The Sit&See Tool:

An evaluation of implementation and use

Contents

Section 1.Background

Sit&See is a simple observation tool which captures care and compassion. Developed by Lynne Phair in partnership with Brighton and Sussex University Hospital Trust and NHS England (Surrey and Sussex), the tool provides a simple system through which staff interaction with patients, visitors and colleagues, can be recorded. Through capturing the smallest things (such as a smile, a little conversation, a reassuring touch), and through a simple recording system identifying positive, passive or poor care, Sit&See enables staff to see through the eyes of the person receiving their service (patient, resident, carer, family member) which helps them to understand the difference that their interactions can really make to dignity, care and compassion.

Working with a range of services, the Sit&See tool has been developed for use in any care setting by staff (of any discipline and in any role), service users, family members and others (such as volunteers or the clergy).

To date, five versions of the tool have been developed for hospitals, community (including primary care), care homes, mental health and high secure services.

Section 2 Evaluating the tool

Ongoing evaluation of the tool feeds into its development.

Evaluating training

Initially, we evaluated the effectiveness of the essential training that service representatives receive in order to use the tool. The report of this is on the Sit&See website.

Evaluating experiences of implementing and using the tool

For the next phase of evaluation, we emailed the individuals leading the implementation of the Sit&See tool in their services to invite them to share their experiences with us through telephone interviews. Thirteen users of the tool were happy to participate. Through semi-structured interviews we gathered information on how individuals and organisations are using the Sit&See Tool, how it has been implemented, benefits and challenges in use and suggestions for development. Some organisations also sent documentary evidence on their implementation and results, which we have incorporated into our findings.

The sample represented approximately one third of organisations using Sit&See at the time of the interviews. The number of organisations using Sit&See continues to grow.

Interviewees and services

The interviewees worked in a broad range of organisations including clinical commissioning groups (CCGs), acute hospital trusts, community health trusts, care home groups, specialist services and universities.

Services where the tool is being used encompassed:
- accident and emergency
- outpatients
- day surgery
- mental health
- high secure
- nursing and residential care homes for older people, people with dementia and physically disabled adults
- learning disabilities
- children's services
- specialist services including orthopaedics, spinal injuries, specialist burns and plastics
- universities running pre-registration, continuing professional development and work-based learning programmes.

The roles held by interviewees included Heads of Patient Experience, Director of Nursing, Operations Director, Care and Development Manager, Quality and Safety Improvement Manager, Heads of Safeguarding, Aggression and Violence Lead, Patient Educator, Associate Professor and Senior Lecturer.

All versions of the tool were in use through the various organisations and some organisations were using all versions in various parts of their service.

The interviewees, all of whom are happy to be quoted in this evaluation, were:

Kathy Brasier, Elective Matron, Queen Victoria Hospital NHS Foundation Trust, West Sussex.

Alison Cannon, Head of Mental Health High Secure and POC Lead, North of England Specialised Commissioning Team, NW Hub.

Kara Gratton, Care and Development Manager, Milford Care.

Lisa Ekinsmyth, Head of Patient Experience. Western Sussex Hospitals NHS Foundation Trust.

Wendy Grosvenor, Teaching Fellow, Care of the Older Person (Dementia), School of Health Sciences, Faculty of Health & Medical Sciences, University of Surrey.

Anne-Marie Hartley, Queens Nurse, Quality and Patient Safety Improvement Nurse, Clinical Quality Division, Sussex Community NHS Trust.

Fiona Lawn, Operations Director, Niram Care Group Ltd.

Sue Lillyman, Senior Lecturer, Association of Dementia Studies, University of Worcester.

Sue Rush, Associate Professor Simulated Learning and Clinical Skills, SGUL, Kingston University.

Anne Worrall, Matron Quality & Safety & Lead for Adult Safeguarding and Dementia, Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust, Gobowen, Oswestry, SY10 7AG.

Other interviewees who we were unable to reach following completion of the evaluation report included:

A Safeguarding Manager in a Clinical Commissioning Group.

A Patient Educator and Management of Aggression and Violence Lead.

An Adult Safeguarding and Learning Disability Coordinator in an Acute Hospital NHS Foundation Trust.

Training and implementation

Several of the organisations, including hospital trusts, community trusts, mental health, care homes and high secure services, had been involved in developing the tool.

Initial training for the interviewees and staff had been undertaken from early in 2012 to 2015.

The number of observers trained in the first wave within each organisation ranged from one individual who then went on to lead the implementation through the organisation, to about 250 observers who received initial training through a series of sessions run in various locations spread throughout a large trust.

Section 3 How organisations are using the tool

Observers

Observers held a broad diversity of roles within organisations:
- Within care homes, observers were home managers, directors, senior nurses, operations directors, activities co-ordinators, domestics, gardeners and maintenance staff.
- Within trusts, observers included nurses, care assistants, consultants, physiotherapists, occupational therapists, matrons, ward managers, chaplains, administration staff, human resources staff, facilities department, medical records, complaints manager, patient experience managers, clinical audit team and staff working in governance.
- Patients, clients, family members and carers, including people with a learning disability.

> *"We have a mix of observers - some admin that work in medical records, some healthcare assistants, HR, facility department, quite a few admin staff that work in governance, complaints manager, patient experience manager, clinical audit team - quite a wide variety"* (Anne Worrall, Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust, Oswestry) .

Most of the interviewees said that their organisations had trained observers who do not normally form part of the organisation, such as Non-Executive Directors, Governors, Advisory Board members or volunteers. Most had also trained patient representatives or patient panel members and families/carers, or were planning to do so.

> *"The Non-Exec Directors were trained to do sit and see two or three weeks ago and I observed the Chair of the Trust Board yesterday doing her first observation. We provide training and then go out in practice with staff to support them through their first observation.* (Anne-Marie Hartley, Sussex Community NHS Trust).

> *"We've trained six of our governors, a number of our office based staff, volunteers and it's part of our development for our healthcare assistants and student nurses"* (Lisa Ekinsmyth, Western Sussex Hospitals NHS Foundation Trust).

> *"We have an Advisory Board and I've explained to them what the tool is about and I want to train two of the directors who don't have a care or nursing background. As directors, when they walk through the homes it would be really good for them to have an awareness. So that's a personal mission that I think would be a really good thing and would help from the ethos of the company - from the very top"* (Fiona Lawn, Niram Care Group Ltd).

