

Regional Centre for Teaching, Trauma & Tertiary Care

Minutes

*of the Flagship Room Design Focus Group held on Thursday 17th June 2010
9:00am to 12:30am in the The Brighthelm Centre*

1. Welcome and Introduction

John Wilkinson, 3T Clinical Planning Manager, welcomed everyone to the meeting and delivered a presentation introducing the 3T Programme and outlining the purpose of the event, which was an opportunity for patients and public to influence the designs of four of the key areas within the hospital redevelopment; single patient bedroom and ensuite, consultation and examination room, receptions and waiting areas and changing facilities.

John introduced the team from Brighton and Sussex University Hospitals NHS Trust (BSUH). From the 3T Programme -Abigail Pride, Emily McWhirter and Ali McKinlay; and from the Patient Experience team Pete Flavell and Hayley Coppard.

2. Reception and Waiting Areas

Abigail gave a presentation on reception and waiting areas which introduced the 3T Programme design philosophy - '3Ts aspires to create a holistic healing environment which embodies the Trust's core values of **kindness** and **compassion**'. The presentation then highlighted some examples of how waiting and reception areas can be designed and posed some questions to stimulate discussion:

Receptions:

- How can we create a sense of welcome?
- What should the reception desk look like?
- Do you think patient self check-in kiosks would be useful?
- Would "meet and greet" staff help make the self check-in kiosks more user friendly?

Waiting areas:

- What features should a waiting area have to make it welcoming and relaxing?
- What kind of seating?
 - fixed or moveable?
 - Lines around the room or sociable groups?
- Background music?
- How would you like to be called from the waiting area for your appointment?
- Would information about how long you have to wait be helpful?
- Television?

The meeting split into two groups to discuss each area. The notes from each of the groups are recorded below;

Receptions:

- It is important to maintain the confidentiality of patients
- Most people agreed that allocating numbers is a good calling system
- Buzzers - there was a lot of discussion about the pro's and con's
- Would a buzzer system delay people going to their appointment? As they would want to finish their coffee first
- The hospital must get its processes right
- Buzzers are good for people with hearing and sight problems, buzzers need to have vibrate alert as well
- Information on waiting times would be good - what and why
- Checking into Reception
 - the group agreed that younger people or people who are used to using technology might like the self-check in pods
 - however a lot of the group would like to keep the human contact and continue to have receptionists
 - the group agreed that choice of both is essential
 - the role of 'meeters and greeters' was discussed - they could help people on arrival. Reservations were expressed in relation to whether this would be too expensive or whether this was an appropriate role for volunteers and whether there would be enough of them
- Accessibility of self check ins - people in wheelchairs need to be able to reach them
- Accessibility of reception desks - need to be low level or preferably dual height with low level
- What makes a good welcome when you arrive?
 - A smile
 - Staff attitude
 - Natural light
 - Named people (staff) - staff that are identifiable and wear identification badges
- Self check in - needs choice of other languages
- Need choice of self check in and real receptionists
- Meet and greeter needs to know what is going on
- Use of volunteers
- What makes a good welcome when you arrive?
 - human contact
 - helpful staff
 - variety of seating arrangements
 - no clutter
- general preference for open receptions, closed receptions create a barrier to communication and can be difficult to hear through

- languages - would be good if information and answers to basic questions could be available in different languages
- Queuing!!!- how can this be managed so you don't have to queue, PRH outpatients given as an example of where people are always queuing
- Reception desk design should be open and of mixed heights

Waiting Areas:

- Choice of chairs
- Not in rows - around tables
- Infection control and cleaning
- Soothing music (not 'muzak')
- DNA - need to be able to get through to someone
- Someone available to ask about delays
- Customer service skills training
- Number allocation so know where you are in the queue
- Up to date info to keep you informed re delays (every 15 mins)
- Patient call - confidentiality important (number preferred, with check by member of staff)
- Consistent system for notes and clinician calling patients in right order
- Noise transfer from clinical rooms
- Chairs with arms
- No music
- No TV? Option in quiet corner
- Art
- Not rows of seats - depressing
- More open
- Choice of height of seats
- Table with chairs so family can seat together
- Choice of sociable/private - flexibility
- Need some fixed chairs - cleanliness, infection control, not fabric
- Warm colours
- Not sofa because of maintenance
- Fish tanks?
- Windows (with a view)
- Prefer being called by name by a person
- Information for reasons for delays - up to date, or where you are in the queue, multiple languages, signage, whiteboard?

