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Milton Keynes General Hospital HALT (Hearing & Listening Together) Project Evaluation Report

The Implementation of National Service Framework Standard 4 (Care of the Older Person in a General Hospital)

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Acknowledgements

Thanks to the patients and staff of Milton Keynes General Hospital for sharing their thoughts and experiences.

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EXECUTIVE SUMMARY

Preamble

This executive summary represents an overview of the HALT project and is divided into sections. After an introduction, the report defines the terminology, provides a background to the project, contextualises the specific situation in Milton Keynes General Hospital with regard to care of the elderly and sets out the perceived aims identified at the outset of the project. Secondly, literature is used to identify national and international trends and tendencies as well as definitions relating to care of the older person, and the discussion provides some theoretical insight into the viability of a specific gerontological ward within the hospital.

The project is then divided into five phases illustrating the way in which it developed and evolved. Fundamental to all sections is the attitude of healthcare professionals to the older person and the ethos of Milton Keynes General Hospital with regard to this patient group as interpreted by the researchers/educationalists involved in the project. The sections are highlighted by findings from education programmes presented in the hospital and interviews with patients and staff. The report ends with conclusions by the researchers and recommendations for the future.

Introduction

According the Department of Health (2001), Age Concern (http://www.ageconcern.org.uk/AgeConcern) and Department of Health Statistics (National Statistics Online: http://www.statistics.gov.uk), the United Kingdom – as is globally the case – has an ageing population. The Department of Health suggests that the population grew by 6.5% in the last 30 years, from 55.9 million in 1971 to 59.6 million in mid-2003. However, population increases have not occurred at all ages. The Department of Health suggests that the country's population grew by 6.5% in the last 30 years, from 55.9 million in 1971 to 59.6 million in mid-2003. However, population increases have not occurred at all ages. The proportion of the population aged 65 and over has increased from 13% in mid-1971 to 16% in mid-2003. Over the same period, the percentage of the population under 16 fell from 25% to 20%.

Terminology

The steering group involved in implementing the NSF for Older People agreed on the following definition, which is divided into three groups:

Entering older age: A socially constructed definition of older age, according to different interpretations, includes people as young as 50. These people are active and independent and may remain so into the late older phase.

Transitional phase: This group of older people are in transition between healthy active life and frailty. This transition often occurs in the seventh or eighth decades but can occur at any stage.

Frail older people: These people are vulnerable as a result of health problems such as stroke or dementia, social care needs or a combination of both. Frailty can be experienced at any stage from age 50 onwards.

Background

Milton Keynes General Hospital is categorised as a district general hospital, has 460 beds and can be divided into five areas consisting of 15 wards in which older people are provided with care. It has a policy of integrating care of the older person on all wards – with the obvious exception of the obstetric and paediatric wards. Older patients are currently transferred to a specific primary care trust ward only if there is a problem with their mental capacity and only if there is space available on the ward. This means that all wards are continually populated by patients of a variety of ages.

The increase in the aging population as described nationally is equally relevant for Milton Keynes and the surrounding areas. While the number of households of pensionable age or over decreased marginally between 1991 and 2001, projection of the population aged 60+ in Milton Keynes is expected to rise from 14% in 2001 to 22% in 2031 (Milton Keynes Council, 2006). The statistics of older people are also, therefore, reflected in the patient population in the hospital and, according to the figures contained in the 2003 National Patient Survey, 22% of the patients admitted to Milton Keynes Hospital were aged 66 or above. In the 2006 National Patient Survey, 41% of the patients admitted were reported in the same age category.

Not only does the higher average age reflect the patient population admitted but, in a publication related to implementation of NSF Standard 4, Young et al.[1] suggest that the length of hospital stay for people aged over 65 is found nationally to be significantly higher than for those under 65. Older patients are admitted for twice as long for elective procedures

[1] This publication is, unfortunately, undated. However, based on the content of the document it would appear to have been published in 2006.

and for three times as long for non-elective procedures (http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=4544&Rendition=Web). This extended length of admission for the older person is supported by other authors (Bull, 2000; Cunliffe et al., 2004; Lundh et al., 1997; Victor et al., 2000).

Due to governmental concerns relating to the national developments of the aging population, the Department of Health issued a call for tenders in September 2003 to support the implementation of the NSF Standard 4 (General Hospital Care for Older People) and Milton Keynes Hospital responded by submitting a proposal. HALT (Hearing & Listening Together) started as a project when Milton Keynes General Hospital was successful in obtaining Department of Health funding to implement the government directive promoting care for the older person in the acute hospital setting. The HALT project aimed to link the improvement of services for older people to staff development and the practical implementation of two Department of Health documents – National Service Framework for Older People (2001) and *Essence of Care: Patient-focused Benchmarks for Clinical Governance* (2003).

Although the project commenced at the beginning of 2004, it met with numerous challenges and staff changes and so took extra time to develop. In October 2004, the Director of Nursing for Milton Keynes Hospital and the Project Facilitator met with members of the Mental Health and Primary Care Research Team, Bournemouth University, to negotiate academic support for the project. The Director of Nursing and the Professor of the Mental Health and Primary Care Research Team were named as project managers, with two project leaders for the HALT project in the steering group. In September 2005, the Milton Keynes project leader was replaced.

Aims of the HALT project

The Department of Health set out criteria for organisations that had obtained funding for projects and suggested that it was essential that a project should not be a single initiative approach to improving services for older people but should help bring about a fundamental refocusing. The project design had to ensure the implementation of NSF Standard 4, achieve a better experience for older people receiving hospital care and demonstrate how an older person focus can help meet access and capacity targets.

The NSF for Older People identified areas of concern regarding the care and treatment that older people receive in care settings (Department of Health, 2001). Another area that has more recently become a concern is elder abuse and undue influence (http://www.elderabuse.org.uk/

index.htm) along with funded research investigating these issues (Department of Health, 2007).

The NSF aims to provide specialist services for key conditions and intends to:

- Root out age discrimination (Standard One)
- Provide person-centred care (Standard Two)
- Promote older people's health and independence
- Fit services around people's needs.

Standard 4 of the NSF (DoH, 2001: 13) relates to general hospital care and states:

> Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.

Based on the above criteria set out by the Department of Health, quality of care for the older person within Milton Keynes General Hospital as a whole and the implementation of the Essence of Care Standards were central to the HALT project and three original aims were formulated:

- To ascertain the necessity and practicality of a specific ward for elderly patients in Milton Keynes General Hospital;
- To raise awareness, knowledge and skills with regard to caring for the older person throughout the hospital;
- To support, where necessary, a change in attitude and philosophy of care among staff with regard to the older person in the acute care setting.

Within the context of NSF Standard 4 for Older People and the link to the Essence of Care document, and in accordance with the Department of Health recommendations, this project focused primarily on staff development related to user participation and satisfaction. The project leaders decided to approach the HALT project from an educational/ professional development vantage point in combination with an audit trail rather than as formal research due to the ethical committee implications related to such a research project and the subsequent time factors.

Project approach

The HALT project was envisaged as being primarily bottom-up and decentralised, linking activities already being undertaken, such as audit and implementation of the equality and diversity policy, to issues pertinent to users, representatives and ward staff. Ultimately, the way the project developed means it can be divided into five phases. Although there is a chronological element to the phases, the process was

evolutionary and organic in its development. There was a degree of overlap in this process and the phases were not planned to follow each other systematically as may be suggested by this paper. Rather, the process developed on the findings and insights as they materialised.

The initial phase consisted of investigating patient complaints, interviews with patients and user representation to ascertain their satisfaction. To link the project to the reality and perception of all concerned, information was collected as follows:

- Complaints lodged by those aged 66+;
- Focus interviews with recognised patient representation such as Age Concern, Patient Advice and Liaison (PALS) and Patient and Public Involvement (PPI);
- Informal discussions with clients and carers as an ongoing part of the care provided to those admitted to the Milton Keynes NHS General Hospital.

The second phase related to staff training and consisted of two parts:

- Interviews with ward management and the discharge coordinators to establish topics they felt were relevant to an educational programme providing a knowledge and skill update for the ward staff, and to ascertain what they saw as the focus for developments necessary in each of the areas within Milton Keynes General Hospital;
- An educational programme provided for staff as a result of the interviews.

The third phase was the critical examination of exit interviews and discharge questionnaires, the fourth phase consisted of interviews with patients for a second time regarding their satisfaction, and the fifth phase was an away day for ward managers.

Literature

Is a specific gerontology ward in the acute hospital setting practical and viable?

Holistic principles suggested by Kelly et al.'s (2005) definition may be applied to all healthcare professionals and can be equally applied to health care across all patient categories. The need to achieve optimal quality of care for all patient categories within health care should not be ignored and lapses in essential care for elderly patients could be indicative of the standard of care in general and should be addressed accordingly. Applying a placebo in the form of 'specialised wards' for the elderly carries the risk of ultimately marginalising this group of patients even more and of masking inferior practice across all patient categories. The only way of achieving acceptable and equal levels of care for all will be to integrate elderly patients into mainstream health care and embrace

the area of diversity they represent. A similar discussion based on cultural and ethnic issues can be entered into but it would be unthinkable to have wards based on ethnic or religious criteria, even though it is well known that care providers are not always aware of, nor do they always adhere to, preferences of patients from ethnic minorities (Cortis, 2000; Kulwicki et al., 2000; Owens & Randhawa, 2004). Age is simply one category of patients that needs to be included in an equality and diversity policy along with categories of race, religion, gender, sexuality and intellectual and physical ability.

The discussion addressed by Kelly et al. (2005) in which the authors state the need to develop an interdisciplinary philosophy of care is one that needs to be taken seriously by all disciplines and at all levels of staffing. This ranges from the delicacy of medically managing the multi-pathology of elderly patients to handling the complexity of nursing care – this has implications for staffing ratios and skill mix. Age, as one component of the equality and diversity debate, should be identified and prioritised; it is an issue that will not disappear but will only increase in magnitude. Attempting to 'shield' healthcare staff from elderly patients will only serve to increase the discrepancy in the quality of health care and marginalise this category of patients even further. Policy makers and managers should use this opportunity to improve the quality of interdisciplinary care rather than attempt to 'solve' the problem by removing elderly patients from general wards.

However, it can also be argued that, by establishing a visible unit and employing staff specialised in geriatric and gerontological care, awareness can be raised and the value of the specialist knowledge and skills can be promoted to a level that is equal to other, more established specialist areas (Hazzard, 2004). This focus on care of the elderly can be beneficial to the status of gerontology and can ultimately serve the interests of elderly patients in the acute setting. However, it would need to be given a clear and lasting priority – a priority that is not apparent within 21st century society. It is also questionable whether establishing a specific gerontology ward in Milton Keynes General Hospital would be practical or achievable.

The number of patients above the age of 65 and their relatively longer admission raises the discussion as to the most appropriate way to care for the older patient in an acute hospital setting. This discussion whether to create a specific gerontology ward within an acute hospital is complicated by the difficulty in categorising the 'age' of the individual – according to chronological or functional aging, or according to the phase of aging as suggested by the NSF categorisation. The question then

arises as to whether it is up to the individual, or up to the healthcare professional, to decide the appropriate method to categorise a patient.

The ratio of elderly patients admitted to the healthcare system also raises discussion as to the practicality of having specific wards and staff focusing on care of the elderly – based on the available figures, roughly 30% of the beds in the acute general hospital would be reserved for patients over the age of 65. This number would need to increase with time to cope with the growing number of elderly patients in the community. It is questionable whether this could be a practical solution.

It is generally accepted that elderly patients have complex and ongoing health problems and that acute health care is generally focused on a curative and technical approach. It is also suggested that healthcare staff are generally inadequately trained and educated to care for the elderly (Hazzard, 2004) and that there is a lack of motivation among nurses to work with elderly patients (McLafferty & Morrison, 2004). Obtaining and retaining staff on wards specifically for older people could, therefore, present the hospital with a huge challenge unless a long-term, proactive approach to staffing, education and professional development is embraced.

The literature has provided a foundation for discussion around the need, viability and practicality of a ward specifically for older patients and these issues magnify the discussion relating to the practicalities of establishing a specific gerontology ward within an acute hospital setting. Further discussion or advice on this area is, however, too extensive within the parameters of this report and would need to be discussed more fully within the organisation.

Phases of the Evaluation

Phase 1:

The perceptions of elderly patients admitted to Milton Keynes General Hospital regarding their care

This section is based on complaints lodged by those aged 66+, focus interviews with recognised patient representation such as Age Concern, Patient Advice and Liaison (PALS) and Patient and Public Involvement (PPI), and informal discussions with clients and carers. Of the complaints[2] (n=323) received from patients aged 66 years and over, the majority (46%) were to do with the organisation of health care in general.

[2] All statistics used in this document (see Appendix 1) are based on information provided by Milton Keynes General Hospital sources; however, specific details of the complaints lodged are unavailable due to issues of confidentiality. Statistics for other age groups are currently not available and so, at this stage, no comparisons can be made. There has been no correlation between the complaints referred to in the text and patients who have been interviewed.

Basic care and safety

Statistics based on complaints made by patients indicate that 6% of the total number of complaints was related to dissatisfaction with the care provided by nursing staff at the Milton Keynes General Hospital. Interviews with patients[3] show that they perceive nurses in a positive way but that image is often used as an excuse by the patients when they don't receive the standard of care that they expect. All the situations in which the patients describe substandard care are linked to a level of passivity and subservience on the part of the patient. This may be to do with a generational sensitivity to authority, but may also be related to perceptions of power and paternalism. This too would need to be researched.

Safety for the elderly patient can be related to physiological needs in the form of food, drink and basic physical comfort. However, they can also relate to the expertise of the healthcare professional being competent to recognise and act upon signs and symptoms in the event of the patient being unable to sound alarm for themselves.

Dissatisfaction with discharge arrangements features in 5% of the formal complaints made by the age group 66+. The situations described by patients can be interpreted on an obvious, practical level but there are points needing attention regarding the patient's discharge in terms of information preparing them for the future.

Complaints arising from the lack of medical care totalled 11%. There is, unfortunately, no detail on what constitutes such care; however, there is some detail available indicating that it alludes to the manner and attitude of staff – this constitutes 5% of the complaints.

Information and paternalism

Communication problems may be underpinned by numerous factors which cannot be fully identified by the current information. However, the desire to be informed is mirrored by the hospital statistics in which 4% of the complaints concerned the request for information not being met. Patient situations may be related to inadequate discharge planning, staff attitude or a lack of information but, whatever the underlying cause, basic communication would need to be improved. There were, however, also illustrations of good communication in the discussions with patients.

General complaints regarding hospital service

Although the general complaints regarding the patient's stay in hospital

[3] Interviews were conducted informally with patients to ascertain their level of satisfaction and were not related to known formal or informal complaints.

arise from a variety of issues, it is worthwhile mentioning as these complaints total up to 11% of all formal complaints received for this age group.

Phase 2:

Interviews with the ward managers and the subsequent educational programme on care of the older person

Different areas within the complex care for the elderly are not being dealt with appropriately and have been highlighted in the literature: adequate support of and collaboration with elderly patients and their carers with regard to discharge planning, the staff's paternalistic attitude and negation of the individual's autonomy, continuity of care, dealing with mental health issues and communication. This insight provided the backdrop for discussing the knowledge and skill development of staff and the focus of development as seen by the ward managers.

Interviews with the nursing staff at Milton Keynes General Hospital highlighted the need for more attention to be paid to cultural and ethical issues affecting the elderly, physical and psychological assessment, care of vulnerable patients in general and the elderly patient in particular, collaborative inter-professional roles in providing optimal care, medication and pharmacology related to multi-pathology in the elderly, nutrition and continence issues, falls prevention and mobilisation, and the availability of social services and social work specifically directed at care of the elderly. Interestingly, palliative care and end-of-life issues with regard to care of the elderly appear to be absent from the interviews and consulted literature.

Phase 3:

A newcomer's impression of the HALT project and a critical examination of exit interviews and discharge questionnaires

At this point, those involved decided to approach the HALT project from a different angle. It moved away from its initial objective and distant nature and became more subjective and interpretive. The rationale was an attempt to break through what seemed to be a status quo within the organisation. A researcher was approached to evaluate the Exit Questionnaires from Milton Keynes General Hospital and The Campbell Centre, enquire about the perceptions and experiences of older patients regarding their stay in the hospital for a second time, gauge the attitude of the ward staff in general and, more specifically, explore the staff's philosophy of care.

Phase 4:

Second round of interviews with patients

The researcher spent time in the discharge lounge where patients are transferred to from the ward prior to leaving the hospital to go home. During the time he spent in the discharge lounge, he collected

information via informal discussions with the patients regarding their perception of the quality of care they received and their level of satisfaction with their hospital stay.

