NHS
Institute for Innovation and Improvement

Releasing Time to Care

The Productive Community Hospital™

Patient Involvement

Version 1

This document is for clinical leaders, department managers and senior therapists

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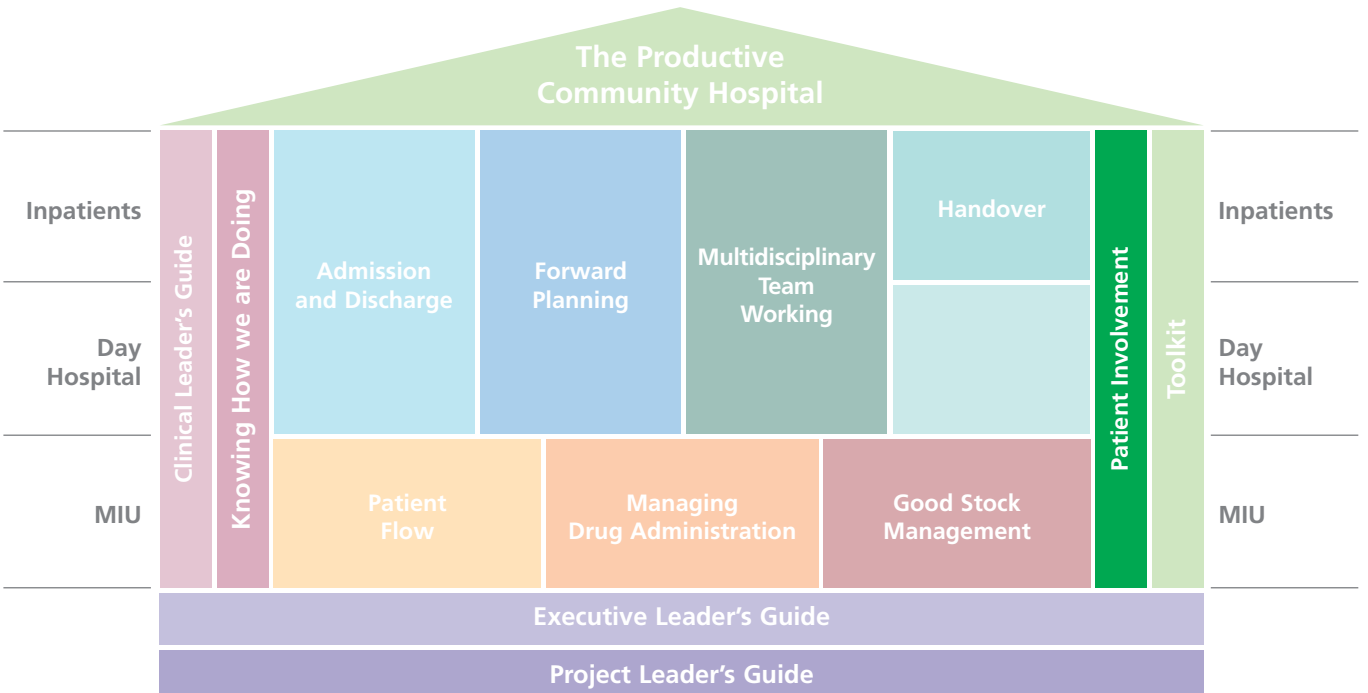
Contents

These modules create The Productive Community Hospital



Patient Involvement

What is it?

A practical way to improve the communication with and involvement of the patient and his/her carer in the planning and management of their own care.

Effective involvement is where:
- the patient is viewed as an equal partner in the planning and delivery of care
- communication is planned and targeted to the patients' needs
- feedback is sought about the effectiveness of communication

Why do it?

A patient fully informed and involved is more likely to understand and comply with treatment and be physically and psychologically prepared for discharge, transfer or end of treatment.

What it covers

This module will improve your patient involvement by demonstrating:

- where you are now in relation to patient involvement in the admission and discharge process
- the approach to reviewing current information provision and requirements
- good practice guidance on the content and type of information for patients and carers
- examples of information material from both inpatients and day hospital
- how to evaluate your improved patient involvement and make continuous improvement to sustain the changes you have made

What it does not cover

This module will not describe best clinical practice. It will help you identify areas that could benefit from improvement work, understand how they could be improved and help you to make it happen.

Learning objectives

After completing this module, you will:

- understand what good preparation for the module is
- develop audit as an activity
- understand how patient involvement currently works
- understand what is meant by effective patient involvement
- develop patient and carer involvement to allow staff to work more productively

How will you achieve these objectives?
The first three objectives will be met by the step-by-step approach within this module to help you to assess the current ways of working and diagnose the problem areas by performing three pre-improvement audits. These are:

- Patient Information Audit
- Review of Written Information Audit
- Requests for Information Audit

By carrying out these audits you will be able to identify what you do well and not so well in patient involvement.

As you work your way through this module you will be able to identify what needs to change about the way the you involve patients and carers in their treatment and care.

By repeating these audits you will be able to measure the differences made to the patient involvement process.

The last two objectives will be met through a step-by-step approach to describe what a good process is and how you can achieve it.