Summary

There were three overarching themes to the feedback on reception and waiting areas; **Effective communication, processes & furniture.**

Effective communication was the most important aspect for many of the group members. It was felt that staff attitudes, the role of a meeter and greeter and in most cases a friendly smile were the key factors in effective communication within the reception or waiting area. Secondary to this were the **processes** in

place to ensure effective communication and timely checking-in of patients (reducing queuing). It was agreed that using technologies such as check in kiosks and Buzzers had a role to play but these should not replace personal communication as the sole means of registering. Any process using technology to aid the reception and waiting process should be carefully designed to avoid unnecessary waiting, for instance outside the consulting room. after being called from the waiting area. There was agreement throughout most of the group that allocating a number is a suitable and simple means of calling a patient from a waiting area. The third theme was based around the range and availability of different **furniture**. There was a strong consensus that there should be choice of a range of seating options within a reception or waiting area with a focus on providing a range of chair heights and flexible spaces for different groups to sit (e.g. quiet areas, table and chairs).

3. Consultation and Examination Rooms

John gave a presentation on consultation and examination rooms. The presentation described the role of the consultation and examination rooms and explained the different types of consultation examination room, the medical specialities involved (Oncology, Clinical Infection Service, Fracture Clinic, Ear Nose and Throat, Rheumatology & Neurosciences) and described the move towards multidisciplinary clinics in many areas. The presentation then went on to examine a design for the consultation and examination room which had been drafted by the 3T programme team previously. The presentation then highlighted some examples of consultation and examination rooms and posed some questions to stimulate discussion:

- How should you sit in relation to your healthcare professional?
- Should we provide chairs for carers, relatives, friends?
- In a clinic run as an MDT, would you like to see the team members individually or as a whole team?
- Is it useful to refer to IT resources e.g. X-rays and results on computer during your consultation?
- Where should students be seated within the room?
- How do we ensure your privacy and dignity

The participants split into two groups to discuss each area. The notes from each of the groups are recorded below;

Consultation and Examination Rooms:

- Patients need to be able to see computer screen
- A monitor on a turntable was suggested to achieve the above
- Curtain - there needs to be enough space around the couch for patients to change
- There needs to be enough room round the couch to accommodate the doctor and carer
- Visitor chair should be next to the patient chair
- Medical students should sit behind the patient
- All rooms should have wheelchair access

- Translator service for patients who require it is essential

- Multidisciplinary Team clinics (MDT)
 - first visit to see the doctor should be one on one rather than seeing a group
 - advance notice, via clinic letter, of who might be there would be good so that you can be prepared

- How should the Doctor sit?
 - Don't care
 - Full view of patient
 - Moveable square
 - No IT barrier? i.e computer
 - At 90 degree to the patient

- Clinician to come and get patients (welcoming)
- Engage with clinicians
- Dual access couch is best or use couch with two head ends
- Good to be able to show results etc on the PC screen
- Doctors chair on casters and moveable
- Patient chair very flexible
- PC screen should be able to swivel
- Cleanliness
- Air conditioning should be able to be directed at patients
- Patient and carer chairs should have arms
- Curtains should be installed with chair, shelf/pegs to put your belongings/clothes
- Door should hinge so that when being opened much of the room would be hidden if it happened that other staff opened the door and interrupted the consultation
- (Walking on) cold floors - underfloor heating?
- Colour? Do they have to be the same colour
- Relaxing but hygienic - doesn't have to look austere and clinical
- Anatomy etc diagrams hidden behind closing whiteboard so that you can write/draw on the closed side

Summary

The focus of the discussion on the consultation and examination rooms was the interaction between the clinician and the patient during the consultation. There was a consensus that the clinicians attention should be paid to the patient for the duration of the consultation and that there should be no distractions (interruptions or use of computer). It was felt that there should not be a desk between the patient and the clinician and that a chair should be provided for a friend, relative or carer. Most of the group agreed that there was a role for computers (or other visual aids) in the consultation as a means for the clinician to share results and to help explain treatment and prognosis but that the computer should only be used for this purpose during the consultation.

There was acceptance across the group that, as a teaching hospital, there may be students within the examination room (with consent of the patient). There

was some difference of opinion over where a student should best be positioned with some members of the group preferring students situated behind the patient and some preferring the student to be positioned as to take active part in the consultation. There was a general agreement that that focus of the clinician should be the patient rather than the student wherever the student is positioned.

There was a discussion over the model of consultation within a multidisciplinary team. There seemed to be a general preference within the group for the team to visit the patient individually or in small groups rather than as a complete team as it was thought that the patient could become intimidated by a large team of clinicians. Two group members who had experienced this type of consultation stated that the clinic worked very well and patients had a good experience (aided greatly by a representative from a charity taking part as a member of the MDT).

4. **Benefits Realisation**

John introduced Anna Barnes, Associate Director. Anna talked to the group about the benefits realisation project that will ultimately measure the success of the project. Anna explained that she was currently conducting interviews with patients discussing their current experiences. This information will be used as a baseline. Anna took the opportunity to conduct some interviews with members of the group.