Phase 5:

The ward managers' away day

The HALT project appeared, to date, to have highlighted willingness among staff to provide high quality care for the older person on one hand but, on the other hand, organisational confines – building, evaluation forms, etc. – appeared to restrict what staff felt they could achieve. We were more convinced than ever that the voices of the ward staff needed to be heard and a ward managers' away day was organised to facilitate reflection on how they envisaged attaining the goals they set out to achieve with regard to caring for the older person in an acute general hospital setting.

Reflections and Findings

As previously indicated, a number of environmental issues identified within the hospital appeared contrary to the ethos of patient-centred care. Further issues had been identified in the approach to evaluating the patients' stay in hospital which supported the assumption that there might be more fundamental issues relating to staff attitude and the relationship between the staff and management that needed to be addressed.

Conclusion

The HALT project has taken a longer, torturous and more unexpected but, hopefully beneficial, route to address the initial aims set out in 2004. Although it would appear that a single definition is lacking or a categorisation of what constitutes 'an older person' is unclear and may marginalise this group of patients even more, the steering group has agreed on a definition they wish to use. It is important that this choice and underlying rationale is disseminated among the ward staff and incorporated into individual ward-related philosophies, developed by the staff. There have been times throughout the process where there has been raised awareness and *a focus on the knowledge and skills with regard to caring for the older person* in the hospital. The information and discussion does provide insight into areas needing attention and improvement. With the exception of the organisational issues, those areas needing to be addressed can be linked to staff attitude, vision of caring and service, and communication – all of which can be addressed through education, audit and clinical supervision and would not necessarily require a large financial investment.

Extra levels of awareness have been uncovered in the course of the project. Possibly the most important being the feeling of *disempowerment and powerlessness* as experienced by the ward managers during the away day. This mirrors the perception of power imbalance between the older person in the general hospital setting and the staff, as described by the patients and their representatives. The outcomes of the exit questionnaire evaluation indicating the need for change, and the choice within the organisation not to make radical changes to its format, seem to underscore the perception of inequality.

While the HALT project aimed to introduce, develop and sustain awareness and quality of care for the older person, it has inadvertently uncovered aspects of the hospital culture related to leadership and management that need to be addressed prior to developing quality of care for the patient. This awareness may prove to be confrontational, uncomfortable and challenging but seems to be symptomatic of two leadership strategies colliding: authoritarianism and inspirational leadership. There is a choice that needs to be made and both can result in, but have consequences for, the quality of patient care – one will be inclusive while the other exclusive of the patient and their representatives.

Achievements

- Information has been obtained at various times from patient representatives and users with regard to their satisfaction of the service.
- Themes regarding knowledge and skills needed to care for the older person have been identified by staff.
- An interactive programme, based on learning needs analysis of the ward staff, has been developed and presented. This programme includes topics such as medication, communication, culture & ethics, nutrition & continence, mental health, physical & psychological assessment, elder abuse, discharge planning and fall prevention. Those who attended the sessions evaluated them positively.
- Literature has been discussed in relation to the needs perceived by staff, informal interviews with users related to their satisfaction of the service provided, and formal complaints lodged by the age group 66+. This provided more insight for stimulating discussion regarding establishing a specific ward for the older person within the hospital.
- Collaboration with clinical governance has resulted in existing audit instruments being extended to include age which will allow further age-related data to be gathered, analysed and used in management and education within the hospital.

Way Forward

- A change in attitude, philosophy and quality of care is not something that can be evaluated comprehensively in the short term alone. As such, the impact of the HALT (Hearing & Listening Together) project will need to be evaluated over time, incorporating user feedback and satisfaction, staff perspectives, ongoing audit and patient outcomes.
- The ward managers are encouraged to name a champion in each department/ward and will, where necessary, be supported in setting out a plan of action, implementing change and disseminating knowledge in each area.
- Care of the older patient should be visibly linked to the hospital policy of equality and diversity and so prevent a further marginalisation of the older patient within the organisation.
- The training programme underpinning the implementation of the NSF Standard 4 and Essence of Care should mirror the perceived needs of the staff.
- Departments and wards should be stimulated to develop projects specific to their area of work in which they champion equality and diversity among patients in general and the older patient in an acute hospital setting in particular.
- A programme should be developed in the future that focuses on the development of a hospital-wide, multidisciplinary vision of care and clinical supervision used to support the implementation at departmental/ward level.
- At some stage in the future a more detailed investigation should be carried out to (a) identify the specific nature of complaints lodged by older patients and (b) compare the magnitude and nature of the complaints with other age groups.
- It would be advisable to bid for future funding aimed at researching the outcomes and effects of such a project for both users and staff. This would provide the project leaders with time to obtain ethical approval for a research project involving clients and staff.

INTRODUCTION

This report presents an overview of the HALT project and is divided into sections. Some sections are presented in a formal, conventional way, whereas others are presented in italic font as reflective narrative. We could argue that the whole report is a narrative piece, but these sections are the researcher's first-hand observations and discussions with patients and staff, and so are one person's interpretation rather than the result of an interpretive chain.

After an introduction, the report defines the terminology, provides a background to the project, contextualises the specific situation in Milton Keynes General Hospital with regard to care of the elderly and sets out the perceived aims identified at the outset of the project. Literature is used to identify national and international trends and tendencies as well as definitions relating to care of the older person. The discussion provides some theoretical insight into the viability of a specific gerontological ward within the hospital.

The project is discussed in five phases, illustrating the way it developed and evolved. Fundamental to all sections is the attitude of healthcare professionals to the older person and the ethos of Milton Keynes General Hospital with regard to this patient group as interpreted by the researchers/educationalists involved in the project. The sections are highlighted by findings from education programmes presented in the hospital and interviews with patients and staff. The report ends with conclusions by the researchers and recommendations for the future.

Context

According to the Department of Health (2001), Age Concern (http://www.ageconcern.org.uk/AgeConcern) and the Department of Health Statistics (National Statistics Online: http://www.statistics.gov.uk), the United Kingdom – as is globally the case – has an ageing population. The Department of Health suggests that the country's population grew by 6.5% in the last 30 years, from 55.9 million in 1971 to 59.6 million in mid-2003. However, population increases have not occurred at all ages. The proportion of the population aged 65 and over has increased from 13% in mid-1971 to 16% in mid-2003. Over the same period, the percentage of the population under 16 fell from 25% to 20%.

Over the last three decades, the median age rose from 34.1 years in mid-1971 to 38.4 in mid-2003. This ageing is primarily the result of past

patterns in the number of births, although declines in mortality rates also contribute. The Department of Statistics (http://www.statistics.gov.uk) furthermore suggests that continued population ageing is to be expected during the first half of this century because the number of elderly people will rise as the relatively large numbers of people born after the Second World War become older. The working age population will also fall in size as the baby boomers move into retirement, also due to the fact that relatively smaller numbers of people have been born since the mid-1970s. While the White ethnic group had the highest proportion of people aged 65 (16%), 9% of Black Caribbeans were aged 65 or over, reflecting the first large-scale migration of people of minority ethnic origin to Britain in the 1950s. Immigrants from India and Pakistan arrived mainly during the 1960s. Many people of African-Asian descent came to the UK as refugees from Uganda during the 1970s, most Chinese and Bangladeshi people came to Britain during the 1980s, and many of the Black Africans arrived during the 1980s and 1990s. These statistics suggest that progressive ageing of the minority ethnic population may be anticipated in the future, which has direct implications for healthcare provision (National Statistics Online: http://www.statistics.gov.uk).

Terminology

Prior to entering into any detail about the project, we first want to clarify some of the terminology. Defining the term ‘elderly patient’ gives rise to discussion because, in general terms, ‘elderly’ is simply defined as being ‘somewhat old, past middle age’ (Allen, 1984: 236). Another definition suggests that ‘Old age consists of ages nearing or surpassing the average life span of human beings, and thus the end of the human life cycle’ (Wikipedia, 2007: http://en.wikipedia.org/wiki/Elderly).

With increased longevity of life in Western countries, one of the primary issues leading the discussion is whether chronological or functional aging should be used in defining the criteria for categorising older people. In the National Service Framework (NSF) documentation (Department of Health, 2001), older people appear to be categorised according to their journey within the aging process rather than being strictly linked to their calendar age: entering old age roughly between 50-65 on completion of their working life, transition from independence to dependence around 70-80 and then frailty which is considered to be in late old age. Old age is described by Hazzard (2004) as being above the age of 75, and suggests that the ‘truly elderly’ are above 85. In January 2006, the steering group involved in implementing the NSF for Older People agreed on the following definition, which is divided into three groups:

Entering older age: A socially constructed definition of older age, according to different interpretations, includes people as young as 50. These people are active and independent and may remain so into the late older phase.

Transitional phase: This group of older people are in transition between healthy active life and frailty. This transition often occurs in the seventh or eighth decades but can occur at any stage.

Frail older people: These people are vulnerable as a result of health problems such as stroke or dementia, social care needs or a combination of both. Frailty can be experienced at any stage from age 50 onwards.

In terms of healthcare provision, it may help to consider a definition related to caring for the older person. Kelly et al. (2005: 16) describes gerontological nursing as:

> A person-centred holistic approach to promote positive aging, enabling the individual and their families to adapt to age related disabilities, health challenges, trauma or illness and eventual palliation.

Kelly et al.'s (2005) definition contains principles that incorporate a holistic approach and help the patient to adapt to and cope with an altered heath state, health challenges and ultimate death. The definition also suggests that it includes the scientific study of the biological, psychological and sociological phenomena associated with old age and aging – a more holistic approach and more appropriate for a discussion in the healthcare arena.

BACKGROUND

Study Setting

Milton Keynes General Hospital is categorised as a district general hospital, has 460 beds and can be divided into five areas consisting of 15 wards in which older people are provided with care. It has a policy of integrating care of the older person on all wards – with the obvious exception of the obstetric and paediatric wards. Older patients are currently transferred to a specific primary care trust ward only if there is a problem with their mental capacity and only if there is space available on the ward. This means that all wards are continually populated by patients of a variety of ages.

The increase in the aging population as described nationally is equally relevant for Milton Keynes and the surrounding areas. While the number of households of pensionable age or over decreased marginally between 1991 and 2001, projection of the population aged 60+ in Milton Keynes is expected to rise from 14% in 2001 to 22% in 2031 (Milton Keynes Council, 2006). The statistics of older people are also, therefore, reflected in the patient population in the hospital and, according to the figures contained in the 2003 National Patient Survey, 22% of the patients admitted to Milton Keynes Hospital were aged 66 or above. In the 2006 National Patient Survey, 41% of the patients admitted were reported in the same age category.

Not only does the higher average age reflect the patient population admitted but, in a publication related to implementation of NSF Standard 4, Young et al.[4] suggest that the length of hospital stay for people aged over 65 is found nationally to be significantly higher than for those under 65. Older patients are admitted for twice as long for elective procedures and for three times as long for non-elective procedures (http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=4544&Rendition=Web). This extended length of admission for the older person is supported by other authors (Bull, 2000; Cunliffe et al., 2004; Lundh et al., 1997; Victor et al., 2000).

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Although the project commenced at the beginning of 2004, it met with numerous challenges and staff changes and so took extra time to develop. In October 2004, the Director of Nursing at Milton Keynes Hospital and the Project Facilitator met with members of the Mental Health and Primary Care Research Team, Bournemouth University, to negotiate academic support for the project. The Director of Nursing and the Professor of the Mental Health and Primary Care Research Team were named as project managers, with two project leaders for the HALT project in the steering group. In September 2005, the Milton Keynes project leader was replaced.

Aims of the HALT Project

The Department of Health set out criteria for organisations that had obtained funding for projects and suggested that it was essential that a project should not be a single initiative approach to improving services for older people but should help bring about a fundamental refocusing. The project design needed to ensure the implementation of NSF Standard 4, achieve a better experience for older people receiving hospital care and demonstrate how an older person focus can help meet access and capacity targets.

The NSF for Older People identified areas of concern regarding the care and treatment that older people receive in care settings (Department of Health, 2001). Another area that has more recently become a concern is elder abuse and undue influence (http://www.elderabuse.org.uk/index.htm) along with funded research investigating these issues (Department of Health, 2007).

The NSF aims to provide specialist services for key conditions and intends to:

- Root out age discrimination (Standard One)
- Provide person-centred care (Standard Two)
- Promote older people's health and independence
- Fit services around people's needs.

Standard 4 of the NSF (DoH, 2001: 13) relates to general hospital care and states:

> Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.

Based on the above criteria set out by the Department of Health, quality of care for the older person within Milton Keynes General Hospital as a whole and the implementation of the Essence of Care Standards were central to the HALT project and three original aims were formulated:

- To ascertain the necessity and practicality of a specific ward for elderly patients in Milton Keynes General Hospital;
- To raise awareness, knowledge and skills with regard to caring for the older person throughout the hospital;
- To support, where necessary, a change in attitude and philosophy of care among staff with regard to the older person in the acute care setting.

Within the context of NSF Standard 4 for Older People and the link to the Essence of Care document, and in accordance with the Department of Health recommendations, this project focused primarily on staff development related to user participation and satisfaction. The project leaders decided to approach the HALT project from an educational/ professional development vantage point in combination with an audit trail rather than as formal research due to the ethical committee implications related to such a research project and the subsequent time factors.

Project Approach

The HALT project was envisaged as being primarily bottom-up and decentralised, linking activities already being undertaken, such as audit and implementation of the equality and diversity policy, to issues pertinent to users, representatives and ward staff. Ultimately, the way the project developed means it can be divided into five phases. Although there is a chronological element to the phases, the process was evolutionary and organic in its development. There was a degree of overlap in this process and the phases were not planned to follow each other systematically as may be suggested by this paper. Rather, the process developed on the findings and insights as they materialised.

The initial phase consisted of investigating patient complaints, interviews with patients and user representation to ascertain their satisfaction. To link the project to the reality and perception of all concerned, information was collected as follows:

- Complaints lodged by those aged 66+;
- Focus interviews with recognised patient representation such as Age Concern, Patient Advice and Liaison (PALS) and Patient and Public Involvement (PPI) to ascertain the expectations and needs of service users, but also to encourage (ongoing) user participation in staff development/training packages, development of (client) information packages and to develop standards of care within a general hospital;
- Informal discussions with clients and carers as an ongoing part of the care provided to those admitted to the Milton Keynes NHS General Hospital. These interviews involved both clients and carers in intra- and extramural care settings to obtain information of their hospital experience. Further information was obtained regarding client and carer expectations and evaluations of their hospital admission, care and treatment by way of the admission and discharge interviews.

The second phase related to staff training and consisted of two parts:

- Interviews with ward management and the discharge coordinators to establish topics they felt were relevant to an educational programme providing a knowledge and skill update for the ward staff, and to ascertain what they saw as the focus for developments necessary in each of the areas within Milton Keynes General Hospital;
- An educational programme provided for staff as a result of the interviews.

The third phase was the critical examination of exit interviews and discharge questionnaires, the fourth phase consisted of interviews with patients for a second time regarding their satisfaction, and the fifth phase was an away day for ward managers.

LITERATURE

Is a specific gerontology ward in the acute hospital setting practical and viable?

The holistic principles suggested by Kelly et al.'s (2005) definition may be applied to all healthcare professionals and can be equally applied to health care across all patient categories. The need to achieve optimal quality of care for all patient categories within health care should not be ignored and lapses in essential care for elderly patients could be indicative of the standard of care in general and should be addressed accordingly. Applying a placebo in the form of 'specialised wards' for the elderly carries the risk of ultimately marginalising this group of patients even more and of masking inferior practice across all patient categories. The only way of achieving acceptable and equal levels of care for all will be to integrate elderly patients into mainstream health care and embrace the area of diversity they represent. A similar discussion based on cultural and ethnic issues can be entered into but it would be unthinkable to have wards based on ethnic or religious criteria, even though it is well known that care providers are not always aware of, nor do they always adhere to, preferences of patients from ethnic minorities (Cortis, 2000; Kulwicki et al., 2000; Owens & Randhawa, 2004). Age is simply one category of patients that needs to be included in an equality and diversity policy along with categories of race, religion, gender, sexuality and intellectual and physical ability.

The discussion addressed by Kelly et al. (2005) in which the authors state the need to develop an interdisciplinary philosophy of care is one that needs to be taken seriously by all disciplines and at all levels of staffing. This ranges from the delicacy of medically managing the multi-pathology of elderly patients to handling the complexity of nursing care – this has implications for staffing ratios and skill mix. Age, as one component of the equality and diversity debate, should be identified and prioritised; it is an issue that will not disappear but will only increase in magnitude. Attempting to 'shield' healthcare staff from elderly patients will only serve to increase the discrepancy in the quality of health care and marginalise this category of patients even further. Such discrepancy should not be underestimated; it has been documented in medical and nursing journals and has been well publicised in the media (http://society.guardian.co.uk/health/story/0,,2177677,00.html; http://blogs.guardian.co.uk/news/2007/09/older_patients_suffer_undignif.html; http://news.bbc.co.uk/1/hi/health/3701855.stm). However, this exposé should highlight the need to address both the educational needs

of healthcare professionals and possible unprofessional and unethical practice. Policy makers and managers should use this opportunity to improve the quality of interdisciplinary care rather than attempt to 'solve' the problem by removing elderly patients from general wards. Kelly et al. (2005) also warns of the risk of reductionism when patients are over-categorised in that they become too removed from a holistic view.

