The Kings Fund
"The Point of Care"

A report on the findings of qualitative research among healthcare professionals

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By Victoria Wood
vwood@lalawood.com
020 7328 9351

Produced as part of the ***Point of Care: Seeing the Person in the Patient*** report. It contains interviews and focus groups, and the transcripts from the recordings which were analysed to produce this final document.

Contents

Introduction to this report

Background and objectives

The Point of Care is a programme being developed by the King's Fund to help hospitals deliver a continuous, reliably good experience of care to patients and their families. It aims to help hospitals & their staff tackle the problem of dehumanisation and depersonalisation in hospital care and attend to the person inside the patient.

Lala & Wood were commissioned to conduct research across a spectrum of healthcare management, professionals and support staff, to explore the terms and concepts they use to talk about patients' experience and how patients are treated, individually. This learning would provide guidance for the language used in communicating the Point of Care programme.

Specific objectives for this research which are were

- To investigate the language hospital staff use about patients' experience in hospital
- To investigate how the language and terminology varies between groups (profession/job title, status, age, etc)
- To explore with members of staff their own feelings about language currently in use which describes the patient and their experience of care

During the course of the project, it emerged from talking to those who are responsible for providing healthcare services that the way The Point of Care programme is presented may be critical to its successful implementation. Potential issues which may influence its acceptance by the healthcare population are therefore discussed in the second part of this report.

The Point of Care
Part 1: The Language of Care

The meaning of 'care'

Before venturing into any discussion about the language of 'care', or identification of language that might most effectively communicate a programme of change to improve the patient's experience, the first step was to define the concept we wished to communicate.

It was immediately apparent at the start of most interviews that this was not a simple task: when asked what language they used to describe good practise in care, in terms of a good experience for the patient, most respondents either gave examples of interventions that were considered good care, rather than defining terms, or simply stated that there was no language in common use in their particular spheres of healthcare.

The variation in the responses of those who did attempt a definition revealed the lack of clarity on this issue:

"Errr.... the process by which someone's needs are met?"
(Senior clinician)

"I think caring is about more than just meeting the needs - there are a lot of things you'd like, as a patient, that aren't just needs"
(Senior clinician)

"Difficult. Abandon the need to 'do' things, and be comfortable with loss of control. Then you'll find you can do a much better job"
(Trust director)

"There's getting a job done, and there's getting a job done with caring. It implies a quality to what you do"
(Associated healthcare professional)

"To me it goes beyond the technical delivery - it's the way it's delivered, with humanity and sensitivity"
(Trust director)

As the subject was probed further, and respondents asked how they had been taught or trained in terms of delivering a good experience for the patient, what was taught nowadays, or what was policy in their departments, many agreed that this aspect of patient care is not formalised: 'care' is not taught as such, and the principle of ensuring a good patient experience is not formally prioritised or discussed, hence there is no apparent universally recognised language.

"I can honestly say I've not had any conversation with a senior about the concept"
(Junior doctor)

"It's not discussed as an aim. It tends to be discussed only after things have gone wrong. We talk about what we could have done better, but it's not necessarily focused on the patient!""
(Therapist)

Most learned merely by example, observing skilled practitioners:

"I think you learn it more if you see someone who has that attitude"
(Junior doctor)

In fact, the only respondent who described highly developed, systemised but undoubtedly effective techniques for ensuring she always delivered the best possible experience to those she dealt with, had received this training when she had worked in a bank, prior to her career in healthcare.

Conversely, some doctors regretted that caring was not nearer the top of the agenda for some of their colleagues:

"I worked with a consultant here who said, actually they are not interested in the person at all - they're interested in the body, and actually it's an inconvenience to know the person and treat the human being"
(Therapist)

"They tell you to harden yourself up, and detach yourself from the patients"

"One of our colleagues was told she cares TOO MUCH about the patients, and if she carries on that way, she's going to run into trouble!"
(Junior doctors)

However, all respondents here felt they instinctively recognised good quality care, and also, could tell when it was absent, and all believed it was informally or subconsciously always a personal aim to ensure their patients had a good experience alongside a positive outcome:

"You couldn't do this job if you didn't care"

Two perspectives on 'care'

An initial source of confusion, when introducing the concept of 'The Point of Care', was that there are different interpretations of what is meant by 'care'.

Many respondents commented that a successful clinical outcome could be delivered 'uncaringly', and that a patient could leave hospital successfully treated but also having had an unpleasant or dehumanising experience in the process.

Two perspectives on 'care' were perceived here:

- one; care as a protocol or pathway, i.e. a series of interventions leading to an outcome, and
- two, care as an attitude in which those procedures are delivered.

Perspective 1. Some illustrations of care as an intervention

"My grandmother had a care package, which meant that the carers came in for 15mins 3 times a day to give her medication, change her and put her on the commode – whether or not she needed to go! And that's your 'care' package!"

"There is a tendency for people to kill with kindness - there's a tendency for families to think that TLC will get granny better - I'm afraid that doesn't happen - I'm a bully - in the nicest possible way!"
(Doctor)

"A lot of doctors say, I've got to give antibiotics because my patients expect it! That's rubbish! They'd rather their GP explained that they don't need them!"
(Trust director)

"They might want to lie in bed, but that is obviously detrimental to their care so you have to say, 'You've got to get up now'. But patients sometimes see the less confident nurses who let them lie there as the 'caring' ones"
(Nurse)

" We've become very paperwork-obsessed. Set on achieving targets and looking good. And the 'care' is actually equated to the paperwork being filled in properly, rather than the care you're giving the patient at the time!"