One organisation had undertaken a formal piece of work with the Patients Association in the A&E Department to observe at night.

"We wanted to provide assurance that during the busy winter months with high pressures in our departments that we were providing the best possible care especially out of hours. Working with the Patient Association was really positive. They provided rich qualitative feedback, positive encouragement and ideas for improvements" (Lisa Ekinsmyth, Western Sussex Hospitals NHS Foundation Trust).

How observations are conducted

The interviewees described a range of ways in which observations were conducted:
- Some organisations had pre-determined programmes of observations around the various service areas and different times of the day.
- Some did impromptu observations in between times.
- Some used for staff peer review, sometimes managers.
- Some paired observers, for example clinical and non-clinical including volunteers or representatives from CCGs and provider organisations.

"The hospital bedded units submit an observation every six months and that is included in the performance report that goes to our monthly Trust Board. One of those is an internal observation that the staff can do themselves and the second one is a peer / external review. In the community we've started rolling the tool out. We wanted to embed the community hospitals before we started the roll out to the community services so we had some clear oversight and could respond to issues if necessary. When community staff do live supervision they can observe one another with patient interactions or they can observe a handover. We felt that the way that patients are spoken to or about in a handover can be representative of how staff are likely to behave and also how they interact with each other. This helps us understand the team culture". (Anne-Marie Hartley, Sussex Community NHS Trust).

"I've used it in partnership with a provider in an acute hospital on a couple of different wards where we've done half a ward each and done a comparison of our observations and fed back to the ward manager and that has been fed back through the governance system. I've done it in a mental health setting in a locked ward and again I did that in conjunction with the provider. It's been really productive because you can highlight good practice and you can highlight areas for improvement but you can do it together because you are observing the same thing in a CCG- provider relationship, to be able to be on the same page on how you want to improve patient care and also to celebrate what the staff are doing really well. You can feed back in real time to the staff on the ward and the ward manager and you can go away and write that up to report at a commissioning level. Working in a CCG is a very different way of using it - to add it to our observation tools for visits to providers and also potentially in response to any themes of safeguarding concerns that might come up. Just a way of going in and assessing if there are themes of concern and encouraging people to use it for themselves, rather than waiting for someone to raise issues, you can do this for yourself". (Safeguarding Manager, Clinical Commissioning Group).

" Initially we will be looking in a generalised way looking at the environment. But when I first saw the tool I was working with aggression and violence and we saw potential for the tool to be used with individuals - looking at interactions to see if there are issues that are maybe leading to a person becoming aggressive towards us. So at the moment it will

be a generalised environment assessment but hopefully looking to progress on an individual basis. And to look at culture - assess what cultural issues there might be. Each observation will depend on the environment. We plan for 20 minutes initially then meet monthly and assess whether we need to reduce to 15 minutes or increase that". (Patient Educator, Management of Aggression and Violence Lead).

"I visit the homes and will do a Sit&See as often as I can. Also, for example I did one over lunch in our new home because I wanted to see the resident experience". (Kara Gratton, Milford Care).

"We have a programme working two months in advance so that each observer is paired with another and are scheduled in for the observations. We observe most areas within the trust at least once a month. Outpatients and pre-op assessment, recovery and theatre, radiology, X ray, therapy department. We marry people up as partners and allocate an area. They organise it themselves and do that observation" (Anne Worrall, Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust, Oswestry) .

Recording findings

Most organisations use the Sit&See paperwork to record findings, sometimes supplemented with additional recordings.

"We use the Sit&See paperwork. Observers handwrite their observations send to Clinical Audit department to log in system, it's produced electronically and is circulated. The forms are checked by the observers to ensure they are happy with the information they've filled in and any actions that need to be addressed. The electronic report is sent to the manager of the area so that they've got a record of it. Obviously they need to action anything that comes up. We produce tables with percentages" (Anne Worrall, Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust, Oswestry) .

Section 4 How evidence from the tool is being used

Feeding back to staff

Interviewees described a range of ways in which Sit&See findings are fed back to staff.

" When I feed back at Senior Managers they then go back on to the wards and feed back. They'll immediately do an email and say 'these issues have come up' from my visits, which are unannounced. Sometimes I'll go to watch a patient visitor's experience. And I'll also go into the workshops and education and the recovery college and horticulture so I try to cover the whole of the patient experience. They feed back to the area - that it's really positive, or we could do better on this. That feeds into their High Secure Governance Board". (Alison Cannon, North of England Specialised Commissioning Team, NW Hub).

" We want to look at the evidence from a team-based point of view, to go back to the managers and look at how the evidence can support them in supporting their staff in seeing what they're doing really well. I'm also looking at feeding this into our patient safety programme and I'm hoping that some of what we collect (1) will provide us with evidence to make changes through the patient safety programme (2) as we continue with the patient safety programme and we're looking at the model for health improvement with that, Sit&See may provide us with evidence for that as well". (Patient Educator, Management of Aggression and Violence Lead).

"We record the information then that is uploaded onto a central database. Anything specific is fed back to the staff immediately - positive or negative. More generic things are mentioned at the unit meeting. We have an audit tool in our matron data which is fed into our Board Report. Our quality lead takes that on board" (Kathy Brasier, Queen Victoria Hospital NHS Foundation Trust, West Sussex).

Feeding into quality assurance, governance or patient safety

Findings from Sit&See observations are being incorporated into quality assurance, quality monitoring systems, evidence for Care Quality Commission (CQC) inspections, performance reports, Board reports and patient experience reports.

" It forms part of our corporate Quality Assurance. We use Sit&See to show auditors, who might be County Council, CQC, CCGs. It's useful for that as well" (Kara Gratton, Milford Care).

" In our quality monitoring systems we talk about Sit&See - short summary reports are included in our monthly patient experience report alongside our other feedback data. The results are reviewed at our patient experience and feedback committee, And also our governors have talked about their experience using the tool at Trust Board". (Lisa Ekinsmyth, Western Sussex Hospitals NHS Foundation Trust).

"One of my managers had a CQC inspection in the new format. She fed back that it was our intention to introduce the tool and this was positive. And I'm looking to building it into our QA system as evidence that we're taking responsibility and are looking at the way staff are conducting ourselves, not just from the usual training perspective and mandatory training, we are actually trying to look at dignity and compassion from a different point of view" (Fiona Lawn, Niram Care Group Ltd).