5. **Single Bedroom and Ensuite**

Emily gave a presentation on the single bedroom and en-suite. The presentation explained the rationale for the new building being planned to include 69% single bedrooms on average across the wards with the remainder of beds being in four bedded bays. The presentation then described the exemplar design of a single bedroom an en-suite and used some computer 3D modelling to help the group examine the design in more detail.

Single Room:

- opposite bed window
- visibility to nurses
- 'isolation' in rooms a concern
- View from bed versus view from staff - layout shown does not make it possible to see the door, and therefore staff, and the view from the window
- Buzzing - when you buzz a nurse and there is a delay in them coming then want to know the reason for this
- Window sills and infection control
- 7 people voted for single rooms and 8 people voted for bays of 4
- Concern that technology is taking over
- Lack of patient contact, too few nurses

- Patient leaving room safely
- Communication system
- Entertainment system - can patients bring their own?’
- Increasing technology could mean more isolation and less human contact i.e ordering meals on touch screen rather than on paper where someone comes to collect it

Summary

There was discussion within the group about the ratio of single bedrooms to those provided in four bedded bays. Some members of the group would prefer accommodation to be provided in a single room with the rationale being improved infection control and more privacy. Other members of the group would prefer a room in a four bedded bay as it was thought to be more sociable and there were concerns over patients becoming isolated in a single room. A straw poll was conducted which showed opinion was divided approximately 50:50.

There were two overarching themes to the feedback on the design of single rooms; **Infection control and communication.**

There was consensus that the room should be designed in order that it can be cleaned and maintained effectively in order to ensure effective infection control. There was agreement that the room should be able to be completely cleaned between different patients using the room. Communication between a patient and the staff (particularly the nursing team) was discussed at length. There were concerns that the majority single rooms would make contact with the staff difficult. There was agreement that touchdown bases (i.e. small worktop areas distributed throughout the ward) were a good idea to ensure nurses spend more time with patients. There was a discussion over the use of technology to aid communication within the ward. There was consensus that the use of technology should never replace the need for human contact, particularly when patients may feel more isolated because of the majority of beds being in single patient bedrooms. It was agreed that there was a place for nurse call systems and improved communication systems (between staff and between staff and patients) but that these should be used to improve the safety of the patients rather than as a primary means of communication.

There was a strong preference that the rooms should be designed to take advantage of the views the building will benefit from, including ensuring patients in bed can see the view.

There was some discussion about patient entertainment and telephone systems. The group expressed some dissatisfaction with the current arrangements in providing these services stating that the service was overpriced and difficult to use. It was suggested that as portable entertainment systems were becoming increasingly common the design should be developed with this in mind (Patients able to access Wi Fi, charging points).

5. Patient Changing Facilities

Ali led an exercise to gain the groups views on changing facilities. Changing facilities include changing rooms and cubicles in Imaging, Radiotherapy and Cardiac Investigations. Attendees were asked to indicate whether they agreed or disagreed with the statements below. The figure in each box represents the number of attendees that ticked that box.

	Totally disagree	Disagree	Don't agree or disagree	Agree	Totally agree
It's OK to walk from a changing cubicle to a scanning room in front of other people	10	3	-	-	-
It is OK to change in a cubicle that opens directly onto a scanning room	-	-	-	6	7
It is OK to change in a cubicle and then wait in a waiting room with other people not in gowns	12	2	-	-	-
It is OK to change in a cubicle and then wait in a waiting room with other people in gowns	8	1	2	2	-
It is OK to change in a cubicle and walk along a private corridor to the scanning room	3	2	-	8	-

Attendees were asked to rank their preference of changing facilities design (exemplar drawings provided) using stickers.

	1 st Rank	2 nd Rank	3 rd Rank
Stand Alone Cubicle Design	-	-	8
Hybrid Cubicle Design	-	8	-
Pass Through Cubicle Design	13	-	-

6. **Summary and Next Steps.**

John thanked everyone for attending the meeting and for being so open and honest about their experiences. John assured the group that the wealth of information gained today would be used to inform the designs of the areas in question. John confirmed the notes of today's meeting would be shared with Laing O'Rourke, the construction company who are designing the building and the design leads within the clinical services. There was a question from the group on how the 3T programme would ensure this would happen. John replied that there was an active Patient and Public Design Panel, a reference group for the design process. John suggested that he would circulate an application form to join this group for any members of today's meeting who would like to commit to a longer term commitment and involvement in the design process. It was also suggested that today's event could be repeated in the future with a view to reviewing progress against the outputs of today's meeting. John agreed that if the group agreed this was worthwhile he would be happy to arrange a further meeting.

As the focus of the event was on the design of the four flagship areas there was little opportunity to discuss town planning issues such as heritage, building massing and car parking. There were considerable concerns throughout the group about car parking. John agreed to receive any specific comments about parking and to pass them to the appropriate lead within the 3T Programme. John explained that town planning issues were mostly addressed through the Hospital Liaison Group and agreed to circulate the details of this meeting with the notes.