The 6 phase process

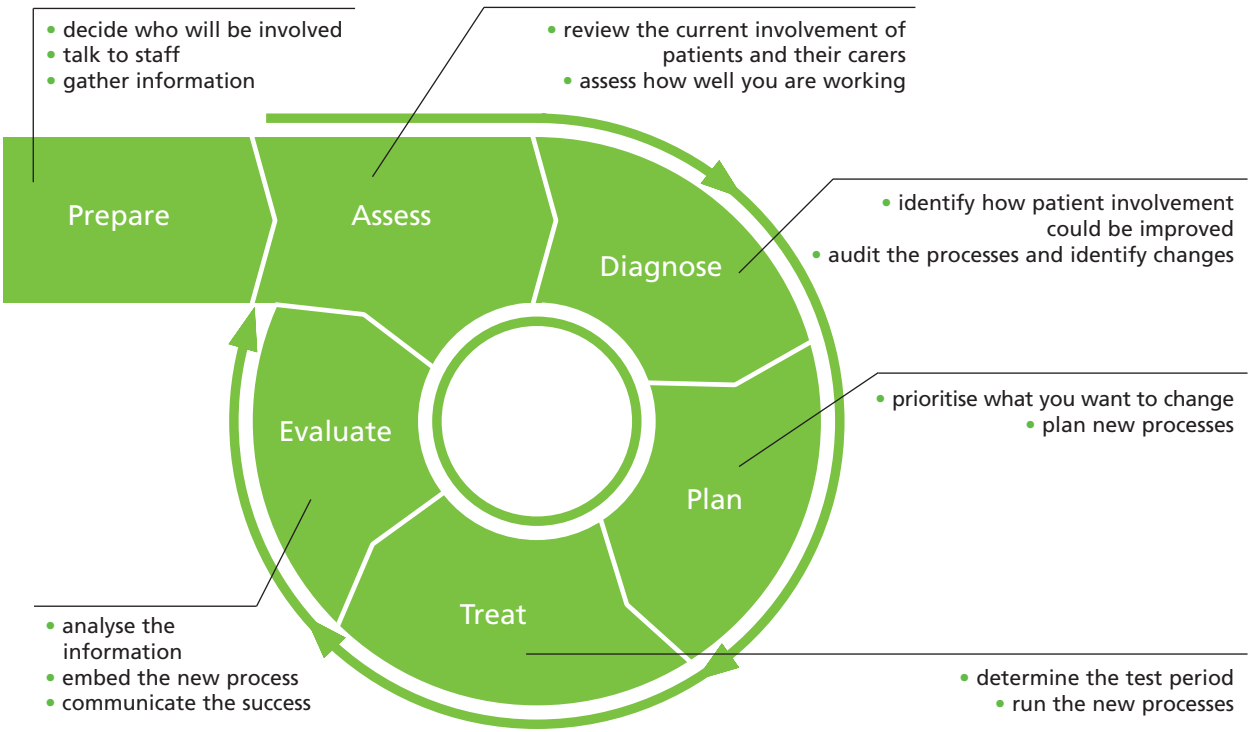
All of the modules in the Productive Community Hospital series are based on the standard nursing process of: prepare, assess, diagnose, plan, treat and evaluate.

While illustrated using a patient care cycle, the six phase process is the same as the generic improvement cycle Plan, Do, Study, Act and gives clinical staff a structured approach to improving clinical area processes that is very similar to the care cycle they are familiar with.

It is a cyclical process of continuous improvement. Once you have worked your way through this module, you should return to the assess section and repeat the steps. The results that you capture each time will show how you have improved since the last time.

As you work through the module you will be reminded about the stage of the process that you are working on.

The 6 phase process



The tools

In order to know how well you are doing and help you treat any problems that you find with your patient involvement process you will need to use the tools listed below.

Tool	Toolkit reference number
Interviews	Toolkit General Section 2
Patient Information Audit	Patient Involvement Tool 1
Patient Information Booklet	Patient Involvement Tool 2
Patient Comment or Request Form	Patient Involvement Tool 3

Copy the module checklist on page 49. Completing this will help you monitor your progress throughout the module.

Prepare


IF YOU FEEL YOUR CONDITION IS
WORSENING
PLEASE LET A MEMBER OF STAFF
KNOW
IMMEDIATELY.

Involving the right people

Decide who will be involved
To achieve effective patient involvement you will need to engage with all members of the team.

- establish a core team who will lead and take responsibility for the work in this module. These might include those listed in the box
- widen this group when you require more involvement from other members of the staff and patients

Core module team	
Who?	**What will they do?**
Ward/department manager or senior therapist	• take the lead for implementing this initiative • communicate the goals and objectives • encourage and support the team throughout the initiative • keep the focus on searching for opportunities for improvement
Ward staff, therapists, social care team, medical staff etc.	• be willing participants in the discovery of issues and implementation of new approaches
Patient/carer	• bring a fresh perspective and a unique insight • ensure that improvements are patient focused

The 5 step process


1. Talk to patients
Use Toolkit General Section 2. To ensure your processes are patient-centred, the views of patients should be sought as part of your general preparation.