"Results are shared with providers and also the commissioners for that service and directors of quality. It can be used to feed into all kinds of different meetings. So if some things are appropriate to be picked up through contracts they can be picked up through quality, safeguarding and improvement plans. And if it's a good experience I'm more than happy to report that it's good care that you get to celebrate and highlight what is happening in practice" (Safeguarding Manager, Clinical Commissioning Group).

"Findings feed into patient experience reports which summarise information in the last six months, any trends, passive as well as positives. The report is fed into our Quality and Safety Committee and Clinical Effective Committee. The report also goes to our Patient Panel Group so they see the results as well. We're just looking at

setting up a new group that will be looking at any actions - the trends and themes".
(Anne Worrall, Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust, Oswestry) *.*

Public reporting

Through virtually all of the organisations represented in the interviews, information from Sit&See reaches public domains through at least one of a range of means including websites, Trust Board, public board meetings, patient representative groups, reporting of CQC inspections and in other public-facing documents.

"We've been quite public that we are going to be using the Sit&See Tool" (Patient Educator, Management of Aggression and Violence Lead)

"The Patient Panel has a multitude of people such as Healthwatch, the Welsh Community Health Council, Dementia Alliance Group, Friends, Rheumatology Association, so there's lots of groups who will get a copy of our results. That's the public voice that we use to engage with the public" (Anne Worrall, Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust, Oswestry) .

"I'm very keen to promote it and am mentioning it at provider meetings. Sometimes within our homes we can have a negative CQC inspection and I'm hoping that this tool will be a good way of showing that you are taking steps and trying to get to the nitty gritty of what's going on - the culture. You can show the inspectors evidence - to CQC, Commissioning bodies and local authorities" (Fiona Lawn, Niram Care Group Ltd).

"I did a presentation about Sit&See at our nursing conference and that was definitely Twittered about. We also gave a presentation to visiting Directors of Nursing from Iceland which was very well received" (Lisa Ekinsmyth, Western Sussex Hospitals NHS Foundation Trust)

Many of the organisations were considering how they could develop their profiles on social media. For example:

"We are starting to get Facebook and Twitter comments and they are normally complementary - people saying about their visit. We're developing in that area" (Anne Worrall, Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust, Oswestry) .

In one of the organisations, service and client information needs to be kept confidential because of its political and media sensitivity so findings are not reported publicly.

Section 5 Challenges in implementation

Interviewees identified a range of challenges in implementing the tool but, notably, these were not specific to the Sit&See tool and would likely be present in trying to implement any new tool.

Key challenges were:

- Time pressures - not in the time that the tool takes to complete, rather in identifying staff time to train to use a new tool, management time to implement a new tool and to sustain the implementation.
- Reluctance to be observed or to observe and feed back to colleagues.
- Being distracted during the observations particularly when observing in own work area.
- Specific sensitive clinical situations. i.e. where 'sitting' to observe could feel overly intrusive and inappropriate so observing from a distance was preferable.

Time pressures
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"Time is a problem for me. I don't think it's excessive in the time it takes to do it" (Alison Cannon, North of England Specialised Commissioning Team, NW Hub).

"The problem we had is not so much about the tool per se it is because there's been a huge amount of work to do. So simply there has not been capacity to do audits. And essentially I need to co-ordinate the audits, at least initially. This is not a reflection on the tool which seemed to be relatively straightforward but you need to use it to get used to it and learn how to document what you've seen" (Adult Safeguarding and Learning Disability Coordinator, Acute NHS Foundation Trust).

"The size of our organisation can make implementation challenging. We are a very large community trust so getting the message out and get people trained and feeling confident about doing sit and see can be a challenge. When you're in a hospital environment and confined within a building it's a lot more straightforward to implement" (Anne-Marie Hartley, Sussex Community NHS Trust).

"Time is always going to be a factor. But it doesn't actually take long and I don't think you get benefit from doing it for a long period of time. It's better as a snapshot" (Safeguarding Manager, Clinical Commissioning Group).

Reluctance to observe or be observed

"Being observed is always challenging and you try your best to give people reassurance on what you're doing, and what the purpose is. But particularly at a time when health and social care starts to feel heavily criticised, it can add to the anxiety if it's not approached in the right way. But I think it's down to the observer to stop that happening. I didn't have any problems personally" (Safeguarding Manager, Clinical Commissioning Group).

"And when I've taken it to junior staff on their development days there is sometimes a resistance around them thinking we're asking them to spy on people. So we've had to talk through that and some remain unconvinced and don't like it. But we say that every day you're on a stage and should be acting as if you were on the television. But most people after using the tool and giving feedback realise that it is a very positive way to support staff and it doesn't take extra time and it reinforces that message I think" (Lisa Ekinsmyth, Western Sussex Hospitals NHS Foundation Trust).

"Strangely a patient was the only person who had an issue with it. We had explained what we were doing. I was sitting in a corner and one patient said 'I feel sorry for the staff having people checking on them all the time'. So feeling quite loyal and protective towards the nurses. I explained again but she was quite 'umm'. It's just how you go about it". (Safeguarding Manager, Clinical Commissioning Group).

Distraction during the observations

"It works better when people don't do it on their own clinical area. That's a big thing. Things like -'they saw me there so came to ask something' - more of an interruption than the tool didn't work. They sit there in uniform and they get called" (Sue Lillyman, Association of Dementia Studies, University of Worcester).

Specific clinical situations

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"Sometimes when I'm on a ward and there's a man who's acutely ill, it's wrong for me to sit there for 10 minutes - it's not helping at all. But where I have been able to sit for half an hour or have spoken to patients on more settled wards, at a community meeting or patient council meeting, it's been fine. So I think the barriers are around clinical presentation on the day. And sometimes it's around protecting the patient's dignity when staff are dealing with them. I may watch from a distance but I wouldn't sit there and stare at it" (Alison Cannon, North of England Specialised Commissioning Team, NW Hub).

Other comments

Some users had not experienced any challenges.

"I've not experienced any and I'm not aware that anyone else has either" (Kara Gratton, Milford Care).

Sometimes, views of the tool changed with experience of using it.

" When we first trained, we had some staff that were not resistant but were not certain of the value of the tool. But what is interesting is that one of the staff who was quite resistant, since she's been using it and practising in her environment, has completely changed her opinion of the tool and what it's going to be able to achieve for them and their team. So we may come up against lots of people like that but hopefully as they use it they will see the value" (Patient Educator, Management of Aggression and Violence Lead).