However, it can also be argued that, by establishing a visible unit and employing staff specialised in geriatric and gerontological care, awareness can be raised and the value of the specialist knowledge and skills can be promoted to a level that is equal to other, more established specialist areas (Hazzard, 2004). This focus on care of the elderly can be beneficial to the status of gerontology and can ultimately serve the interests of elderly patients in the acute setting. However, it would need to be given a clear and lasting priority – a priority that is not apparent within 21st century society. It is also questionable whether establishing a specific gerontology ward in Milton Keynes General Hospital would be practical or achievable.

The number of patients above the age of 65 and their relatively longer admission raises the discussion as to the most appropriate way to care for the older patient in an acute hospital setting. This discussion whether to create a specific gerontology ward within an acute hospital is complicated by the difficulty in categorising the 'age' of the individual – according to chronological or functional aging, or according to the phase of aging as suggested by the NSF categorisation. The question then arises as to whether it is up to the individual or the healthcare professional to decide the appropriate method to categorise a patient.

The ratio of elderly patients admitted to the healthcare system also raises discussion as to the practicality of having specific wards and staff focusing on care of the elderly – based on the available figures, roughly 30% of the beds in the acute general hospital would be reserved for patients over the age of 65. This number would need to increase with time to cope with the growing number of elderly patients in the community. It is questionable whether this could be a practical solution.

It is generally accepted that elderly patients have complex and ongoing health problems and that acute health care is generally focused on a curative and technical approach. It is also suggested that healthcare staff are generally inadequately trained and educated to care for the elderly (Hazzard, 2004) and that there is a lack of motivation among nurses to work with elderly patients (McLafferty & Morrison, 2004). Obtaining and retaining staff on wards specifically for older people could, therefore,

present the hospital with a huge challenge unless a long-term, proactive approach to staffing, education and professional development is embraced.

The literature has provided a foundation for discussion around the need, viability and practicality of a ward specifically for older patients and these issues magnify the discussion relating to the practicalities of establishing a specific gerontology ward within an acute hospital setting. Further discussion or advice on this area is, however, too extensive within the parameters of this report and would need to be discussed more fully within the organisation.

PHASES OF THE EVALUATION

Phase 1

The perceptions of elderly patients admitted to Milton Keynes General Hospital regarding their care

This section is based on complaints lodged by those aged 66+, focus interviews with recognised patient representation such as Age Concern, Patient Advice and Liaison (PALS) and Patient and Public Involvement (PPI), and informal discussions with clients and carers. Of the complaints[5] (n=323) received from patients aged 66 years and over, the majority (46%) are to do with the organisation of health care in general. From the information available it is not possible to ascertain the specific details of each complaint, but it would appear that these concern situations not specifically related to the elderly patient. Some of the patients interviewed mentioned problems with waiting for treatment and waiting lists.

Table 1: Complaints relating to the healthcare organisation received from the age group 66+ for the year until May 2005.

Healthcare Organisation	
Admission delays	21%
Difficulty in getting dentist appointments	5%
Difficulty in getting GP appointments	1%
Treatment delays	2%
Access to specialist treatment	4%
Lack of resources	3%
Availability of NHS treatment	3%
Follow-up treatment	1%
Personal costs of NHS treatment	1%
Medication prescription	2%
Transport problems	3%
Total	**46%**

Due to the generic nature of the complaints included in this report, discussion will focus more on issues affecting the remit of the hospital staff. Discussion of restrictions to the healthcare organisation in general will therefore not be taken forward in this paper.

Basic care and safety

Nydén et al. (2003) discuss the basic needs of elderly patients in terms of Maslow's hierarchy, in which basic physical and physiological needs

[5] All statistics used in this document (see Appendix 1) are based on information provided by Milton Keynes General Hospital sources; however, specific details of the complaints lodged are unavailable due to issues of confidentiality. Statistics for other age groups are currently not available and so, at this stage, no comparisons can be made. There has been no correlation between the complaints referred to in the text and patients who have been interviewed.

have to be met and personal safety provided prior to the patient being able to progress to more abstract requirements such as information processing and self-actualisation. Nydén et al. (2003) suggest that little attention is given to the non-urgent needs of elderly patients and that prioritisation is made by the healthcare professionals, thereby excluding the patient from the decision-making process.

Statistics based on complaints made by patients indicate that 6% of the total number of complaints was related to dissatisfaction with the care provided by nursing staff at the Milton Keynes General Hospital.

Table 2: Complaints relating to basic nursing care and safety received from the age group 66+ for the year until May 2005.

Nursing	
Lack of care (nursing)	6%
Discharge arrangements	5%
Falls and safety	1%
Total	**12%**

Interviews with patients[6] show that they perceive nurses as follows:

> *…they were all lovely, they were nice to me. They're all so busy – it's rush, rush, rush for them. I didn't like to ask for things.*

This positive image is often used as an excuse by the patients when they don't receive the standard of care that they expect. One patient described how, post-operatively, she had not been cared for:

> *But they didn't* [come and clean me]. *I lay in the blood and urine all night. I was in pain – it hurt when I moved, but I remember trying to move to find a dry patch. It wasn't a very nice experience. I'd forgotten it till now.*

Pain management is an issue that was mentioned by another patient who was admitted as an emergency with biliary colic but did not receive any form of pain medication for almost 12 hours. Archibald (2003) and Rond et al. (2001) discuss issues related to pain management in the acute setting. Greene & Adelman (2003) discuss similar issues with pain management in elderly patients diagnosed with cancer. These literature sources mirror patient claims indicating that their pain was not managed adequately. Reasons behind this can be varied and would need to be researched in more detail. However, pain management is a nursing

[6] Interviews were conducted informally with patients to ascertain their level of satisfaction and were not related to known formal or informal complaints.

intervention and needs to incorporate a well-grounded philosophy of caring as well as expertise in the appropriate specialist field and good inter-professional communication. Interestingly, all the situations in which the patients describe substandard care are linked to a level of passivity and subservience on the part of the patient. This may be to do with a generational sensitivity to authority, but may also be related to perceptions of power and paternalism. This too would need to be researched.

Safety for the elderly patient can be related to physiological needs in the form of food, drink and basic physical comfort. However, they can also relate to the expertise of the healthcare professional being competent to recognise and act upon signs and symptoms in the event of the patient being unable to sound alarm for themselves. Safety for the elderly patient can not only be expressed in terms of freedom from fear, anxiety and chaos (Nydén et al., 2003), but also relates to actual physical safety, such as prevention of falls (Archibald, 2003). The statistics in Table 2 indicate that only 1% of the patients complained about falls and physical safety, and one patient interviewed discussed her nightly angst at the activities of an Alzheimer's patient in an adjacent bed. This patient described how she was in pain and couldn't move but mentions nothing of staff intervening or resolving the situation.

Dissatisfaction with discharge arrangements features in 5% of the formal complaints made by the age group 66+. One of the patients interviewed described how she had been taken to the hospital by ambulance due to an emergency and, after being seen at 3am and not needing to be admitted, had been discharged without any clothes. This situation described by the patient can be interpreted on an obvious, practical level but McKain et al. (2005) discuss patient discharge more in terms of information preparing them for the future. One may assume that in the situation put forward by this patient, support and/or preparation for discharge would also have been lacking.

Another situation was described in which an 80-year-old lady was discharged without anyone being informed – the person described how the patient had been found by accident the next morning by volunteers after sitting all night in the position where she'd been left. Nolan et al. (1996) identifies this issue and sees the inclusion of informal carers as being essential to a successful discharge.

Complaints arising from the lack of medical care totalled 11% (Table 3). There is, unfortunately, no detail on what constitutes such care; however, there is some detail available indicating that it alludes to the manner and

attitude of staff – this constitutes 5% of the complaints. In the interviews with patients, only one patient mentioned a positive interaction with a consultant:

> *…he used to sit on my bed. I felt I could talk to him, he'd tell me a good joke. He was easy to talk to. I felt he really knew about me.*

It is interesting that only one interviewed patient mentioned a member of the medical staff in either positive or negative terms. This may be related to the fact that medical staff generally see patients for very brief moments during investigations or ward rounds, whereas the patient's relationship with the nursing staff is more intimate and intense. It may, however, also be related to the perceived status of medical staff.

Table 3: Complaints relating to medical care and safety received from the age group 66+ for the year until May 2005.

Medical	
Lack of care (medical)	5%
Result delay	1%
Complications	1%
Problems with diagnosis	2%
Inter-professional referrals	2%
Total	**11%**

Regarding the other areas of complaints – delayed results, complications during procedures and problems with the diagnosis – Greene & Adelman (2003) indicate the necessity for doctors to be aware of the complexity of diagnosing conditions in the elderly as many symptoms may be attributed to a natural aging process when they are, in fact, related to multi-pathology. Elderly patients often need more time to grasp what is being said to them so the medical staff, ideally, need more time with each patient. This is not always possible due to the staffing ratios of medical staff, but the benefit of personal attention is illustrated clearly by the previous quote in which the patient verbalised a feeling of trust and appreciation. Greene & Adelman (2003) suggest that some medical staff do not always provide aggressive treatment or comprehensive health promotion and disease prevention as options for the older person, and is indicative of what they call 'institutionalized ageism'. This could be linked to complaints related to accessibility of resources and treatment although this cannot be firmly concluded from the information currently available.

Information and paternalism

Nydén et al. (2003) indicate that, although patients wanted to be informed, they didn't want to have an active role in decision-making.

Table 4: Complaints relating to communication received from the age group 66+ for the year until May 2005.

Communication	
Communication in general	6%
Information requests	4%
Confidentiality	1%
Total	**11%**

Communication problems may be underpinned by numerous factors that cannot be fully identified by the current information. However, the desire to be informed is mirrored by the hospital statistics in which 4% of the complaints concerned the request for information not being met (Table 4). This was articulated by one of the patients interviewed, who said:

> *They were friendly, but they never tell you anything. I wanted to know when I was going home. They wouldn't tell me.*

The above situation may be related to inadequate discharge planning or may relate to staff attitude or a lack of information, but whatever the underlying cause basic communication would need to be improved. There are, however, illustrations of good communication. An example of communication with a clinical nurse specialist is highlighted by one of the interviewed patients:

> *The nurses were lovely. I got to know them, but* [X] *was the best. She really cared: she gave me her phone number. She always phones me back if I leave a message. No-one else does that.*

Any lack of communication results in frustration, worry and fear (Nydén et al., 2003) along with insufficient explanation relating to care regime and patient expectations. It may also result in passivity on the part of the patient (Archibald, 2003; Greene & Adelman, 2003; McKain et al., 2005; Nydén et al., 2003) and hostility by the informal carers (Nolan et al., 1996) – all of which can influence the patient's perception of satisfaction.

Nydén et al. (2003) discuss the need for the patient to experience equity in the relationship with the healthcare professional in order to feel that they belong, build meaningful relationships and perceive their own place in the social structure of health care. This feeling of belonging provides a foundation for confidence and self-actualisation which leads to the patient's ability to be autonomous. Nydén et al. (2003) also suggest that patients avoid verbalising dissatisfaction for fear of not being taken seriously by the healthcare professionals and possibly jeopardising their position to receive the care required.

General complaints regarding hospital service

Although the general complaints regarding the patients' stay in hospital arise from a variety of issues, it is worthwhile mentioning as these complaints total 11% of all formal complaints received for this age group (Table 5).

Table 5: General complaints regarding hospital service received from the age group 66+ for the year until May 2005.

General complaints regarding hospital service	
Cleanliness	1%
Infection control	1%
Hospital procedures	1%
Noise	1%
Lost property	2%
Contact details	1%
Out of hours	1%
General manners and attitude	1%
Service general	2%
Total	**11%**

With the exception of an interviewed patient mentioning that it was hard to sleep at night and another saying that it was a long walk to the eye clinic, no general complaints arose during the informal interviews with the patients. In fact, 4% of the formal communication with patients included in Table 5 concerns positive feedback, commendations or advice.

Phase 2

Interviews with the ward managers and the subsequent educational programme for care of the older person

According to the literature, in the acute hospital setting the older patient is seen, in curative terms, as being the least challenging patient category. The nursing care is considered to be boring due to its routine and physical nature focussing on basic comfort and hygiene (McLafferty & Morrison, 2004). This is an unfortunate attitude as care of the elderly is complex and demands a wide range of skills in which healthcare professionals are challenged to link cues in all domains if they are to provide holistic care. The complexity of elderly care where there is a question of dementia is highlighted by Tolsen et al. (1999) and Rutschmann et al. (2005). These authors discuss the importance of carer involvement, but also the lack of planned and documented medical and nursing care – this highlights the criticism that elderly patient care in the acute setting focuses largely on physical, curative care while undervaluing attention on psychological needs.

One generally accepted argument in defence of a specific ward for the older patient (currently, older patients are transferred to a specific ward for the elderly if there is a problem with their mental capacity) is that staff choose to work with this client group and would therefore be particularly motivated. Gilloran et al. (1994) indicate in their research with staff working in psychogeriatric wards that, although a number of staff actively choose to work with this category of patient, the staff's perception of work satisfaction is generally low and the work perceived as being unchallenging. Based on these perceptions, recruitment and retention of staff could provide challenges for hospital management if they are to earmark sufficient beds to house the number of patients admitted to an acute hospital that meet the criteria of being 'older persons'. McLafferty & Morrison (2004) provide additional insight into the perceptions staff have of needing less advanced nursing skills when dealing with the elderly patient and so essential care is delegated to largely unskilled staff. This is contrary to the concept of providing adequately educated and experienced staff to deal with complex care situations.

Different areas within the complex care for the elderly are not being dealt with appropriately and have been highlighted in the literature: adequate support of and collaboration with elderly patients and their carers with regard to discharge planning (Nolan et al., 1996), the staff's paternalistic attitude and negation of the individual's autonomy (Kelly et al., 2005; Nolan et al., 1996), continuity of care (Hazzard, 2004), dealing with mental health issues (Harrison & Zohhadi, 2005) and communication (Greene & Adelman, 2003; McLafferty & Morrison, 2004). This insight provided the backdrop for discussing the knowledge and skill development of staff and the focus of development as seen by the ward managers.

In addition to the list of important areas obtained from the literature and referred to in the previous paragraph, interviews with the nursing staff at Milton Keynes General Hospital highlighted the need for more attention to be paid to cultural and ethical issues affecting the elderly, physical and psychological assessment, care of vulnerable patients in general and the elderly patient in particular, collaborative inter-professional roles in providing optimal care, medication and pharmacology related to multi-pathology in the elderly, nutrition and continence issues, falls prevention and mobilisation, and the availability of social services and social work specifically directed at care of the elderly (Appendix 3). Interestingly palliative care and end-of-life issues with regard to care of the elderly appear to be absent from the interviews and consulted literature. Plans were made for a training programme and experts in the field who were employed by Milton Keynes General Hospital were approached to

provide interactive workshops. However, due to staffing issues, registration for the teaching sessions was minimal and the programme was postponed.

Shortly after the programme was planned, a new initiative was introduced in the form of a mandatory educational programme on equality and diversity which was to focus primarily on race, culture and ethnicity. As this programme had Department of Health priority, voluntary attendance at the sessions on care of the older patient dwindled and the sessions had to be cancelled. Attempts were made to integrate the older person into the equality and diversity agenda, but the Hospital's training department was obliged to adhere to the Department of Health's focus on ethnicity. Although there was collaboration with the training department to set up combined equality and diversity/NSF Standard 4 sessions, this led to confusion among staff and the teaching sessions on care of the older person were postponed for a second time.

The sessions were planned for a third time in July 2006 (Appendix 2) and, again, experts were approached to provide the content. The up-take for the sessions was, again, minimal even though there had been a top-down message that these sessions were now mandatory. The start of the programme was encouraging, but attendance dwindled and the final session on elder abuse had to be cancelled. This experience was demotivating for the organisers but the evaluations of the sessions were encouraging (Appendix 4).

Phase 3

A newcomer's impression of the HALT project and a critical examination of exit interviews and discharge questionnaires

After the experience with the educational programme described above, those involved decided to approach the HALT project from a different angle. It moved away from its initial objective and distant nature and became more subjective and interpretive. The rationale was an attempt to break through what seemed to be a status quo within the organisation. The researcher and educationalist involved in the project felt there was lip service paid to agreeing with the project in words, but passive aggressive behaviour was illustrated by the non-attendance of staff at the educational programme as discussed in Phase 2. Dr Westwood was approached to evaluate the Exit Questionnaires (Exit Q) from Milton Keynes General Hospital (MKG) and The Campbell Centre, enquire about the perceptions and experiences of older patients regarding their stay in the hospital for a second time, gauge the attitude of the ward staff in general and, more specifically, explore the staff's philosophy of care.

