Improving and safeguarding patient communication during dental procedures using an original hand-signal system - The Helping Hand

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Improving and safeguarding patient communication during dental procedures using an original hand-signal system – The Helping Hand

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Pé ní atá geallta duit, gheobhaidh tú é

Abstract

Aims This planned organisational development project aims to design and introduce an intuitive and visually appealing hand-signal communication system in the dental setting. This system is aimed to improve and safeguard patient communication, patient safety, patient dignity and add value.

Rationale During dental procedures verbal communication between patient and dentist is routinely absent. This can lead to misunderstanding, dissatisfaction, impaired consent and poor patient experience. The literature reflects the growing study of dental patient safety, quality in dentistry, patient dignity and communication. Central to all of these is the patient's consent and shared-decision making ability. The Helping Hand System fulfils requirements in these areas and adds value to the patient journey.

Change Process Intuitive, unambiguous hand-signals, professionally illustrated and labelled in simple English and other languages were created. A stakeholder coalition was assembled. A pilot scheme including a training session, questionnaires and communication protocols was devised to educate the dental team for use of The Helping Hand utilising the Health Service Executive Change Model.

Evaluation An evaluation strategy encompassing innovation, testing and scale up with spread has been devised to capture and disseminate the results.

Results and Conclusion With regulatory change driven by expected legislation, this innovative project will fulfil impending requirements for patient communication and safety. The proposed evaluation and implementation of this planned project predicts high dentist and patient engagement via a pilot phase in August 2015. The balanced discussion of strengths and limitations will be further added to, along with recommendations informed by the pilot.

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Chapter 1

1 Introduction

1.1 Introduction

Central to the provision of safe, reliable and satisfactory dental treatment is clear communication between dentist and patient. The essential nature of dental treatment involves restorative and surgical procedures in the oral cavity. Verbal communication between dentist and patient is obviously significantly reduced during any procedure. At present there is no standardised or reproducible protocol for clear communication during these procedures. This deficiency can lead to patient discomfort, dissatisfaction and also can jeopardise patient dignity. The proposal contained in this dissertation relates to the introduction of an innovative hand signal system. This Helping Hand System will augment the procedures undertaken in the dental clinic. In particular, this easy-to-use system will benefit the patient (by providing a clear unambiguous signal system). It will also benefit the dental team (dentist, nurse, hygienist, therapist) by providing a safe, reproducible and convenient method of non-verbal communication during operative procedures. The system can form part of the patient's clinical notes supporting continuity of care and annotating the care given.

1.2 Organisational Context

The author is Clinical Director/Clinical Lead with a private provider of dental care in Ireland. With 20 clinics nationwide, over 80 dentists and in excess of 100,000 patients per annum, the project is intended to have a positive effect on the practice of modern dentistry throughout the group.

1.3 Rationale

There exists a gap in service provision currently where communication between dentist and patient is severely curtailed during operative procedures. The interventive nature of dental procedures lends itself to short or long periods of non-verbal communication between dentist and patient. In particular, patients undergoing restorative treatment (e.g. fillings, crowns, bridges etc.) often have a rubber dam (toughened medical plastic sheet) used for tooth isolation. This leads to long periods of mouth opening and an inability to verbalise. Of note is that the use of rubber dam is mandatory in root canal treatment.

The lack of any dependable or recognised communication system during operative procedures can lead to misunderstanding, patient dissatisfaction or an impaired patient experience. Brown & Swartz (1989) found evidence that satisfied patients were more likely to adhere to medical recommendations than those who were less satisfied and also less likely to action professional misconduct legal proceedings.

In the past number of years, the increase in complaints and legal issues with dental provision has increased significantly, (D'Cruz, 2010). At the core of these issues is communication between dentist and patient. The General Dental Council (GDC) (2013) in the United Kingdom set out specific standards for the dental team. These standards specifically refer to the dignity of the patient. Indeed the Patient Experience Indicator 4 of the Dental Quality and Outcomes Framework (Department of Health, UK) specifically asks if the patient feels involved with their management (Mills & Batchelor, 2011).

Of note also is that Campbell & Tickle (2013) have recently suggested that quality improvement in primary dental care is a prospective activity in which ways to improve care on a continual basis, as part of the everyday routine is a central premise.

There is also the proposed Dentist Act (expected 2016) due in the Republic of Ireland, which it is suggested, will contain significant guidance on clinical governance and regulation – at the core of which is the patient journey. This has been the experience in the UK with the appointment of the Care Quality Commission (CQC) inspecting the day-to-day practice of dentistry.

In addressing the above rationale for the adoption of the Helping Hand System, its benefits can be considered under the following areas:

Rationale Overview:

To improve dentist patient communication during operative procedures

To improve patient comfort, particularly for those for whom English is not their first language

To add value to the patient journey through the recognised system, safeguarding patient dignity and improving patient satisfaction with service provision

By improving communication, it is anticipated that there would be a decrease in delays and/or complaints during operative procedures. This will increase trust, reduce delay and increase productivity. This in the longer term, could lead to reduced claim frequency and thus reduced indemnity premia.

By creating an inexpensive, easy to use system that will promote patients return for treatment and encouraging others to attend.

By designing an intuitive system that is highly visual, easy to reproduce and has the potential to be a unique selling point for patients attending the provider nationwide.

1.4 Aims and Objectives

1.4.1 Aim

To design and implement a hand signal system to:

- improve dentist-patient communication
- improve patient satisfaction with care
- safeguard patient dignity
- Improve patient safety
- Provide a unique selling point (USP) for patient care which is marketable

1.4.2 Objectives

By introducing a simple, easy to understand clear (line-drawing) chart of hand-signals/symbols which are utilised by the dental patient, the operator can at all times maintain easy two-way communication. With reference to the SMART objective criteria, the aims are as follows:

- To develop a clear unambiguous and inexpensive hand signally system which will facilitate better patient-dentist communication in month 1.

- To receive endorsement of a recognised expert group in the area of non-verbal communication nationally (Lámh) and also to gather a coalition of change with buy-in from foreign embassies through

the production of the system in English and the other major foreign languages used by patients daily in the clinics in month 2.

- To facilitate increased patient satisfaction and safe-guarding of patient dignity. All clinical staff will have attended a training seminar by Month 2.

- To deploy this project within a short time frame (2 months) through a pilot scheme.

- To measure the system's adoption and efficacy which can be evaluated through dentist compliance and patient satisfaction/utilisation and to gain 100% use by patients of the "Helping Hand System" at projects end Month 3 via a pilot study. The use of the PDSA cycle and clear evaluation methodology will allow real-time feedback to better inform implementation.

1.4.3 Planned Outcomes

It is expected that early adoption of this innovative hand signal system will aid clinicians in their day-to-day operating. It is also anticipated that patients will feel secure, protected and in control by having the system in place.

In building a safety culture, the dental team (with particular emphasis on the dental nurse) will be able to monitor and assist in ensuring the patients' wants and needs are always monitored. The corrective action,

as indicated by the system will ensure that communication remains constant.

