nurses, commonly but not always in a nurse consultant or specialist nurse role, take leadership of one or more patient services, wards or departments which would traditionally have been led by a consultant doctor

PEG feeding

A form of feeding for patients unable to eat by mouth. A feed tube is surgically inserted through the abdomen

Pilot

A practice-run to try out a tool or process. Often done with questionnaires to see if they are understood by participants prior to the main survey being carried out

Practice development

Informal means of exploring practice e.g. patient care and people's views of it. Not as rigorous as research but can be systematic and perfectly valuable in its own right

Primary care

Care carried out outside of the acute hospital setting. Care in the community setting

Pro-forma

A structured form, designed for easy completion using few words

Red House

A residential rehabilitation facility in the community.

Referrers

Staff who refer patients for admission to services

Sampling

Selecting who within a population will be selected for inclusion in a study e.g. who to send a questionnaire to

Sampling frame

A plan of who to include in a sample. Can often be complicated so it is set out clearly so that it can be followed

Sampling strategy

The approach to sampling. How a researcher plans to implement their sampling plans

Secondary data

Data (information) already in existence that needs collating rather than generating e.g. minutes of meetings, newspaper articles, reports

Transcribing

The process of typing up a tape recording of an interview or discussion

APPENDIX

Below are the free text contributions participants made using the comments box, graffiti board and first impressions questionnaires.

Comments Box

Patients/visitors

- Evening entertainment
- Hi, get some evening entertainment
- Lower notice boards for wheelchair users
- More activities for patients at night especially those without visitors
- More activities at night for residents with no visitors
- Warm plates before serving up meals
- When ordering small meals put on large plates
- Meat pie at dinner too chewy/gristly/unchewable. A lot didn't like it. More tender meat in pies (Sunday beef wonderful)
- Highly satisfied with everything, food etc
- Everything OK
- Everything satisfactory — they are doing everything right for me
- Highly satisfied with everything and everyone
- Highly satisfied with everything
- Although I consider the standard of care given by the staff you have is very good, caring and friendly, the hospital is very understaffed and I feel sorry for the burden of work the nurses have. I think the reduced opening hours of the hairdressing salon is disgusting and a big blow to the morale of the patients. Overall this is the best hospital I have been in, even to the quality of the meals which is of a good standard. How the powers that be can consider reducing staff is beyond belief. I wonder if they have ever been ill in hospital and dependent on anyone

Staff

- Must improve patient journey with regard to discharges
- Discharges motivated/rushed because of need to admit
- Appears that once patient is in no one cares – just rush them out
- Poor communication between staff, relatives and patient with regard to discharge – always rushed and appears unsafe
- There needs to be a vast improvement needed in communication between Nurse Consultant/Nurse Practitioner and the rest of the team to prevent: jobs/paperwork being duplicated; even worse jobs/paperwork not being completed; patients arriving on the ward and no-one other than the Nurse Consultant/Nurse Practitioner aware they were being admitted; last minute paperwork being done for discharges and admissions; patients arriving on the ward before their notes have been ordered from Central Library; patients arriving on the ward before others discharged resulting in having 25 patients on a 24 bedded ward
- If we are nurse-led and not taking medically unstable patients, why does every admission need an ECG and X-ray? If for investigations into medical condition should they not be in a medical bed until deemed medically stable?

Graffiti Board

Patients/visitors

- Smoking area
- Lovely warm dinner today

Staff

- Discharges not planned – done around admission needs – does not feel quality discharge for patients
- An admission on day after a discharge is preferable to admission on same day
- Try to avoid 2 or 3 admissions on same day

- More preparation time for discharges
- When patient admitted should they come when someone in primary team on duty to do at least basic admission. Also should someone in each team be on duty on each shift for it to work?

First Impressions Questionnaire

Forty-six questionnaires were partially or fully completed:

Things that struck new patients/visitors:

- Too ill to bother
- Too poorly and disorientated — night time
- Chair to sit, on facilities for putting your clothes and drawer space, and welcomed by the nurses
- How hard the chair was
- Worried might have to stay in bed all time
- I was first put in a single room but I had to be moved. I don't like it at first but now I think its friendly
- Spacious room and very friendly and welcoming staff
- Impressed
- It were alright in them days its lovely
- Its right nice to be back amongst such nice people
- Someone came to greet us. We weren't left too long before being shown to a bed. Were asked if we wanted a cup of tea which was very nice
- Being made welcome
- Welcoming, friendly atmosphere, relaxed
- Relaxed atmosphere
- Friendly, helpful
- I was struck – have been more than once – when nurses and doctors appear so quickly – not only come so quickly but get on with what is required