As a new member to the team, Dr Westwood was asked to document his observations and critique the reality of the HALT project and the hospital

as he saw it, in an attempt to contextualise the development of the project to date. Regarding the HALT project he wrote the following:

> *I'd read previous documentation and had been struck by the acronym HALT (Hearing and Listening Together) and by an apparent holistically focused (person centred) aim which was dissonant with their rather traditional style.*
>
> *HALT troubled me because I believe it matters what we call things if we want the names we give to things to embody essential qualities of what they are supposedly about. What it means and how we go about enacting our words is a recurrent theme in this report. 'Hearing and listening together' is a dialogue thing; it's about the flow of conversation and the reciprocity of that. Ideally it's about both parties in the dialogue learning something, expressing themselves, and feeling understood or listened to. This is a flowing and dynamic embodied event.*
>
> *HALT on the other hand is an order in the form of an imperative verb and as such has nothing to do with dialogue. It's about obeying orders and the one-way flow of rather reductive information. I understand that it's nice to have an acronym but suggest choosing a less paradoxical one, one that embodies the aims of 'hearing and listening'.*
>
> *'Hearing and Realising Together' would be HART and there are doubtlessly many other options you could try. Often the labels we call things embody implicit assumptions about how we're going to approach a task. The HALT acronym embodies a paternalistic set of ideas regarding obedience ('hear' is linked semantically to 'obey' through its association with 'hark,' and in many languages the words for 'to hear' and 'to obey' are identical) and yet is supposed to be about dialogue. This sort of paradox concerns me.*
>
> *In the case of the declared holistic stance of the paper and it's fairly robust quantitative style and in the issues regarding the chosen acronym HALT I do feel there are points to be made that tap into more general issues and in this sense these points stand as symbols crystallising those wider issues that I've found so far.*

Regarding the hospital, Dr Westwood's impressions were as follows:

> *I felt like something of the geometry and number orientation of MK town had been figured into the hospital and wasn't surprised that the wards went by number only (with the exception of specialist units and Milton Mouse – variously known as ward five). At forty I have what I'd regard as fairly good vision but I struggled a good deal to make any sense of the index on the plan/map of the hospital. Eyesight issues recurred in my talks with older people.*
>
> *I found the main reception dark and fairly unwelcoming. This came as a surprise because I had stood for some time, being early, looking at the impressive and wholly appropriate statue in the centre of the roundabout directly outside the main entrance. The sculpture seemed to capture – in its three intertwined and inscrutable figures – many issues to do with my associations with the experience of being in hospital, both as a patient and as a nurse. The figures, with their ambiguous expressions, are readable in many ways and some of the issues that came to me regarding them were fear, longing, helping, support, cooperation, insecurity, warmth, comfort, concern.*
>
> *I found this a potent symbol and was impressed on walking around the hospital at just how much high quality art was on display. This seemed on the one hand odd in that the building itself seemed unwelcoming in its design and that wards were numbered rather than named. This sort of thing feels paradoxical to me as I associate art and expressiveness as complex implicit feminine qualities that don't tend to thrive in hard-edged masculine spaces.*
>
> *Holism is a contextual and feminised way of approaching things like experience and dialogue and has an ambiguous nature – like the sculpture I mentioned – and is not possible in reductive environments. My feeling is that this will be a main issue in the research as it is one that echoes through much of what I've found, including the questionnaires…*

Regarding the MKG Exit Questionnaire:

> *This form isn't dialogic and provides no space for people to discuss things that may be complex/implicit/ambiguous. Although patients may read at the bottom of the form that they*

can use overleaf for any further comments, because of the design of the form, the likelihood of this happening is remote.

The hierarchy of information-giving is rather odd. At the top (and by implication the most urgently viewed) are the issues to do with cleanliness on the ward; second in order of apparent importance is information; third comes privacy and dignity; fourth is discharge information; and last comes the demographic info of 'about you'.

Beyond the face value of what items are about, the questionnaire seems to have three levels of criticism. This structure becomes important when we're dealing with closed dialogue where people don't really say what they mean or feel and/or where the client group is particularly hard to engage in a dialogue where they will potentially be giving negative feedback.

The elderly are particularly vulnerable for various reasons to not expressing their real opinions to others (esp. 'professionals') and because of this the Exit Q is more of a 'coded' form that has an ambiguous face value/hidden value quality. This means that any items marked negatively may well be a disguise for other criticisms that the older patient is too frightened to articulate. If a respondent is to answer negatively there are three levels of item severity (not face value):

On what I'll call Low Level of criticism we have a 'No' answer to 'Were information leaflets offered to you before discharge?' This is unlikely to make someone feel particularly anxious regarding criticising an institution that is charged with caring for them. This type of item represents a 'safe' way to criticise MKG.

On a Mid Level of criticism we have answering 'No' to an item like, 'Were the following areas clean?' where a 'No' would represent an anxiety- provoking criticism on the part of the respondent. This isn't a 'safe' bet regarding providing negative feedback, especially with the older patient who is particularly vulnerable to demand characteristics, obedient to authority, has a siege mentality, is acquiescent etc. this will be a strong statement to make.

On a High Level of criticism we have items such as, 'Did you feel your dignity was respected during your care/therapy?' and here a 'No' would probably constitute a very anxiety-provoking

experience as well as opening the door to a set of feelings that are very upsetting on face value i.e. regarding staff disrespecting them. In fact, to ask this question at all and only provide a Yes/No tick box constitutes, in my view, disrespect of the person's feelings by not honouring a dialogue about them so that they could be explored and/or remedied. Questions of this nature must honour the answer with time and space.

While some questionnaires are specifically devised to place more emotive (face value) items centrally so that the respondent has time to ease into being asked questions, I don't feel that this is the case here.

The items 'When you had important questions to ask the doctor did you get answers that you could understand?' and the similar one about nurses seem to be problematic. Firstly they imply that there will be a difference in how understandable the communication of doctors and nurses will be – this can set up a tension for the respondent. There is also the assumption that the patient had important questions to ask, as well as the patient possibly feeling these questions imply they have low intelligence. Better wording regarding how clear the communication was of various staff members on the ward would be better and this also wouldn't polarise doctors and nurses in the eyes of the respondents.

Several people I spoke to were slightly annoyed that they had no option to identify themselves as English and this seems a fair point. If the form distinguishes between Pakistani, Bangladeshi, and Indian as well as between Caribbean and African why doesn't it allow English people to identify themselves as such when the history of the English is very different from that of the Celts and does, or at least can, constitute a separate identity just like Pakistani, Indian and Bangladeshi.

The lack of space to describe experiences is what primarily defines this form as inappropriate to gather the sorts of rich, descriptive information that I believe we are trying to get. Several items need rewording and the format needs changing.

The Campbell Centre In-Patient Satisfaction Survey:

This is much more dialogic and gives space for respondents to further describe their experiences to which they've just ticked a

box to primarily identify. This space is a great improvement on the MKG Exit Q as the respondent is given a chance to personalise their response and go into the complexity of it.

On the items with a Likert-type scale there is a significant problem; Likert-type scales almost always have a 'neutral' position and therefore usually have a five-point scale. The issues re. what 'neutral' means to respondents is complex and has inherent problems but these aren't as grave as basically forcing the respondent to praise or criticise when we know well that in such situations respondents are far more likely to pick the praise option even if that doesn't match their experience (false positive). For example, item one on this form is, 'Did you feel that your admission was…?' followed by four boxes identified as relating to 'very welcoming', 'welcoming', 'unwelcoming', and 'very unwelcoming'. It's clear that unless the respondent picks either 'very welcoming' or 'very unwelcoming' that their actual choice is being heavily affected by there being no mid-point which would amount to an indifferent welcome or one where the respondent was undecided about what sort of welcome they got.

We know that people find it hard to criticise, although this is less evident in psychiatry, and are likely to play safe with questionnaires. Response Acquiescence Set (Polit & Hungler, 1991) is the term we give to the tendency people have to agree rather than disagree with items on questionnaires or surveys. To balance for this, items are usually an unpredictable mixture of positive and negative statements and the response scale is reversed accordingly. Here, because there's no mid-point, the respondent either has to say they were 'welcomed' (most likely, because of response acquiescence) or made to feel 'unwelcome'. My feeling is that not having a five-point scale pretty much invalidates the items that use the Likert-style response scales.

I also found it difficult to work out which Yes or No box related to which staff group on the first page because the boxes were quite far away from the staff groups and weren't colour coded. Many clients in psychiatric services may have their vision affected by their medication and I'd imagine a clearer form would help them a great deal.

Poor grammar and query spelling on the last page should be cleared up. On one hand the form is a discharge survey and

implies that the person filling in the form is being discharged, but on the other hand the message at the end of the survey implies that the client is currently still on the ward: 'If you have any further comments or suggests (sic) to make about ways that we could improve your stay…' This implies that the client isn't being discharged or if they are that they're likely to be readmitted again. I doubt this is the intended meaning of the message.

Twenty questionnaires already filled in:

First I had a look at 20 completed Exit Questionnaires that were available in the Transfer of Care Lounge. Of the 20 I looked at, 11 were entirely positive in their responses. Nine contained negative items and, of these nine, six were filled out by people over 66 years old. Although the older age group constituted the majority of the report of negative items, it's the quality of those criticisms that interests me.

One was from an unidentified age range, one was from the 36-50 age range, and one was from the 16-35 age range. The respondent of unidentified age reported that the bathroom area was unclean, care plan not discussed, doctors were unclear in their communication, nurses unclear in their communication. This was very interesting because it represented the harshest critique of the hospital of any of these questionnaires and I couldn't help thinking that had something to do with the added anonymity of not disclosing the age range.

On the Exit Q there are graded critiques in that some items are fairly easy to express some negative attitudes about ('Were you given a copy of the discharge summary?'), some have a mid range of gravity regarding the negative response ('When you had important questions to ask the doctor did you get answers that you could understand?') and some would be fairly frightening to answer in the negative due to the complex issues associated with doing that within an environment not conducive to dialogue ('Did you feel your dignity was respected during your stay/therapy?').

The six patients aged over 66:

Two of the six had written in added/qualifying info on the sheet and this probably has something to do with the restrictiveness of the scope of the questionnaire. One patient reported that their

care plan wasn't discussed with them nor did they receive info leaflets.

One patient avoided answering the first items regarding cleanliness and went on to say that meds weren't explained and that they received no info leaflets.

One other patient reported that meds were not explained and no info leaflets given.

One patient reported that bloods weren't explained and no d/c summary was given.

One patient reported that bloods weren't explained.

One other patient reported that bloods weren't explained.

None of these older people marked any of the more harshly critical items negatively (cleanliness, communication, dignity, privacy). As I went on to speak to older patients I found that the non-reporting of negative experiences regarding these more critical items was a reliable predictor of the person's age. By this I mean I started to feel that if I looked at completed Exit Qs I thought I could fairly accurately predict the age of the respondent by evaluating the level at which they registered their criticism. This was interesting and quite worrying. Older people are often very vulnerable and also come from a different 'culture' than younger people – a 'suffer in silence' one rather than a 'complain and blame' one.

Issues to do with response acquiescence set, social desirability and evaluation apprehension are well documented in social science research and the elderly are particularly vulnerable to these pressures to give 'good' answers. This flags up questions to do with the style and scope of the Exit Q and more widely to do with what 'honest' communication is regarding older patients. This touches on what I called 'coded' responses earlier: most groups use coded communication – like medics and lawyers – and depending on the vulnerability of the group in question the coding will be more or less covert. In the case of 'powerful' groups, the coding is very overt and constitutes almost a different language that tends to be exclusive. Exclusion is not a good basis for dialogue. The highly overt coded language of medicine is ill-equipped to dialogue with the covert codes of

> *vulnerable groups where what is not said can be more important than what is said.*
>
> *A paternalistic/medical style of communication will greatly vitiate the ability of vulnerable older people to report their actual experiences. Older people have a particular docility and/or fear in the face of authority and have a background culture of 'suffering in silence' and 'yes saying' to those in authority. A different style of communication is needed to get to their underlying feelings and experiences. The reductiveness of 'medical speak' is extremely unlikely to encourage openness and without openness we have little hope of finding out what the real issues are.*

After providing this feedback to the steering group, the exit questionnaire was minimally altered and the discussion concluded. This apparent resistance to make fundamental changes to the exit questionnaire when approaching the (older) patient contrasts strongly with the second point of the NSF Standard 4 which is about person-centred care. The first key intervention states that the standard will be met through 'appropriate personal and professional behaviour by staff in all care settings, which can be particularly important at the end of life'. The views of patients and carers about their experiences will be sought systematically (Department of Health, 2001: 24).

Two things stand out with this statement. Firstly, 'personal' behaviour, which is an important feature and, as a result, is a more personal and individually responsible way of being/communicating – something which is considered important in nursing. This is about a 'close' rather than 'closed' or distant type of language that allows and encourages patients and staff to have in-depth dialogue. Secondly, what does 'systematically' mean regarding seeking the views of patients and carers? The Exit Q was systematic, but of little real use in eliciting those views. When 'systematic', linked to 'efficient', is conflated with 'good' or 'correct' it is worrying because such techniques are extremely unlikely to engage and empower older people or anyone else to really talk about their experiences.

Older women in particular are likely to have a history of not being involved in decision making and often find it impossible to advocate for themselves when they are talking to 'professionals'. Other factors affecting the quality of older people's reports of their experience are the levels of institutionalised living they're already familiar with, perceptual limits (e.g. is vision clear enough to see if the ward was clean?) and

depression (which is now thought to be grossly under-diagnosed among the elderly). These other factors make them particularly vulnerable to 'going along' with things which aren't in their best interests (Department of Health, 2007). Even a good, more dialogical questionnaire would be unlikely to record the individual's actual experience because of the pressures that older people feel and which make them very susceptible to 'not rocking the boat'.

Phase 4

The second round of interviews with patients

Dr Westwood spent time in the discharge lounge where patients are transferred to from the ward prior to leaving the hospital to go home. The period of stay in this unit can vary between one and eight hours. During the time he spent in the discharge lounge, he collected information via informal discussions with the patients regarding their perception of the quality of care they received and their level of satisfaction with their hospital stay.

Respondent A:

Was in as an outpatient and said that the only issue of annoyance or concern for them was the wait for the ambulance to take them home. Stressed that they are picked up on time to get to the hospital according to the hospital's schedule but then is left waiting for a long time once the 'hospital has finished with me'. Said they were scared by the scanning machine and appeared to want to make other comments but was very cautious.

Because I felt this, I said had they been an inpatient at MKG in the past. They said yes they had, many times and that years ago (five years) the wards were very 'slapdash' and that 'the doctors were rushing all over the place and had no time to talk' – there was little or no clear communication. One particular male doctor was unpleasant.

They then said that things had changed a lot since then but I felt like this wasn't a heartfelt comment but was more a safe way to frame grievances. This older person seemed concerned that I was asking them questions and I became aware of putting them under pressure simply by talking to them.

When I asked about what being scared by the scanner was like they ignored my question and quickly said that the person doing the scan had explained what was going on. I felt like this patient

was anxious that I didn't infer any criticism in their current dealings with MKG. They went back to issues re. previous admissions regarding unclear doctors' communications, unexplained bloods, no leaflets before discharge.

A final comment (repeated by several others) was that they were English and not British and why in England English isn't a response option on the form. I agreed and stated that my national identity is English and that I find it concerning that forms like this imply I should feel otherwise.

Respondent B:

This individual was very compliant and positive in their replies – too much so in fact and this alerted me to issues I was starting to find regarding the great difficulty in encouraging honest dialogue with vulnerable older people. They said that the ward number system was confusing because it's more natural to remember names than numbers. I found it very hard to engage with this respondent on what I'd call a 'real' level because of their defended position of giving otherwise glowing appraisals of MKG.

Respondent C:

Visibly anxious at answering questions. Made me wonder at the ethics of me approaching patients seeing as the environment (they were still on MKG premises and I was a staff member) was so heavily pressing them into 'good' response patterns. This patient was clearly concerned about giving negative feedback but also obviously wanted to mention some critical things.

They seemed to negotiate this by picking the safe items on the Exit Q to vent critical opinions and then quickly de-valued the criticism they'd just given in a way so as neutralise it. By the time I'd got to the end of the form this patient had had enough and by now I'd started to develop an understanding of the level of response acquiescence set that was playing out in my interviews with older people.

As well as issues I'd already identified re. the vulnerability and fearfulness of older people, I now became more aware of how difficult it was for them to 'complain' to an authority figure. I also was aware that older people have many years of experience in 'reading' other people's reactions and behaviour and are in fact very skilled at tapping into these so as to 'please' others.

I had the sense of being 'worked out' by most of the older people I spoke to. In one case, the working out was made very explicit and because I welcomed this I ended up having the only 'real' interview out of all of the patients I spoke to. I'll come back to this later.