"The tool was well received by staff. There were no complaints about it being overly complicated. The only mumblings were 'will you help us when we first use it?' - just that confidence which I don't think comes back to the tool. It's more that once you've been trained you need to have a go so that you have the confidence and, rather than being exposed on your own, you are supported through that process" (Adult

Safeguarding and Learning Disability Coordinator in an Acute Hospital NHS Foundation Trust).

Section 6 The impact of Sit&See on care and compassion

All of the interviewees confirmed that the Sit&See tool helps them to identify and 'unpick' the detail in practice -' the little things', the quality of interactions and, crucially, the experiences of the patient / service user. Whether the service was deemed to be positive, passive or poor, identifying the elements and feeding the findings back to staff ultimately impacted on the care and compassion with which the service was delivered. For example:

> *"I'm picking up all the time on things all the time. I sometimes think - was that passive or was it negative but, once I've done the calculations, there were much more positives. So I found that quite empowering. I think it's human nature to pick up on the negative things - and there are negative things that need to be addressed, but when I did my calculations it was only about 6% whereas in another home it was 12% -15%, but the positives far outweighed the negatives and that was important in the feedback I gave as I was able to say it in an encouraging way - that was really wonderful the way you did this. But there was an occasion when somebody walked through a lounge with a hoist and didn't acknowledge anybody. Even a smile and a nod would have been better that just ploughing through with the hoist"* (Fiona Lawn, Niram Care Group Ltd).

Improving care and compassion

Interviewees were invited to describe how the tool had been used to celebrate care and compassion or raise the pride and self esteem of staff. All had positive responses.

> *" I think it will be used to celebrate care and compassion and raise the self-esteem of staff - employee of the month type stuff, referring to the tool - it was recognised that this person is particularly strong, consistent, dignity champions. And I have strong links with the local safeguarding nurse and want to talk to her about how we are using the tool. By having the tool we can evidence how we are doing things and how we've reached those conclusions"* (Fiona Lawn, Niram Care Group Ltd).

Some interviewees gave specific examples from practice:

> *"Yesterday I went with the Chair of the Trust Board to undertake an observation and she gave feedback to the ward team which was very positive and nice for them to hear. They especially valued the feedback coming from one of the Non-Exec Directors. We're finding that this helps everyone be in touch with each other , rather than just receiving the information via a report. We trained the Non Exec Directors and the bands 2 and 5 together – this was a very worthwhile experience"* (Anne-Marie Hartley, Sussex Community NHS Trust).

> *"In a mental health setting there was a particular situation. Very simple - but that's the point of it isn't it. A member of staff was helping a patient do her hair and I was observing so I was quite removed from the situation and they were no longer aware*

of me. And they were laughing and it was just so genuine - just really sharing a good five minutes together while she was braiding her hair - laughing and chatting. Nothing to do with any particular task or job description element, just a really nice interaction between a nurse and a patient. It was just nice to be able to note how your saw staff interacting with people who were really quite poorly on a locked ward and be able to observe that relationship, to share it, and to feed back. The nurse wasn't really aware of it and it was only when I was discussing it with her afterwards and said 'can I just say that your manner with your patient is so lovely and particularly highlighting that example of when you were doing that lady's hair - just laughing and chatting - just your interaction with her'. And she was really pleased but I don't think she was aware of it. But they're the things that people really appreciate - the nuances. You do pick up the small things but it's the small things that make a big difference to people" (Safeguarding Manager, Clinical Commissioning Group).

" I visited one of our homes and did a Sit&See and just saw the most lovely communication and care - people with dementia being given choices in very different ways which met their individual needs, people talking in a way where they clearly knew the residents, I saw flash cards being used so that was a very positive experience with very little negativity. And I fed that back to the staff at handover and they were really delighted. I think the biggest thing is that staff go about their daily work and they don't realise how good they are at what they're doing. And when you sit there and say 'how you spoke to that person, I could see you knew the person, that you spoke to them really nicely' 'Oh did I?'. That's the most recent example" (Kara Gratton, Milford Care).

All of the interviewees gave examples of the impact when they shared the results of Sit&See observations. For example:

"At our Senior Nurses Forum we share good practice. A lot of our observations are outstanding - 90-100%. Reports are displayed on each ward Quality and Safety Boards so staff can see the Sit&See results. I don't think we celebrate enough" (Anne Worrall, Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust, Oswestry) .

"In our dignity conference we talked about the tool, which we'd introduced a year earlier. I did a ten minute presentation on the tool, then had a slide show of all the amazing comments that had been made about their experience. We acknowledge difficult comments but chose not to reflect on these and use the experience as a reflection and to inspire how fabulous we often are in our organisations. Quotes from the Patients Association, from our Governors and from patients about what had been observed. We played a song 'it's not what you do it's the way that you do it' and had a continual flow of all the brilliant comments so we gave the feedback that way" (Lisa Ekinsmyth, Western Sussex Hospitals NHS Foundation Trust).

Identifying areas in need of improvement

Interviewees were invited to give one example of when the tool had been used to identify areas in need of improvement and how this process was managed. The descriptions included examples of passive and poor care.

"In one of the bedded units the Matron picked up a lot of issues on the safety, infection control part of the tool. That led them to changing how they manage linen and laundry. She witnessed it for herself but before that she hadn't realised how the staff were actually managing it – the staff had never perceived it as an issue . as the practice had become normal to them. We made improvements there and now monitor how they manage this" (Anne-Marie Hartley, Sussex Community NHS Trust).

"In A&E we observed how when a patient is sat on a trolley in an A&E cubicle they can't see the staff and what's going on. And it gave A&E staff the evidence to do intentional rounding 'we haven't forgotten you'. It wasn't poor care but it was a poor experience" (Lisa Ekinsmyth, Western Sussex Hospitals NHS Foundation Trust).

"We did an observation with our governors and in one ward there had been a series of poor observations so we used that as the starting point for a review of what was happening when the sister wasn't there. The behaviours were very different to what the sister would expect. That was fed back and monitored - the director of nursing fed back that day about what had been observed by the governor. We went back and fed back the good stuff to staff as well. Iit was quite intensive" (Lisa Ekinsmyth, Western Sussex Hospitals NHS Foundation Trust).

