Implementing change in older people’s acute care

A nurse in one trust initiated a project so carers of older patients with dementia could visit outside of traditional visiting hours – and analysed its impact on staff and patients

In this article...
- Strategies for engaging people in your campaign
- How to ascertain what other people think about your ideas
- Raising the profile of your project among key people

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Visiting times on wards providing care for older people (HCOP) wards were explored as part of a master’s in advanced nursing. Restricted visiting was not found to be evidence-based so strategies were used to explore alternative options. This small-scale project, which set out to benefit the care of older people on acute wards, used a systematic, inclusive approach to involve staff at all levels and demonstrates how evidence and theory can be translated into practice.

Traditionally, visiting patients in hospital was restricted to set times (Ismail and Mulley, 2007). Family-centred care has become well-established on paediatric wards but restricted visiting remains in place elsewhere, such wards providing care for older people. An Alzheimer’s Society (2009) report showed there is evidence that, for some people with dementia, hospital admission results in a deterioration in their physical and mental condition on discharge. It calls for, among other things, greater involvement of family and carers while in hospital.

Open visiting
Open visiting gives staff more opportunities to engage with relatives and learn about patients in a family context (Ismail and Mulley, 2007), and allows for cooperative ways of working that can help improve patient care (Ciufot et al, 2011). The disadvantages include potential noise and disruption to care delivery – although this is often the case with restricted visiting times when visitors are on the ward at a set time instead of spread throughout the day.

An open visiting policy would fit with national guidance that promotes patient-centred care (Francis, 2013; Department of Health, 2012, 2010; National Institute for Health and Care Excellence, 2010, 2006). It would fit with local guidelines – such as that at Nottingham University Hospitals Trust on patient-centred care (NUHT, 2015) and “caring around the clock” (NUHT, 2016) – and with the Nursing and Midwifery Council’s (2015) Code, which requires patients’ human rights to be upheld. These rights include the right “to uninterrupted and uncensored communication with others” and “the right to respect for one’s established family life” (Liberty, 2016), both of which can be achieved by the implementation of open visiting on hospital wards. Reflecting

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5 key points
1 Implementing change requires commitment and cannot be done alone
2 Mainstream and social media can help you advertise your campaign or project and gain support
3 Backing up your claims with evidence will give credence to your goals
4 Be realistic about what you can achieve and what help you need
5 Collaborative practice and an inclusive approach with a range of stakeholders can bring sustainable benefits

Open visiting gives staff more opportunities to engage with relatives
on the NMC Code to improve care is also now a prerequisite for revalidation (NMC, 2016).

At NUHT, local strategies appear to be geared towards holism and person-centred care, with a focus on improved patient experience, quality, and staff, patient and public involvement (NUHT, 2015).

Addressing the idea of change
I decided to investigate how I could improve care for older people in the clinical area where I work, particularly those with dementia and cognitive impairment. Based on the reported benefits of open visiting, I looked at visiting hours at my trust. The trust’s visitors’ code states visiting times on adult wards are 2.30pm-8.30pm.

The idea of open visiting would be a big change for staff so I adopted the idea of a carer’s passport. This is a card issued to family and loved ones that entitles them to visit at any time, and to be the main contact regarding care of their relative. The concept aimed to familiarise staff with the concept of open visiting and give them a degree of control while ensuring patients have open access to their loved ones.

The card represents a philosophy of care rather than an expectation that relatives should visit just to deliver essential care. Indeed, some visitors are older and need help themselves, which can sometimes add to the workload of busy nurses. For example, visitors may have mobility problems and need a nurse to take them to the exit in a wheelchair to get a taxi home.

I based my work on the Promoting Action on Research Implementation in Health Services framework (Rycroft-Malone, 2004), which focuses on evidence, context and facilitation.

Evidence to support change

Context for change
Examining the context meant looking at the ward environment, staff culture and wider organisation. The organisational structure might offer resistance to open visiting, citing lack of resources, time, money and staff, or expectations of the public and professional standards. In this case it signposted me to the NUHT team running the change management programme, Better for You (Bit.ly/NUHTBetterForYou), and the shared governance initiative (Bit.ly/NUHTSharedGovernance), which embraces positive changes that benefit care.

Facilitating change
The project was implemented with the facilitator as the leader of change. Various leadership strategies offering a broad approach should be adopted, rather than relying on one approach that may miss opportunities to initiate change, particularly in individuals. The role of facilitator lends itself to transformational, authentic or inspirational styles of leadership with a focus on teamwork, democracy, and enabling and empowering the team. I wanted to reflect on the impact I have on others and used the Myers-Briggs type indicator (Barr and Dowding, 2012) as a self-assessment tool to explore this.