Respondent D:

Again, started in an unrealistically positive way. Unrealistic in that if the person felt that happy about being in hospital they wouldn't want to go home but they very definitely wanted to go home. Stressed they were self-reliant and adaptable and it seemed very important to them that I confirmed this for them. After initially saying that everything was wonderful I asked about feelings of safety and they instantly said that they had to tape up their locker door but then found it hard to articulate why this was the case and what was going on around 'fear' and 'anxiety' for them.

Seemed to stall their flow of buoyancy. I got the sense that they were indeed anxious about being in hospital but found it much easier to identify needing to tape the locker door closed as an example of being worried about something rather than talking whatever that something was.

I started to feel that by approaching patients with the Exit Q (which I already had concerns with) I was part of a reductive framing of what can and can't be talked about. This sort of framing happens very subtly but is very powerful; Singer (1996) has written at length about issues surrounding thought manipulation and recently re. issues to do with elder abuse/ undue influence and the techniques often employed to do this.

This patient's dialogue pattern became framed with practicalities by the Exit Q (which itself mimics the practicalities on the wards) but these practicalities seemed to point to something else more implicit. I felt like the form was actually inhibiting my ability to talk to patients about their experience. It also became clear to me that the item, 'Do you feel that your dignity was respected during your care/therapy? Yes…No…' is actually an undignified thing to do to someone's experience because the form makes no allowance for the complexity and space an individual may need to describe this.

I was now seeing a pattern developing where older people would place their negative feelings about issues re. their stay in

the safe 'bloods not explained' and 'no leaflets' items. I began to suspect that these least confrontational items are a catch-all for other criticisms. I have no idea whether these items have any face value about the actual things they ask about because they seemed to so commonly come up as items only for the elderly patients who were more anxious about being critical generally.

I decided to try approaching a patient without the form so I wouldn't be framing the spectrum of 'appropriate' responses.

Respondent E:

By not using the form, this respondent was able to weakly criticise the cleanliness of the bed area. The cleanliness items are in the mid-range of criticisms so this was interesting. However, after saying this, the respondent gave glowing reports about their stay – especially regarding being listened to and cared for.

They said that they were 'treated like they mattered even though they are old' and followed this with, 'Most people treat you like you're senile because you're old' (briefly tearful after saying this) then said that compared to other hospitals MKG is really good. Said how filthy 'the other one' was but wouldn't tell me the name of 'the other one'. I mentioned to them that they had just told me that the bed area was dirty on the ward and they quickly qualified this by saying that compared to the other hospital that was nothing.

Again I had the feeling of not being able to get clear and heartfelt dialogue from this patient. They clearly wanted to 'sing the praises' of MKG and seemed to think that that was what I wanted them to do. My feeling was that all the praises were a result of feeling vulnerable after opening the dialogue with a criticism regarding the cleanliness of MKG. I have no idea if 'the other' hospital exists or whether this was an invention to divert blame from MKG.

Respondent F:

Seemed confused and found it hard to understand me. Had possibly filled in an Exit Q on the ward. Seemed anxious and was apologetic about 'not being helpful'. Despite not understanding me, did say that communication on the ward was clear. I found this curious seeing as they clearly found it hard to understand me. Even though this was the case they were able

to 'work out' that I wanted them to say something nice about MKG. I felt that this person was anxious because they couldn't 'help' me, and also that they didn't actually want to talk to me but agreed to because they thought they should. This was quite unsettling and added to my sense of the vulnerability of the elderly.

Respondent G:

Initially glowing reports but then said that they 'didn't take to one of the doctors'. After this they began to rationalise their criticism so as to de-emphasise it – the doctors are so busy, other people letting them down, the ward was stretched etc. – the sense of it being very hard to allow or give permission to older people to be critical of their care.

This was another pattern: an initial criticism (which may or may not have face value regarding what it purported to be about) being followed by a string of positive statements, many of which seemed over-blown and unrealistic. The glowing reports of this patient were very probably exaggerated. Another reason for this being that people are generally happy to be going home and this happiness seems to affect their retrospective critique of their stay on the ward.

Were slightly annoyed that they couldn't identify themselves as English. After this criticism they went on to say that communication on the ward was good although they'd scored negatively in all three items re. discharge info. This seemed clearly contradictory and when I asked what they then meant re. the negative scorings on the Exit Q they avoided the question and became very 'philosophical' – this amounted to rationalising a 'good' stay in hospital as being one where you lived to go home from (siege mentality).

At this point I felt it would be inappropriate for me to push the issue but I was convinced that this again was a 'symptom' of the factors that so affect the communication style of the elderly.

Respondent H:

Had been listening to the earlier interview (privacy??) and said that they had nothing to add to what had already been said. Seemed anxious about talking but did mention that on occasion the food was cold (the previous respondent had said that the food was 'wonderful' and 'always piping hot' – having been on

the wards at lunchtime I found this description unrealistic with even the best will in the world. Found it odd too that the staff ate different food to the patients and that the staff food by most accounts was much nicer).

Again I got the feeling that criticising the food was a safe way to vent negativity that would be too threatening to speak openly about. I felt this for several reasons; one being that the critique of safe items was often heavily loaded. The patients would become quite animated about it and be quite severe, and this level of emotional/psychological energy being expended on fairly trivial issues made me feel that the negative feelings were actually attached to something else which was deeper and more troubling.

Respondent I:

This patient followed the pattern that I'd noticed before; any critique would be to do with bloods or leaflets and all other responses would be unrealistically positive. If a patient was critical of an item on the Q then they would be likely to exaggerate how positively they felt towards the higher level items like the ones to do with dignity and privacy.

On my travels round the hospital I noticed instances of older patients not being treated with dignity or privacy and I've seen this sort of thing in most hospitals I've been in or worked in. I noticed these things in a fairly short space of time and find it unrealistic that a patient would be so positive about these items when obviously there is room for criticism.

By this point I was beginning to think that the only way to have an open dialogue regarding issues on the wards from a patient's perspective would be to talk to someone who'd had a dreadful experience regarding their stay. As luck would have it, the last patient I spoke to had had such a stay.

Respondent J:

This patient was unreservedly critical but in a reasoned and concerned way. They found the staff unsympathetic and unclear in their communication, they found little concern for privacy and dignity, they found the ward dirty, the food awful, the noise excessive. They also said that pain management was poor and that there was a lot of fear on the wards regarding older people. This articulate individual didn't appear to have 'an agenda' other than being shocked by the care they'd received.

They were aware of what 'research' is and jokingly identified themselves as an 'outlier' who I could cut out of the picture because they didn't fit under the bell-shaped curve of statistical averages. They clearly understood that statistics makes a habit of removing 'extremes' for the sake of the statistical average and making the maths 'work'.

I was reminded of several things while I spoke to this patient. Firstly, I was reminded of my work as a psychiatric nurse where the environment is very different from the medical one. As a psychiatric nurse I became not only used to being overtly and forcefully criticised but it was also part of my duty to assist and support clients in making official complaints about the staff on the ward or even myself (depending on the nature of the complaint).

This openness to 'negative feedback' and the dialogue that ensues around it is something that is noticeable in its absence from medical wards. Here there is little dialogue as such because the hierarchy of communication is not dialogic (HALT) but rather one regarding orders and prohibitions. Doctors have their language and nurses have their language and between the two the possibility of 'real' dialogue is virtually non-existent. This isn't the case on psychiatric wards.

Psychiatric nurses have more autonomy than general nurses and this creates a more personalised style of communicating – one which is suited to the aims and goals of psychiatry and is by nature dialogic. It seems that issues regarding experience, especially if they are negative, won't be encouraged or even possible within the medical style of communication.

If MKG wants to actually find out how things are on the wards for the elderly they'll need to have a more open and dialogic approach generally as it is inappropriate to have a paternal/ medical style of communicating throughout the patient's stay only to ask them to 'open up' just before they're discharged.

Like three others, this person mentions sleep deprivation but unlike the others they said that the results of this were severe and counterproductive to getting well. This, of course is true and I was surprised whilst talking to other patients who'd said that their sleep had been badly disturbed that they then said that it didn't matter when I asked more about it. Sleep deprivation adds

to the suggestibility and vulnerability of people and in particular the older person and is in fact one of the methods used in brainwashing and behaviour modification to make people 'receptive' to info. Poor nutrition and 'helping' too much so people become dependent (Singer, 1996) are other factors that may be relevant.

I enjoyed speaking to this patient most because I felt I was having a real conversation.

Given the great difficulties getting older people to criticise their care, such 'outliers' present us with a rich source of feedback and in this sense I'd favour case study/critical case rather than develop a new and more discriminating Exit Q which, unless it is backed up by more dialogic communication on the ward, will do little except further reveal the reductiveness of 'medical speak'.

Several respondents mentioned poor eyesight as an issue to do with the Exit Q and this meant me going through it with them and that had obviously confounding factors. I noticed just how suggestible the older people were and how much they were affected by subtle choices of words, emphases and gestures.

The issues, questions and notes:

I doubt a tweaked Exit Q will be the answer to the issues (not) presented by the older patient but certainly a better one would be a start. The current form contributes to what I'll call a reductive framework of cues that determine what can be spoken about and how. In this sense the form is coded in a way so as to get positive results from the elderly. If there is a need for a new Exit Q it should be measuring how well a pre-defined (at admission and repeated on the ward) mission statement/ philosophy of care was carried out otherwise there isn't much meaning or purpose to it. A new form will need to incorporate the space for response features present on the Campbell Centre form.

Real communication means human warmth inhering in it and this is essential for all our dialogues and perhaps particularly in those with the elderly. Older people have a compounded situation that is both to do with their 'culture' but also in feeling vulnerable and I'd say that these issues are unlikely to disappear once this generation of elderly people die i.e. the 'suffer in silence' generation. The vulnerability and the pressures

about pleasing others who have more power will likely be an ongoing issue that each generation of older people feel.

Permission-giving re. raising issues and criticisms would be a good idea on admission so would the unavoidable presence on the wards of a core values/nursing philosophy and the encouragement for people to give feedback of any kind. I only noticed one ward with an actual nursing philosophy although many have statements (mostly generic) from the ward's sister. Many had a generic message re. respect, cleanliness and care alongside a photo of the matron. The generic statement is slightly altered for the children's ward to include the family more.

The more technical the ward (CCU, CDU, etc.) the more technical the notice outside – 'No mobiles, assaults on staff not tolerated etc.' – no mission statement as such…machines don't speak.

The generic message which is repeated on many wards is a bit abrasive and termed in language which I don't associate with nursing and is more like PR speak: 'I'm the matron and I've got the authority to change things…' This seems abrasive at first but then seems disingenuous once one realises that most wards have the same message that is supposed to be a personal message from the matron on each ward. This is a bad indicator regarding real dialogue, especially of the more personal and close language that nursing needs in order to operate holistically in a client-centred way (a main aim identified by the NSF recently and identified by nurses themselves for many years).

The environment for dialogue…

Permission giving. Listening to concerns and not rationalising them re. workload or being busy or it being more important that physical health needs dealt with (non-holistic). Still seems to be a blame culture in nursing. Quite common for 'dialogue' to be coded in that it's quite clear that people don't really want to talk and deal with issues, like the form with its Yes… No… N/A… boxes rather than real space to talk. If someone says 'No' my dignity wasn't respected then that's the end of the 'talk' and we don't know what the circumstances were; we simply have a 'No' with no chance to actually deal with the issue – what point is there of having information like that??

Issues:

Overt – sleep, bloods, leaflets, cleanliness, clarity of communication especially of doctors, eyesight, food.

Covert – almost exclusively avoid the high level more emotive items. Actually could argue that my approaching people in TCL wasn't respecting their dignity or privacy but no one mentioned this because this sort of 'disrespect' is normalised in the hospital setting.

Outlier research – one in 30 respondents isn't statistically significant (not that I'm interested in statistics) but according to my perceptions and intuitive and professional understanding of human behaviour I'd have to say that, in this client group, Respondent J may well be representative of their underlying feelings. I believe that if outliers (positive and negative) were interviewed re. their experiences it would be more likely that the negative outliers' responses would be realistic or at any rate more representative. In fact, the positive outlier is actually normalised when using the Exit Q because the majority (11 of 20) of respondents gave entirely positive feedback. This casts grave doubt on the discriminatory power of the Exit Q.

For this very vulnerable client group, outlier research could be the way forward because patient responses seem so safety orientated that their meaning is negated. We need people to speak out about negative experiences and to do this we must change how all staff deal with this more open and dialogic style of communicating.

Lessons can be learnt from the psychiatric nursing framework and this seems good because it is still a nursing framework with the core values of nursing but is more dialogic and open to 'hearing and listening' regarding people's experiences, irrespective of whether these are positive or negative.

Issues around frustrated communications – any negative feedback/concerns are rationalised with 'busy workload' or by 'we have to look after medical issues first' and this is a large disincentive for people to even try to engage in meaningful dialogue.

Historically nurses hear this from managers (I know I have) that they want them to raise issues, only to have those issues negated by talk of 'budgets', 'audits', 'workloads' etc. so that the nurses themselves are in the same trap of non-dialogue as the patients. If nurses want to give holistic care then it's not good enough to use these (plausible) rationalisations and we must

say that because of the workload or time pressures we are having to fragment the holistic nature of our care and this means compromising our ethics. This would be an interesting conversation.

There's a change in the 'culture' of nursing that seems linked to the emphases that Project 2000 places on academic work and in particular the drive for evidence-based practice. Unfortunately the evidence which nurses are increasingly basing their practice on doesn't come from nursing research but rather from medical or academic research. This is inappropriate and has been part of a 'distancing' language and mentality becoming more evident in nurses as well as making nursing at higher levels more of a bureaucratic exercise which nurses feel a high level of frustration about. This is a large point and one that concerns many nurses and nurse researchers. Dawn Freshwater and Gary Rolfe's book Deconstructing Evidence Based Practice *(2004) draws these deeper issues into focus.*

Although these issues are large, they are worth addressing and it is appropriate that the very ill-advised new Mental Health Act – which was largely bureaucratically generated – has been overturned in light of continued resistance to it from service users and concerned health professionals. The main criticism of this Act is related to the unsound methodology and ethics of the Government-generated diagnosis of Dangerous and Severe Personality Disorder (Corbett & Westwood, 2005).

Probably the most interesting thing about the Exit Q and my interviews is just how little those reductive techniques manage to gather the information that they are supposed to. These forms may well be very reliable in that they report similar answers at different times and in different places but their validity is almost certainly minimal in that they do not measure what they are supposed to be measuring. In the case of the MKG Exit Q, I'd guess that what is reliably being measured is the patients' fear of being critical and their alienation at being communicated with in that style.

Why did I mention elder abuse and undue influence early on? Currently these are buzzwords but in the US have been being researched for around 25 years. We lag behind the US by some 15 to 20 years in developments in healthcare and sometimes this is an advantage and sometimes it isn't because not all 'progress' is actually progress.

Currently undue influence focuses on cases where a powerful agent coerces a vulnerable individual into doing something that they don't want to do. However, we can conceptualise undue influence as stopping someone from doing something they do want to do. In this sense I'd argue that the current Exit Q and the culture of communication in the hospital unduly influence this vulnerable group to not *reveal their actual experience of being at the hospital.*

Perhaps the clearest issue coming from this initial piece of research is that because it's so hard to elicit the real experience of older patients a much more human type of dialogue is needed so that they can disclose issues that are either anxiety-provoking in themselves or anxiety-provoking because they are critical of the care they received. It's obvious that 'medical speak' militates against this sort of real communication and is therefore inappropriate.

The Exit Q and the language style of the wards actually seems to manipulate vulnerable older people to give falsely positive reports of their experience in the hospital and, as such, unduly influence those patients to both give positive feedback and to not *give negative feedback.*

As a final note, seeing as we do lag being the US by some 15 years, we may like to look at why we're still talking about person-centred care when in the States this has moved through two further evolutionary phases: firstly in client-led care (because so many litigations sprang from person-centred care not doing what it said on the label) and now into relationship-centred care (which emphasises the importance of real dialogue). We may be able to save ourselves some 10 years of litigations by taking the relationship aspect of care seriously right now.

Phase 5

The ward managers' away day

The HALT project appeared, to date, to have highlighted willingness among staff to provide high quality care for the older person on one hand but, on the other hand, organisational confines – building, evaluation forms, etc. – appeared to restrict what staff felt they could achieve. Also, the passive aggressive behaviour (as we saw it) towards the planned teaching sessions illuminated a darker side. We were more convinced than ever that the voices of the ward staff needed to be heard and a ward

managers' away day was organised to facilitate reflection on how they envisaged attaining the goals they set out to achieve with regard to caring for the older person in an acute general hospital setting. The idea of an away day was introduced to the ward managers prior to the event by one of the modern matrons, who was also involved in the HALT project.

Information provided by the participants present on the day has been included to prevent any interpretation bias on the part of the researchers as their comments tell their own story.