"Particularly when you're looking at care homes and getting concerns coming in, part of a range of responses could be to encourage the staff to do a Sit&See amongst themselves. Particularly staff who aren't qualified who might feel over-criticised. They have quite challenging roles but perhaps don't get the credit to empower them to take a more objective look at practice, to share and to do it as a rotation perhaps - people on one shift do it and then another shift do it and feed back to your colleagues and peers what you've seen. So it doesn't feel like a punitive thing - just like peer review. When you're in the tunnel so to speak, you don't always realise the things you do really well but also you don't always realise what you're doing - how you're impacting on dignity and how you might not enjoy that if it was you. Sometimes you just need to be removed from the situation to see things objectively" (Safeguarding Manager, Clinical Commissioning Group).

"In the new home over the lunchtime experience - while there were some positives it identified some poor practices. How the service could be improved for the residents but also about how people were communicated to, lack of choice, that type of thing. I also used the tool for feedback with kitchen staff. We changed the dining room as to how we sit the residents and we've done training about communication. I'm back at the home today and we've seen a really good improvement" (Kara Gratton, Milford Care).

"Quite a few positive feedbacks. They use it and want to use it again. It's just the little things. Just forgotten things like not leaving the bell with someone, or saying 'I'll be two minutes' and come back 15 minutes later. Not leaving people alone if they have any element of confusion. Interaction, communication to stop them getting bored. These things are fed back to whoever was doing the tool there and then" (Sue Lillyman, Association of Dementia Studies, University of Worcester).

" We've been asked to redo a Sit&See. We do follow up each month. One area is our Out Patients where there's a lot of building work going on and the pre-op area has

been relocated and there have been areas around confidentiality. Because of Sit&See, this influenced our estates team to improve the environment for privacy where patients are. From an environment point of view it certainly has helped" (Anne Worrall, Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust, Oswestry) .

Section 7 Changing organisational culture

Interviewees were asked if Sit&See had contributed to changing culture in their organisation. Most said that Sit&See, sometimes alongside other measures, has helped, is helping, or has the potential to improve their care culture.

"Absolutely. I think that is the key to it really, I think kindness, care and compassion are key to having a good culture" (Patient Educator, Management of Aggression and Violence Lead).

" I think it is doing. There's lots of things that have contributed to changes in mental health care recently, particularly in high secure, and part of that has been around the recovery model of giving patients ownership of their own health and wellbeing" (Alison Cannon, North of England Specialised Commissioning Team, NW Hub).

" I think it will change the culture. Also you can back it up. The DVD is excellent because you really see the difference between the matter of fact approach and wording things differently which seems much kinder and people maybe have a better acceptance of what you're trying to do, and it could help diffuse situations. If staff have that awareness and you have that in the culture of the home maybe if someone comes to them a bit irate with a complaint, it's going to help with that as well. So it's not just about sitting and doing the observations, it's about how it's going to affect how staff respond in any situation" (Fiona Lawn, Niram Care Group Ltd).

"I think so. When we do the training we explain that when we find something that is passive or poor we're not saying that people are purposefully doing that. It may be very well meaning but they might not have thought how that might be perceived by somebody from the outside looking in. We're not criticising (which is what staff worry about), it's just an observation, so yesterday for example, we witnessed patients being referred to as Bed 1, Bed 2. Actually the person doing that was aware that there were observers in the room so was trying to maintain the confidentiality of the patients she was talking about. She was doing it for the right reasons. So we said 'yes we understand why that was but it might have been slightly nicer to say 'the patient in bed 1' because it sounds more dignified and respectful'. They took that on board and told us that it was useful for them" (Anne-Marie Hartley, Sussex Community NHS Trust).

"I think that if you are empowering people to do things for themselves, empowering them to change things from the people working on the shop floor to the management. For people doing hands-on care, particularly in challenging environments, it's a good way of exploring what you do and having those conversations at staff meetings, such as how things can be perceived but you haven't really seen that before" (Safeguarding Manager, Clinical Commissioning Group).

There were comments that Sit&See can be particularly effective in culture change when used alongside other measures.

> *"I think so. We've also got dementia mappers in our group. With the mapping you are looking intensely at an individual and also looking at everything else around - the environment and how things are happening, how people are speaking and how that impacts on that person so the two go well together"* (Kara Gratton, Milford Care)

> *"Generally our organisation is mindful of the 6 Cs and compassion is part of our quality strategy. I think we need to celebrate it more. Getting everyone familiar with Sit&See so that all the wards are having observations done at least once a month. Staff are quite happy. At first they were wondering what were they there for and what were they watching but now it's part of the working and it's expected fitting in with our quality and safety strategy. So Sit&See is used as assurance of practice and also evidence that the observations are being carried out and we are noticing things and acting on things that need improvement"* (Anne Worrall, Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust, Oswestry) .

Section 8 Sit&See in education

How the tool is being used in education

Three of the interviewees worked in universities using Sit&See:
- with student nurses within pre-registration education programmes
- with registered nurses undertaking continuing professional development (CPD) programmes and
- with healthcare assistants on work-based learning programmes.

One university worked with 'sim' patients (mannequins) to create simulated situations.

> *"Where Sit&See is fitting in very nicely in education is where we have 'sim' men simulating situations where they're managing a deteriorating patient, recognition of a deteriorating patient so they're looking at the more technical side with them"* (Sue Rush, Kingston University).

> *"If the group has two hour simulation they then have two hours feedback. So once they've finished the simulation they will then stay 15-20 minutes with their role player receiving feedback from them. The two students who spent the two hours with them will get that feedback. What we then do is a formalised feedback for the whole group of students working in that ward. So it might be 15-20 students who were working with a number of patients. There's then a formalised handover period so that students can see the type of work that's going on elsewhere that they haven't been involved in, so there's some learning there. Then we were going back to the Sit&See, using some video footage that we'd captured from the students and helping them to identify the care and compassion demonstrated in that simulation"* (Sue Rush, Kingston University).

An alternative approach was with members of the public, many of whom have experienced healthcare services, acting as role players in simulated situations in which they receive care from one of two students. After about an hour after, with a lecturer present, they then feed back to the students about their experiences. The lecturer interviewed highlighted that the Sit&See training *"helped them identify what was really good care or good compassion"* (Sue Rush, Kingston University).