You should seek guidance from your nursing director/public and patient involvement (PPI) lead:

- what is the patients experience of their involvement?
- how would they like to be involved?
- do they have any concerns regarding the assessment and planning of care?

2. Talk to staff  
You will need to talk to staff and get their views on involving patients and carers. Use Toolkit General Section 2 and ask:

- what currently happens?
- what causes problems?
- what they would need from improved involvement process?

3. Gather information from patients complaints:

- look back over the past year and identify any complaints that indicate dissatisfaction with communications between patients and staff

4. Gather information from incident reports:

- look back over the last 50 incident reports
- look for any evidence regarding poor communication between patients and staff

5. Obtain your trust policy or guidelines for admission:

- gain information regarding the trust policy for criteria and process for involving patients
- gain information on trust policy for including patients and carers in assessment and planning
- compare your performance in engaging patients in their care with your trust policy

Prepare - milestone checklist

Move on to ***Assess*** only if you have completed all of the items on these checklists.

Checklist	Tick if complete
Decide who will be involved	
Talk to staff	
Talk to patients	
Gather information from patient complaints	
Gather information from incident reports	
Obtain your trust policy or guidelines for documentation	

Effective teamwork checklist	Tick if yes
Did all the team participate?	
Was the discussion open?	
Were the challenging questions discussed and answers agreed by all?	
Did the team remain focused on the task?	
Did the team focus on the whole process, not on limited individual steps?	

IF YOU FEEL YOUR CONDITION IS WORSENING

PLEASE LET A MEMBER OF STAFF KNOW

IMMEDIATELY.

Assess


IF YOU FEEL YOUR CONDITION IS
WORSENING
PLEASE LET A MEMBER OF STAFF
KNOW

Assess the current patient involvement process

The next thing you need to understand is what typically happens to involve and communicate with patients and carers.

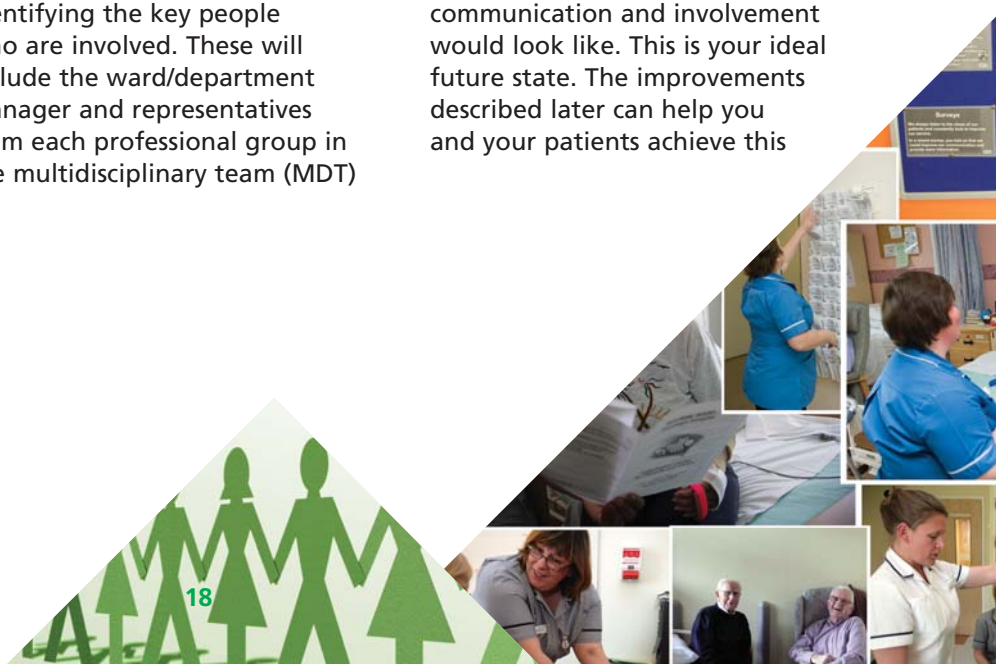
There is added value in getting everyone involved in understanding how things currently happen and what the future state should look like.

Do this by:

- identifying patient and carer representation is vital
- describing the current ways you involve patients in their care
- identifying the key people who are involved. These will include the ward/department manager and representatives from each professional group in the multidisciplinary team (MDT)

Focus on:

- pre-admission
- planning care during patient stay
- planning discharge
- describing what ideal communication and involvement would look like. This is your ideal future state. The improvements described later can help you and your patients achieve this



Assess - milestone checklist

Move on to ***Diagnose*** only when you have completed ALL of the items on these checklists.

Checklist	Tick if complete
There is a clear understanding of the importance of patient communication and involvement and how it currently works?	
All participants in patient and carer communication and involvement have been represented.	
There is an understanding of the key issues in patient and carer communication and involvement	
There is a draft description of an ideal future state patient and carer communication and involvement	
All the staff have been able to give their feedback of the current patient and carer communication and involvement	

Effective teamwork checklist	Tick if yes
Did all the team participate?	
Was the discussion open?	
Were the challenging questions discussed and answers agreed by all?	
Did the team remain focused on the task?	
Did the team focus on the whole process, not on limited individual elements?	