Another planned outcome is to provide a unique selling point (USP) for the business. Due to the highly visual nature, easy to understand gestures and expected patient compliance – this system could be used in a marketing campaign – due to its innovative and unprecedented nature.

1.5 Role of the Student in the Project

The role of the student in the planned change is multifaceted.

(1) The creation of a clear and unique hand signal communication system for use by dental patients to compliment existing practices. The symbols will reflect five basic commands : stop, proceed/ok, question/inquiry, rinse out, evacuate/suction.
(2) To gain approval or endorsement by recognised experts in the field of non-verbal (sign language) communication (Lámh) and buy-in from foreign embassies.
(3) To design a visually attractive, competent and simple one page menu with clearly defined meanings for each symbol
(4) To introduce this Helping Hand System into an existing clinical setting initially in a pilot scheme manner.

(5) To measure its efficacy in aiding communication and its use by clinicians.

(6) To evaluate patient satisfaction and measure service improvement

1.6 Summary and Conclusion

The introduction of a standardised non-verbal communication tool which compliments existing verbal communication in the dental setting will help build trust and secure patient dignity during treatment

At the fundamental core of dental treatment is trust between patient and dentist. Like the Theatre Checklist, (Wilson & Walker, 2008), this Helping Hand System is negligible in cost, easy to understand and has the capacity to provide increased patient safety and comfort. It has the potential to create a significant change in the existing culture in patient management. The added value to patient satisfaction could translate into greater levels of cooperation and understanding during treatment, a reduction in complaints and increased trust between dentist and patient. (Brown & Swartz, 1989).

With the proposed new Dentist Act (expected 2016), the envisioned increased regulation of the profession will see a Patient Safety and Quality Assurance provision, in line with other jurisdictions. It is anticipated that this will be in line with the Care Quality Commission

standard in England and its associated counterparts in Scotland, Wales and Northern Ireland. The Helping Hand system will adequately fulfil criteria in meeting their existing requirements for an improved patient journey and safeguarding patient dignity.

Chapter 2 of this dissertation will examine themes in relation to the existing literature in this field. Chapter 3 will detail the methodology and methods in its proposed implementation. Chapter 4 will suggest evaluation of these methods and Chapter 5 will detail the conclusions and end with a discussion of the potential impact of this project.

Chapter 2

Literature Review

2.1 Introduction

This chapter will review the relevant literature in relation to the subject matter of the proposed plan. A refined search strategy will yield the pertinent background to the existing literature, highlighting the current thinking and underpinning the reasons for change.

In particular, the review will look at four main themes – Communication, Quality in Dentistry, Dignity of the patient and finally Patient safety.

It is the author's contention that these four areas will adequately evidence the rationale for the introduction of "The Helping Hand". The chapter will close with a conclusion based on the evidence gathered.

2.2 Search Strategy

With access to review search engines, CINAHL, PUBMED, Science Direct and Emerald, the review yielded a lot of worthy publications. Google and Google Scholar were also used. Some references listed within publications were also examined, explored and reviewed, as they tended to appear regularly. Publications from Governments and reports pertaining to dentistry – including those in the UK, and worldwide, where the experience, (though different) is indicative, the author suggests, of future research and policy here.

The search terms employed for the literature review included “dental patient safety”, “dentist patient relationship”, “dentist patient communication”, “patient dignity”, “dental patient experience”, “quality in dentistry”, and “clinician communication”.

2.3 Themes

2.3.1 Communication

At the heart of all successful healthcare lies good communication. The dental surgery is a prime example of a healthcare setting where good communication skills are critical for success. Campbell & Tickle (2013) suggest that patients may concentrate on communication skills and continuity of care as a marker of quality in dentistry. In the UK, the General Dental Council (GDC) issued “Standards for the Dental Team” (2013). This publication lists several patient expectations. Amongst these expectations, is the expectation of being listened to and having their preferences and concerns taken into account. In its guidance to the dental team, the GDC suggests that the dentist should be aware of how their tone of voice and body language might be perceived.

In reviewing the literature with regard to General Medical Practitioners (GMPs), Burt *et al*. (2014) assessed the communication quality of primary consultations in primary care – with reference to the Calgary-Cambridge Guide to the Medical Interview. This paper underlines the

essential role of communication in providing an accurate, efficient and a supportive experience which leads to improved healthcare outcomes.
In the author's experience, this holds true for the dental examination. Most patients will attend with a specific dental issue e.g. pain. The initial examination is vital not only in assessing the patient's treatment need, but also establishing trust though communication.

The literature also suggests that traditionally, most assessments of clinician –patient communication under use the patients' feedback to better inform improvements. In the US, Wener *et al*. (2011) examined the rationale and process for patient assessment and dental student self-assessment as clinical communication instruments. They suggest that amongst the advantages of better communication comes higher patient-rated clinical efficiency which will yield better patient adherence to treatment planning and a consequent reduction in risk of malpractice claims.

The dentist-patient dynamic is key to quality healthcare delivery. As dentistry is, by its nature, an interventive speciality, it requires significant trust. The dental patient typically spends most of the dental visit supine, and with dental instruments in the oral cavity. As will be discussed a little later, this has significant implications for patient dignity, but also for the ability to communicate verbally. It is interesting to note that Wener *et al*. (2011) highlight the sharing of information and decision making with

attention to comfort as being of importance to the communication dynamic.

Further in their review, Wener *et al*., examine the non-verbal communication skills as part of their evaluation of the communication experience.

In the British Dental Journal, Shaw (2007, p.570) examines the issue of "continuous consent". He underlines the specific challenges to communication that face the GDP (General Dental Practitioner) in surgery by noting that "..the patient very often cannot reply, for the simple reason that the dentist is working inside their mouth." (Shaw, 2007, p.570).

Campbell & Tickle (2013) also draw attention to the almost unique feature of most dental patients attendance: that dental care is very often provided when the patient presents with pain and discomfort. In the author's experience the challenge of providing successful outcomes for patients in discomfort takes a particular skill-set, developed over years of clinical experience. As an adjunct to verbal communication, the "Helping Hand" tool should improve communication between patient and clinician, particularly where interventive treatment is required while the patient is in pain.

In the GMP/Physician setting, Beck *et al*. (2002) state that the favourable medical interview is critical to short-term, intermediate and long-term outcomes – by influencing patient adherence to treatment, recall and symptoms resolution. Beck *et al*., also reflects on the importance attached to the participatory decision making aspect of the interview, leading to improved outcomes.

From a practical viewpoint, with the spiralling cost of professional indemnity premia (with almost annual increases), the appetite for litigation appears to remain high amongst the patient population. Levinson (1994) long ago underlined problems with communication as a major factor in malpractice litigation. By improving all avenues of communication, and through introducing a standardised non-verbal communication system, it is the author's contention that this will benefit both the dental team and the patient.

2.3.2 Quality in Dentistry

It is accepted that quality healthcare is a complex concept (Tickle & Campbell, 2013). Much of the literature surrounding quality in healthcare is centred on medical care and management of healthcare systems. Though there is sparse literature on what qualifies as quality primary dental care, a series of three recent papers in the British Dental Journal by Campbell and Tickle (2013) examines the area.