> *" We do role player development days around how to give feedback and to recognise compassion etc. and the work we've been doing with Sit&See has really helped them to identify things like that. Because as they're lying in bed waiting for the nurses to come they are observing all sorts of things which they can then feed back"* (Sue Rush, Kingston University).

> *"What we're trying to do is enable students to understand what is meant by 'compassionate' and what is meant by 'care'"* (Sue Rush, Kingston University).

Another university employed a similar approach:

> *" We integrate the tool within our patients scenarios ... and we use Sit&See with the students to feed back to each other. Actors role play different scenarios with two students observing. They then swop scenarios. We focus in year one on privacy, dignity, self empowerment. We are looking to integrate this into other modules but are seeing how it works on year 1. So far it has worked really well, enabling students to feed back and to structure their feedback. So talking about empowerment and how they involve the person and how that involvement is or is not shown in practice. The tutors go around and assist in the feedback"* (Wendy Grosvenor, Surrey University).

A third university used Sit&See with registered nurses undertaking continuing professional development (CPD) programmes.

> *"We train people to use the Sit&See tool. It's part of the course - they have to use it then come back and tell us what sort of experiences they've had. Experiences are totally varied. We get some excellent ones, we get some saying it's good to be able to just sit and observe and listen and we get some where it hasn't worked at all"* (Wendy Grosvenor, Surrey University)

> *" We also have two dementia CPD modules as well as a work based dementia module. I teach them about the tool, then they go into practice areas to observe. We tend to do this at specific times, mealtimes or handover. They tend to go into areas that are not their own areas and come to feed back. We then encourage them to develop action plans. There is a timetable for them to feed back and we look at how they can look at the things they've identified that need improving. This can inform their trust action plan and obviously we are looking at how we can support them. With the CPD learning, the tool is used in conjunction with the King's Fund Environmental Audit. So they audit their care environment and then using Sit&See they audit the care in their ward or care home - so they are looking at care and environment - a two pronged attack, to look at what changes they want to see"* (Wendy Grosvenor, Surrey University).

Sit&See in student/course member records

Currently, the findings of Sit&See observations were not being fed into student records although this was being considered for the future. The findings were supporting learning in other ways, such as helping students in giving verbal feedback to each other, in helping to structure their thinking around positive, passive and poor care. For CPD course members, Sit&See feeds into an action plan for their service.

> *"It forms part of Trust governance, feeding into CQC. It's used with the Kings' Fund environmental tool and alongside the Butterfly Scheme. So using Sit&See alongside other audits can be particularly useful for audits and governance"* (Wendy Grosvenor, Surrey University).

Challenges in education

A range of challenges were identified. These were generally not specific to using the tool, for example the limited life experience of young student nurses, confidence in being observed and confidence in giving feedback. Time was also an issue.

> *"We've gone through the stage of recruiting older students and are now recruiting students who are fresh out of school - 17-18 year olds. Their life experience is limited and they've had very little experience of going into any real practice, certainly within the acute setting. Certainly if they're interested in mental health, they can't get into a clinical area, and for some even the word 'compassion' is quite challenging, trying to unpick that and trying to help them to understand what is meant by that"* (Sue Rush, Kingston University).

> *"Confidence, not with students because they are in a safe environment and with simulated patients, but certainly where we've incorporated it in practice areas, they can feel quite uncomfortable being observed, and it can take some talking through so that they don't see it as a negative or that it's a management 'cosh' . We have had a couple of students where we've said 'ok you don't have to do this' and reassure them that it's useful for them, it's not a negative, that most of say 'we'll yes I've actually done that or said that' and it's development - seeing people - it's so valuable"* (Wendy Grosvenor, Surrey University).

> *" Even half an hour is a lot of backfill time, particularly in care homes. But often from the busy times, you can get so much value from observing at these times"* (Wendy Grosvenor, Surrey University)

In terms of Sit&See changing service cultures, interviewees were positive about the potentials.

> *" With the right support - definitely. I think that, with any tool, there is a danger that students come on a course, are inspired and empowered to make change, get back to reality and find challenges. Which is why we get them to identify practice changes. It is definitely of value in an organisation. We can give support but we are not there in the practical reality, so they need support"* (Wendy Grosvenor, Surrey University)

Advantages of using Sit&See in education

A range of advantages to using Sit&See in education was identified, specifically the simplicity of the tool, assisting with communication, helping people to frame and hear feedback, unpicking the elements in care and identifying what person centred care actually looks like.

> *"It's just such a simple tool to use. People tend to focus on the passive/poor but when we get them back we have a discussion about when they're doing and help them unpick what is passive and what is poor, it helps them have the discussion"* (Wendy Grosvenor, Surrey University).

> *"Communication is something we've had to really work at. The tool has helped us to look at the students' communication and see how this is developing"* (Sue Rush, Kingston University).

> *"It helps people to hear feedback, especially in relation to communication, involving the person, the fact that they're in the zone of providing care so they're not thinking about being observed. So particularly for those who haven't had healthcare experience, it can help them when going into practice"* (Wendy Grosvenor, Surrey University).

> *" From an education point of view it has helped us in how we deliver person centred care and how we get that across to students via experiential learning, rather than just talk at them, getting them to think about what it actually means. It helps to frame how they see the service and how they want to see the service"* (Wendy Grosvenor, Surrey University).

Examples of where Sit&See identifies care and compassion through education

> *"For first years, things can seem quite small but they're the things that make a difference. We had students who were caring for patients with head injury lying flat. Some managed to have eye-to-eye contact rather than standing half way down the bed or at the end of the bed so that patient couldn't see who they were. But not invading their personal space either. So that was fabulous"* (Sue Rush, Kingston University).

> *"One of our students had taken one of these work experience students aside and said 'what we're going to do now is to brush her hair so that she looks nice for when her uncle (or whoever it was) comes in to see her'. And brushing this mannequin's hair - the hair's not real - it's plastic - but the compassion they showed - working with this person who had just died so that she could look the best she could when the relative came along. And they were so genuine. Our students were very junior but were already thinking about bringing in a work experience student and being compassionate towards the work experience student as well. And it's those little bits - they were actually behind a curtain and were viewed on a video so in that way we're doing Sit&See from a distance as well. So there was no lecturer there, this was done just by the student, and that would have been missed if we hadn't been thinking about care and compassion"* (Sue Rush, Kingston University).

