USING WELL-BEING CHAMPIONS TO DELIVER HOLISTIC CARE

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This article outlines the development of a new role called the ‘patient well-being champion’, which was introduced with the aim of delivering more personalised, patient-centred care.

BACKGROUND TO THE PROJECT

This project originated from the hospital chaplaincy while working with other health professionals during local implementation of the Liverpool Care Pathway (LCP) for the Dying (Ellershaw and Wilkinson, 2003). The LCP provides a generic and standardised framework for the provision of high-quality end-of-life care in all healthcare settings. An audit of its implementation in the trust was carried out, followed by structured teaching sessions (see Background box, p38).

The findings gave cause for concern, given the growing emphasis on the delivery of spiritual and religious care (NMC, 2007).

The need to explore and resolve these questions was the catalyst to address not only religious and spiritual aspects of care but also many other holistic concepts that are often overlooked, such as dignity. Equally, the audit highlighted the fact that these issues were not only important to end-of-life care but to all types of patient care.

SETTING UP THE PROJECT

It was imperative that this project be supported by a key member of the executive team. The chief nurse was approached and agreed to support it from inception through to the different phases of implementation. In partnership with the senior clinical tutor and the patient and public involvement manager, a strategy was devised and presented to the trust’s matrons and senior managers.

TRAINING

Line managers were asked to nominate appropriate professionals to be trained to implement the patient well-being champion (PWBC) role. Nominees had to fulfil certain criteria, one of which ensured they were in a position to effect change within their clinical area. This role was inextricably linked to the development of their Agenda for Change KSF (DH, 2004) outlines.

The PWBCs represented a diverse range of clinical disciplines/specialties, including midwifery, paediatrics, critical care, elderly care, oncology, surgery and occupational therapy. There were 17 participants in the first cohort, each of whom continued in their clinical role while developing skills to help them integrate the patient well-being ethos into practice.

The organisation recognised the PWBC role as part of champions’ continuing professional development. No financial incentive was offered as the selection process was structured to reflect a level of competence in line with nominees’ current KSF to reflect the post outline.

The PWBCs were equipped with the necessary knowledge, skills and competencies through education and training. This consisted of an introductory pre-course day followed by a five-day programme. The programme involved a range of clinical/academic specialists who addressed the key areas as detailed. In accordance with post-registration standards for CPD, the participants were released to undertake the training with full support of their managers. This was a vital prerequisite to ensuring the project’s success.

Interprofessional learning and service-user involvement was advocated throughout the programme. The use of action learning sets (Marquardt, 2004) encouraged the development of peer-group networks that explored and addressed key themes within practice. These consisted of:

- Customer care;
- Spirituality in healthcare;
- Multifaith and cultural awareness (including race and ethnicity);
- Dignity;
- Confidentiality and consent;
- Patient and public involvement;
- Communication and breaking bad news;
- Training;
- Bereavement care;
- Sudden loss and change.

The teaching method consisted of lectures, small group study and patient experience seminars focusing on multiprofessional learning. The active involvement of service users included engagement with the local patient and public involvement forum, and inclusion of a patient representative on the steering group (for full details see nursingtimes.net).

IMPLICATIONS FOR PRACTICE

- Practitioners should collaborate with patients and carers to design educational programmes for patient and public involvement.
- Nurses should use complaints received within the organisation to shape future training needs analyses.
- Practitioners should work in partnership with all health professionals and patient representatives to implement and develop care/educational pathways in key clinical areas.
- Staff should work with the trust’s chief nurse to develop a strategy for local implementation of national guidance on patient care and dignity.
BACKGROUND

● An audit of the Liverpool Care Pathway’s implementation was undertaken within the organisation. Analysis of information from the audit indicated that there was a disparity between the quality of religious and spiritual care that practitioners felt they were providing and that which they actually were providing.

● This issue was explored through structured teaching sessions in which healthcare workers expressed feelings of inadequacy about understanding the issues and competently meeting patients’ spiritual and religious needs.

● The concerns expressed by healthcare staff validated the evidence correlated from the audit process.

To safeguard the well-being of the champions, an ongoing clinical supervision programme was included in the programme.

CONTINUING PROFESSIONAL DEVELOPMENT

The unique nature of the role meant an individual CPD framework was needed to support the champions. Customised post outlines were therefore devised to assist professional development and to cement the role within clinical practice. The core and specific dimensions, as outlined in Agenda for Change KSF (DH, 2004), served as benchmarks to show how practitioners successfully effect change in care delivery. This also gives organisations a system to monitor and demonstrate the continual development of the practitioners delivering safe, high-quality and coordinated care.

THE ROLE

The primary role of the PWBCs is to ensure all patients feel safe, secure and valued when receiving direct care. They should also encourage and develop collaboration with patients and carers to involve them in their treatment and rehabilitation. This is achieved by ensuring all patients in clinical areas where PWBCs have been appointed are aware of the role and what it entails.

Noticeboards were used to identify champions and inform patients about the initiative on admission to the clinical area. A patient information booklet supported by a screensaver to be introduced via Patientline (a service offering patients individual access to a television and phone system) are in the design stages and will be implemented this year.

A number of key initiatives were implemented to ensure dignity within care. These include nominating a dedicated lift for use in transporting patients, for example to surgery or for diagnostic tests. Removeable signs have been introduced to attach to curtains, reminding all staff to request access before entering.

EVALUATION

The project is being evaluated using patient experience trackers from Dr Foster, an organisation that collates information to improve the quality and efficiency of health and social care. These were piloted where PWBCs were operating. Ward teams can elicit prompt patient feedback on the quality of care delivered in key areas.

Five questions are programmed into a hand-held monitor for patients. The data is fed into a central system and disseminated in a weekly report to the clinical teams via the heads of nursing. This enables staff to see and respond to the findings.

Within the first month of introducing the tracker system, patients expressed satisfaction in relation to the dignity question. The only amendment to the system was rewording one question, which was heavily biased towards ward settings, as opposed to other departments and units.

A poster is displayed in clinical areas enabling patients, relatives and staff to monitor the progress and outcomes of the feedback. This complements the patient surveys undertaken by a number of champions throughout the organisation. Several patient representatives have commented that this process, in conjunction with the PWBCs’ role, is a positive step forward for patient involvement.

COST

The PWBC initiative has been extremely cost-effective. Project leads incorporated programme delivery into their existing schedules but, as the demand for the programme exceeded supply and was recognised in the local community for possible commissioning, it was necessary to employ a part-time PWBC lead. This was noted in the business plan presented to the chief executive.

CONCLUSION

The demand for this initiative at all levels can be demonstrated by the planning and implementation of subsequent cohorts of PWBCs – the trust now has 37 champions. In June 2007, healthcare support workers accessed and completed this training, and further training is planned to include all clinical directorates throughout the trust. The chief executive has requested that all staff be able to access this training within three years.

REFERENCES


For the full version of this paper, including background to an implementation of the project and full reference list, log on to nursingtimes.net, click NT Clinical and Archive and then Clinical Extra.

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