The Regulation and Quality Improvement Authority

Guidance for Inspectors and Lay Reviewers on Observation

Quality of Interaction Schedule (QUIS)

(October 2013)

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Communication and behaviour is a vitally important component of dignified care. The quality of interaction audit is tool designed to help evaluate the type and quality of communication that places on the ward inspected.

The tool described in this guide has been designed to help inform evaluations of the type and quality of interaction that takes place between staff and older people and their visitors in an acute hospital setting.

What is a quality of interaction audit (QUIS)?

This is method of systematically observing and recording interactions whilst remaining a non-participant. It is a technique first developed for use in long term residential mental health settings, but the tool has undergone substantial revision and has been adapted for more general use in residential and general hospital settings (Dean, Proudfoot, & Lindesay 1993).

It can be used as both a qualitative and quantitative tool to provide a measure of the quality of interaction between staff, patients and visitors. It is designed to develop the therapeutic and more sensitive communication within a ward or department.

It should be used sensitively and discreetly with full knowledge of senior managers, staff, patients and relatives.

Using observation during inspection

During inspections the views and experiences of people who use services are central to helping the inspection team make a judgement. This is one of a number of different tools which will be used to allow patients and visitors to share their views and experiences.

As interviews and questionnaires are unlikely to capture the experiences of cognitively frail older people who are unable to tell us themselves and may have the greatest care needs observation is a practical and proven method that can help us to build up a picture of the care experienced in a given care setting.

The main focus of the observation is to review the way that staff respect and interact with older people and their visitors. If inspectors undertaking observation, observe practice that may put the patient at risk the observation should stop and the observation immediately reported to the person in charge. If any team member sees that a patient is in danger they should immediately call for help from staff.

The limitations of observation
Person centred care is care which demonstrates compassion, dignity, privacy, clear communication and shared decision making. Not all aspects of person centred care can be observed and not all observations can be interpreted without additional information.

Observation data will therefore be used alongside findings to provide a more complete picture of the care of older people and to put the observation data in context.

Getting started

On arriving at the ward a notice will be given to the person in charge for dissemination to staff. Observations will generally be carried out at times of day when speaking with older patients or handing out questionnaires would be inappropriate or obtrusive. It is important that you observe in an unobtrusive way that preserves people's dignity and human rights. If anyone becomes distressed by your presence you should immediately stop observing. If anyone is concerned about confidentiality assure them that this will be respected. Do not start any interaction with an older patient or visitor during the observation period.

- Let the staff and patients in the bay/or point of observation know what you are doing.
- Always observe in a communal area.
- Select your observation point and find somewhere that is unobtrusive to sit and record for 20 minutes.
- Do not following patients out of the observation area.
- Be happy to explain/ chat – "but after I have finished this, in a few minutes"
- Say goodbye and thank you before leaving.

The number of people you can observe will be determined by the number of older patients being cared for in the observation area, the layout of the ward or bay your observation position, and the level of ward activity. Typically not more than six older patients will be observed.

Equipment

- Observation sheets – usually at least 5 sheets per person per observation
- Highlight pen for events (optional)

What should be observed?
The focus of the observation is interaction:

- All staff – patient interactions that take place within the ward during the period of observation should be recorded.
- Any staff – visitor interactions that take place within the ward during the period of observation should be recorded.

Note: Interactions by the following should not be recorded unless you there is something significant to record. Any equality and diversity issues must be recorded

- Staff – staff,
- Older patient – older patient
- older patient – visitor

Rating the interactions

When rating the quality of the interaction:

- Be consistent
- Use common sense but give a fair picture
- Negative interactions even as part of a 'better' whole must be identified. A sharp instruction or command, belittling, or inappropriate behaviours or endearments stick in the mind of patients and relatives.
- Rate straight away – this is essential

Discuss your thoughts with your colleagues, some activities or events just need extra thought and discussion

You will record a short description of each observed interaction between staff and older patients or between staff and visitors during the observation period, including verbal and non-verbal interactions. You will also rate the quality of interaction using one of three categories: positive social interaction, basic care/neutral interaction or negative interaction.

Coding categories
The coding categories for observation on general acute wards are:

Examples include:

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic Care: (BC) –** basic physical care e.g. bathing or use if toilet etc with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away	**Examples include:** Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others • Staff use of curtains or screens appropriately and check before entering a screened area and personal care is carried out with discretion	

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (N) –** communication which is disregarding of the residents' dignity and respect.
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions. • Not showing interest in what the patient or visitor is saying.	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations. • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness'). • Seeking choice but then ignoring or over ruling it. • Being angry with or scolding older patients. • Being rude and unfriendly • Bedside hand over not including the patient

Events
Remember you may observe event or as important omissions of care which are critical to quality of patients care but which do not necessarily involve a 'direct interaction'. For example a nurse may complete a wash without talking or engaging with a patient (in silence).

Record and highlight as an event on the observation sheet.

An example of an omission of care may be

- a patient repeatedly calling for attention without response,
- a patient left inadequately clothed,
- a meal removed without attempts made to encourage the patient to finish it,
- a patient clearly distressed and not comforted.

Feedback and presentation of the results
Provide initial feedback to the person in charge and as part of the overall feedback session a written summary on all the 20 minute observations will be provide in the report.

Simple percentages of the quality of interactions will be used for evidence of the quality of verbal and non-verbal communication e.g. 20% of observation were positively social (n=20), 70% were basic care interactions (n=70), 5% were neutral interaction (n=5) and 5% were negative interaction (n=5).
These will be presented visually in the report as a Venn diagram (pie chart)

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.