- Was glad to be here – in so much pain at home
- The really lovely, warm welcome. I was looked after. Brian was helpful – you can tell him I said it as well!
- Friendly, welcoming, fully aware of reasons for admission
- Cheerfulness of nurses. Nice bright clean room
- How clean it was
- Cheerful and friendly staff everywhere and very clean and smelling fresh - nice big windows letting in the light
- The kindness and efficient staff. The cleanliness of chairs and tables
- The cleaner. The helpful staff
- Pleasant and clean surroundings
- Nice and big. Nice and clean
- Its how cheerful you were, everybody was nice to you, very clean
- Very clean, friendly staff and very clean
- Cleanliness
- Clean. Plain but very tidy
- Nurses nice. Everything looks nice and clean
- How busy everybody was
- I don't know duck
- Can't remember
- Alright
- Felt it was alright
- Everything was straightforward
- Not very much
- Nothing
- Not in the least impressed
- It was different from (Ward x) as I have been in (Ward x)
- Have been on ward before
- Very nice. Don't forget I'm grateful for what they've done for me
- Patience and dedication to patients
- The attention the staff gave to the patients

First impressions gained:

- Very good
- Very nice indeed, nurses as well as patients
- I was most impressed seeing how quickly doctors and nurses appeared and got on with helping
- A happy ward
- Really good atmosphere. Didn't feel you were coming into a hospital
- Drink offered – very kind
- Everyone was friendly and very helpful
- I liked it. People was friendly. Very impressed with the staff. Don't care for blue/green teams as some staff ignore you
- Nurses were very civil and caring
- Staff were cheery
- Like I said before, kind and friendly
- I thought it was quite reasonable, very nice, friendly. They had a job to do. It's different like me flat.
- People treated you better. You don't have to buzz and wait half an hour for the toilet for one thing. I can't see very well but it was clean and tidy as far as I could see. Patients were well looked after
- The staff were most helpful and made me feel at ease. I was brought a cup of tea and felt relaxed
- The same faces always very friendly and smiling. A very good atmosphere
- Personal touch, reassuring. Excess of admin work for nurses
- How busy everyone was
- Organised, clean, staff friendly and approachable
- Very impressive, spotlessly cleaned. Lovely outlook (view from window)
- Clean, well-organised. Very helpful and clear what is happening
- It was clean
- Clean and tidy
- Neat and tidy

- Knew she was coming to hospital but nothing else – too poorly
- No great impression but curious to what treatment he would get
- Excellent
- Excellent in every way
- Very positive
- Quite good actually - different
- Friendly staff, very helpful
- Enjoyed
- Very nice
- It weren't bad at all like Marks and Spencers, very nice
- Much better than last time I came in
- I thought it was quite nice
- Thought it was quite nice actually
- Okay
- Everything was OK
- Had been on it before and it was fine
- Well it were alright, lovely job
- Alright
- Felt it was alright
- Nothing much
- I don't know. I'm back, daft this is

Suggestions for improving the experience of ward newcomers

- I don't think you could make it any better
- Myself, I don't think you could improve it
- I don't think you can improve
- The attention the staff gave to patients is first class
- Not much room for improvement, everyone so friendly
- On my visit there was no room for improvement
- Not possible – nothing can improve – the ward was perfect

- I don't think you could do anything better. Staff are wonderful. Judith is wonderful
- Nothing – very positive
- Can't think of anything, everyone was friendly and reassuring
- It's very nice. I've been in worse places. It's like me flat. I'm very grateful for getting on me feet
- That's a hard one. I think let them come in more slowly and let relatives come and unpack for them so they know they are alright and have a minute with them before they go
- I wasn't given a booklet so I didn't know why I was here. I didn't know who to approach
- Explain what was going to happen (treatment)
- I would have liked a little feedback the first day ie what test/treatment. Maybe a small history on coming into the ward ie general things – likes/dislikes, habits, which all staff can access
- Would like to be changed more at night
- A few books and magazines to read at bedside
- A lunch
- Get better propelled wheelchairs
- Television could do with height adjustment
- To let patients lie on the bed when they arrive rather than sitting in a wheelchair when first come in
- Have staff assigned to greet you
- Felt unsettled at first
- It was a trauma to even come in the ambulance as she hadn't been out for two years, but felt safe on the ward on arrival but unsure
- To make them welcome in every way. This was the experience given to myself. One vast improvement – the cooking. The cookhouse staff make delicious food but is spoilt by it being served up on ice cold plates
- Can't get to toilet when wants to go
- Have a staff member spend a few minutes settling the patient in
- Make chairs softer

- All you people work so hard. You put yourselves out to help us. Thank you. Thank you for giving us time (to give feedback)
- Nothing. Nowt duck, lovely. Doctors coming tomorrow.
- It's different now ta olden days. You got more rest in them days
- Don't get me puzzling duck. I don't know and that's bloody it
- Some staff are very nice, others are grotty
- Unable to comment on this
- No its alright
- No way
- Nothing
- Don't think so
- No I don't think so, everybody has been lovely
- Can't think of anything
- Find nothing wrong. Pleasant
- They only need to be on the ward a few minutes

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