The perspectives of all stakeholders must be considered when thinking about quality in dental healthcare provision. The various stakeholder groups include the public, patients, the dental team and policy-makers. Donabedian (1988) rightly asserts that a clear definition of quality is the foundation upon which everything is built.

There are many similarities between general medical practice and general dental practice. However, dentistry by its very nature is usually interventive/surgical in nature, task lead and operative in execution. General medical practice on the other hand, tend to be more diagnostic in nature and less interventive. (Campbell & Tickle, 2013).

Individual perceptions of quality in dentistry by patients tend to be event driven – e.g. being seen on time, pain relief, cosmetic improvement etc. Quality for a population (the public) may be seen as care that provides equitable access particularly to patients with greater treatment needs.

Campbell & Tickle (2013) also assert that the traditional view of quality in dentistry is centred around complex, expensive care with a significant cosmetic component. This notion, they contend is outmoded and is of little relevance to the experience of most practitioners. They do contend that there is significant cost associated with care provided. This in turn informs patients' value of quality.

In Ireland, the point of access to dentistry for the majority of adult patients is free. With almost 80% of Irish adults entitled to a free dental examination through the Pay Related Social Insurance Scheme (PRSI) or the Dental Treatment Services Scheme (DTSS). These two schemes did allow for more extensive subsidised treatment but were severely curtailed in accordance with the Report on the Special Group on Public Service Numbers and Expenditure Programmes (McCarthy *et al*., 2009). The revised schemes both allow for free examination. The DTSS allows also for minimal treatment. The PRSI scheme retains only the examination.

Set against this backdrop of austerity, with the majority of interventive treatment costing the patient directly has lead to dentistry being perceived as a 'luxury'. The implication thus for quality from this stakeholder group resides largely with value for money. This significantly shapes the dynamic of the dentist – patient relationship, particularly the level of patient expectation and has implications for patients' understanding of treatment outcomes.

In Australia, Sbaraini *et al*. (2012) also examined quality in dentistry. In particular they examined the concept of what the patient values. In exploring the tenets of quality, this paper suggests that patients are more concerned with attitudes and communication skills of the dentist rather than the technical prowess of the dentist. In this paper also, it is interesting to note that they recorded evidence of patient who wanted a

caring dentist who would listen to their concerns. The paper further asserts that patients perceived dentists as being in two schools – "old-school dentistry" (p. 188) with a "mandate for fillings" (p.188) and "new-school dentistry" (p.188) – who educated patients and reassured them in tandem with treatment.

Edwards *et al*. (2001) examined the views of quality in the shared decision making approach of healthcare. In their focus group study, the findings looked at the results of 47 participants attending 6 focus group interviews in a UK primary care setting. The findings reiterated the notion of participation with a major theme of reassurance and a reduction in anxiety. Participants placed a high premium on appropriate involvement which was context dependent.

The patient experience as detailed in the General Medical Practitioners Quality Outcome Framework (GPQOF) (2013) in the UK is an important domain which Campbell & Tickle (2013) suggest is underdeveloped in dentistry. Indeed they postulate that given the length of consultations, interventive procedures, levying of charges and marketing of cosmetic interventions, it is even more relevant to dental practice.

2.3.3 Dignity of the Patient

In the GDC's "Standards for the Dental Team" (2013) it lists Standard 1.2 which states : (p.12)

“You must treat every patient with dignity and respect at all time”.

The GDC, the regulatory body of dentistry in the UK, issued these revised Standards in response to various legislative changes.

The experience in Ireland is somewhat different, though in spirit is the same. In the Irish Dental Council’s “Professional Behaviour and Ethical Conduct”, (2012), its guiding principal on treating patients is clear in Code 5.1: (p.7)

“It is essential that you maintain good communication with your patients. Before you begin any treatment, you must be satisfied that your patient understands: the diagnosis; treatment plan; likely outcomes; and the costs involved. This is particularly important if your patient’s first language is different to your own”.

In examining these codes and standards, it is of interest that the GDC further suggests that to fulfil their Standard 1.2 (p.12) it proposes:

”You should take patients’ preferences into account and be sensitive to their individual needs and values”.

In reviewing the literature, Shaw (2007, p.570) in the British Dental Journal makes the valid point that the very nature of dentistry, with instruments in the oral cavity, can lead to effective “communication withdrawal” – jeopardising consent itself. Shaw further suggests that at

present patients may put their “hand on the dentists arm” or “even try to push the dentist away” (Shaw (2007), p.571). Shaw rightly suggests that this is far from ideal and can lead to (unfounded) charges of harassment/restraint.

Muirhead *et al*. (2013) examined dentist-patient relationships with regard to older peoples quality of life. They examined the role of trust in dental professionals by older people to aid alleviating stress and uncertainty in their oral health. The unmet dental treatment needs of older people, they postulate, is directly related to perceptions of trust and confidence in dentists. They further suggest that evidence-based patient experience indicators in relation to patient outcomes be utilised to compare and reward positive patient experiences.

Baker *et a*l., (2007) explored interpersonal continuity of care in the primary care setting. In their cross-sectional survey, they examined patient preferences and experiences. Their results suggest that a vast majority of patients place a high value on continuity of care. In particular seeing someone “known and trusted” (Baker, 2007, p.288) was important to 62% of responders. While this study looked at GMPs, the experience within dentistry, the author would posit is similar if not higher.

Mills *et al*., (2014) reviewed the Patient Centred Care (PCC) approach in general dental practice. The main features, as described in the literature,

of PCC stress the importance of ‘soft skills’ of the dentist. In particular empathy, emotional understanding of the patients’ perspective were cornerstone tenets.

This paper closely examined the existing literature in this area and concluded that there is a variance in understanding of the concept of PCC in dentistry. Tellingly, it also suggests that further research is essential to fully appreciate, document and extrapolate from the patients’ perspective.

2.3.4 Safety in Dentistry

“To Err is Human : Building a Safer Health System”, by the Institute of Medicine (Kohn *et al*., 2000) highlighted the need for a safer higher quality health system. The report indicated that between 44,000 and 98,000 patients died annually from medication errors. At the very centre of quality in healthcare is the provision for safety. Adverse events in healthcare have always been present but it only in the past two decades that particular attention has been focussed on their measurement and developing strategies to overcome them.

In their study in the American Journal of Public Health Research, Yanik & Cetin (2014) examined the levels of patient safety and the reporting of adverse events in oral and dental health centres in the Thracian region of Turkey. Their discussion reflects the increased rate of patient studies in this area of patient safety.

Yanik & Cetin (2014) also suggest that dentists tend to work in a more individual way due to the nature of their speciality. They further contend that other healthcare and administrative workers in a healthcare setting have an obligation to report adverse events. They conclude that an institutional patient safety culture should improve overall patient safety and that the very nature of active research yields an increased awareness in participants.