"Something that's done TO somebody"
(Therapist)

"Some doctors feel they've got to DO something, because without 'doing', they feel impotent"
(Trust director)

"In those days, you were a doctor in a white coat, and you asked questions, did a history, test, diagnose, treat and discharge. That was care"
(Trust director)

Perspective 2. Some illustrations of a caring as an attitude

"If you ask all patients what was good, they say, 'oh, the staff were so friendly!' Sometimes you just need a friendly face"
(Nurse)

"Care has a feeling of gentleness to it which I like - not necessarily of speed. Well it could do, but putting the patient first at the same time"
(Trust director)

"The whole patient experience- quite often we talk about clinical care - but in the Trust, we're trying to have a much more holistic use of the word care - the compassionate way, the dignity, treating someone as a human being.
(Trust director)

"Remembering dignity - examining the patient without exposing their bottom to the rest of the ward!"
(Trust director)

"Put yourself in the shoes of the patient - you've come to the clinic for the first time cos you've noticed your eyesight deteriorating - you don't want to hear 'there's no point fixing your eyes' with no further explanation"
(Doctor)

"It's to do with body language and the way people touch each other - some people touch patients as though they're a piece of rag, but other people touch in a way that is sensitive, and realises that's a person in the bed"
(Therapist)

"I think communication is part of caring really, even if someone's just got 2 minutes to talk to you"
(Junior doctor)

"Patients don't want to sit in an outpatient clinic for 2 hours to see someone stare at a computer and not talk to them. My patients put up with a 2 hour wait coz they know they'll be communicated with - if they understand why they're waiting, they really don't mind"
(Doctor)

"There's no point in a doctor or a nurse thinking they understand what a patient wants, without putting themselves in the position of finding out and allowing the patient to tell them"
(Trust Director)

"When you look at complaint forms, we've had 3 in the last six months saying, 'and they didn't even get to wash me until 3pm'. The usual answer is 'nobody's ever died from not having a wash', but it might not be a priority to us, but to the patient, that's what they consider care"
(Nurse)

"Care is not necessarily giving them treatment. They might have just wanted a hand with a wash, or giving them a towel, or just a chat! So they know you're there for them – they might not need any hands-on at that particular point"
(Nurse)

"They come out saying, 'oh they did this and they did that, they were fantastic'. Perhaps they ***had*** *to do those things, but the person comes out of hospital thinking, 'somebody was KIND to me"*
(Ward clerk)

"A friend of mine who was in hospital felt like he was on a conveyor belt. Then he happened to mention to the consultant that he was a concert pianist, and the attitude of the consultant changed immediately - he couldn't give him enough information"
(Therapist)

"Understanding what the patients are experiencing when they come in"
(Therapist)

"When they come in, they can stand there and just absolutely cry. They're frightened"
(Care assistant)

"You have to sit down and talk to them. It's no good when they say 'What's going to happen to me now?' and you're walking out of the room to rush to do something else"
(Nurse)

""Sometimes I think the patients feel more comfortable talking to us than they do to the nurses or the doctors - sometimes an old bloke will say to be 'I haven't understood a word that doctor's just told me, coz he's talking too technical', so you go back to the doctor and ask"
(Porter)

"They want to tell you their life stories – you may have phones ringing, but you've got to sort them out, because if you don't, that patient is going to think 'she's not interested in me'"
(Ward clerk)

This sense of duty towards the patient, and ability to cope in all circumstances, often appeared to be built on a very sensitive understanding of the patient's frame of mind, (and in many cases, a much needed sense of humour), as was shown particularly clearly in the examples some of the support staff gave:

"Sometimes they tell you things you shouldn't really know, but you've got to listen!"
(Care assistant)

"They seem to change as soon as they come into hospital. Sometimes they say 'shall I get my pyjamas on' straight away – and they've come on the bus! But they think they're 'poorly', so they want to get their pyjamas on and get into bed – and you have to say to them they don't need to!"
(Ward clerk)

"They want to be pampered, like it's a hotel, or they assume they're on their deathbeds. One day I was asked to go up and collect a patient for X-ray because he couldn't walk and needed a wheelchair. When I got to the ward he wasn't there – I was told, 'Oh he's not here mate – he's just gone down to 'B' floor for a cigarette!"
(Porter)

"Sometimes you get older people that think nobody knows they're in here, you say 'would you like a cup of tea?' and they throw it back at you saying, 'never mind tea! Does my son know I'm in here?', and sometimes they think their food is poisoned and you're trying to kill them"
(Ward domestic)

"We get quite a lot of drug addicts and you've got to respect that person, however much you might be looking at them and thinking, 'how can this happen?' – you've still got to treat that person the same as the old lady next door who's never been in trouble in her life"
(Ward domestic)

"Even when they're being really aggressive and throwing things, it is hard, but you can understand if they've had some bad news and they have to take their temper out on someone"
(Ward clerk)

"One of the ways I've found of dealing with it on reception is saying 'What can I do for you now?" – it's the word 'I' – if I let them know I'm doing my best, and ask them 'Is it Ok ….?", you've asked their permission, and once they say 'Yes', you've shown them we're there for them, and dealing with it as best we can, and they're quite calm about it"
(Receptionist)

"A lot of people say, you're not supposed to get involved. but it's human nature – you can't help trying to get involved if somebody's in distress. You can't just turn a blind eye. That's what we've come in to do"
(Ward domestic)

The sense of 'care' for which we were seeking language was the second sense above, the one which everyone felt determines a good experience, and that is the attitude of the healthcare workers and system to which the patient is exposed in the course of treatment.

All respondents here, as shown in the comments above, demonstrated an understanding of the fact that the way a person is treated in hospital is critical to their perception of the experience.

Describing a caring attitude

For the reasons already discussed above, a caring attitude was found to be much easier for respondents to conceptualise and define than the more abstract idea of good 'care'. A number of attributes and concepts emerged in discussion, such as

Respect
Dignity
Communication
Sensitivity
Understanding
Compassion
Gentleness
Welcome
Thank you
Relationship
Kindness
Human
Friendliness
Comfort
Smile

Many respondents described a similar piece of advice they had been given or gave to others to ensure the delivery of good care, which was to regard the patient as though they were a member of your own family and treat them accordingly.