To persuade others of my vision of allowing carers of patients with dementia to visit the ward at any time, I had to engage people at all levels within and outside the organisation. To ensure the project was sustainable, I wanted to make certain that most staff were in agreement; this also helps to “flatten” hierarchies between frontline nurses and management. As a result, I met with staff – including nurses, doctors, domestics, porters, fire safety officers and management – on a one-to-one basis and in groups.

I developed a Likert scale and compiled an evaluation form asking staff members whether they thought the following were not likely, neutral or very likely and to comment on them:

» A carer’s passport will increase complaints;
» A carer’s passport will increase my workload;
» I will feel stress because of the carer’s passport;
» A carer’s passport will improve patient care and experience.

I categorised the feedback into themes to determine common concerns. All staff in the HCOP directorate were sent a digital and hard copy of the form. In total, 26 were completed by nurses (n=11), healthcare assistants (n=7), doctors (n=2) and other staff (n=6); staff members categorised as other included a physiotherapist, an occupational therapist, a domestic worker, a receptionist, a volunteer and a student nurse.

Most nursing staff said they were open to my vision:

“This could be also available to future carers, not just existing ones, so they can get used to providing care before discharge. Very good idea”

“It would be good for relatives to be involved and feel part of the care for their loved ones. This would also benefit the loved ones as it would comfort them!”

Some thought it was a good idea but mentioned caveats and concerns:

“Seems like a good idea, however […] would the ward be overrun with visitors? Also, for patients with delirium/confusion, would crowds of people and all the extra noise (voices etc) cause further confusion? I guess it’s a good idea as long as they are here to help and not add to our daily workload”

“Not everyone has got relatives […] also some relatives may use it as a come early just to visit, and distress the person that they have come to see, and it may confuse the patients as to what time it is. […] sometimes 9am is too early to visit, as it’s very busy in the morning […] the doctors will be inundated with requests on their way around the bays”

The questionnaire highlighted concerns from staff and enabled me to develop the project further in an inclusive way. I realised I needed to work with others to implement the project so established wider connections within the organisations to make this happen.
The questionnaire will be used for post-project evaluation and can be used to compare results against the pre-implementation views (Fig 1).

Managing change
Staff were:

» Given information;
» Involved in decision making;
» Offered the opportunity to visit other areas, such as the paediatric ward, which had successfully implemented open visiting.

At a wider level, I accessed social media, such as Twitter, to network, join forces with others, disseminate my project idea and find out about other similar initiatives. I linked up online with like-minded nurses who have done similar projects - we ran a Twitchat, which helped me interact with others, raise awareness and gather more feedback about the initiative.

I also used mainstream media to publicise the campaign and promote discussion. I wrote about the concept of open visiting and the carer’s passport in nursing journals, blogs and national newspapers, participated in discussions in nursing journals, and I was interviewed on television and radio. This raised the profile of my initiative and stimulated interest at local and national level.

The project started in spring 2013 and took longer than anticipated. The energy and enthusiasm needed to support the project became difficult to manage alongside clinical work and studying for a PhD. It helped that the trust’s communications team designed the passport. I also applied for funding from the NUN charity, which is always keen to support new initiatives that benefit patients. The cards were trialled on one of the acute HCOP wards.

The Better for You quality improvement programme and head of patient public involvement at the trust worked together on a poster to publicise the carer’s passport project, which was presented to the executive board and patient–public involvement committee at a change management event. The orthopaedic ward manager offered to conduct a further trial, which was helpful as we wanted to know how it would work on the surgical unit. The project received positive feedback from the board and the patient–public representatives; I received the first draft of the amended hospital policy on visiting and details of the carer’s passport were published on the hospital’s website. This process generated some key learning points, which are outlined in Box 1.

Implications for practice
The carer’s passport offers an opportunity to provide holistic, family-centred care to older people in acute hospital wards. This is particularly important for those with cognitive impairment, such as dementia, and at risk of delirium, and allows staff to work with patients and families to provide personalised care to older adults.

The future
This project has been built on solid foundations so I see no major obstacles to its implementation trust-wide but I suspect it will evolve naturally as each specialty finds ways to implement it in their own area. The carer’s passport itself can be adapted to different specialties within the hospital context. Hospitals may wish to give extra details on the card about hospitality services, such as reduced-price meals or car parking arrangements for carers. Alternatively, the future could include a blanket ban on restricted visiting with open visiting for everyone, so there would be no need for the passport at all.

Whatever happens, I am optimistic about the future and convinced the project will benefit patients and carers, while helping staff to get to know their patients better and keeping communication smooth. Recently, I led some workshops with dementia champions to explore how to break down barriers to implementing the carer’s passport scheme in their own areas. One nurse asked: why don’t management just change hospital policy? The answer? Management are wary of alienating staff by implementing top-down policies and want everyone to be part of the journey to change. Collaborative working and good leadership are invaluable when it comes to changing practice.

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