In the International Dental Journal, Yamalik & Perea-Pérez (2012) remark that the adoption of a safety culture and subsequent measures has taken longer to achieve within healthcare than in other high-risk areas such as aviation.

They also submit that the dental field in particular is lagging behind and is quite immature in comparison to the broader medical field. The reasons for this include the almost negligible morbidity associated with dentistry. However, the Council of European Dentists (CED) , (2008) issued a resolution in response to the workings of the World Health Organisation (WHO), The Organisation for Economic Cooperation and Development (OECD) and the Council of Europe.

The main strands of patient safety tend to analyse latent risks, i.e., features of a system that allow or even encourage adverse events. Where an adverse event has particular severity or frequency it may be deemed a ‘sentinel event’.

The core feature of patient safety is its non-punitive characteristic, it does not seek to punish those responsible for the adverse event. The nature of engendering a Patient Safety Culture has, at its essence the ideal of information sharing in all events – to improve overall safety within an organisation.

Retrospective studies tend to analyse sentinel events and often use a Root Cause Analysis (RCA). Prospective studies in this area are concerned with identifying key risks with potential treatments, work organisation, appliances or materials. Failure Mode and Effect Analysis is often used with these studies.

The International Patient Safety Classification (ICPS) is a conceptual framework which Yamalik & Perea-Pérez (2012) posit may be adapted for dentistry in particular. They also suggest that "…. leadership, teamwork, the provision of evidence-based care, communication, learning and patient-centred care are all important core values for a safety culture". (Yamalik & Perea-Pérez, 2012, p.195).

The peculiarities associated with the provision of dental care are worth examining here. The provision of treatment is usually less aggressive, less invasive (than general surgery or hospital medicine) and patients are usually ambulatory.

However, Yamalik & Perea-Pérez (2012) also submit that use of drugs, advanced technological appliances (Xray, laser etc) all have the potential for serious harm in the dental setting.

Most dental care is provided by isolated practitioners who are outside the hospital hierarchical structure. Awareness of the study of patient safety is minimal, particularly within private practice, where dentists are not in regular contact with other health professionals. Adverse events may also have a significant effect on trade is also noted by Yamalik & Perea-Pérez.

It is timely to refer once again to the ethical codes of the Dental Council when considering patient safety (Irish Dental Council, 2008), and indeed the Hippocratic principle “Primum non nocere”.

Also, the ethos of patient safety, aside from “doing the right thing” is inherently linked to quality in dentistry (Campbell & Tickle, 2013).

It is also noted by Yamalik & Perea-Pérez (2012) that improved patient safety will lead to decreased legal claims against practitioners.

The experience in the UK is shaped by the Mid Staffordshire NHS Foundation Trust Francis Report (2013) where Berwick is emphatic that the placement of the quality of patient care, particularly patient safety, must be above all other aims. Pemberton (2014) identifies specific

strategies to develop safer healthcare in the dental field. One of the strategies includes : “Communication and education about patient safety”. (Pemberton, 2014, p.336). In particular Pemberton mentions the publications produced by the UK dental defence societies based on the complaints or litigation which they deal with annually. In echoing Yamalik & Perea-Pérez, Pemberton further discusses creating a patient safety culture and also underlines the close teamwork of the dental professionals (nurse, hygienists and dentists).

2.4 Implications for the Project

The above literature review yields an informed review of current thinking in the various areas detailed above. It is evident from the review that the study of patient safety in the dental context is in its infancy. The area of quality in dentistry can also be viewed as in an immature state in relation to its contemporary medical counterpart. While the literature is in agreement that good communication is essential for better healthcare outcomes, there appears to be a lack of consistency in both its delivery and measurement.

The views of the patient, and particularly the patient experience appears to be under utilised and indeed under reported.

In reflecting on this review, and its implications for the proposed change project, the author believes that the introduction of the Helping Hand System will add to value to the various areas mentioned. In particular the

area of communication will benefit which in turn, as highlighted above, feeds into the concepts of quality, safety and patient dignity.

2.5 Summary and Conclusion

Dentistry currently and traditionally is largely provided in Ireland by isolated practitioners. Awareness of the study of patient safety and the emerging field of study in relation to quality in dentistry are still largely unknown or remain a low priority. As noted in Chapter 1, the impending Dentist Act (scheduled for 2016) will see sweeping changes to the regulation of the profession. The proposed changes to governance, particularly of the governing body, the Dental Council of Ireland are hinted at in the “Report of the Consultation Process on New Legislation to Replace the Dentists Act, 1985” (Department of Health and Children, 2014). The changes, the author believes, will be in line with the experience in the UK.

In looking at that UK experience, several of the key outcomes listed by the GDC may appear here in the not too distant future. Against the backdrop of increased litigation, focussed regulation and reduced patient attendance, this may be the opportune time to introduce the Helping Hand System – whose benefits of to communication, quality, protection of patient dignity and increased patient safety will be demonstrated in the following chapters.

Finally, it is worth commenting that this literature review, aside from highlighting key areas to support the planned change, also underlined the needs and requirements of further study in the respective areas in the context of operative dentistry. The author would suggest that a study examining the experiences of general dental practitioners within the Republic of Ireland in the areas detailed above would provide a clearer picture in this jurisdiction and further strengthen the rationale for this project.

Chapter 3

Methodology

3.1 Introduction

This chapter will identify the Organisational Development (OD) model which will be employed to carry out the planned aims and objectives detailed in the previous chapters. In particular, the Health Service Executive (HSE) Change Model will be utilised in this regard. A critical review of the approaches to OD will be undertaken below and a comprehensive and detailed elucidation of the project will then be recorded. The chapter will conclude with a discussion of the planned implementation.

3.2 Critical Review of Approaches to Organisational Development

Change management has been prescribed as the process of continually renewing an organisation's direction, structure and capabilities to serve the ever-changing needs of external and internal customers (Moran & Brightman, 2001). Graetz (2000, p.551) suggests"… that few would dispute that the primary task for management today is the leading of organisational change".

Kotter (1995) states that 50% of companies fail in implementing change in the early stages and Young (2009) suggests that a failure rate for change implementation of 70% exists.

In examining the various current models for change management, similar issues and core strengths exist to make a change successful. Sirkin *et al*. (2005) note that soft factors such as leadership, motivation and culture are key to success. They also caution, however that these soft factors may not directly impact the outcomes of the change programme. They also advocate a close examination of the hard factors of any transformative initiative – particularly – time (necessary to complete the change), people (required to execute the change) and finally the financial result that the change is expected to realise.

Sirkin *et al*. (2005) continue by suggesting in their study that a DICE score would assist in predicting and executing a change project. The Duration (D) of the project, the Integrity (I) or capability of the team, the Commitment (C) of staff and finally the Effort (E) of the employees.

De Witt and Meyer (2005) report that most change is heralded by some organisational crisis and that the response is often reactive.

With these factors in mind, the literature yields many models from which to choose for OD implementation. On review of the literature, the author suggests that for a change to be successful, it is almost self-evident that a compelling and clearly articulated vision is described. The needs of the service user (in this case the patient) should be at its centre. The planning and delivery of the change should have an integrated approach (across a team ideally) and be measurable. Ideally any change should

be collaborative in nature, engaging with all the relevant stakeholders, service providers and service users (patients).