"Walking in someone else's shoes: how would I feel? How would my family feel?"
(Nurse)

"If you think of your own mum, you'll not go far wrong"
(Care assistant)

"I think you can respect people but not empathise with them - and they may not have the best experience as a result"
(Doctor)

Empathy

Essentially all advice and examples of good care could be reduced to one concept: empathy. All agreed that empathy for the patient, in the systems the patient encounters on their journey through hospital, and in the delivery of care by the individual, is vital in delivering what a patient would regard as a 'caring' experience – whether or not they are able to appreciate it at the time:

"My cousin said to me, he's not my dad any more - what we've got to remember is it's the illness we're looking after, not my dad. I think often we don't recognise it's the pain that's making people the way they are, and that's NOT the person"
(Nurse)

"You are the first in line - and if they've not had a very good night, they might be swearing at you"
(Ward domestic)

"Once that person steps over the threshold they're a different person - it's about understanding that they're scared"
(Hospital receptionist)

Some illustrations of lack of empathy in the patient's needs

"On surgical ward rounds there's a lot of talking over them, and the patient may have heard things they don't understand. But patients often don't want to be any trouble, and if you look busy, they don't like to ask. And ward rounds happen at a time of day when there's never any family there to ask for them"
(Junior doctor)

"When I was on a postnatal ward having had my baby, I remember waking up the next morning and thinking 'I'm starving' and wanting breakfast, but the nurses were so busy and I didn't want to bother them – they just stuck their heads round the door and said 'anything for pain?' and closed it again – but it turned out later that they were supposed to tell me that all I had to do was go down the corridor to the breakfast room!"
('Clinician')

"The way nurses talk and the words they use... we had a patient who was unbelievably anxious – it was just routine surgery for us, but there were three incident report forms on the desk because of her bad behaviour – kicking off that the nurses didn't care! Somebody had said to her that she was obviously frightened and upset, and she took that as an insult. Her husband told us she's a really nervy person, but by the end of the day he was saying how much she'd improved, and she was saying how much better she felt.
And actually nothing was any different – nothing had changed, but some more senior nurses had talked to her again and used different words"
(Nurse)

"We get patients coming in our ward who don't know what they're coming in for! You say, well did they not explain it to you?' and they say, well no, I've never been in hospital before and I didn't understand a word they said'. And that's WRONG!"
(Care assistant)

Thus, the basis of good care, and the key to the communication and successful realisation of The Point of Care, was expressed most effectively in the idea of empathy.

Terms in current use

The discussions highlighted that it is important to achieve precision and clarity in the choice of language to convey a new and important programme. Currently there is ambiguity, particularly in relation to approaches to patient care and ways of ensuring positive experiences of treatment.

"It's amazing how often you can be having a dialogue with someone, and you ask them what they think they've been discussing, and it turns out they've been discussing something quite different!

Because their understanding of that term is something quite different to mine"
(Trust Director)

The reason for this ambiguity was twofold. One was that some terms here are vague and imprecise and therefore easily misinterpreted, particularly if they are not widely used. But the other reason is that people's roles and priorities at work inevitably give them different perspectives on certain terms.

Different perspectives and language according to job function

Most here had a strong sense of teamwork, and awareness of their own role within their organisation and within the patient's pathway of care. However, at the same time was an almost paradoxical sense of isolation and lack of empathy from and for others, perhaps because of current stresses on time and resources which apparently tended to minimise inter-department communication. As this led some to suspect others don't have the same perspective or understanding of one's own particular challenges, language which seemed to be that of 'others' could be confusing or even alienating, and too easily dismissed.

Across the sample, the jobs of respondents interviewed tended to belong to groups with one of three predominant objectives:

- clinical outcome (e.g. doctor)
- support for the patient (e.g. care assistant)
- management of the organisation (e.g. director of Trust)

The main exception to this was the nursing role, which had the dual tasks of a good clinical outcome whilst providing as good as possible an experience for the patient.

Each group of employee types often preferred – or indeed disliked – language that they strongly associated with a particular group, as will be seen in the examples below, depending on how closely it reflected or supported their own view.

Therefore, it is vital to have a commonly recognisable language for the Point of Care, which all understand and can respond to.

Discussion of some key terms in current use

Key terms discussed

- **customer, client or patient**
- **basic care**
- **patient centred or person centred care**
- **personalised care**
- **dignity**

Customer, client or patient?

Describing patients as 'customers' provoked some derision among most of those on the clinical side. Only some of the youngest most newly qualified doctors, along with those in management, recognised the free market principles implicit in this term as being a driving force in improving the patient experience in hospitals, i.e. patient has a good experience at that hospital, and tells others; more patients use that hospital, more revenue is generated by and for the hospital, and hence, better quality of care can be delivered.

Hospital managers in particular broadly approved and agreed with the principle behind the term, and felt it was helpful to adopt a customer focus and customer care approach, in the context of patient choice.

"We try very hard here to recognise patient choice – they can choose NOT to come here, so I'd expect good quality customer relations, as in any organisation, because we want people to choose us"
(Trust director)

Many explained that the complaints they received from patients were usually to do with a poor experience, rather than any issues with the quality of the interventions they had received.

*"I read every single complaint that comes into the Trust, and a recurring theme there is people feeling that they're a cog in the wheel, that not enough **time** is given to the reassurance and the explanation"*
(Trust director)

However, they predicted (correctly with respect to these findings) that this language would not be right for the entire audience of clinicians because of its impersonal tone:

"I don't think you can call an individual person a customer but in a collective sense, e.g. customer experience, its not inappropriate"
(Trust director)

Some of the doctors and nurses disliked the commercial implications of the term

"I'd say it's shocking, because the customer's always right! And they're not! You relate it to going shopping. And in all the shops, there's not a lot of courtesy."
(Nurse)

"It's not right, because the majority of patients don't actually want choice because they don't know enough or can't make a choice in a confused and vulnerable state. So they still say, 'what do you think?' or 'Tell me what's best'"
(Nurse)

But they acknowledged that there is often a difference in the attitude of someone who's paying for the service or attending a hospital in a well-served area where there are other options, who knows they have a choice, compared to a person who cannot exercise any choice, and sensitivity to this might be reflected in (and be driven by) remuneration for good performance in this area:

"If you thought patients' assessments of our performance were important to our career progression, you'd sit up and take notice!"
(Junior doctor)

However, most other clinical, i.e. patient-facing, staff objected to the use of the word 'customer' because it so strongly implied a different attitude to patients, and many were cynical or even affronted at the implication that they were being told to regard their patients in a different way. Most doctors and nurses were inclined to reject such a term, and some even saw its use as a potential insult because of the implications behind the assumption that the purpose of adopting this term was to modify their attitudes or behaviour:

"They'll be asking us to say 'have a nice day' next!"
(Nurse)

"Customer? Absolutely not! That would really annoy me"

"Customers is British Rail really"

"The customer demanding something isn't the basis of good care. Care is a 2-way process – allowing patients to say what they want and what's frightening them, and then using your skill to give them the best possible outcome"
(Doctors)

"It makes it sound like there's no care either way. Your just giving them something and they're taking. There's no relationship in a 'customer'"
(Nurse)

The term customer also implied an imbalance in the relationship between the patient and the care provider. Some found the suggestion of subservience to the patient mildly distasteful, whereas others found the term disrespectful to the patient.

