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Patient information



Patient information

What is it?

Good patient information ensures that patients are prepared and fully aware of the next step in their pathway so they are able to plan ahead. It helps to involve patients and carers in their care and improve their overall experience. See also [enhanced recovery](#).

The Information Standard is a certification scheme for health and social care information. It has been established by the Department of Health to help patients and the public make informed choices about their lifestyle, their condition and their options for treatment and care. It applies to all organisations producing evidence-based health and care information for the public. Any organisation achieving the Information Standard has undergone rigorous assessment to check that the information produced is clear, accurate, balanced, evidence-based and up-to-date.

When patients are anxious or worried about their condition, treatment or procedure, it is often difficult to retain information and difficult to decide which information is reliable when faced with the plethora of online resources, so having clear written information they can go back to and re-read is vital.

Good information also helps healthcare services to run more efficiently by helping to reduce DNAs and cancelled procedures by ensuring that the patient has certain information, including:

- when and where their appointment will take place
- how to get there
- any prior information relating to the procedure or treatment, eg no drinks containing caffeine before a nuclear medicine heart scan
- how to get in touch if they are unable to attend.

This tool gives you guidance on how to go about creating patient information.

When to use it

Whenever patient and carer experiences are captured and analysed, information always comes up as a big issue. Regardless of how good healthcare staff think the information they give out is, the experience of patients and carers is often that it could be a lot better.

Often there are glaring errors in the information given. For example, when looking at a project focusing on patient experience of day case surgery, it was found that the appointment slots had been increased during each day, but the information for patients, including when to fast from, etc, had not been updated. When information is unclear, it can create a great deal of anxiety for patients and carers and have a negative impact on their experience.

How to use it

The best way to write appropriate information for patients is to involve patients in the creation of the information (see [gaining insights from/working with health service users](#)). It is difficult for healthcare professionals to know what information is important for patients and carers and this can also vary greatly between different conditions or procedures. Involving patients will help greatly, but other specific things to consider include:

- Always write from the patient's point of view and always assume you have only a little knowledge of the subject. A good way to achieve this is to try and imagine yourself in the patient's shoes. If you were a patient what would you want to know? [Fresh eyes](#) can help here too.
- Use everyday language without being patronising – avoid jargon and acronyms.
- Use patient friendly text – personal pronouns such as 'we' and 'you'. If it is difficult to avoid using medical terminology such as 'nuclear medicine', explain what each term means.
- Information should be complementary to other information ie letters and leaflets and be relevant to individuals.
- Reinforce the information that patients have been told at clinic.
- Explain instructions, eg why a patient shouldn't eat for six hours.
- Help people make decisions by giving them facts about risks, side effects and benefits.
- Tell people what other information, support and resources are available. If possible, give the name of an individual they can contact, eg a named nurse.
- Be up to date – give the most recent practice and latest phone numbers.
- Let people know if information is available in other formats.

You are aiming to make the text accessible to a wide audience so use short sentences – in general no more than 15 to 20 words long – and write in lower case letters where possible in a minimum font size of 12. You should use present and active tenses ie 'your appointment is on...' not 'your appointment has been made for...'

How the text looks is also important: white space makes the information easier to read. Aim to have small blocks of text: a question and answer format or bullet points are both effective ways of dividing up blocks of text. Use large bold font to emphasise text (avoid upper case letters, italics and underlining.)

Labelled diagrams and pictures can illustrate content where appropriate, but avoid using clip art. Images and pictures from the NHS photo library can to create a more professional finish if you need to use images.

The planning stage

- Identify who needs to be involved and how you will keep them involved.
- Identify the need for specific information from patients, carers or clinicians.
- Check what other relevant information already exists in the organisation and from other sources such as NHS websites or third sector organisations.
- Consider how information will be distributed ie on a rack, handed to the patient, posted or sent via email. Who takes responsibility for this?
- Think about how the information can be personalised. Information contained in a letter addressed to an individual is more likely to be read than a generic information leaflet.
- Identify resource requirements. How will reprints be organised and funded? Photocopying information that is designed to be colour printed may lead to patients thinking the information contained is not important.

The writing stage

We recommend that you use the small test of change cycles (see [PDSA](#)) to help you develop patient information. Consider the following when writing for patients:

- Is it easy to read? Check your draft against the guidance. Make changes and produce another draft. Check it with members of your team. Do rapid cycles of testing until it seems easy to read.
- Is it correct? Check your draft with colleagues, clinicians, experts and patient support groups.
- Involve secretaries and booking staff. If you are sending it to someone for comment, always specify a deadline for them to feedback to you.
- Is it good for patients? Check a prototype with patients or with people in the hospital who are not familiar with the topic area.

Final checks

- Ensure information doesn't conflict with other information.
- Verify contact phone numbers by calling them.
- Use general names for local contacts, for example, 'cardiac rehabilitation nurse'.
- Use general drug names, for example, 'paracetamol' not 'Panadol'.
- Ensure any email addresses and website links are correct and active.

The consultation stage or sign off

- Ask patients to assess the information, eg through patient groups and give a final draft to interested parties with an appropriate deadline for responses.

The distribution stage

- Make sure patients receive information at an appropriate time, not half an hour before a procedure or when they are in shock.
- Monitor how the information is used. For example, is it handed out and by whom? Is it used for the intended purpose?

Examples

Weston Area Health NHS Trust developed a new approach to providing information for relatives and carers. A survey carried out in a medical ward highlighted that patient and relative information concerning ward times and direct dial numbers was poor.

To address this, an information card was developed to give out to all relatives and carers. This included basic information about where their relative was in hospital, the ward name, address, direct telephone number and in some cases, visiting hours. The name of their consultant and times of ward rounds was also written on the back of the card.

Although the trust has not formally evaluated the direct impact of the information card, patients and relatives frequently comment that it is very useful. The business card style adopted seems to prevent loss of the card and it is more professional than the scraps of paper that were used in the past. The cards are printed off site and cost approximately £170 for a pack of 4,000 cards. In surveys since the introduction of the card, the results for patient information have improved.