Senior and Swales (2010) developed a model which has six distinct steps in its methodology

(1) Diagnose a Current Situation

(2) Develop a Vision for Change

(3) Gain Commitment to the Vision

(4) Develop an Action Plan

(5) Implement the Change

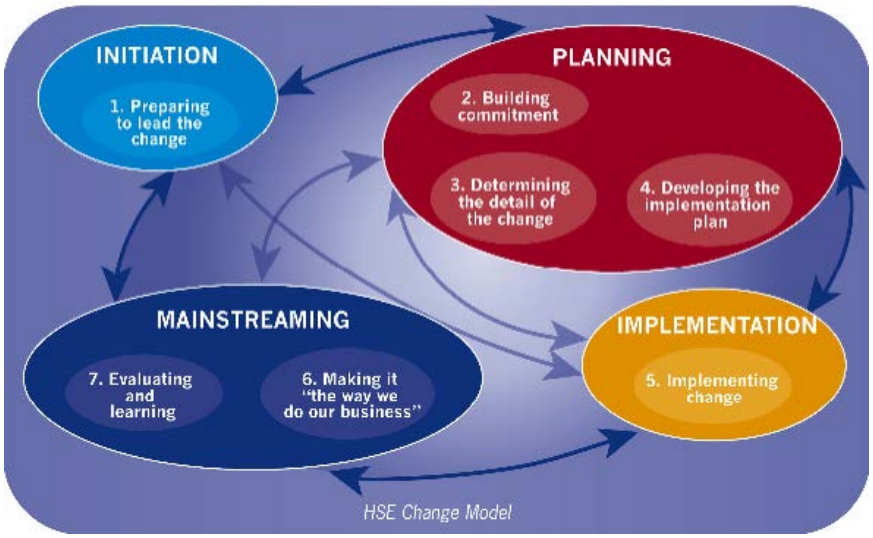
(6) Assess and reinforce the Change

This model, in common with many, is underpinned by the idea of "unfreezing" a behaviour, making the necessary change and then "refreezing". This is based on Lewin (1989) teachings.

The Senior and Swales model is comprehensive and encompasses the many steps required to bring about change. It is recognised in their own work that this model has its limits – particularly in the public sector where resources (pertinent in the current climate particularly) may only be approved by senior management. Also, the culture of an organisation can have an impact on the success of any OD model – and Senior and Swales also suggest that the public sector may have more difficulty with change than private sector.

In reviewing the HSE Change Model (2013) it acknowledges that change is not linear but rather an ongoing and adaptive process in which all inter-related elements can (and do) influence each other.

FIGURE 1 – HSE Change Model (HSE, 2008)



The four main steps of Initiation, Planning, Implementation and Mainstreaming are evident in the figure above. It provides a comprehensive and almost reflective mechanism for OD.

The Coghlan and Brannick (2014) model also has four steps : Constructing, Planning action, Taking Action and Evaluating Action. For the purposes of this planned OD project, the Coghlan and Brannick Model falls outside the criteria. However, it is noted that this is a popular OD model which also has merit, but as it is action dependent, it is not feasible to employ it for this particular planned project.

3.3 Rationale for OD Model Selected

In choosing the HSE Change Model, the author feels that it is the ‘best fit’ for the project involved. Given that this model has been developed to:

(1) Improve the experience of patients and service users

(2) Help staff and teams play a meaningful role in working together to improve service

(3) Promote a consistent approach to change across a system.

It is evident from these 3 aims in the model’s development criteria that the “Helping Hand” system proposed here easily fits this OD model. The author would posit, as will be evident below, that the simplicity of the change suggested will also clearly lend itself to each of the steps listed. In choosing this model, the author would also add that the other models, while exhibiting many merits could potentially be a little too complex for the change proposed.

In particular, the HSE Change Model specifically acknowledges (and provides for) managing reactions to change, managing the uncertainty of change and supporting people through change – while understanding some inevitable resistance.

3.4 OD Model – HSE Change Model

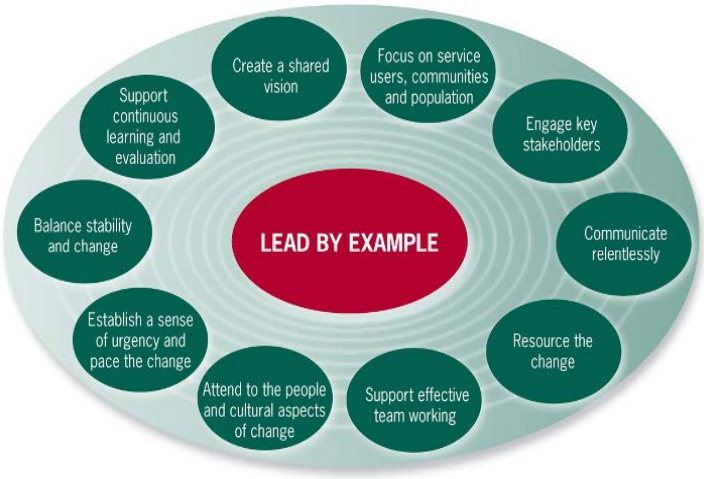
At its core, the HSE Change Model has the following guiding principles, as described in their “Improving Our Services, a User’s Guide” , HSE, (2008):

(1) Ensuring the needs of the service users and interests of staff are at the centre of the proposed change
(2) Building integration and a whole-system approach
(3) Encouraging collaboration between all stakeholders
(4) Promoting active engagement and participation of all
(5) Placing a particular emphasis on partnership
(6) Prioritising long-term sustainability of the change
(7) Providing for a transfer of knowledge and skill so that the system can “self-adapt”
(8) Promote organisational learning via feedback
(9) Locating the responsibility to manage change at all levels within the system.

To underpin the critical understanding of the HSE Change Model, the activities for change are central to its success.

The activities which are described as critical are summarised in the figure below.

FIGURE 2 – Activities (HSE, 2008)



Some of the headings within the above figure are self-evident in their goal. In relation to the "Helping Hand" System, the author would particularly note three of the following subheadings listed above, to better understand their utilisation for this OD project in the context of the private sector:

(1) Lead by Example – this is at the heart of any change. The author, a general dental surgeon, with many clinical years experience understands the value of leading a clinical team. In engaging and demonstrating the importance of the project and its predicted benefits to both fellow dentists, dental nurses and auxiliary non-clinical staff, the proposed change has the best chance of success.

(2) Communicate Relentlessly – by keeping the project's aims and objectives at the forefront of each member of the clinical team,

this will support and assist in keeping the team focussed on implementation.

(3) Support continuous learning and evaluation – as will be discussed below, learning from the experience of those implementing the change is key to adapting to as yet unforeseen issues that may arise which could hinder its adoption and mainstreaming.

3.41 Initiation

The purpose of initiation is to ascribe the scope of the change under consideration. It is also a key step in creating a viable foundation for successful change.