Diagnose

The audit process

To help you diagnose the current state of your patient involvement undertake the following pre-improvement audits specific to this module. These are:

- Patient Information Audit
- Review of Written Information Audit
- Requests for Information Audit

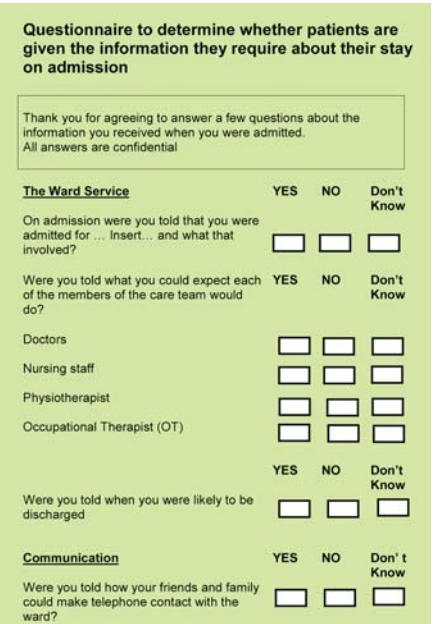
An explanation of how to carry out these audits is provided on the next pages.

Patient Information Audit	Review of Written Information Audit	Requests for Information Audit
Targeted survey of information given to patients on admission, asking patients how and when they receive information and how they seek it	Identification of all information formats used to provide information for patients	Survey of the type of questions patients and carers ask staff shortly after their admission

Patient Information Audit

This audit will tell you how you how and when patients receive information and how they seek it. What you needs to do is:

1. Choose a day that you will undertake the audit and inform staff.
2. The day before the audit ask the patients if they are willing to participate. Explain that they can complete it with their carers if they prefer.
3. Allow a couple of days to complete the audit. Inform patients when you will be collecting it.
4. Use the Patient Information Audit in the Patient Involvement tool 2.
5. Give this to all patients on the ward on the day of the audit, or to 25 patients over a period of days, if less than 25 patients on the ward.
6. Collate the findings to identify the issues.



Questionnaire to determine whether patients are given the information they require about their stay on admission

Thank you for agreeing to answer a few questions about the information you received when you were admitted.
All answers are confidential

The Ward Service	YES	NO	Don't Know
On admission were you told that you were admitted for … Insert… and what that involved?	☐	☐	☐
Were you told what you could expect each of the members of the care team would do?	YES	NO	Don't Know
Doctors	☐	☐	☐
Nursing staff	☐	☐	☐
Physiotherapist	☐	☐	☐
Occupational Therapist (OT)	☐	☐	☐
	YES	NO	Don't Know
Were you told when you were likely to be discharged	☐	☐	☐
Communication	YES	NO	Don' t Know
Were you told how your friends and family could make telephone contact with the ward?	☐	☐	☐

Review of Written Information Audit

This audit will tell you what written information sources you have in place for patients.

What you needs to do is:

1. Create a simple table as detailed in example shown.
2. Make a list of all the sources that you are aware of that are provided when admitting or discharging a patient.
3. Ask the MDT if they have more to add to the list.
4. Collect the information and review if there are any overlaps.
5. Make a list of the overlaps and gaps.

You will also use this when you move into the Plan stage.

Information source	Given by	At what point	Content overlaps with other?
Patient information leaflet	Ward clerk	On arrival	Ward booklet
Ward booklet	Admitting nurse	On admission	Patient information leaflet
Discharge leaflet	Discharge nurse	When discharge planned	Some similarities with ward booklet

Review of verbal information

This audit will tell you what verbal information sources you have in place for patients.

What you needs to do is:

1. Choose a week where there are five working days and tell your team that the audit is being undertaken.
2. Create a simple table as detailed below.
3. Provide copies for each member of staff, including the ward clerk and medical secretaries.
4. Ask your staff to record the questions they are asked by patients and carers over a five day period.
5. Make a list of the questions and how much time is being used to respond.

Date and time	Team role	Question	How long in minutes	Telephone	In person	Other
18/01/08, 09.00	Ward clerk	When will the Dr. be here?	3		X	
18/01/08 11.30	Ward clerk	Can I smoke in the court yard?	2		X	


PATIENT ATTENDANCE
The Minor Injuries Unit is staffed by experienced Emergency Nurse Practitioners
What can you expect ?
WELCOME TO
Minor Injuries Unit
QUEEN MARY'S HOSPITAL
Tel: 020 8487 6499
Surveys
Patient Documentation
WAITING

Diagnose - milestone checklist

Move on to ***Plan*** only if you have completed ALL of the items on these checklists.

Checklist	Tick if complete
Undertake the Patient Information Audit	
Undertake a Review of Written Information Audit	
Undertake a Request for Information Audit	

Effective teamwork checklist	Tick if yes
Did all the team participate?	
Was the discussion open?	
Were challenging questions discussed and agreed by all?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not on individuals?	

Plan


IF YOU FEEL YOUR CONDITION IS
WORSENING
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KNOW
IMMEDIATELY.