"They don't come in with barcodes on!"
(Trust director)

This was important, because many believed so strongly in the principle of mutual respect as the basis of good care and a good experience for the patient.

"Doctors often complain about 'the difficult patient'. Maybe the doctor's difficult, the nurse is difficult, it may be a difficult situation, but it's NOT one or the other, it's more complex than that"
(Doctor)

"The care bit is not in an ego-driven way, where a doctor or nurse knows best, but creating an atmosphere where people are comfortable enough to tell you what's really important"
(Trust director)

Among support staff, individual ego was less of a reason for rejecting this term than concern to show respect for the patient, and on this level, their responses were highly emotive:

"Oooh - that's WRONG!"

"Imagine people going into theatre and saying to the surgeon, 'your next customer's 'ere!"

Associated professionals accepted the term on an intellectual level, understanding the rationale for its use. But their response spanned the opposing views of management and clinicians: it was not necessarily more 'caring' – and therefore, it was by no means certain that it would engender the caring attitude intended by The Point of Care:

"By moving toward a more businessy model are we moving away from 'caring'?"

Client

This term was regarded by management as an outdated term, but it was familiar to doctors, and known still to be used by consultants, and local authorities, but was not seen to be meaningful or helpful to the debate on improving the patient's experience.

Support staff too had heard the word used by consultants, but considered it was also an inappropriate term in this context:

"Seems a bit uncaring - you'd have a client come in for a loan"

However, associated professionals were the ones who disliked it the most. For them, this was a more distasteful term than 'customer', implying business, 'conveyer belt', fast pace - and profit.

"It's the same feel as we're getting these days from discharge planning, which I think makes the hospital feel like a hotel: you're a client, booked in for three nights only!" That's not caring"
(Therapist)

Patient

The preferred term overall was therefore the traditional, familiar and unambiguous 'patient'.

Many firmly supported the term as it gave the people/customers/clients a special and universally understood status, particularly compared to the neutral term 'people':

"They're not 'people' - they're a special type of people because they're here for treatment"
(Doctor)

"When they come to us, they are patients with a clinical need for treatment – it's a recognition that they are unwell, vulnerable, possibly fearful. That is why it's important to have that distinct term – because you can miss so much of the vulnerability if you forget that they are patients"
(Trust director)

"Ultimately - it is about somebody who's sick, and you can't get away from that in the whole notion of care"
(Therapist)

More importantly, in the view of the associated professionals, the term 'patient' engenders 'caring' in a way that 'customer' doesn't:

"We do talk a lot about the patient's experience - what feels better for the patient. But would you be saying 'what feels better for the customer?!"

Basic Care

Basic care was a term which was open to misinterpretation, and rejection, depending on the context in which it was heard or understood.

Associated professionals perceived two meanings. One was the traditional, common sense aspects of nursing care - the 'Florence Nightingale' approach - i.e. what **should** be happening to every patient to avoid neglect and ensure a good experience. The other interpretation was simply 'the bare minimum', i.e. a phrase which would not convey to everyone who heard it the intended idea of a good patient experience.

Nursing staff perceived the term 'basic care' as literally the foundation for the whole experience for the patient:

"The most important bit!"

Not only was it important to get the basics of care right, but this then gave them the opportunity of talking and developing a relationship and empathy with the patient:

"The vital part of what we do - and if you've done the care, you learn about the patient"

Some members of management took a similar view:

"There is a phrase drawn from the nursing world which is 'The essence of care', which is a whole suite of tools which add up to how the essence of care is fulfilled. I think that's a better way of expressing 'basic care'"
(Trust director)

Perhaps not surprisingly, doctors did not see this as their domain:

"Implies the unpleasant bits of nursing!"
(Junior doctor)

The support staff interpreted it in this second way, and objected to this as a guideline for good care, as 'basic' means 'no frills', yet they clearly added a lot of extra value to the experiences of their patients.

Person- or patient- centred care

Reaction to this term was interesting, given that it might appear to be a particularly straightforward term. Aside from the preference for the term patient already discussed, there was no distinction between 'person-centred' and 'patient-centred', the focus being on 'centred'.

Management tended to find it unhelpful as a guideline, as it is vague and gives no suggestion as to how good care might be delivered.

"I don't think that's what people want to tap into. It doesn't take them onto a different thinking, of well, how do we do it?"
(Trust director)

"I don't like patient-centric or customer-centric. It seems very businessy, and doesn't give you a sense of a mission"
(Trust director)

"It doesn't make me want to get out of bed every morning because I want to be more patient-centred'
(Trust director)

"It's become a completely devalued phrase, because it's been tarted around for so long. And what does it mean? It means a patient-led NHS. What does that mean? It means nothing, unless there's genuine interest and understanding that the patient and their carers should be a the heart of everything you do"
(Trust director)

"Yes, I'm guilty of using 'patient-centred', but I think a simpler way is 'Putting patients first' or 'what's right for patients rather than the organisation'"
(Trust director)

As language, some also felt it had a suggestion of selfishness, i.e. encouraging patients to believe they can demand whatever they want, whenever they want it, and whatever the cost! It failed to acknowledge the patient/provider partnership, especially sensitive where they were already concerned about the issue of stretched resources and of educating patients about the value of these resources, and in their responsibilities to use them wisely.

"A percentage of our outpatient appointments are wasted because people don't turn up – there's an opportunity cost lost, and if we could encourage patients not to treat the service like a free good, that means we can care for more patients"

"They see it as a FREE service, and treat it as such, not bothering to turn up for appointments and so on, and it's NOT free - it's a precious resource"
(Trust directors)

Some could see therefore that a 'patient-centred' philosophy would tolerate this behaviour and, if widely known, would invite the response from patients that the service was theirs to treat as they liked!

Some managers also saw the inherent difficulties in this against the realities of having to make the best of available resources, which may sometimes mean prioritising one patient's needs over another:

"What about if you have a dilemma? We live in a world of finite resources and have to make decisions we perhaps wouldn't make with more money. We can't be all things to all people, but we can explain why we've made those decisions"
(Trust director)

Although many were strongly predisposed to instilling commercial-style customer service disciplines in hospital culture to ensure all staff realised that patients had the choice to go elsewhere if they did not receive good experiences, they also felt that tonally, this phrase had a sense of indulgence, which many already stretched workers would resent.