Planned Implementation

This project is a Planned Implementation project. At the early outset, the author's organisation was acquired by a UK company. This happened just before the start of Year 2 of the Master's Programme.

This had implications for the project, as the management structure changed. The organisation itself does not have an Ethics Board per se. In completing the necessary ethical approval form for the RCSI Ethics Board, the form itself did not lend itself to the type of OD project entailed. The author, decided along with his organisation, that the Planned Implementation option would best suit the timeline for successful completion. It would also offer an opportunity to thoroughly prepare for

the implementation of the “Helping Hand” system – and potentially signpost areas which may prove barriers to successful implementation.

At initiation it is evident that a clear purpose and vision is essential. In analysing the deliverables for this project, the author reviewed the following issues:

(1) The purpose of the change – to improve communication between patient and dental team.
(2) To ascribe leadership roles – both the author and the dental team each have a leadership role in this project’s implementation.
(3) The drivers of change are clearly evident to all members of the team – particularly upcoming legislation and the area of safeguarding patient dignity.
(4) The readiness and capacity of the organisation to adapt to the change proposed is key – its adoption by the team is key.
(5) The Business Case for the desired outcome is prepared at initiation – in this case, a reduction in miscommunication and or misunderstanding will lead to more communicative patient visits, improved satisfaction and a decrease in complaints.

Overview:

The project is concerned with introducing an innovative hand signal system to ease communication for dental patients. In detailing the level

of change methodology, the author will throughout this and following chapters detail and refer to the projected Pilot of the scheme. In reflecting on this proposed pilot, the author will indicate, at crucial points, the expected reaction, resistance and outcomes. This is done so using the author's experience of similar initiatives within the author's current role in the organisation. These potential scenarios are based on real time observations and experience.

To that end, it's envisaged mechanism of action and protocol will be as follows, using a Pilot clinical team in a centrally based dental clinic in the capital city.

(a) At arrival for registration at the dental clinic, along with the registration forms, the patient is given a laminated re-usable A4 page which has the signals clearly marked with a one/two word action word underneath each signal.

(b) The signal is written clearly underneath each signal in English and Irish or English and the language of the patient (where English is not the patient's first language).

(c) At the dental examination, after the history is completed, the dentist will make reference to the system, again explaining each signal, before any interventive treatment is undertaken.

(d) The sheet will appear on the wall opposite the patient, within their view -laminated and displayed in a prominent position.

(e) The sheet (in an appropriate size, scaled to meet requirement) will also appear on the ceiling – also within easy view of the patient.

This will facilitate the patient's eye-line, as the patient will be reclined in the chair.

(f) The dental nurse will be on hand to observe the patient's movement/use of the signals and bring these to the attention of the dentist.

(g) The dentist too will be aware of, and primed to observe the patient.

(h) When the signals are used, the indicated action occurs (e.g. rinse out).

(i) A note of this is made in the clinical notes – indicating the patient's use

Below (**FIGURE 3**) is the Helping Hand System – in this version, the two national languages of Ireland – English and Irish. A professional Illustrator, with experience in aviation safety illustration (for a national airline) was commissioned to produce the drawings.

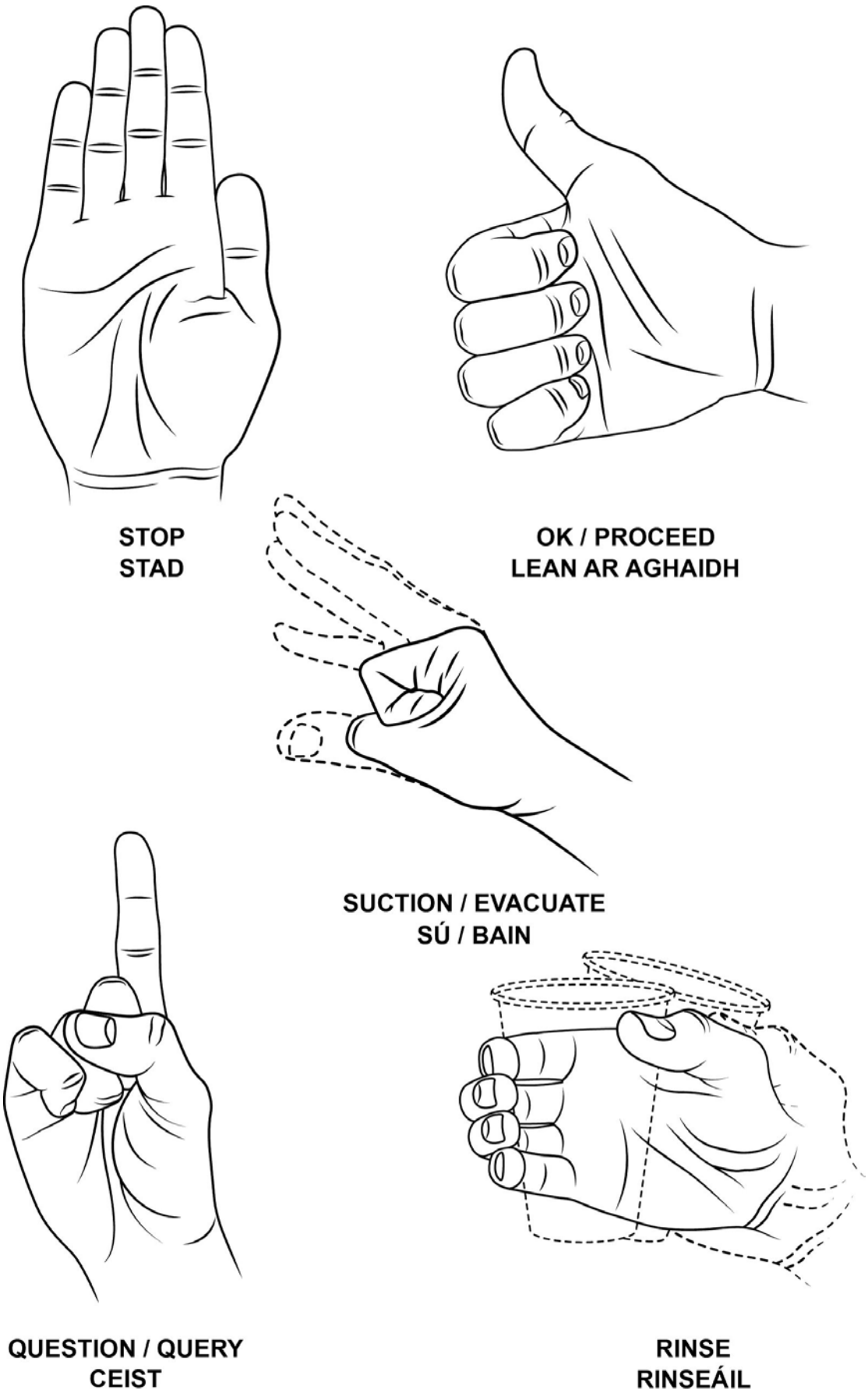


FIGURE 3 – THE HELPING HAND SYSTEM

3.41.1 Preparing to Lead the Change

In preparing to lead the change, the HSE Change Model makes reference to the following areas which require attention

(a) Identifying the Drivers and Degree of Urgency

(b) Clarifying Leadership Roles and Key Stakeholders/influencers

(c) Assessing readiness/capacity for change

(d) Attending to Organisational Politics

(e) Identifying leverage points and opportunities for change

(f) Performing an Initial Assessment of the Impact of the Change

(g) Outlining the Initial Objectives and outcome for the change

(h) Agreeing Initial Resource Requirement

(i) Outlining the Initial Business Case for Change

(a) Identifying the drivers and degree of urgency

The dignity of the patient (as cited by Shaw, 2007) and added value to their experience, coupled with upcoming legislation and the backdrop of increased litigation are some of the drivers identified. Individually these are important drivers, collectively they are a potent catalyst for change.