Planning to improve your patient involvement

Having diagnosed the current status of your communication with patients and carers, this section will take you through the planning steps to help you to treat your communication and make it better.

This will help to make your communication and involvement better by helping you to:

- create a patient information leaflet/booklet
- create a patient and carer comment and request sheet

The following good practice examples are available in the Toolkit, Patient Involvement Tools 2 and 3:

- Patient Information Booklet
- Patient Comment or Request Form

You will need to:

- obtain your trust policy on the development of patient information
- involve your PPI lead and communications team

Patient information leaflet

Patient and carers will have many concerns about their stay and even though you and your team may have good verbal communication skills, patients and their carers will appreciate written information which they can refer to. It will also save time when simple questions about the stay can be provided before or on admission.

The objective for developing a patient information leaflet is to provide guidance on how to create and agree the content and format of a patient information leaflet.

Provided is an example of a leaflet used in community hospitals which you can adapt and use.

Suggestions on how to improve your patient communication:

1. Identify who is involved in the provision of information about admission and discharge, both written and verbal on your ward/department. It is likely to be a variety of professionals and support staff.

2. Let them know that you are planning to create a new patient information leaflet to address the issues you identified in the audits.

3. Ask for volunteers to join a working group, making sure you have representation from the key staff groups involved.

4. Ensure you include a patient representative and a carer on the group.

5. Set up a process to test out an early version with a group of patients and carers.

6. Draft the leaflet addressing the issues you identified in your patients' information audits, using the following headings as good practice guidelines.
(continued on page 33)

Example headings and information to include in your patient information leaflet

Welcome to the department
General introduction to purpose of the department and its staff.

Your care
Description of model of care, such as assessment followed by individual programme aimed at rehabilitation or management of symptoms.

Communication
- visiting times
- telephone enquiries
How you will talk to your patients, share written information with them. How they will talk to you, ask you questions. How and when their relatives and carers can visit with the reasons explained.

Members of your patients' care team
- medical staff
- nursing staff
- therapists
- care manager
Description of who all the team members are in your patients' care team and what their role is.

Your inpatient stay
- meals and refreshments
- clothes and toiletries
- department services
Description of meal and refreshment choices and times, your patients' personal clothing and toiletries' management and service such as newspapers, hairdressers, volunteers, group work available to the patients.

Your discharge
Outline here that discharge is planned for from admission and how this takes place, including who is involved, what after care will be considered, etc.

Tip: Have a blank section which you complete with an expected date of discharge that you and the patient will be aiming for.

An example of a pilot site's patient information booklet is provided as Patient Involvement Tool 2, Patient Information Booklet.

BOURNE WARD

Farnham Hospital

Bourne Ward
Farnham Hospital and Centre for Health
Hale Road, Farnham GU9 9QL
Telephone: 01483 782020

Welcome to Bourne Ward

We are a unit dedicated to your rehabilitation. We are an enthusiastic multi-disciplinary team who will help you achieve the best possible recovery.

Our staff is also skilled in providing palliative and end of life care, with close links with the Phyliss Tuckwell Hospice and the Macmillan nurses.

Bourne Ward has the following facilities:

- 21 single rooms with en-suite toilet and wash basin.
- Dining room
- Day room
- Therapy facilities

▲ Your Rehabilitation

After an initial assessment, the Team plans your rehabilitation with you. An individual rehabilitation programme will be developed for you. Goals will be set with you to guide and monitor your progress throughout rehabilitation.

Communication

Sharing of information is essential for good communication. With your permission, we will be happy to address any concerns you or your family may have. If required a family meeting may be held to allow discussion with the team regarding planning your discharge from hospital.

7. Update the draft leaflet based on comments received.

8. Agree with the team and your line manager how the patient information leaflet will be updated and shared.

9. Agree a start date with the team and your line manager.

10. Publicise the start date with a copy of the patient information leaflet and guidance notes for its use.

11. Set a date for the working group to formally review the success of the leaflet after six months.

This doesn't mean you will not informally review it in the meantime. During the ***Treat*** stage you will be asking your team at handover and at staff meetings how they feel it is working and record the comments as well as asking the patients for their feedback.

Tip: If you are having the leaflet printed, do not submit it until you have undertaken the "Treat" stage and you are sure the detail is correct; amendments add cost

Patient Comment or Request Form

- identify who is involved in the day to day contact with patients on your ward/department. It is likely to be a variety of professionals and support staff
- let them know that you are planning to create a Patient Comment or Request Form
- ask for volunteers to join a working group, making sure you have representation from the key staff groups involved
- ensure you include a patient representative and a carer on the group
- set up a process to test out an early version with a group of patients and carers
- draft a Patient Comment or Request Form, addressing the areas you identified in your patient information audits

This is a pilot site example and is provided in the Toolkit, Patient Involvement Tool 3.

Patient /family comment sheet

Patient name_____

Form filled in by_____

Thank you for taking the time to fill in this comment sheet. We understand what a difficult time it can be for you in hospital, and want to address any concerns you may have. If you have specific questions you would like answered, then please write them in the boxes below. We will do our best to address them as soon as possible.