On the day, facilitated by Dr Westwood and Dr Esterhuizen (PE), most of the staff members present were confused about what to expect and some believed they were attending a regular meeting. Many hadn't recalled receiving information about the day. This uncertainty made a space for us to be creative in but also generated some apprehension and scepticism. Before we started introductions, we asked the four groups to each discuss what they would want from the away day. The groups' objectives would then combine with our own to shape the day.

Group 1:

We are very confused about why NMPC has been cancelled and about the hijack...however, we want:

- *Networking*
- *½ hour moan time*
- *Ideas for team building of our teams (that cost nothing but time!!)*
- *Philosophy*
- *Strategy*
- *SMART objectives for the day – time plan*
- *De-stressing (see 2nd point)*

Group 2:

Pub lunch! and coffee breaks
Effective communication
Why are we here?
De-stressing session
Leadership skills
What's happening with MK General?
What's expected of us?
Team building/networking
Understanding different areas
Home 4pm please?

Group 3:

Fun! Not too heavy
Get to know others
Support mechanisms
What do we have in the vision for the hospital
Communication
Leave feeling zippy and motivated
Pub lunch
Work more effectively with others

Group 4:

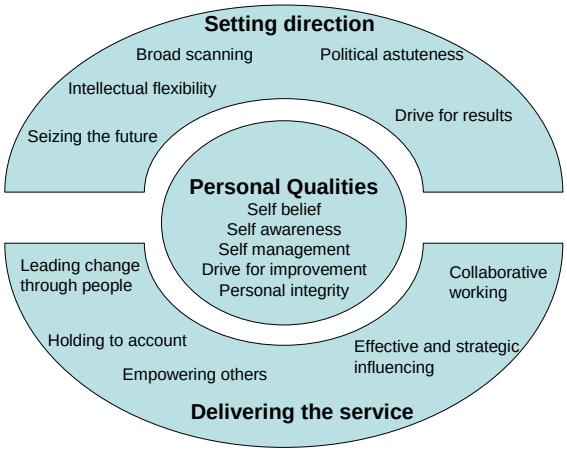
Network with peers
Leadership-improving skills/knowledge
Communication
Ways of improving to promote better care for patients
Dissemination of information
HALT – what it is and how it impacts and influences practice to improve standards on wards
Respect people's views
Group co-operation
Time management
Participation from all group members
Listening to others
Feedback session at end of day to evaluate what you have achieved

We introduced ourselves saying that we were both from Bournemouth University and supported the HALT project, which was about the implementation of the NSF Standard 4, Care of the Older Person in the General Hospital. Because our work on the HALT project had highlighted issues to do with inclusive communication within the hospital, we felt it would be useful to have an away day. In this first instance, our focus was on communication, leadership and philosophy of care.

I (PE) referred to the NHS Leadership Qualities Framework (2006; http://www.nhsleadershipqualities.nhs.uk/portals/0/the_framework.pdf) – see Figure 1 – and indicated that the starting point for managers is the individual's personal qualities; the rationale being that we can't set direction or deliver a service without self knowledge.

Figure 1:

NHS Leadership Qualities Framework



I introduced the concept of *courageous dialogue* (see Figure 2) which I took from the work of an American nurse, Dr Rumay Alexander (2006). She uses this approach for addressing issues of diversity. I related courageous dialogue to the day's objectives.

Figure 2: Courageous Dialogue (Alexander, 2006)

C onfront reality
O therness
U nderstanding
R ules of engagement
A wareness
G enerosity of spirit
E mpathy, empowerment, encouragement
O pportunity to achieve equity/shift power
U nity in community
S tories create critical reflection

D ynamic exchange
I nclusion
A cknowledgement
Learning
O penness
G estalt of forgiveness
U nsettling the grips
E nthusiasm
S ystems change/change management

During introductions, Dr Westwood thanked the first member of the group to talk in a more courageous way and pointed out that this level of sharing was what the day was about. We linked this to the trust values and began to discuss feelings around these and whether we felt that we, and others, enacted them.

Trust Values

- To be open and honest
- To be inclusive and involving and to listen
- To be fair
- To value and treat people with dignity and respect
- To be compassionate and caring
- To strive for excellence in all we do

Following on from this, we asked the (newly re-formed) groups to critique and re-design the trust values.

Group 1:

Values	
Good	**Manage**
1. To celebrate good basic nursing care	Manage poor practice and have support to stamp it out
2. Understand quality, holistic basic care	Things will only change if we enable to and challenge
3. Open and honest is a two-way street. Need a way of maintaining relationships with colleagues	WHAT IS FAIR?
4. Respect needs to work for us. Patients and relatives' behaviour needs to be challenged	
Protect time to experience new things	

Group 2:

- Trust values too woolly and open to individual interpretation
- One statement for values which encompasses a 2-way process at:
    - All levels of organisation
    - With community
- Mission statement should focus on such statements as 'vision', 'excellence', 'celebration'
- Values are everyday behaviours.

We hope you will share with us effective communication channels which are open and honest, to enable everybody to be treated with respect and dignity.

Group 3:

Open and honest:	Relevance Within realms of confidence Boundaries within levels → protection Explanation Ways of communication
Inclusive, involving and listen	Empowering people Ways of communicating Relevance Allow groups to evolve/develop
To be fair	Listen, communication
Value, dignity, respect	(Within) Government targets
Compassion, caring	Care for staff, benefits
Excellence	Celebrate achievements! Say thank you Recognition

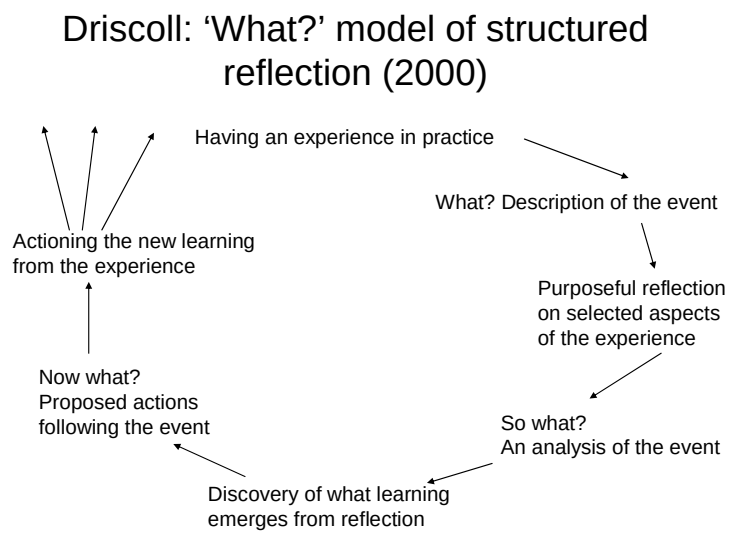
Group 4:

- Do unto others as you would be done by
- Offer praise when it's due
- To be valued, to value ourselves and each other
- Celebrate our achievements
- Acknowledge our difficulties but embrace a no blame culture
- Active involvement in staff support and development
- Ultimately striving for improved patient care.

These re-designed values led us into more feeling-toned discussions. One of the prominent features of these discussions was a sense of helpless or disempowerment. I (PE) suggested that we become aware of this and realise that we have the choice to stay in a negative spiral or to use the situation to our own benefit and to learn from it.

Driscoll's (2000) model supports structured reflection (see Figure 3) and includes a 'So what?' aspect which implies taking some sort of action. Identifying actions for the future allows us to take these forward as individual learning goals arising from a situation we've already experienced and prepares us to face similar situations in the future.

Figure 3



Way forward

We asked the groups to suggest how they, as ward managers, viewed the future and how they thought they could take the development further.

Group 1:

- Build on today
- Revisit existing ward manager meetings:
    - Divisional meetings, NMPC, ward manager meetings
    - Are they duplicated? Make space for change
- Re-establish a cycle of supervision led by:
    - Peer facilitation (free i.e. no costs involved)
    - External facilitation (if free i.e. no costs involved)
    - Internal (appropriate person)
- Outcome – share tools/techniques with teams and staff.

Group 2:

- Monthly meeting/session for ward managers/department managers
- Action learning/clinical supervision (who would facilitate?)
- More visible Director of Nursing – visit wards/departments weekly, come to work within wards/departments when invited
- Re-introduction of monthly newsletter from Director of Nursing.

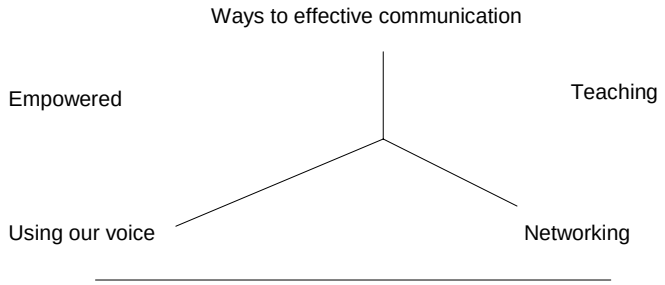
- The need to appreciate staff
- The need to look at communication methods and how cascaded
- Different learning styles required for individual staff
- Meeting different people
- Feeling more positive leaving than felt before coming
- Strong feelings of disempowerment from the group.

Group 3:

- Arrange regular meetings open to any manager junior/senior who wants to participate
- Two/three hours monthly – team building, changing our attitude and behaviour as managers
- Group size 8-10
- (Meetings) away from trust?

- Ideas to motivate staff
- Importance of effective communication
- Networking
- Nice to see everyone
- Nice to just be and to talk freely.

Group 4:



- Celebrating achievements – Value staff
  Disseminate via poster boards in hospital
- Open and honest
- Continue meetings - Develop Support & Unity
  Supervision
  Networking
- Improving Service – Basic Nursing Care

Evaluation of the day

- Got to know different people
- Respect for people's opinions
- Networked
- Positive outcomes: achievable solutions, good ideas
- Feel more supported: safe environment, part of a team, valued
- More aware of different areas and different constraints
- Empowered to make changes.

- I was not looking forward to spending a day being talked at (I was expecting the NMPC) but felt cross that the day had been changed with no prior warning

- I have enjoyed the freedom to talk freely and have benefited from shared experiences. I do feel empowered to look at my work environment and question traditional ways of working; however I am aware that I need to keep the momentum going over the longer term
- Effective communication is a vast issue and the crux of many problems within the Trust. As an area we need to continually review instances of poor communication and learn from them, then put the learning into practice to complete the circle.

- Useful to be able to network
- Useful information given about HALT which I wasn't aware of prior to this session
- I enjoyed the open and honest approach to the day
- Found the ability to set own aims and objectives for the day useful
- As a new arrival to Milton Keynes Trust, enable me to be aware of some of the issues and ideas to improve practice within the Trust
- The sessions were all very useful
- Suggestions for the future: more study time – two days maximum
- Thank you both for a useful session and your time.

- First time attendance to this meeting, good to meet new people
- By midmorning observed majority of colleagues had same views as me
- Discussions were open and honest
- Complete eye-opening session which allowed me to reflect on my role as a manager
- Facilitators were equally open and honest. Didn't find them intimidating.

- There was no prior agenda or clarity to the day's meeting. Perhaps it would have been helpful if we could have brought our own objectives to the group
- A lot of the objectives were discussed with previous G-grade workshops
- We seem to have covered very little ground for a whole day (1) setting objectives, (2) Trust values, (3) Action plan – one hour's work?
- I am disappointed. There is so much going on in the Trust at the moment. Hospital strategies, Foundation Trust status, ward moves and new developments. How about someone telling us about a new clinical or managerial success
- Too much theory not enough meat!

- Overall I found the day interesting

- Hearing the views and feelings of people within the group provoked my line of thought – as in is this the kind of place I wish to work and how can staff be allowed to feel like this?
- I feel this day has uncovered a huge 'can of worms' and one day has not been enough to cover everyone's objectives
- I am pleased that some of the group have mentioned they have found today useful and are leaving more motivated than when they arrived
- On a personal note I am pleased that the group felt comfortable with my presence and it did not prevent stories and feelings being shared
- Thank you for providing us with a thought-provoking day which I have enjoyed.

- Today was not what I thought it was going to be. I believed it was going to be more structured and looking at leadership/ communication. This could have been the way it was communicated to us
- The objectives we set at the beginning of the session were partly met, and I was slightly disappointed that HALT project was not discussed more as at least 75% of the group were unaware of it and it was one of our objectives
- The day has made me more aware of the different learning styles that there are and which ones I prefer. This I can take back to the ward area and be aware of them for my staff when organising teaching sessions
- Setting of the action plan at the end was a positive thing and would like to see some, if not all of it, carried out.

- Today has not been what I thought it would be. But have enjoyed a different type of learning
- I will take away with me to value myself and value my team more; to communicate more effectively
- I enjoyed meeting other people and networking with other wards; listening and talking about experiences.

- Frustrating start to the day – not sure of the direction we were going in with very negative comments. Non-structural approach
- By end, feels some goals are achievable
- Positive network framework established
- All G-grades seem committed to moving forwards and achieving action plans
- More sessions I feel would be very beneficial.

- Objectives met: networking, need for effective communication

- Process was initially confusing, but objectives/goals developed by the end of the day
- Take home points: celebration of achievements, thank yous, the need to meet as a group to facilitate changes we want/need.

Didn't get pub lunch but enjoyed brown butty! Now seriously:

- Felt communication was effective. Generally by facilitators being open we were encouraged to be open too
- Networking was good: got to know people a little better and put a face to name
- Getting to know people will hopefully enable us to trust and support each other a little more in difficult situations e.g. discharge planning
- Feel to have a voice today but a small one in terms of the wider organisation. I'm aware my voice stops others speaking
- I feel much more motivated about my department and the team of G-grades. More empowered to cope with the difficulties outside that box
- Hopefully the reminder to 'own' my feelings from Philip will remind me to stop moaning and 'do' something openly and honestly within my department
- Feel that facilitators enabled very open honest discussion by being vulnerable and honest themselves. Thanks.

- Meeting with others, putting a face to the name, feeling part of the structure
- An opportunity to share with others who have similar concerns
- To feel that the forum is confidential
- This has been an opportunity to gain an understanding of how colleagues work within other areas as well as having an opportunity to share my own values and beliefs
- I am proactive in the need for other forums but am concerned that they just become another time to moan. The meetings need to be structured and to show some evidence of improvement
- It was important to have the time but I feel not enough time to discuss ways forward (not specific ways forward) but appreciate the need to have this opportunity. I hope this is just the beginning
- I valued the input from Philip and Tris and feel that they would be beneficial in helping us to take this forward.

- At the start I was unclear as to why I was here and what was going to be discussed during today's session
- All of the objectives that were set at the beginning of the session were very much achieved

- I have acquired ideas on how to motivate members of staff and have learned therefore about leadership qualities
- Today was a great opportunity for networking. It was nice to discuss with other managers difficulties that we are experiencing on our ward and to offer resolutions to problems that other managers are experiencing
- Having been quite uncertain about why I was here I can now conclude that today has been most beneficial and hope to attend more sessions like this.

- My initial feelings prior to the meeting were that we would discuss and formulate the nursing strategy, a daunting thought that sounded as dry as a ship's biscuit
- When the meeting started it appeared that we had all come for something different and by the end of the day this had truly been the case, but we all got to the end on the same foot eventually
- The whole networking process was good, sharing thoughts, feelings and emotions is always hard but I think everyone was given an opportunity to share
- The Trust's Values exercise was really useful, it's a shame that it can't be re-written and all the views from the floor shared to make it a living, working document – perhaps in time it'll be reviewed and more people will get an opportunity to comment
- I think this has been distressing for some and for me it has also shed light on areas that I needed to clarify in my head!!!
- I, like others, would value the opportunity to meet again and hopefully we will be able to re-establish this in the near future
- Personally I will look at the way I communicate and try to be more of a listener. Thanks for the day.

- I think it was difficult to list objectives for today as it seemed to be quite a 'free' session, plus the confusion felt by many who expected an NMPC meeting. After we had identified objectives, our group's people were quite defensive about the objectives i.e. humour, pubs and moans, but this is because they felt 'trapped' and wary of why we were here
- After the facilitator shared his OHP slides it was clear that he had expectations from us, and it was difficult to work out whose objectives we were meant to meet
- By late morning people were expressing their feelings about disempowerment and being undervalued and common themes emerged. More people felt comfortable to speak out and even talked through the tea break time

- The facilitator used interesting tools and techniques to move the day along, always returning the action to the nurses. It was interesting to observe his use of the personal tense when confronting 'perceived negativity'. It was a tool I may copy in future when appropriate, not for my juniors, but looking ever upwards
- I believe there was true encouragement for nurses to put their heads 'above the parapet' but that had to come from them. It is an uncomfortable place to be, but there is a certain power in group action. I believe we owe it to our juniors and ourselves to carry forward the ideas from today.

- Objective achieved
- Being able to network and getting to know others with the hope of improving and building on this
- Communication: the different ways this can come across and how keeping this 'basic' is achievable and relevant to my job
- Looking at what really matters! And how it can be achieved.