Pilot Implication

By clearly demonstrating the above drivers, a clear mandate for change strengthens credibility, promotes alignment and buy-in from the stakeholders and also clarifies expectations for the change. In presenting

the relevant literature in a concise manner to the piloting clinical staff, this will strengthen the degree of urgency.

(b) Key Influencers and Stakeholders

A stakeholder analysis is important, particularly to focus on both opportunities and possible concerns from these groups which will directly influence the success of the project.

STAKEHOLDER ANALYSIS CHART – TABLE 1 – Adapted from Borgoyne (1994)

	STAKEHOLDERS	**ANALYSIS**	
HIGH			HR COO
MEDIUM		Practice Managers	Pilot Dentist GDPs
LOW		Dental Nurses	
	NO COMMITMENT	ON THE FENCE	COMMITTED

(c) Assessing Readiness for Change

POSITIVE FORCES (+)		NEGATIVE FORCES (-)	
Impending Legislation	5	Change Fatigue (since recent takeover)	2
Experience in the UK (CQC)	5	Knowledge Deficit	1
A potential USP	5	Culture	1
Improved Patient Return Rate (via increased satisfaction)	5	Time constraints	4
TOTAL = 20		TOTAL = 8	

FORCE FIELD ANALYSIS – TABLE 2 (adapted from Lewin (1951))

To help assess the readiness for change, a force field analysis proves useful. The nature of team work within dentistry is kernel to successful patient outcomes.

Pilot Implication

With the introduction of the “Helping Hand” system, it will change the dynamic slightly. It adds an extra step at the initial examination stage – where the patient is given the information. The dentist will have a responsibility to instruct/review the system with the patient. The dental nurse will also be important as it is they who will be vigilant for the patient’s use of the gestures.

By increasing the readiness for change, a significant reduction in expected resistance should be achievable. This analysis will also aid to focus on the areas that must be worked on to create the energy required for this change to occur.

TABLE 3 - CAPACITY FOR CHANGE

	Readiness			**Capacity**		
Activities for Change	**HIGH**	**MEDIUM**	**LOW**	**HIGH**	**MEDIUM**	**LOW**
Overall readiness						
Level of responsiveness						
Level of shared understanding of Vision						
Effectiveness of Communication						
Culture of Continuous Learning						
Capacity to balance Stability with Change						

(d) Organisational Politics

Culture and politics within any organisation can have a positive or negative impact on the success of any change (Handy, 1993).

Pilot Implication

For the “Helping Hand” system, the author suggests that, at its core, the system is practical, simple, easy to understand and potentially effective. The culture of dental healthcare provision, the delivery of high quality dental treatment demands clear attention to detail – both in diagnosis and treatment. The author suggests that given this culture of action, the “Helping Hand” would suit early adopters. The Pilot dentist in particular will be central to success. It should be noted that the implication of physically noting within the patient’s chart that the system was used is of key importance to adding weight to the political will to use the system in the longer term. Simply put, if it is documented in the notes, it sends a clear signal to other dentists (who may review the notes) that the system is real and a ‘live’ protocol.

From the management’s perspective the politics of seeing a real and demonstrable improvement in patient satisfaction should allay any concerns/misgivings. That said, in the “real politik” of industry and business, it is vital to create engagement and partnership across all levels of the organisation. Credibility is key. Credibility comes from many sources e.g. a record of prior success coupled with evidence of a low-

threat approach will enhance credibility (Handy,1993). The author would suggest that previous success in change management (the introduction of updated medical history forms) should clearly demonstrate ability and bolster credibility as a change-agent.

(e) Identifying Leverage Points and Opportunities for Change

S.W.O.T. (Strengths, Weaknesses, Opportunities and Threats) ANALYSIS – TABLE 4

INTERNAL	
STRENGTHS	**WEAKENESSES**
Engaged and Committed Champion Team Esprit de Corps Support of Senior Management External Drivers (Impending legislation/regulation)	Some training Resistance to change Time constraints (perceived) Culture
EXTERNAL	
OPPORTUNITIES	**THREATS**
Being ahead of expected regulation Offering a USP Setting Standards rather than following them Enhanced Company Reputation	New Staff rotation (turnover)

In establishing leverage points and opportunities, the author undertook a SWOT analysis.

Pilot Implication

By building a coalition outside the organisation, whose credibility and influence would support the change, this will be seen as significant leverage, in particular, buy-in from Foras na Gaeilge, Lámh (Irish Sign Language) and the various European embassies. The combined weight of influence here, and in particular a visible association with these bodies will add credence to the pilot, particularly to the discerning patient who will recognise the organisations and embassies involved.

(f) An Initial Assessment of the Impact of the Change

GANTT CHART – TABLE 5

Project task, stage, step or milestone		Month 1	Month 1	Month 1	Month 2	Month 2	Month 2-4
1.	Plan project						
2.	Meet stakeholders						
3.	Establish Coalition of External Stakeholders						
4.	Training of Dentists and Dental Staff						
5.	Implementation of Helping Hand System						
6.	Evaluation						
7.	Analysis of Evaluation						
8.	Scale up and Spread						

A projected look at the timeframe of the change is detailed in the GANTT chart. It reviewing this chart, suggested impacts on culture, cost, time, and perspective can be extrapolated.

This initial assessment is a powerful tool to gain insight into planning, resource allocation, and engagement. It also helps to assist in a whole-system picture of the change process.

Pilot Implication

The use of a Gantt chart by the participating clinic will be seen as a visual reminder of progress. The Piloting dentist in particular will be driving the change within the clinic. As a visual trigger, the Gantt chart will prove invaluable.

(g) Outlining the Initial Objectives and Outcomes of the change

Pilot Implication

The use of SMART objectives underlines the achievable and timely nature of the change using the “Helping Hand” System. The dentist, dental nurse and clinical administrative staff will be aware of the true purpose and objective.

(h) Agreeing Initial Resource Requirements

This important step identifies areas which will require careful consideration – particularly in implementing the “Helping Hand” System. The most significant resource is the time taken by staff with the patient. The value of this “extra” time with the patient will be demonstrated and discussed in Chapter 4 via evaluation.