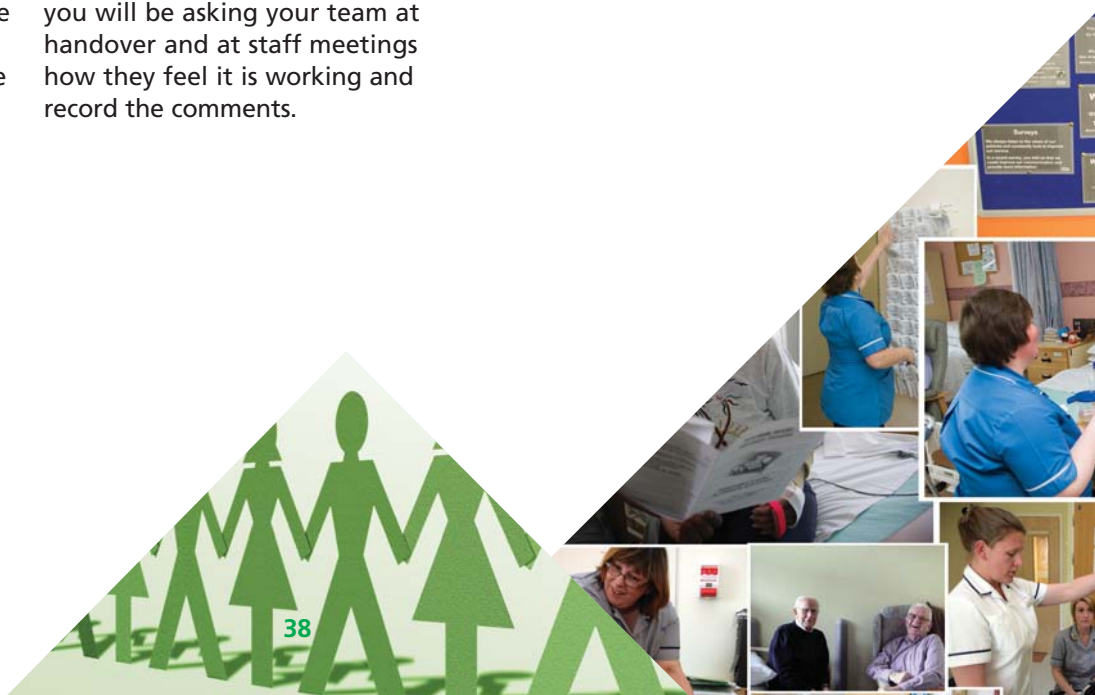
Medical- (Comments or Q's about your medication, why you are in hospital, your treatment plan…etc.)

Mobility –(Comments or Q's you may have for the Physio about mobility, how you managed at home, your expectations etc)

Actions:

- update the draft form based on comments received from patients and staff
- agree with the team and your line manager how the Patient Comment or Request Form will be updated and shared
- agree a start date with the team
- publicise the start date with a copy of the Patient Comment or Request Form and guidance notes for its use
- set a date for the team to formally review the success of the Patient Comment or Request Form

This doesn't mean you will not informally review it in the meantime. During the ***Treat*** stage you will be asking your team at handover and at staff meetings how they feel it is working and record the comments.

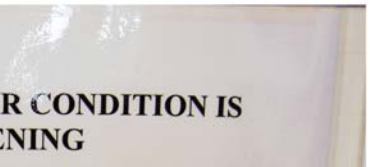


Once you have improved the Patient Comment or Request Form, you can introduce into practice.

- give the patient/carer comment/request sheet to the patient on their admission
- inform them they can complete this at any time during their stay to request more information
- ask them to hand it into the ward staff who will ensure a timely response
- make sure the forms are accessible to patients and carers at all times

What to do if…
Staff are using the Patient Comment or Request Form in place of good verbal communication.

When introducing the new templates, ensure that staff understand that the forms are no substitute for good verbal processes.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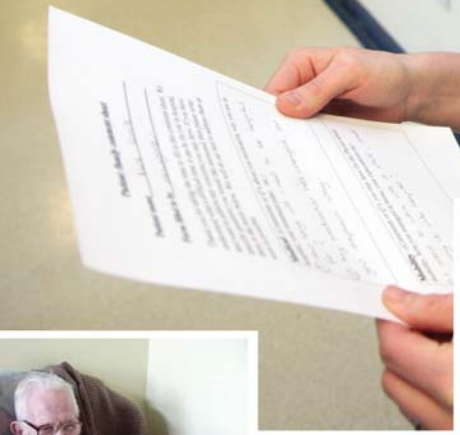
Plan - milestone checklist

Move on to ***Treat*** only if you have completed ALL of the items on these checklists.

Checklist	Tick if complete
Create a patient information leaflet?	
Create a patient comment/request form?	
Engage the patients and carers in the above tools?	

Effective teamwork checklist	Tick if yes
Did all the team participate?	
Was the discussion open?	
Were challenging questions discussed and agreed by all?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not on individuals?	