Among doctors there were different reactions. More recently qualified doctors tended to accept this as a positive phrase, but older ones, and nurses, dismissed it as 'jargon'.

"Terms like personalised care I find are bandied round in admin corridors by people who haven't frankly got a clue what it means"
(Doctor)

"A lot of it comes down from nursing management - people that put policies and procedures together - it's their terminology"
(Nurse)

At best, it was too idealistic: laudable ambition,

'What I came into nursing expecting to be doing'

but (they suspected), totally idealistic and unrealistic in today's climate.

Support staff were the most dismissive of this term. Most of the group were unaware of it, and viewed it as meaningless jargon,

"One of them words that's been brought out to sound a bit more than it is. Like what a boardroom would come up with. Not a hospital word"

Personalised care

Reaction to this term was perhaps surprisingly muted.

Almost all Trust executives disliked this term; they felt it had become devalued and was now meaningless.

"You could probably come up with 50 definitions of what it may be"
(Trust director)

One explained that he did not feel personalisation per se was the route to excellence

"I don't care if it's personalised or exactly the same as everyone else's if it's good"

In the context of our discussion in presenting a care programme, it did not convey the importance of empathy.

Doctors felt this term was not used commonly as it did not serve any really useful function, some even describing it as a platitude.

"Strikes me as like a lot of terms that are comfortable and say what we're doing - but don't say a lot"

Therapists felt that this was one of the terms that doesn't imply 'caring' and is therefore of little value in promoting the idea of empathy so central to the Point of Care: they felt that personalised care could be totally mechanical delivery of a care pathway, without any reference to the manner in which patients were treated.

Among nursing staff there was some awareness of this term, but it was described as *'a catchphrase'* rather than a helpful or meaningful term for a recognised aim, i.e. it was not central to their understanding of good care.

"Sometimes, these things are the buzz word of the moment. Like protected meal times. It's like ticking the box, 'oh yes, we've done that, done that' – so we care!"

The responses of the support staff agreed with this. They were uncertain of its meaning, assuming it referred to dealing with individual needs, although in common with the associated healthcare professionals, they felt care could be personalised, i.e. tailored to an individual's requirements, without any humanity being apparent.

Dignity

Dignity was regarded as a very important term in any description of principles of good patient care. However, it was regarded by all as just one aspect of a good experience of care, and so insufficient on its own as a guideline.

Support staff saw it as an idea they recognised and aimed to achieve e.g. respecting privacy by ensuring curtains are properly drawn around a patient's bed, but some members of management recognised that citing dignity as the main objective would not guarantee that the hospital experience would always be as intended, because they felt it was quite possible to treat patients with dignity but without an underlying caring attitude - e.g. ensuring the curtains are properly closed around a bed to give a patient privacy, but then dealing with them in an impersonal or perfunctory manner. *"Were the curtains closed? check."*

Some doctors agreed with this, explaining that even if the curtains are closed around a patient's bed, this does not guarantee privacy, and therefore dignity, as they don't also block out sound:

"Everyone can hear everything on ward rounds. The effect of a curtain pulled round is just to make everyone else in the bay listen a bit harder!"
(Junior doctor)

Doctors and nurses considered dignity a powerful and important term, but heard mainly in relation to end of life, and therefore not the whole story in care –

"There's a lot to care that isn't encompassed by dignity - like making sure they've got the food they like"

A hospital porter echoed this view:

"When you take a body away, you've got to make sure the entire ward is covered up – you can't let other families see you wheeling a body out. And it might be a dead person, but it's still ***a person*** *and you've got to show care for them. Dignity and respect go hand in hand"*

Associated healthcare professionals summed it up by seeing dignity as a key word inherent in good care, but alongside and complementary to others, such as humanity, respect and empathy.

"It's almost like you're putting together a coat of arms with all the values: dignity, humanity, respect and empathy"

Language and meaning preferred by all

The findings above show how universally recognised 'human' values and language were key to a programme concerned with restoring humanity to the experience for hospital patients, and were preferred by all, whatever their specialisation or perspective.

They also show how important it is to have a common language, otherwise it is too easy to dismiss the new programme as 'not aimed at me', as competing factions were a potential obstacle.

Dignity was a strong but specific word, useful as part of the lexicon but insufficient alone to encompass the principle of The Point of Care.

The term 'empathy' was preferred, as it was the most recognised and accurate expression of what all respondents felt lay at the heart of the best experience for the patient: often expressed as treating them as though they were members of your own family.

The term 'patient' itself was still very much preferred to customer or client. The patient is the focus for all, whether dealing with them directly or not, though not by making staff subservient, as is implied in 'customer'; the concept of partnership in the delivery of healthcare was very important for some.

Phrases that were deemed 'corporate speak', i.e. platitudes or jargon devised for effect, e.g. 'patient-centred', 'personalised care' etc. were disliked almost universally, for their tone if not for their meaning. Such a tone is suggestive of 'corporate' objectives (time, targets, etc) which removes the humanitarian element and focuses on delivery to the most profitable segments (i.e. those with most influence and/or financial power) and is still felt by many to be contrary to the spirit of the NHS, i.e. providing healthcare to anyone who is in need of it.

The Point of Care
Part 2: Issues to consider in effecting change

"As medical staff, we all know what good care is - it's just that we haven't got time to do it!"
(Nurse)

Throughout the exploration of language, although engaged in the debate, many respondents revealed underlying unease about the prospects for its application, and this second part of this report is concerned with discussion of some of the issues raised.

The aims of The Point of Care

The aims of the Point of Care programme were presented to respondents as essentially:

"*...to achieve improvement in patients' experience of hospital care, developing and testing interventions that will help* ***hospital staff*** *attend to the person inside the patient.*

The aim is to help ***hospitals*** *deliver a continuously reliable good experience of care to patients and their families"*

With reference to the role of hospital staff, a central fact which quickly became apparent, and which must not be underestimated here, is that everyone here who dealt with patients in any capacity already regarded themselves as 'caring', and indeed their motivation – and in some cases main reward – was delivering the best care they could to their patients.