Interviewees were asked if Sit&See contributed to improving care cultures.

"Absolutely. It certainly has within our simulations. I think it's also helped with student feedback in that we're focusing on celebrating care and compassion, rather than 'this isn't very good' " (Sue Rush, Kingston University).

Suggestions for developing the tool in education

"It's important to use areas that are not the students' own areas because, even if they aren't in uniform, they get drawn into other things" (Wendy Grosvenor, Surrey University).

" For students we want them to focus on the communication, empowerment, privacy and dignity so if there was a way of developing the tool so that you could use parts of it that would be useful. For CPD students they use the whole tool because they are using it within a clinical environment where things like infection control are important but within education we want to focus on the person centred stuff so it would be useful to have a reduced tool - focusing on involvement and empowerment to make the changes they've identified" (Wendy Grosvenor, Surrey University).

Section 9 Developing the tool

All interviewees were happy with the overall structure of the tool and how it works in practice. Some said that it need no amending.

"We like the categories of positive, passive and poor. The tool is easy to use" (Anne Worrall, Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust, Oswestry) .

" It's quite user friendly. It gives us what we need from it and is easy to use" (Kathy Brasier, Queen Victoria Hospital NHS Foundation Trust, West Sussex).

"We're quite happy with it all. We just love it. We love using it. I was talking the other day to a relative about how I'd done the Sit&See and how it has brought about change and she said 'relatives would not even know that was happening'. So we have a relatives meeting and I'm going to talk to them about Sit&See. It made me think we need to publish it more, to relatives and to a wider audience" (Kara Gratton, Milford Care).

A few comments suggested that it took a little time to become accustomed to the tool but that, within a short time of practice, observers were able to use it fluently.

"The students say that it just takes some getting used to the language but once you get to know it you are not checking all the wording - what's poor, what's this? It's not the tool, it's the mechanisms when using it for the first time. But when they did it again they didn't need to take the bit of paper with them to keep checking" (Sue Lillyman, Association of Dementia Studies, University of Worcester).

Various suggestions were made on how the tool could be 'tweaked' to make the content more focused on specific areas, for example for mental health, A&E or learning disability services:

- *"make it a bit more mental health, particularly to capture the recovery concept and how staff are working*" (Alison Cannon, North of England Specialised Commissioning Team, NW Hub).
- *"in our settings incontinence is not so relevant*" (Adult Safeguarding and Learning Disability Coordinator in an Acute Hospital NHS Foundation Trust) .
- *" I haven't had so much observation of the infection control aspects. I'm not saying that's a problem because we need to do more and there will be times when I see them disposing of dirty laundry. I'm getting just four or five ticks but it is picking up things. So at the moment the tool seems fine*" (Fiona Lawn, Niram Care Group Ltd).
- *" I'm comfortable with the tool. Staff in some areas have said 'can we have more specific prompts about A&E or Outpatients or another area' but I don't think it's necessary really because it's all there. And observers can ignore the bits that don't apply to that area. And it's worked really well in our Outpatients so ...*" (Lisa Ekinsmyth, Western Sussex Hospitals NHS Foundation Trust)
- *"Developing the tool for learning disability services and that might be something we want to link into. Certainly the team I support that manage the aggression and violence training have some learning disability people on that and yesterday I was providing some information on what the tool was about and they were really interested. They could see that fitting in well with the work they do around behaviour and functional analysis so that's a potential area for development*" (Patient Educator, Management of Aggression and Violence Lead).

There was a suggestion that future learning materials could include scenarios showing a broader range of observers:

> *"The DVD is very nursing focused. it would be good to have more generic scenarios that we could show to staff such as housekeepers, paramedics, community, mental health, prison - to encompass different settings"* (Wendy Grosvenor, Surrey University)

One interviewee said she would find an electronic version useful.

> *"I use an i-Pad, so to be able to generate a report straight away would be great. If you could just click on something every time you observe an interaction and then just click to generate a report that would be less time consuming to analyse your data and generate a report"* (Safeguarding Manager, Clinical Commissioning Group)

One of the university interviewees had a member of staff interested in doing a Masters degree and developing the tool for use within education*. "There are some other aspects that we're also seeing in feedback from lecturers, like professionalism and courage, which the tool doesn't capture at the moment. It's about how we integrate this into the learning for the students, looking at how we capture professionalism and courage as well"* (Sue Rush, Kingston University).

Interviewees were also finding local ways in which to develop how the tool is used, for example:

"I had a meeting with our Sit&See observers last week and asked them to think about having some sort of newsletter regarding Sit&See and how this is working" (Anne Worrall, Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust, Oswestry) .

Section 10 Summary of findings from the evaluation

1. The Sit&See tool is being used in a broad range of services including accident and emergency and outpatients, day surgery, mental health, high secure, nursing and residential care homes for older people, people with dementia and physically disabled adults, learning disabilities, children's services, specialist services including orthopaedics, spinal injuries, specialist burns and plastics. It is also being used in universities running pre-registration, CPD and work-based learning programmes.

2. It is being used by staff from all disciplines and at all levels, by people involved in all aspects of services (including as Non-Executive Directors, Trust Board members, the clergy) and by service user representatives (including patient representatives, carers and people with a learning disability).

3. Given a few hours of training plus some supported practice, people find the tool user-friendly, simple and straightforward to use.

4. Observation sessions are conducted in a variety of ways, some organisations set out pre-determined programmes, some do impromptu observations in specific areas or at specific times. Some pair observers, for example clinical and non-clinical people including volunteers, or representatives from CCGs and provider organisations working together. Most organisations use the Sit&See paperwork to record findings, sometimes supplemented with additional recordings.

5. Evidence from Sit&See observations is used to feed back to staff informally and in regular meetings. It is used in peer review and team review. It feeds into patient safety programmes, Board reports, quality assurance, quality monitoring systems, evidence for CQC inspections, performance reports and patient experience reports. It is also used in contract monitoring, safeguarding and service improvement plans. Findings also reach public domains through websites, Trust Board reports, public board meetings, patient representative groups, reporting of CQC inspections, public presentations and, recently, through social media such as Facebook and Twitter.