Treat


IF YOU FEEL YOUR CONDITION IS
WORSENING
PLEASE LET A MEMBER OF STAFF

Treat

What are you going to test?

- have we improved the experience for patients?
- have we improved the experience for staff?
- have we reduced time taken to keep the patients and carers informed?
- does everyone in the department understand the new processes?
- are we sticking to the new process?

Before the test starts:

- determine what the time period will be for the test
- it needs to be:
  - long enough to allow for failures
  - short enough to allow changes and retesting
- set the start and end dates and communicate them to everyone
- identify how and when the repeat audits will take place
- update all staff on progress, at meetings and across all shifts
- use your communications board as a secondary way of making sure that you communicate with all the staff

During the test:

- get daily feedback from staff and patients on how they feel the new processes are working, allow time during shift handover or in meetings for staff to feedback
- audit weekly for the test period:
  - this is key to understanding whether your changes are improving care
- review of verbal information:
  - see if you can see any common themes emerging
- invite senior management to comment on some of the improved processes
- if further straightforward improvements are identified; implement them, don't wait until the end of the test stage

Treat - milestone checklist

Move on to ***Evaluate*** only if you have completed ALL of the items on these checklists.

Checklist	Tick if complete
Test period defined	
All patients and staff informed	
Try out the new Patient Information Booklet	
Try out the new Patient Comment or Request Form	
Repeat audits	
Get staff, patients and family feedback on the new processes	

Effective teamwork checklist	Tick if yes
Did all the team participate?	
Was the discussion open?	
Were the challenging questions discussed and answers agreed by all?	
Did the team remain focused on the task?	
Did the team focus on the whole process, not on limited individual steps?	

Evaluate

Evaluate progress

1. **Collect information**
   At the end of the agreed test periods you will need to repeat the audits:
   - Patient Information audit
   - Review of Written Information Audit
   - Requests for Information Audit

2. **Analyse the information**
   Set up a review meeting to include the original core team for The Productive Community Hospital Programme.

   Use the results from the audits to help you to evaluate the changes made.

3. **Further improvement**
   This information will help you to understand where you need to go back to. Decide where there are still opportunities for improvement and repeat the process until your future state is achieved and sustained.

4. **Communicate success**
   Don't forget to tell people, staff and patients, what you have achieved, verbally and on your communications board.

Evaluate - milestone checklist

When you have completed the checklists below, go to the module checklist on page 49.

Checklist	Tick if complete
Talk to staff, patients and relatives about the new processes	
Look at the before and after audits	
Consider further improvements	
Communicate success	

Effective teamwork checklist	Tick if yes
Did all the team participate?	
Was the discussion open?	
Were challenging questions discussed and agreed by all?	
Did the team remain focused on the task?	
Did the team focus on the area/process, not on individuals?	

How to sustain the change?

Monitor and audit continually	• conduct the audits regularly to ensure that the changes that you have made are being continued and are working
Ensure leadership attention	• ensure that senior managers are engaged and informed of what you are doing • give regular feedback about the progress that you are making at meetings which involve key people • ensure that you display and discuss the audit results with department staff regularly to keep up the pace of change
Do not stop improving	• encourage the department staff to continue to find new and better ways of doing things – it is not about doing this once but about improving things continuously • encourage staff to suggest and implement changes themselves

Module checklist

The grid below allows you to measure your performance against the checklists for this module. You should copy this page and shade in the boxes according to your achievement of the measure (green for complete, amber for in progress and red for not started). Your progress will then be clearly visible.

Patient involvement module checklist	Before	After 2 weeks	After 4 weeks	After 8 weeks
Amount of written and verbal communication understood				
Written information standardised				
Patient information leaflet revised or introduced				
Comment/request form introduced				
Patients feel better informed and involved in their care				
Staff provide appropriate and timely information				

Have we met the learning objectives?

Five objectives were set at the beginning of this module.

- test how successfully these objectives have been met by asking three team members (of differing grades) the questions in the grid on the next page. Ask the questions in the second column and make an assessment against the answer in the third column
- if all three team members' responses broadly fit with the answer guidelines then the learning objectives of the module have been met
- note the objectives where the learning has only been partly met and think about the way that you can approach the module next time

Remember, the results of this assessment are for use in implementing this module and are not a reflection on individual performance in any way.

Objectives	Question (ask the team member)	Answers for outcome achieved
Understand what good preparation for the module is	Describe the things that you need to do in the prepare stage of the module	• establish a core team • talk to patients and staff • find information relating to complaints • obtain discharge policy
Develop audits as an activity	Describe the purpose of the audits and how you undertook them	• measure the baseline before any improvements or changes are made • key aspects of patient information were assessed in detail using a standardised format and in sufficient numbers to provide a sound measure
Understand how the patient involvement currently works	Explain how you learnt about the current patient involvement	• carry out Patient Information audit • Review Written Information • Requests for Information Audit
Understand what is meant by effective patient involvement	What is a good patient involvement?	• one where the patient has been involved in the planning of their communication needs • one where patients are not reliant on asking for basic information about their stay and care
Develop patient involvement to work more productively	How do you know if our communication and patient involvement is more efficient and effective?	• the repeated audits will show improvements • patient satisfaction will increase


NHS

Case study

Farnham Hospital and Centre for Health - patient and carer communication and involvement

The hypothesis
Involving and communicating with patients and carers optimises clinical outcomes and could reduce unnecessary days in hospital.