Thus, three issues emerged here which could be important in successful implementation of the programme:

1. Who owns the task of embedding 'caring' into hospital culture: staff or 'system'?

2. Potential obstacles to its acceptance

3. Engaging staff in the process

Ownership of the task: staff or system?

An exploration of language implies that there is a need to communicate a particular message, which in turn, suggests it is aimed at modifying individuals' behaviour.

It is doubtful if there was one person in any patient facing role interviewed here who would not have described themselves as a 'caring' person. Therefore, it was difficult for some initially to envisage a programme designed to improve 'the experience of care' for the patient by improving the quality of care which they delivered. In fact it would not be inaccurate to describe the situation as that the majority felt that they were delivering their very best in the face of adversity.

There were many examples and anecdotes relating to 'the system' and the way it works, to support this, but underlying all were the themes of underfunding and pressure on time and resources, and a sense that all were battling to maintain standards:

"You wouldn't be allowed to get into a state where we had 100 patients between 3 of us, if 'people' really bothered about care that much"
(Doctor)

Clinicians - at all levels – felt they would be better able to deliver good quality care if they had less pressure and more time for each patient:

"It's about having time, to explain difficult things. It's not something you can do in 2 minutes"
(Doctor)

They all, including support workers, therefore concluded that the real need lay in hospital organisation and systems which gave them too much to do that was not directly of benefit to the patient,

"Senior nurses spend too much time bed-managing, trying to get patients discharged"
(Nurse)

"We pick up the pieces for everyone and everything – a patient comes in and we have to go and collect the notes – the admissions clerk won't bring them. Now whose time is more valuable? We're there to look after patients, not run around after notes!

"The porters won't fetch the latex allergy trolley, cos it's not a patient. But who's it for? A patient!"
(Nurses)

and systems which were badly organised and which could be difficult and dehumanising for patients to negotiate – NOT in any aspect of the care which they themselves delivered on an individual level.

"You don't even get to meet them before they go to theatre! They have their pre-op assessment on one ward, then go to theatre, then to another ward, and they don't know who's looking after them! If I was a patient, I don't know how I'd feel about that"
(Nurse)

However, others did not always agree about the causes:

"I don't accept that it has to take time - I accept it's often easier to say 'this is what the X-ray says' than deal with people's emotions, but it doesn't take time to smile and reassure a patient, and can save a lot of time in the long run"
(Trust director)

"A consultant said to me recently, I don't know what it is with doctors these days, but they don't know how to talk to people, or how to engage. Maybe we're just not getting the right people into the profession, with everything now becoming so academic""
(Therapist)

Thus, there was disagreement about the origin of the problem - and on 'ownership' of the task ahead.

The causes of current failure to deliver the best experience of care to patients

In attempting to identify who was responsible for change, many tried to analyse where they felt the root of the current problems lay. There were various theories, with different respondents seeing the causes as historical, cultural, or purely circumstantial.

Historical causes

Part of the reason for 'care' not being prioritised in some functions - with emphasis on **doing**, not doing in a **caring** way - was felt to be historical, i.e. the ways of doing things were long established and assumed but did not specifically prioritise or teach a caring approach. These causes lie way back in time and apart from being able to turn back the clock and/or change old habits, solutions would mainly apply to tomorrow's practitioners. This was felt to be particularly true in the medical profession

*"When a patient is really ill, you just think, I **need** to get a blood sample, I **need** to get a cannula in, and they just become objects more than anything"*

"On any ward, there's an old person that shouts 'Nurse, nurse' incessantly - and there's always a nurse that's very skilled at dealing with it. But that means that starting when you're a medical student, you learn to ignore someone shouting for help. Which is terrible"

"From a training POV, 'caring' for the patient isn't a box you tick, whereas catheterising them might be"
(Junior doctors)

Cultural causes

Many staff spoke of how hospital culture can gradually have a depersonalising effect on them, and impair individual initiative and proactivity and ultimately, the quality of care that is delivered. Those with experience of different cultures compared large hospitals with smaller ones, claiming that many aspects of large hospital culture are felt to be dehumanising by those who work there:

"In smaller hospitals, you know everybody, everyone gets along, and things run smoothly. Here, I wouldn't even know who to complain to, to change the curtains that don't fit!"
(Junior doctor)

Consequently, staff become familiar, accepting, and ultimately inured to this culture:

"You think, it's always like that, so that's how it's going to be"

So, as a cause of sub-optimal quality of care, in this scenario it is care that is (or isn't) delivered by staff, but the **cause** is the hospital itself, via its culture and systems.

Circumstantial causes

These are similar to, and involved with, hospital culture. The difference here was that the situation was more acute: there was more of a sense of uncertainty and loss of focus recently, rather than an acceptance that poor standards were an inevitable consequence of a large organisation's impersonal culture, as above.

There were numerous comments relating to recent acceleration of the needs to meet certain standards and accreditations (particularly in relation to infection control), or of often arbitrary or unrealistic targets for treating and discharging patients, none of which were believed to have beneficial consequences on the quality of care delivered.

"The requirement of having 98% of patients coming though A&E within four hours – a wholly laudable objective, but when we are caring for more patients than we have facilities to do so, it risks becoming a very mechanical exercise and very pressured – the system and processes aren't sufficiently organised to allow the care patients and staff would want. That's one of the dangers of looking at the process as a series of slices, rather than from the patient's perspective, as one a patient works his or her way through"
(Trust director)

"What do trusts respond to? Government pressure. Nowhere in the serious list of 'must do's' is anything about making the patient feel cared for"
(Trust director)

"Yes, OK, it's an admirable target to try to get all patients in for surgery with two week appointment times. But in actual fact, if they're coming in for something major like cardiac surgery, they may want a bit longer to think about it and prepare themselves for it"
(Nurse)

"People have become very focused on changes in the NHS. 'And maybe we're not as patient-focused as we would want to be, all the time. We're all too busy thinking about '18 weeks' and electronic records, and everything"
(Therapist)

"The pressure at the moment is the speed at which you are expected to get patients out of hospital. Patients being told they'll be leaving on day 3. It's a good thing from the Trust's point of view, because there's a clear start and an end, but it's quite anxiety-making from the patient's point of view –I've had some say to me, 'I've got to go in 3 days – what happens if I'm not better?' "
(Therapist)