- The fact that the day appeared to be led by us whilst still being managed was great
- We had opportunity to discuss debate, challenge, praise and generally build relationships with people we knew and people we were meeting for the first time
- I had no idea what to expect today, setting objectives and using those was excellent, very clever, as many sessions you are asked to set objectives and after you are given objectives set by the facilitator!!
- If I take away one thing with me it's the realisation that we as ward managers are a powerful force and can empower ourselves to make changes, to better ourselves, our staff and subsequently improve patient care. I have enjoyed the day, thank you.

- As the day wasn't 'structured' traditionally it was quite strange to begin with; as a group we are used to being dictated to
- I feel we met the objectives that were set and have begun to formulate plans for the future. However nothing concrete has come out so I feel another session would be incredibly useful to facilitate the formulation of a group to take forward
- It was refreshing to be able to talk freely and from a more emotional perspective
- The networking was extremely beneficial.

- Objectives were met except for the pub lunch
- Very clever session for the day. All objectives have been met without

us realising it and a cohesion within the group and a way forward has been formed and hopefully we will manage to meet these new objectives as a group and develop and go forward

- A relaxed session once everyone had got over their fears of what the day was about
- No pretensions, able to talk freely and discuss and realise we are all in the same boat but looking at it differently and actually we have achieved a very good day with clear guidance
- Looking forward to meeting up with everyone again.

- Got to know people from other areas
- Had some moan time
- We do have a voice but we need to use it
- We've come up with some useful ideas to take this day forward.

- I felt I didn't really know what was expected of me for today
- I didn't really know where the day was going.

- I feel more supported in that we all have similar problems, views, challenges
- Feel part of the wider hospital – not just own department
- Would definitely like to meet as a group again.

- Networking – meeting others from around the hospital. Recognising mutual problems and difficulties
- What voice do we have in the vision of the hospital – as a group we have a strong voice, through unity and communication
- Team building – as a group networking and resolving to move forward and develop
- Achieved at least half an hour moan time!
- Achieved greater awareness of other areas and difficulties.

- Achieved moan time
- De-stressed
- Got to know different people/areas
- Respected and supported each other
- Open and honest discussion
- Found out about HALT
- Feel more motivated and empowered as individual and group
- Ideas for future – celebrating our achievements/successes
- We must support and value each other much more
- Found the day heavy at times but good leadership to turn around the sessions and make solutions/positive ways to move forward.

Reflections and Findings

As previously indicated, a number of environmental issues identified within the hospital appeared contrary to the ethos of patient-centred care. Further issues had been identified in the approach to evaluating the patients' stay in hospital which supported the assumption that there might be more fundamental issues relating to staff attitude and the relationship between the staff and management that needed to be addressed.

Dr Westwood spent time on a number of allocated wards in an attempt to obtain insight into staff communication. The underlying motivation was to get some sense of how nurses relate to one another and themselves, and how that relatedness works throughout the ward. Furthermore, he wanted to understand what is said about the philosophy of care and the communication between nurses, medics, physiotherapists and other healthcare professionals. He reported as follows:

> *The issue of a ward philosophy became something important some time ago because Philip had identified it as a central focus of having a clearly defined and visible piece of communication that is both doable and that nurses engage with. It's also important in that clients can see it and therefore interact with it regarding their own experiences of how far nurses 'did' the philosophy. Since then I've become interested in the textual event of ward philosophies and see them as a powerful symbol regarding many of the issues I've found so far in this work.*
>
> *I've read most of the ward philosophies in the hospital and have read many on the internet and something has struck me: that they are increasingly termed in a language that I don't believe belongs to, or comes from, nursing. The language and the sense it makes tends to be looking over one shoulder at lawyers and the other at business managers who like to hear the latest buzzwords and have no real connection with what those words might mean beyond being a sign pointing to an 'in word'.*
>
> *Several people have said to me when I asked what they thought about ward philosophies that they don't know who they're written for because they (nurses/student nurses) can't understand them and the patients are very unlikely to understand them. This again says something about the infiltration of a more abstract and 'technologised' (masculine) language into the feminine space of nursing. And we all know*

well enough that this has come from the largely masculine 'sensibilities' within universities now that the academic strand of nursing has become so dominant.

I've become interested in how this abstract or distant (from the grounds of real experience) language interacts with nurses. It is comparable to, in the sense, if people say they feel differently when they speak French to when they speak German. What is the feeling people get of using variants of one language (seeing jargon and elitist language as a distinct dialect)?

I've noticed a distance and brittleness in the relatedness of some nurses and there are doubtlessly many reasons for this but what I find interesting is that 'new' nurses often seem to have a different sensibility towards what being a nurse means. They are also often less practical or, more than that, seem to find the practical aspect of nursing (including real communication) uninteresting or even distasteful. For me this is an outcome of the academic influence within nursing which is nurtured by using particular types of thought/language which are abstract (clean and convenient) and therefore collide with the reality of ill people…and life in general.

Words as actions because they're embodied, and as the strong implication for action:

The analgesia may need to be reviewed

v

She's crying with pain.

Universities are training nurses to think/write/talk like medics, or even worse, academics, and this is creating a distance in their relatedness to themselves as it hinders reflexivity by turning it into an intellectual exercise rather than a 'thinking with your feelings' experience. This distance to self obviously creates a distance to others.

Here are some notes I made in the order I made them re. my last visit[7]*. One of the interesting features is in the first bit and calls for reflection:*

***Idea number 1:** Use a generic ward philosophy (I've seen so many now and there is a fairly generic structure in non-specialist*

[7] In writing this report I've taken the liberty of numbering the issues to promote clarity, but have further kept the text in the original format.

areas in particular) to start a dialogue with nurses re. the issues. What does it mean? How is it doable? Who is it for? Why? Whose language is it? How would patients perceive/ comprehend it? What does it mean to have a ward philosophy that might alienate nurses and patients? What has happened to nursing language?

Idea number 2: *Use the text of the now fairly generic ward philosophy as an enactment of the 'masculinised' language style which nods to the other masculine professions of Law and Business. This generic philosophy (the signs and sounds of masculine preoccupation) would be something we could have dialogues about individually (probably because of nurses' fear of saying 'we can't actually do what we say we are doing on our ward' in front of other staff. Would it be unprofessional to expect them to do this? I had initially thought of a dialogue group responding to the ward philosophy written on a flip chart but there are too many inhibitory factors about doing this – an interesting idea though and even more interesting when viewed in relation to the perceived threats by the staff to articulate their ideas in a 'caring' environment.*

Idea number 3: *Strange that to some extent I have to decontextualise the dialogue about the ward philosophy to make it safe for people. But I understand this and anyway I think the power of doing this with individuals is that it may be an uncomfortable experience and one which they're more likely to enter into privately and in reading/writing rather than speaking. It will cause a tension I reckon and that will likely affect the relationship nurses have with that language style. It will be a good opportunity for nurses to reflect on what a real doing-language might be and about how things currently are getting further away from this.*

So, as a result, ***idea number 4:*** *Ask a selection of nurses to respond in writing to the text of the ward philosophy and then place the philosophy in context to these perceptions in a poster or in the report to create an interesting conversation between experience and theory. This would probably be quite powerful because if people basically deconstruct the language and intention/meaning of such a piece of text with their feeling/thinking experience then we have a collision of two language styles where each language is actually doing and implying different things. This is a short step away from realising*

that some styles of language, and the thinking they encourage, are better than others for particular things.

The issues around communication are a symbol of the current mental health of nursing as a profession and, now that we know it, also imply doing something about these findings. I've already heard enough nurses say, with encouragement, that something has gone badly wrong with nursing, that communication is a big part of that and that somehow people have a different attitude now.

Idea number 5: *Crisis in confidence in nursing – the universities have changed nursing so much that nurses feel so much needed changing and are listening to the loudest voice for guidance, meaning masculine systems. What has happened to the autonomy of nurses? The academics have actually disempowered them by making nursing a theoretical pursuit and making nurses wannabe doctors/academics.*

What was so wrong with nursing that its practice/language/ research has had to be 'edified' by masculine systems of thinking? What is this brittle focus which decontextualises doing? The twilit feminine space whose 'vagueness' isn't about there being little there but about holding on to context with emotional consciousness. It is being hindered and cramped more and more – being filled up with so-called evidence. But, as I see it, not the evidence that nurses obtain from their practice and in their interaction with their patients.

Idea number 6: *Some may say that my writing is 'not real research' because of not using enough jargon, numbers, names – this is what's happened to the frankly descriptive language that nurses used to use more and is what's made quantitative research 'valid' in nursing. 'Good' research is numbers, graphs, technological…decontextual and masculine. Silence is not permission, though, to be dominated by the precepts and habits of the dominant discourse.*

What about the feminised space and consciousness? The vagueness is quiet and unassuming because it's embodied but these qualities lead others to see it as deficient and therefore in need of 'improvement'. The language is becoming more elitist, jargonised and abstract in a futile attempt to prove its credentials (evidence-based practice).

Comments on how my talks with people are open or vague or untechnological (surprise and relief on the part of some of the nurses, but also I think some scepticism about whether I know what I'm doing because I won't dress things up – interesting. They still want the bad medicine despite knowing something's wrong). I want to keep the talks within feminised space and, through reflection on that process, find a way of doing something with this work. Mistrust of feminine space like this with many people – they want hard boundaries and signs – the insidious way language works on people's perceptions/ behaviour. I used a few long words and people looked happier. I felt sad.

Power – the language of power is actually disempowering nurses because nursing isn't a decontextual activity. What we need more is to work on reflexivity to show how much is going on and how many decisions, important decisions, nurses are making every day through thinking with their perceptions/ sensations. We need to highlight this so that this type of knowing can't be demeaned any more or 'improved' by people that make a living out of trying to depersonalise others as much as they themselves are depersonalised.

The revenge of the bureaucrats is to turn nursing into an office job. The more senior (valued) the nurse is, the longer she has to spend on paperwork and this elevates paperwork in importance and so justifies the bureaucrats existence.

Any piece of text like a ward philosophy or job specification will invite a collision of the dominant discourse language style and reality/experience. This being the case; how does the discourse of abstract distance 'train/educate' individuals to be 'good' nurses?

***Idea number 7:** Context – the 'vagueness' of feminine space is as full and potent. Like the way the masculine reductiveness of the Exit Q showed how poor that piece of machinery was at dialoguing with, and receiving, experiential communication. We need*

S P A C E

in those forms (and hence vagueness) in order to make them dialogical. The space is not 'nothing'. On the contrary, all the tick boxes and closed questions are nothing because they don't

represent what the patients are able to share if given the space to do so. We should want to privilege space and spontaneous, implicit, interactive, consciousness – bit of a mouthful, though!

Idea number 8: *Risk – masculine logic tries to eradicate risk with the fantasy of being able to predict things happening in the future. So, we end up removing ourselves from real situations and creating hypothetical ones where prediction can work. The only problem being that if these situations are ones which are supposed to be training people to do practical work there are going to be problems – how many times have we heard that third year nursing students don't know how to measure blood pressures or give injections?*

This regressive conservatism is becoming the textual style of nursing: wholly theoretical, predictive test and the detention without offence of 'DSPD'[8] individuals is a symptom of this movement. But because language and consciousness interact in such implicit and hard to grasp ways we don't see it happening but have an intuition that something's wrong. The irony is that we are getting more distrustful of 'intuition' because it isn't explicit 'fact' and so the means by which we can improve the situation is being diminished through our 'training'. Nursing is being de-feminised (becoming 'efeminate' rather than effeminate – why is there no word with similar meaning to emasculate?).

Idea number 9: *I'm interested in a clear, real and descriptive language – want to tune into that and write it into the new Exit Q which I'll do in collaboration with the two ward managers where I'm observing the interaction on their wards so that it has meaning and then might be properly useful. Depending on the type of ward, the most useful thing might be to have no Exit Q at all.*

This close language describes something and simultaneously describes our own process of experiencing this thing. It is a close and real type of communication which is the food for reflection. The 'clear' and 'irreflexive' descriptions of science don't actually point to close observation but rather to a distance from the self of the writer. How can decontextualised and hypothetical thought be reflexive?

[8] Dangerous People with Severe Personality Disorder.

Idea number 10: *Sisters as embodiment of practical/technical/ theoretical skill. As such, it is time for their views to find their way into policy and regulation that flows from the wards into the offices and universities because there's been too much pollution going the other way.*

Idea number 11: *Freshwater (2000) and Farrell (2001), amongst others, discuss the prevalence of horizontal violence, bullying and harassment in the workplace – all of which can be seen as strategies of maintaining power balances, a status quo and indicates resistance to change. This appears to be in keeping with what occurred with some participants during this programme.*

CONCLUSION

The HALT project has taken a longer, torturous and more unexpected but, hopefully beneficial, route to address the initial aims set out in 2004. Although it would appear that a single definition is lacking or a categorisation of what constitutes 'an older person' is unclear and may marginalise this group of patients even more, the steering group has agreed on a definition they wish to use. It is important that this choice and underlying rationale is disseminated among the ward staff and incorporated into individual ward-related philosophies, developed by the staff. This is an important step in preparing a discussion on the necessity, practicality and viability of *a specific ward for the older person in Milton Keynes General Hospital*. Interestingly, although some staff mentioned the difficulty they had in caring for the older (and especially, the disoriented) patient, none specifically suggested a separate ward for this category of patient.

There have been times throughout the process where there has been raised awareness, and *a focus on the knowledge and skills with regard to caring for the older person* in the hospital. Using information from actual patient complaints and interviews has, sometimes, been shocking to staff and raised their awareness to the plight of the older person. However, some of the information provided by the hospital and discussed in this paper has limitations in that it lacks specific detail (in protection of confidentiality). Furthermore, statistics for complaints made by older patients cannot be compared to those made by patients in other age groups. Nevertheless, the information and discussion does provide insight into areas needing attention and improvement. It is also interesting to establish that the findings from the statistics and interviews with staff and patients are not hugely divergent when compared with the literature.

With the exception of the organisational issues, those areas needing to be addressed can be linked to staff attitude, vision of caring and service, and communication – all of which can be addressed through education, audit and clinical supervision and would not necessarily require a large financial investment. The dialogue and teaching sessions contributed to awareness at the time, if not a lasting change, of *attitude and philosophy of care* among staff with regard to the older person in the acute care setting.

Extra levels of awareness have been uncovered in the course of the project. Possibly the most important being the feeling of *disempowerment*

and powerlessness as experienced by the ward managers during the away day. This mirrors the perception of power imbalance between the older person in the general hospital setting and the staff, as described by the patients and their representatives.

The outcomes of the exit questionnaire evaluation indicating the need for change, and the choice within the organisation not to make radical changes to its format, seem to underscore the perception of inequality. And the investments to construct an educational programme based on the knowledge and skill needs as articulated by the staff and then not to send staff to attend also suggests that initiative and investment are not taken seriously. However, this could also be an indication of passive aggression – a symptom of powerlessness within the organisation.

While the HALT project aimed to introduce, develop and sustain awareness and quality of care for the older person it has, inadvertently, uncovered aspects of the hospital culture related to leadership and management that need to be addressed prior to developing quality of care for the patient. This awareness may prove to be confrontational, uncomfortable and challenging but seems to be symptomatic of two leadership strategies colliding: authoritarianism and inspirational leadership.

There is a choice that needs to be made and both can result in, but have consequences for, the quality of patient care – one will be inclusive while the other exclusive of the patient and their representatives.

Achievements

- Information has been obtained at various times from patient representatives and users with regard to their satisfaction of the service.
- Themes regarding knowledge and skills needed to care for the older person have been identified by staff.
- An interactive programme, based on learning needs analysis of the ward staff, has been developed and presented. This programme includes topics such as medication, communication, culture & ethics, nutrition & continence, mental health, physical & psychological assessment, elder abuse, discharge planning and fall prevention. Those who attended the sessions evaluated them positively.
- Literature has been discussed in relation to the needs perceived by staff, informal interviews with users related to their satisfaction of the service provided, and formal complaints lodged by the age group 66+. This has provided more insight for stimulating discussion with

regard to establishing a specific ward for the older person within the hospital.

- Collaboration with clinical governance has resulted in existing audit instruments being extended to include age which will allow further age-related data to be gathered, analysed and used in management and education within the hospital.

Way Forward

- A change in attitude, philosophy and quality of care is not something that can be evaluated comprehensively in the short term alone. As such, the impact of the HALT (Hearing & Listening Together) project will need to be evaluated over time, incorporating user feedback and satisfaction, staff perspectives, ongoing audit and patient outcomes.
- The ward managers are encouraged to name a champion in each department/ward and will, where necessary, be supported in setting out a plan of action, implementing change and disseminating knowledge in each area.
- Care of the older patient should be visibly linked to the hospital policy of equality and diversity and so prevent a further marginalisation of the older patient within the organisation.
- The training programme underpinning the implementation of the NSF Standard 4 and Essence of Care should mirror the perceived needs of the staff.
- Departments and wards should be stimulated to develop projects specific to their area of work in which they champion equality and diversity among patients in general and the older patient in an acute hospital setting in particular.
- A programme should be developed in the future that focuses on the development of a hospital-wide, multidisciplinary vision of care and clinical supervision used to support the implementation at departmental/ward level.
- At some stage in the future a more detailed investigation should be carried out to (a) identify the specific nature of complaints lodged by older patients and (b) compare the magnitude and nature of the complaints with other age groups.
- It would be advisable to bid for future funding aimed at researching the outcomes and effects of such a project for both users and staff. This would provide the project leaders with time to obtain ethical approval for a research project involving clients and staff.