Their objectives
- to formalise a range of ways of providing information to patients and carers
- to encourage patient and family to comment
- to demonstrate that the staff considered patient and family a key part of their care
- to give clear information as to what to expect following their admission
- to give patients and family the opportunity to raise any concerns on admission, to highlight any barriers to safe discharge
- to give detailed information to the patient on discharge, outlining their hospital treatment and suppport arrangements as appropriate
- to prevent delayed discharges

Rationale for development
It was felt that feedback to and from relatives and patients was ad-hoc and reactive, eg, based on relatives/patients asking for information, there was no evidence for patients and relatives that their involvement was welcome and, in fact, essential.

The team introduced a patient leaflet and patient comment/request form.

Their findings

Patient and carer comments

Pre-improvement:

"I think the ward should have a leaflet with more information on. This is the first time I've been in hospital for an extended time and I do not know what the OT's or care managers do. I'm not sure what rehab is, I thought I was just coming for convalescence. The nurses and physio have explained a lot to me but I feel like I am wasting their time if I ask too many questions."

"I'm not sure if the staff want my opinions about my mother's problems, I would like to be able to help with planning her coming home from hospital."

Post improvement:

"I've never seen a comment/request form before. Although I didn't have many questions it was good to know that my opinion is valued. My family thought it was a really good idea. They were able to tell the OT about my rugs and steps up into the kitchen."

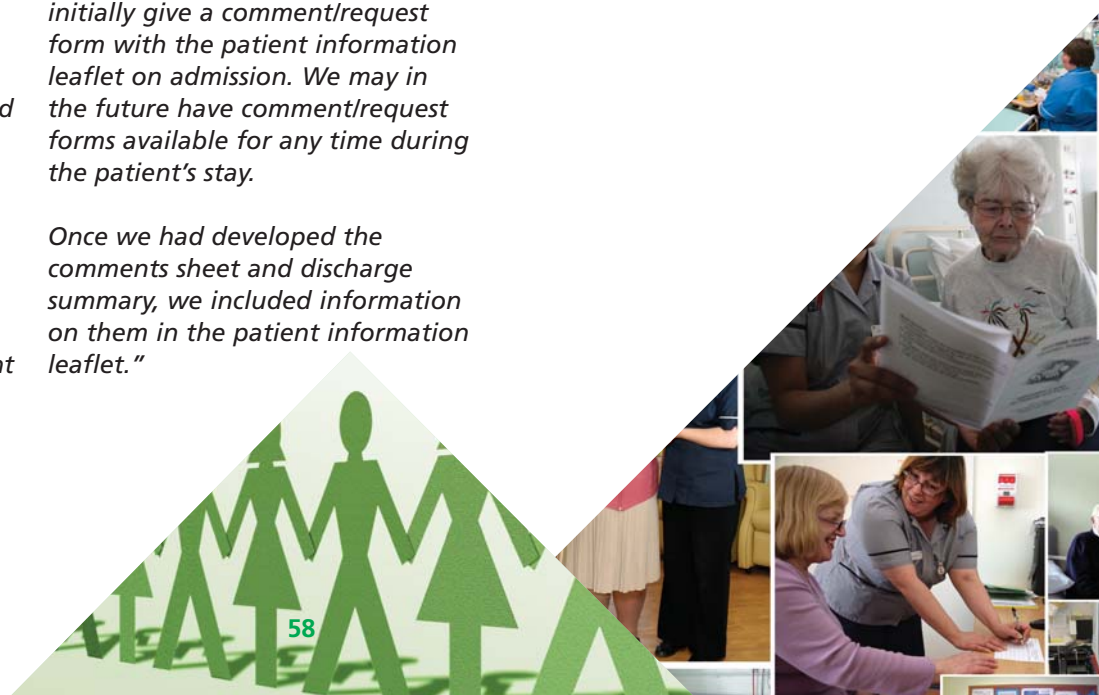
"My Dad came from another hospital, he has problems with his memory, it was very helpful to be able to pass on our concerns to the appropriate staff without having to make an appointment to see anyone. We took the comment/request form home so we could think about what we wanted to ask. The OT phoned us back the next day and was able to answer most of our questions. It really put our minds at rest."

Ward manager

"The idea of having a comments/request form was well received by staff, who felt it was a manageable document, easy to understand and would encourage patients and their families to raise concerns and questions. We decided that the comments would be split into four sections, directed at medical, occupational therapist, physiotherapist and nursing staff. The completed form was given to each discipline as required, to answer the issues raised. The form was then be returned to the patient with our comments, for them to keep, and the concerns documented in the patient record as appropriate.

We discussed how best to implement this and agreed to initially give a comment/request form with the patient information leaflet on admission. We may in the future have comment/request forms available for any time during the patient's stay.

Once we had developed the comments sheet and discharge summary, we included information on them in the patient information leaflet."



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