"We live now in a protocol-driven, target-driven health service – people don't have enough time to sit down and talk, and that's the real danger from a patient's point of view"
(Trust director)

"It's like these infection control accreditations. I just think, 'I don't WANT ICA – I just want the ward to be clean! And it's like, 'let's just tick the boxes and get it done, and then we can put it away' In our directorate, the dirtiest wards are the ones that have got accreditation, so it's meaningless anyway!"
(Nurse)

There was a particularly pertinent issue for nurses, whose aspiration was to have as much patient contact as possible, yet they were frustrated by targets and red tape, leaving the lesser or unqualified care assistants and ward domestics to do many of the traditional 'nursing' jobs on the wards:

"All of us on our ward, we work as a team – doesn't matter who you are, from the bottom to the top, we all help each other"
(Ward domestic)

"It's moved to almost, task allocation – you do your drugs, you do your IV's, and you're trying to do it all to time, and your basics of care, the nice bits, spending time with the patients – the support workers do it"

"If you do a bed bath, you learn a lot about the patient and their family, but now you haven't got time to do that. Even my support workers haven't got time! Everybody's under so much pressure!"
(Nurses)

Senior nurses recognised how this would impact on the care a patient would receive

"What's frustrating for me as a ward sister is I never ***ever*** *get to know people. You get to know a name, you get to know a diagnosis, but you never really get to know* ***them****, unless they stay in longer than the norm – which nowadays is dictated by another target!"*
(Nurse)

Current priorities can dehumanise the experience - and pressures on the system today militate against a caring experience:

"Very often the enactment of targets is at the price of the humanity and sensitivity that is so important to care, because staff and the organisation are so rigorously and bluntly assessed on whether we pass or fail these targets, so that can become the objective for our system and performance management"
(Trust director)

"Most people accept "person-centred care" as a good thing. But there aren't the procedures and incentives in place to make it a priority, so most people would just ignore it"
(Nurse)

"What you are rewarded for doing, or expected to do, are all the procedures and protocols - and NOT to have cared"
(Junior doctor)

"I know some nurses who say, 'we feel guilty if we're seen sitting ***talking*** *to a patient because it looks like we're not doing any work"*
(Therapist)

"The one thing you can't say in this climate is 'sit down and listen to them' – well you can say it as many times as you like, but that nurse has 800 other jobs to do"
(Nurse)

In consequence, for some, there is a tendency to shy away from giving patients more attention than necessary, so as to keep expectations low and ensure a manageable workload:

"You often feel, the more you give, the more they expect - and you don't really have time"
(Nurse)

Naturally, this left some feeling guilty and troubled when they knew they were compromising – and enormously frustrated by a system which allowed this to happen.

Even when there was acknowledgement of the patient experience built in to the targets, the reality of knowing that these were often difficult or impossible to achieve left the staff feeling demoralised.

"Like the A&E targets: they're not to be in A&E more than four hours. AND they have to have had a good experience while they were there. So all the focus is on the four hours, and not the other part. Yet actually four hours wouldn't be so bad if people were really nice to you"

Given many respondents' undoubtedly legitimate beliefs that they were already doing their best, the suggestion of a programme designed to improve the quality of care raised questions for them – and for the implementation of the programme: how can this translate into a better patient experience? And if the programme is to help hospitals deliver the experience, what interventions will staff be asked to adopt?

Those with any line-management responsibility, whether business facing or senior clinical, had their own questions:

- How should my staff respond to that: is it a goal for them or the Trust, or an instruction for reaching it?
- Will it change their behaviour - and is it meant to? (e.g. by attempting to foster or instil more 'caring' behaviour)

Potential obstacles to successful implementation of The Point of Care

As has already been highlighted, there was confusion among 'patient facing' practitioners, given their belief in their own efforts. More seriously, it appeared that the programme could be potentially inflammatory if in communication it was misunderstood, particularly in an environment where staff do not feel valued.

The potential impact of the levels of motivation of staff on how readily they will adopt this – or any - new programme was clearly apparent. It was clear that there could be particular difficulties if it was perceived to be imposed on them without acknowledgement of their existing competencies, and especially if it was construed as an implicit criticism of their efforts.

It was clear that many felt, if not personally, that their roles and contributions were not valued by the trusts by whom they were employed. And this potentially could lead to a lack of interest and support among precisely these people who could make it a success:

"In this Trust, people can feel they're NOT valued - if somebody produced a statement like that, people would say 'oh yeah yeah!"

Senior managers realised the potential difficulties in presenting a programme designed to instil a more 'caring' ethos among workers who already regard themselves as caring people, and perceived the importance of the principle of valuing staff in engendering a more caring culture.

Therefore, some concluded that a system which demonstrates that it values staff by rewarding their efforts might be an effective way of implementing change.

Here, parallels with the commercial world were drawn. The example of the John Lewis Partnership was cited by some, where all staff ('Partners') are stakeholders in the business. The net result is service that is believed by many consumers to be better than other stores.

These managers could therefore envisage a programme which involved making staff feel more valued as a necessary part of its successful implementation.

Engaging staff in the process

Among all patient-facing staff, as well as management, there was a feeling that greater recognition of the part staff already played in delivering good patient care, as well as greater reward for their performance via formalised systems, might be instrumental not only in creating a better experience for patients overall, but would convey much-wanted changes in hospital culture.

Three ways in which staff can feel valued and the whole process improve were suggested here:

1. Appreciation / recognition of their contribution
2. Support to fulfil their roles and potential to the full
3. Reward, via remuneration

Appreciation of effort

Many staff interviewed were clearly natural 'carers'

Their contributions to the experience for the patient was clear - but probably largely unrecognised or taken for granted - in the current system

They therefore responded with suspicion (at least) to any suggestion that the Point of Care might be teaching **them** about what 'care' was (which would almost certainly backfire), and particularly, that this was going to be another management directive - given that they felt they were already often doing more than they were strictly required to in their daily work in order to give their patients the best possible care, which many felt management did not appreciate.