6. Some users have not met any challenges in implementing Sit&See. The main challenge was time, although all interviewees stressed that Sit&See is not time-consuming to learn or use and the problems with identifying time to learn the tool and for management support in implementation would be the same for any tool. A minority of staff, particularly students, had a reluctance to being observed or to observing others. One interviewee identified specific clinical situations, for example when a patient was in a mental health crisis, when sitting to observe would not be appropriate and observation would be better carried out from a distance. When in their own work area observers were often interrupted and observations were easier in an area where the observer did not work.

7. All interviewees described how Sit&See helps them to identify and 'unpick' the detail in practice - 'the little things', the quality of interactions and, crucially, the experiences of patients/service users. Whether the service was deemed to be positive, passive or poor, identifying the elements and feeding these back to staff helped them to improve their practice and the services they offer. There were many examples of positive care and situations where Sit&See had helped to identify areas in need of improvement.

8. Crucially, through observing and identifying the detail in care and interactions, Sit&See helps staff gain insight into aspects of their practice of which they were unaware. Interviewees were clear that this is highly valuable and that Sit&See is the only tool that achieves this.

9. Specifically, Sit&See helps staff to understand what person-centred care looks like. It helps 'unpick the language' of person centred care, to show how to involve patients in their care, how to support and empower people and how to show compassion.

10. Sit&See celebrates care and compassion. While areas for improvement are identified, staff are frequently surprised by realising that most of the care given is positive, caring and compassionate.

11. Sit&See has been found particularly useful in communication, in 'getting conversations going' and in framing feedback to staff.

12. It helps staff in different parts of the organisation, in different roles and at different levels, to connect, thus breaking down barriers, e.g. when Directors or Trust Board members do observations and feed back to staff.

13. All organisations reported that Sit&See had positively impacted on care and compassion in their services and was a key contributor to positively changing cultures of care.

14. Sit&See is valuable in education with pre-registration students, registered nurses undertaking CPD programmes and with work-based learning programmes.

15. Some interviewees reported that Sit&See has changed the way in which they observe and communicate*: "I realise I'm using the principles of Sit&See to observe and I'm feeding back in a Sit&See way. D'you know this has really changed the way I think*" (Alison Cannon, North of England Specialised Commissioning Team, NW Hub).

16. It works well with other tools e.g. King's Fund Environmental Tool, Dementia Care Mapping, the Butterfly scheme. Sit&See is distinct in that it focuses on the service users' experience of care.

Concluding thoughts

"It's so simple but it does what you want it to do and that's why it's popular" (Lisa Ekinsmyth, Western Sussex Hospitals NHS Foundation Trust).

" Sit&See is a really powerful tool. It isn't technological or complicated - it's purely and simply about what patients will be seeing - the importance of the quality of the interactions. It really helps us see the point at which the patient sees things. I'm just

grateful we have the tool to use. It's brilliant. We love the tool" (Lisa Ekinsmyth, Western Sussex Hospitals NHS Foundation Trust).

"The tool does what it says on the box - it's comprehensive. And for us to be able to use the tool in education has been a brilliant experience" (Wendy Grosvenor, Surrey University).

"T*here really is not anything else out there to help you monitor practice. This gives you a nice framework and it's a really good jumping off point. That's the nice thing about it - a format you can utilise. It's a really good framework"* (Adult Safeguarding and Learning Disability Coordinator in an Acute Hospital NHS Foundation Trust) .

"The staff really value hearing the feedback. Our Trust Board absolutely love it. They enjoyed the training. The Chair liked doing it and said 'it makes you see what's right with the world doesn't it, when you come and do one of these'" (Anne-Marie Hartley, Sussex Community NHS Trust).

Appendix with examples

One Trust's overview of the number of observations conducted and the percentage of positive rates per month

	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
A&E	96%	-	-	79%	90%	-	85%	-	87%
AMU	95%	97%	-	100%	-	100%	98%	86%	-
Ward A	-	92%	85%	75%	-	89%	96%	88%	-
Ward B	87%	87%	-	100%	-	-	95%	86%	89%
Ward C	86%	-	100%	100%	-	88%	-	100%	-
Therapies	92%	100%	-	-	100%	100%	-	92%	-
Outpatients	50%	90%	86%	-	-	-	73%	95%	-
Day Surgery	72%	-	92%	71%	-	-	82%	100%	90%
X ray	-	94%	-	-	-	96%	-	98%	100%

Results of the observations are discussed at the time of the observation with the nurse in charge and a follow up report is sent to the manager of the ward or department with action points (if any) to take forward. This is reviewed by the Sit&See observers for the following month to ensure the actions identified previously have been implemented. The report is shared with ward/department staff, and is also part of the performance framework.

Examples from one Trust of positive key themes identified with Sit&See

- Staff Interaction with patients – enjoying banter with medical staff and housekeepers
- Curtains drawn and doors closed for privacy and dignity
- Parents of children that are inpatient are encouraged to be involved in care
- Clean and Tidy Department and Wards
- Nurses polite, approachable and professional
- Porters creating 'small talk' with patients
- Quiet and Calm
- Drinks machine available
- Comment cards available for feedback
- Patients called and spoken to using their first/given names
- Cleaning check lists completed for each room
- Patient attended reception - Quietly spoken no information was overheard
- Receptionist has a very good telephone manner and very courteous on phone and clarifies that patient has understood what she said

- Very helpful directing patients to x-ray/toilets
- Staff sat and chatted to the patients prior to their surgery elevating any fears.
- Witnessed a discharge the patient asked several questions in which the staff nurse answered appropriately.

Examples from one Trust of Passive and Poor Key Themes

Observation: Patient ringing bell in bay – light not working to alert staff help was required
Action: Light bulb has been replaced

Observation: Staff not using hand gel
Action: Constant reminding – posters – infection control awareness – infection control link nurses

Observation: Notes are visible for each patient
Action: Looking in to new cabinets to keep notes locked away.

Observation: Staff walking with cups in front of patients (clinics)
Action: This is due to not wanting to stop consultants clinic, HCA make drinks for them and take them to their consultant rooms – the use of flasks discussed

Observation: Patient and family member asked a nurse if she was going home today, nurse was unsure of the patients discharge date
Action: New patient bed boards will state patient EDD as well as other significant information

Observation: Computer left unlocked with EPR open visible to anyone. Please lock computers when not using them
Action: Staff awareness – information governance checks – constant reminding.

Observation: Staff member taking blood did not use gloves, wearing ring on thumb
Action: staff member spoken to ensure removal of ring and compliance regarding infection control standards.