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Appendix 1

Overview (in percentages) of complaints (n=323) received from the age group 66+ for the year until May 2005

Healthcare Organisation	
Admission delays	21%
Difficulty in getting dentist appointments	5%
Difficulty in getting GP appointments	1%
Treatment delays	2%
Access to specialist treatment	4%
Lack of resources	3%
Availability of NHS treatment	3%
Follow-up treatment	1%
Personal costs of NHS treatment	1%
Medication prescription	2%
Transport problems	3%
Total	**46%**

Nursing	
Lack of care (nursing)	6%
Discharge arrangements	5%
Falls and safety	1%
Total	**12%**

Medical	
Lack of care (medical)	5%
Result delay	1%
Complications	1%
Problems with diagnosis	2%
Inter professional referrals	2%
Total	**11%**

Communication	
Communication in general	6%
Information requests	4%
Confidentiality	1%
Total	**11%**

Record keeping	
Problems with records – errors and accessibility	2%
Lost med notes	2%
Access records	1%
Total	**5%**

General complaints regarding hospital service	
Cleanliness	1%
Infection control	1%
Hospital procedures	1%
Noise	1%
Lost property	2%
Contact details	1%
Out of Hours	1%
General manners and attitude	1%
Service general	2%
Total	**11%**

Positive feedback and advice	
Compliment	2%
Advice - how to complain	2%
Total	**4%**

Appendix 2

Planning for teaching programme – NSF Standard 4 Care of the Elderly in a General Hospital

Date	**Time**	**Content**	**Tutor/ contact number**	**Learning aids**
Tuesday 04/07/2006	09.00-12.00	Communication		
Tuesday 04/07/2006	13.00-16.00	Nutrition		
Thursday 06/07/2006	09.00-12.00	Falls prevention		
Thursday 06/07/2006	13.00-16.00	Physical & psychological assessment		
Monday 10/07/2006	13.00-16.00	Medication		
Friday 14/07/2006	09.00-12.00	Communication		
Friday 14/07/2006	13.00-16.00	Falls prevention		
Monday 17/07/2006	09.00-12.00	Discharge coordination		
Monday 17/07/2006	13.00-16.00	Elder Abuse		

Appendix 3

Lesson Specifications Education Programme

NSF Standard 4 – General hospital care for the older person
COMMUNICATION ISSUES

WHO SHOULD ATTEND

All staff who come into contact with elderly persons in an acute care setting.
(Two dates are set for this session – one targeting clinical staff and the other targeting non-clinical staff. Please be aware of the times and dates.)

REFRESHER TRAINING

This session will be presented as a rolling programme twice a year to allow all staff to attend over a period of time. It is advisable that staff is encouraged to use these sessions as refreshers every two or three years.

COURSE OBJECTIVES

At the end of this session participants will be able to (a) identify age related communication problems such as deafness, sight, etc. and (b) apply methods of dealing with these problems.

COURSE CONTENT

Provide information on age related communication problems.
Identify personal areas of learning linked to age related communication problems.
Discuss methods of dealing with age related communication problems.

NOTE
Is there any paperwork or equipment that staff need to bring.
Are there any pre-requisites to attending this session i.e. prior attendance at another course.
No.

COURSE TRAINER/FACILITATOR

DURATION:

Length of session: 13.00-16.30

COURSE DATES:

LOCATION:

HOW TO BOOK: Please provide details of contact person and number e.g.
Please return your completed booking form to

NSF Standard 4 – general hospital care for the older person
CULTURAL/ETHNIC ISSUES

WHO SHOULD ATTEND

All staff who come into contact with elderly persons in an acute care setting.

REFRESHER TRAINING

This session will be presented as a rolling programme twice a year to allow all staff to attend over a period of time. It is advisable that staff is encouraged to use these sessions as refreshers every two or three years.

COURSE OBJECTIVES

At the end of this session participants will be able to (a) identify cultural and ethnic issues, such as age related norms and values, spirituality and religion and (b) relate these issues to their personal cultural background.

COURSE CONTENT

Provide information on cultural and ethnic issues, such as age related norms and values, spirituality and religion.
Discuss what cultural and ethnic issues mean to the individual and in relation to their personal and professional background.

NOTE
Is there any paperwork or equipment that staff need to bring.
Are there any pre-requisites to attending this session i.e. prior attendance at another course.
No.

COURSE TRAINER/FACILITATOR

DURATION:

Length of session: 13.00-16.30

COURSE DATES:

LOCATION:

HOW TO BOOK: Please provide details of contact person and number e.g.
Please return your completed booking form to

NSF Standard 4 – general hospital care for the older person
MEDICAL AND PHARMACOLOGY RELATED TO MULTI-PATHOLOGY

WHO SHOULD ATTEND
All clinical staff that comes into contact with elderly persons in an acute care setting.

REFRESHER TRAINING
This session will be presented as a rolling programme twice a year to allow all staff to attend over a period of time. It is advisable that staff is encouraged to use these sessions as refreshers every two or three years.

COURSE OBJECTIVES
At the end of this session participants (a) illustrate a basic understanding of medication and pharmacology related to multi-pathology and (b) are able to find the information relevant to their questions.

COURSE CONTENT
Provide information on medication and pharmacology related to multi-pathology and the effect on an older person.
Provide information on where and how to access reliable information.

NOTE
Is there any paperwork or equipment that staff need to bring.
Are there any pre-requisites to attending this session i.e. prior attendance at another course.
No.

COURSE TRAINER/FACILITATOR

DURATION:
Length of session: 13.00-16.30

COURSE DATES:

LOCATION:

HOW TO BOOK: Please provide details of contact person and number e.g.
Please return your completed booking form to

NSF Standard 4 – general hospital care for the older person
MENTAL HEALTH ISSUES

WHO SHOULD ATTEND

All staff who come into contact with elderly persons in an acute care setting.

REFRESHER TRAINING

This session will be presented as a rolling programme twice a year to allow all staff to attend over a period of time. It is advisable that staff is encouraged to use these sessions as refreshers every two or three years.

COURSE OBJECTIVES

At the end of this session participants will be able to (a) identify mental health issues such as confusion, dementia and depression and (b) apply methods of dealing with symptoms such as aggression, restlessness and emotionality.

COURSE CONTENT

Provide information on the signs and symptoms of mental health issues commonly affecting older persons.
Discuss methods of dealing with signs and symptoms of mental health issues commonly affecting older persons.

NOTE
Is there any paperwork or equipment that staff need to bring.
Are there any pre-requisites to attending this session i.e. prior attendance at another course.
No.

COURSE TRAINER/FACILITATOR

DURATION:

Length of session: 13.00-16.30

COURSE DATES:

LOCATION:

HOW TO BOOK: Please provide details of contact person and number e.g.
Please return your completed booking form to

NSF Standard 4 – general hospital care for the older person
FALLS PREVENTION AND MOBILITY ISSUES

WHO SHOULD ATTEND
All clinical staff that come into contact with elderly persons in an acute care setting.

REFRESHER TRAINING
This session will be presented as a rolling programme twice a year to allow all staff to attend over a period of time. It is advisable that staff is encouraged to use these sessions as refreshers every two or three years.

COURSE OBJECTIVES
At the end of this session participants will be able to (a) identify problems related to mobility and falls risks and (b) apply methods of dealing with these problems.

COURSE CONTENT
Provide information on mobility and falls risks and prevention.
Discuss methods of dealing with mobility and falls risks and prevention problems.

NOTE
Is there any paperwork or equipment that staff need to bring.
Are there any pre-requisites to attending this session i.e. prior attendance at another course.
No.

COURSE TRAINER/FACILITATOR

DURATION:
Length of session: 13.00-16.30

COURSE DATES:

LOCATION:

HOW TO BOOK: Please provide details of contact person and number e.g.
Please return your completed booking form to

NSF Standard 4 – general hospital care for the older person
NUTRITION AND CONTINENCE ISSUES

WHO SHOULD ATTEND

All clinical staff that come into contact with elderly persons in an acute care setting.

REFRESHER TRAINING

This session will be presented as a rolling programme twice a year to allow all staff to attend over a period of time. It is advisable that staff is encouraged to use these sessions as refreshers every two or three years.

COURSE OBJECTIVES

This theme covers issues with nutrition and continence.

At the end of this session participants will be able to (a) identify age related nutrition and continence problems and (b) apply methods of dealing with these problems.

COURSE CONTENT

Provide information nutrition and continence.

Identify personal skills linked to age related nutrition and continence problems.

Discuss methods of dealing with nutrition and continence problems.

NOTE

Is there any paperwork or equipment that staff need to bring.

Are there any pre-requisites to attending this session i.e. prior attendance at another course.

No.

COURSE TRAINER/FACILITATOR

DURATION:

Length of session: 13.00-16.30

COURSE DATES:

LOCATION:

HOW TO BOOK: Please provide details of contact person and number e.g.

Please return your completed booking form to

NSF Standard 4 – general hospital care for the older person
PHYSICAL AND PSYCHOLOGICAL ASSESSMENT

WHO SHOULD ATTEND

All clinical staff that comes into contact with elderly persons in an acute care setting.

REFRESHER TRAINING

This session will be presented as a rolling programme twice a year to allow all staff to attend over a period of time. It is advisable that staff is encouraged to use these sessions as refreshers every two or three years.

COURSE OBJECTIVES

At the end of this session participants will be able to (a) undertake a physical and psychological assessment of an older person and (b) identify skills that may need further development.

COURSE CONTENT

Provide information on the physical and psychological assessment of an older person.
Discuss skills needed to undertake a physical and psychological assessment.

NOTE
Is there any paperwork or equipment that staff need to bring.
Are there any pre-requisites to attending this session i.e. prior attendance at another course.
No.

COURSE TRAINER/FACILITATOR

DURATION:

Length of session: 13.00-16.30

COURSE DATES:

LOCATION:

HOW TO BOOK: Please provide details of contact person and number e.g.
Please return your completed booking form to

Appendix 4

Evaluation of the Teaching Programme

Falls Prevention & Mobility Issues

Attended by 10 delegates

Comments made:

- Excellent session perfect balance of theory & practical
- Felt that because I am T&O trained – it was information I already knew – but interesting never the less
- An interesting and informative session, I learnt and enjoyed it.

1. The objectives of the event were clear
   10 strongly agreed
2. The objectives were met
   8 Strongly agreed
   2 Agree
3. The facilitator was effective
   8 Strongly agreed
   2 Agree
4. The delivery methods assisted my learning
   8 Strongly agreed
   1 Agreed
   1 neither agrees nor disagrees
5. The event was adequately demanding
   7 Strongly agree
   2 Agreed
   1 neither agrees nor disagrees
6. The theory sessions were useful
   8 Strongly agrees
   1 Agreed
   1 neither agrees nor disagrees
7. The practical sessions were useful
   9 Strongly agree
   1 neither agrees nor disagrees
8. Attending this event will help me fulfil my role
   8 Strongly agree
   1 Agreed
   1 neither agrees nor disagrees
9. The environment was suitable
   9 Strongly Agree
   1 Agrees

Nutrition & Continence Issues

Attended by 13 delegates

Comments made:

- Maybe red cards at breakfast time so we know who is on red trays and who is not
- Please supply some kind of source after 9pm at Milton Keynes Hospital for patients who are admitted unexpectedly!
- More detail on re-feeding syndrome
- Looking at a typical menu for an elderly person - breakdown of food groups
- I feel the delivery of the presentation could have been more challenging.

1. The objectives of the event were clear
   5 strongly agreed
   8 Agrees
2. The objectives were met
   5 Strongly agreed
   8 Agree
3. The facilitator was effective
   4 Strongly agreed
   7 Agree
   1 neither agrees nor disagrees
4. The delivery methods assisted my learning
   2 Strongly agreed
   7 Agreed
   4 neither agrees nor disagrees
5. The event was adequately demanding
   2 Strongly agree
   5 Agreed
   3 neither agrees nor disagrees
   3 Disagree
6. The theory sessions were useful
   2 Strongly agrees
   9 Agreed
   2 neither agrees nor disagrees
7. The practical sessions were useful
   1 Strongly agree
   3 neither agrees nor disagrees
   1 Disagree
   8 Not Applicable

8. Attending this event will help me fulfil my role
   3 Strongly agree
   8 Agree
   2 neither agrees nor disagrees
9. The environment was suitable
   3 Strongly Agree
   8 Agrees
   2 neither agrees nor disagrees

Communication Issues

Attended by 18 delegates

Comments made:

- Enjoyable session, Found it very helpful and informative.
- Very good session with a lot of valid and interesting points.
- Everyone needs to attend this course

1. The objectives of the event were clear
   10 strongly agreed
   8 Agrees
2. The objectives were met
   8 Strongly agreed
   10 Agree
3. The facilitator was effective
   9 Strongly agreed
   9 Agree
   1 neither agrees nor disagrees
4. The delivery methods assisted my learning
   6 Strongly agreed
   11 Agreed
   1 neither agrees nor disagrees
5. The event was adequately demanding
   7 Strongly agree
   6 Agreed
   5 neither agrees nor disagrees
6. The theory sessions were useful
   6 Strongly agrees
   9 Agreed
   1 neither agrees nor disagrees
   2 Not applicable
7. The practical sessions were useful
   8 Strongly agree
   6 Agreed
   2 neither agrees nor disagrees
   2 Disagree
8. Attending this event will help me fulfil my role
   8 Strongly agree
   6 Agree
   4 neither agrees nor disagrees
9. The environment was suitable
   8 Strongly Agree
   10 Agrees

Medication

Attended by 6 delegates

Comments made:

- Post course objectives +/- reasons for development to ward areas
- I enjoyed the case studies

1. The objectives of the event were clear
   5 strongly agreed
   1 neither agrees nor disagrees
2. The objectives were met
   4 Strongly agreed
   1 Agree
   1 neither agrees nor disagrees
3. The facilitator was effective
   6 Strongly agreed
4. The delivery methods assisted my learning
   5 Strongly agreed
   1 neither agrees nor disagrees
5. The event was adequately demanding
   4 Strongly agree
   1 Agreed
   1 neither agrees nor disagrees
6. The theory sessions were useful
   3 Strongly agrees
   3 Agreed
7. The practical sessions were useful
   1 Strongly agree
   2 Agreed
   1 neither agrees nor disagrees
   2 Not applicable
8. Attending this event will help me fulfil my role
   4 Strongly agree
   2 Agree
9. The environment was suitable
   2 Strongly Agree
   3 Agrees
   1 neither agrees nor disagrees

Physical & Psychological Assessment
Attended by 6 delegates

Comments made:

- Very helpful
- Enjoyed the scenarios
- Very good speaker
- Felt it was balanced in favour of the Physical but I realise Assessment is also the keyword and not how to support these patients through their delirium

1. The objectives of the event were clear
   3 strongly agreed
   3 Agree
2. The objectives were met
   3 Strongly agreed
   3 Agree
3. The facilitator was effective
   3 Strongly agreed
   3 Agree
4. The delivery methods assisted my learning
   3 Strongly agreed
   2 Agree
   1 neither agrees nor disagrees
5. The event was adequately demanding
   3 Strongly agree
   2 Agreed
   1 Disagree
6. The theory sessions were useful
   3 Strongly agrees
   2 Agreed
   1 Not applicable
7. The practical sessions were useful
   2 Strongly agree
   1 Agreed
   1 neither agrees nor disagrees
   2 Not applicable
8. Attending this event will help me fulfil my role
   2 Strongly agree
   3 Agree
   1 Disagree strongly
9. The environment was suitable
   2 Strongly Agree
   2 Agrees
   1 neither agrees nor disagrees
   1 Disagree strongly

Discharge Co-ordinator

Attended by 4 delegates

Comments made:

- Sessions would be ideal over a longer period (full day)
- I would have enjoyed a full day, very interesting

1. The objectives of the event were clear
   2 strongly agreed
   2 Agree
2. The objectives were met
   2 Strongly agreed
   2 Agree
3. The facilitator was effective
   3 Strongly agreed
   1 Agree
4. The delivery methods assisted my learning
   2 Strongly agreed
   2 Agree
5. The event was adequately demanding
   2 Strongly agree
   2 Agreed
6. The theory sessions were useful
   1 Strongly agrees
   2 Agreed
   1 Not applicable
7. The practical sessions were useful
   2 Strongly agree
   2 Agreed
8. Attending this event will help me fulfil my role
   2 Strongly agree
   2 Agree
9. The environment was suitable
   3 Strongly Agree
   1 Agrees

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