For many, the attitude was mutual – another reason why they did not respond positively to orders from management:

"We're given a lot of information from above, and told to get on with it, but we don't have any input into it. They're telling you to do things, and without any disrespect to them, I don't know why, because they've never done it. And they've not been to ask me how to do it!"
(Nurse)

Worse even than feeling unappreciated, some were even conscious of the anxieties management directives could place on the workforce:

"When you have a management decision that is very anxiety-making – when you get rung up and told, 'deal with this NOW!' – I think that makes people quite worried about their jobs, and I think that has a bad effect on patient care, as it does come down from top management"
(Therapist)

'My concern is that the people who can give the quality care are leaving, because they don't feel they can do it any more. And you're left with the people who don't understand what quality care is! If the ones who can maintain the standards don't stay and fight with you, it's going to be in the hands of the people who are less caring'

Therefore, some felt it would be nice to get some recognition and reassurance - even simply the occasional word of thanks – from management.

The Point of Care might therefore be a model for 'other people' (which may include the organisation as much as individuals) to learn from and follow their example.

Support for staff in fulfilling their roles

To clinical staff in particular, particularly those with line-management type functions (consultants and senior nurses), demoralisation is an issue.

Valuing staff is demonstrated by supporting them, yet often a lack of resources makes them feel the opposite, that they're not valued or taken seriously, and it's very difficult to go the extra mile if you're under-resourced to do even the core tasks, just as it is to value your own contribution when you know the patient's experience hasn't been the best.

"No matter what the standard of care, they're always very grateful when they leave, everything's brilliant. No matter what you do, they just put up with it because they've had a near-death experience and didn't expect to be leaving hospital. And I think sometimes that's quite sad, because you know it could have been so much better for them, and you don't get the constructive criticism that we perhaps ought to get"
(Nurse)

Alongside this was also the fear that although the programme sounded impressive in theory, it needed to be sincere, and supported and invested in by the Trust management – otherwise it would be seen cynically as no more than empty words:

"At the moment, if I saw things like that, that the Chief Executive was telling us, I'd think, 'Oh this is just motherhood and apple pie' - just comforting phrases. The reality behind it, absolutely, but they come across as rather glib phrases for people who aren't necessarily going to put their money where their mouth is"
(Doctor)

"There's been a lot more discussion around "customer care" – how the frontline staff deal with patients, etc, but it doesn't necessarily change the way they do behave. There's an awful lot of talk of "we must be ***seen*** *to be..." which is a bit depressing really"*
(Therapist)

In reality, Trust management too were aware of the need for organisational and cultural change, even if their employees did not always perceive this:

"If we 'put the patients first', we'd say, 'how do we design the services around the needs of the patients?', rather than expecting them to follow the convenience of the institution"
(Trust director)

"For me, the challenge with the word 'care' is for it not to be pigeonholed in people's perceptions as nice, soft fluffy stuff, but to be seen as absolutely central to ***all*** *the dimensions of performance that we want – good clinical outcomes and good experiences too"*
(Trust director)

"Care doesn't happen in the finance department, but they can be instrumental in a patient's experience"
(Trust director)

The Point of Care should therefore be seen to be addressed at 'the culture' rather than individuals, i.e. identifying areas in systems and processes which detract from, rather than improve, patients' experiences, as well as areas where the staff too can be given better experiences of working, and support to allow them to deliver better patient care.

To some, this requirement for support even extended to consideration of the atmosphere and environment in which the staff worked:

> *"Caring even includes looking after the environment – here the air conditioning doesn't work, the paint is peeling, there are cardboard boxes just left out on the floor – that doesn't make anyone feel good about where they work, and morale in staff is so important if you want to maintain their commitment"*
> (Therapist)

This might involve consultation with staff on this specific issue, exploring the culture, priorities and processes that impact on them and create an 'uncaring' experience for the patient. Any such consultation would be tangible evidence that their views are taken seriously.

Rewards and the notion of patients as customers with choice

Some managers believed that Trust-wide adoption of attitudes which see all patients as 'customers' would ensure better treatment all round. As has been discussed earlier, there was some reluctance to view patients as 'customers', or to appreciate that they had choice. However, those in particular with business backgrounds knew that adopting this attitude could have significant impact on the quality of service patients received.

With this in mind, both senior management and some doctors recognised the potential of a performance-based reward system involving patients' evaluation of their experiences, casting patients as 'customers' who can exercise choice.

They felt this could work to improve the experience of patient care if it shifts the focus for priorities, i.e. we **have** to do this (because we'll earn more and the hospital will do better) - rather than we'd **like** to do this but we don't have time/resources

The major benefit of this approach is that 'ownership' of the problem becomes universal, i.e. every single employee of the Trust is responsible, and blame cannot be addressed elsewhere. If the whole Trust is rewarded periodically on its performance, it is in everyone's interest to ensure that they and their department perform as well as possible and don't risk letting others down.

The Point of Care could thus represent a change in priorities and become a new performance indicator, at a time when 'care' is currently not believed to be prioritised by some functions.

Perhaps most interestingly, aligned to this could be the care of staff too, with the interesting notion being raised of Trusts being similarly evaluated on how well they care for their staff – assessed of course by the staff themselves. The shift in the balance of power this could create, by giving the staff a greater degree of control over the performance and destiny of the Trust, could be instrumental in bringing about the changes in the experience of care for the patient to which so many aspire today.

Appendix

Methodology for evidence gathering

The research was conducted by Victoria Wood between 17th January - 4th March 2008 at the following locations:

The Churchill Hospital (Oxford Radcliffe Hospitals NHS Trust)

The Queens Medical Centre (Nottingham University Hospitals NHS Trust)

Weston Park Hospital (Sheffield Teaching Hospitals NHS Foundation Trust)

Royal Free Hospital (Royal Free Hampstead NHS Trust)

All respondents were employees of the Trusts concerned at each location, though not necessarily of the particular hospital where the interviews took place.

Two qualitative methodologies were used:

(a) 5 mini-focus groups of approximately 75 - 90 minutes duration. Each comprised 3-5 individuals from each of the following groups:

junior doctors

qualified nurses

healthcare assistants

mixed support staff (ward domestic /porter /receptionist /ward clerk)

allied healthcare professionals (therapists from different disciplines)

(b) 9 Individual or paired depth interviews of approximately 20 - 60 minutes duration, among

Consultants (3 interviews)

Trust non-executive directors (2 interviews)

Chair of Trust (2 interviews)

Trust Executive (1 interview)

Trust middle manager (1 interview)

All interviews and focus groups were recorded, and the transcripts prepared from the recordings were analysed in the production of this report.