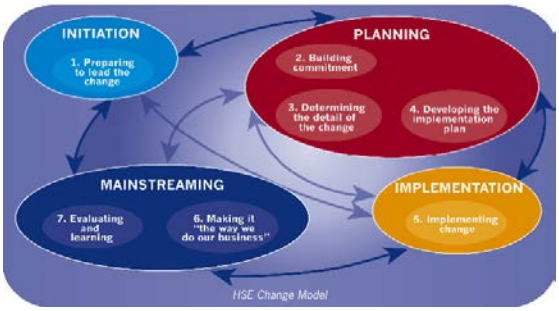
Pilot Implication

The aim of the author in highlighting the resource is to justify the time spent and encourage the piloting dental team to implement the change – giving a benefit to them, through improved patient co-operation.

(j) Outlining the initial business case for change

The business case (also called the Project Initiation Document – PID) empowers leaders to achieve broad approval for the proposed change. It is akin to an end-stage review which reflects an early analysis and outline description of all of the above stages – vision, need for change, roles of the leaders, drivers, leverage points, risk factors (e.g. resistance), purpose, timeframe and costs and communication.

3.4.2 Planning



The central core of planning is to qualify and quantify the specific detail of the proposed change and to create a support for this change. It is self-evident that the broader the support, the easier the change will be to implement.

Planning is divided into the following 3 steps within the HSE Model:

- Building Commitment
- Determining the detail of the change
- Developing the implementation plan

3.4.2.1 Building Commitment

The HSE Change Model closely examines the commitment necessary for any OD project.

The steps necessary to build commitment include:

(a) Build a shared vision

(b) Communicating the vision and business case for change

(c) Increase readiness and the capacity for change

(d) Demonstrate that change is underway

(a) Build a shared vision – this can be achieved through translating the vision into a meaningful picture at a local level. In particular for the “Helping Hand” system, it can be achieved by educating and discussing around the topic of non-verbal communication. A clear

demonstration of the system will help to clearly exhibit the benefits and advantages of the system, thus helping to build commitment.

(b) Communicating the vision and business case.

Pilot Implication

This reflects the idea of “communicating relentlessly” as described above.

With reference to **Table 6** below, it demonstrates the communication prompts which will prove useful.

Table 6 Communication Prompts

Who?	What?	How?	When?	Outcome?
With Whom are We communicating? (i.e. the target audience – which will direct the questions in the column on the right)	What does this pilot team already know?	How will possible difficulties to communication be overcome? How can pilot team be supported?	When is the deadline for progression or review?	Feedback

(c) Increase Readiness and the Capacity for Change

Pilot Implication

The pilot team will be aware of the drivers for change. As this is innovative and novel, it will encourage the team to adopt the change.

(d) Demonstrate that change is underway

Pilot Implication

It is unlikely that activities around the change will have to stop. The nature of the “Helping Hand” system lends itself to blending within the routine examination and treatment protocols which are long established. The purpose here will be to show that change is good. It will be important to demonstrate and acknowledge performance – this will be dealt with more comprehensively in the Chapter 4.

3.4.2.2 Determining the detail of change

It is imperative at this point in the OD that the focus is on increasing the momentum for change. Ways in which this can be achieved include both assessing the current situation against the future vision for change and providing feedback the analysis to key stakeholders

By assessing the current situation against the future vision for change using the pilot team, a close monitoring of the Helping Hand in use at the clinic is essential. This process of gap analysis will help the pilot dentist to support the vision and closely identify area where improvements are required. Methodologies for assessing the gap analysis will include surveys, questionnaires and observation, as will be discussed later in Chapter 4.

In providing feedback of the analysis to key stakeholders and in particular to management, the pilot team will underpin the level of change. So too will dissemination of the results in the longer term. Valid

and accurate feedback will not only increase momentum but can also reflect real and meaningful change without overloading information.

3.4.2.3 Developing the Implementation Plan

This fourth step is at the heart of the plan. It will provide a detailed design of the organisational, cultural and service changes what will assist in realising the vision. This step is specific in its nature about the changes needed.

In the HSE Model there are four parts to this step:

(a) Design the detail of the future state

(b) Assess the impact of the detailed design

(c) Outline and agree the plan for implementation

(d) Complete the detailed implementation/project plan

Pilot Implication

The design of the detailed future state will require both strategic and operational knowledge to ensure appropriate direction which is easily integrated into current work practices. As an example, the pilot is use of the “Helping Hand” System is recorded in the clinical notes of the patients. The importance of this, not just from the dentist’s perspective but also for future reference should the need arise.

In assessing the impact of the detailed design the use of the pilot will prove useful here. The author intends to pilot this scheme in Autumn 2015. The advantages of pilot include, greater buy-in from stakeholders, better refinement of the plan with greater analysis of the impact on the treatment and communication with patients.

With a detailed design the elements of implementation can fall into place – particularly – sequenced actions, key milestones (such as patient utilisation), accurate time frame, development of performance indicators and better communication of feedback.

Once the plan is signed off, communication to all the relevant stakeholders is important. It may be necessary to renew levels of commitment at particular intervals or modify certain aspects of the plan. To prevent drift, a revisit of the Plan may be required to allow for re-negotiation or re-mandating – though with this “Helping Hand” System, the author does not anticipate such an occurrence.

3.4.3 Implementation

This 5th step of the HSE Change Model is focussed on implementation and monitoring the change. It is where the leader(s) are actively engaged in attending to what is actually happening.

To this end, the author is setting a time frame of one month in closely monitoring the pilot and retrieving daily feedback from the dentist involved, in conjunction with other day-to-day duties.

The two steps within this phase are:

(a) Implementing the change

(b) Sustaining momentum

Pilot Implication

Clarity, communication and continuity - these are the three tenets which the author surmises are vital for the success of implementation. To support the new behaviour (the introduction of the “Helping Hand”) will require continual communication. The clarity of its purpose is self-evident however “old habits die hard”. In particular monitoring the initial dental examination process during the pilot, where the system is first discussed by the dental team with the patient - will be crucial to success.

Change takes time to implement. A sustained support around the pilot team who are implementing this system will be required. The feedback (both positive and negative) will better help inform refinement but so too will it inform momentum. If staff are talking about change and its effects then this can only be seen as a positive step towards implementation.

Consideration must be given to problem solving if/when an issue arises. A process to will need to be considered to share the learning from

implementation. In this case, the author suggests his weekly group wide email update.

3.4.4 Mainstreaming

This final phase of the HSE Change Model is concerned with two steps.

3.4.4.1 Making it “The Way We Do Our Business”

This step is essentially comprised of:

(a) Acknowledging success and achievement

(b) Supporting Integration of the Change

(c) Ensuring the decision making processes support the change

Pilot Implication

Celebrating the “small wins” for performance is essential, not just for the success of the project but also for staff morale (Weick, 1995). Change is difficult, particularly where it is a “new thing”. Though the “Helping Hand” should ease communication, it is innovative in its nature and will require a lot of support from the dental teams to ensure it is used and accurately measured.

The “Helping Hand” should not be seen as an “add-on” to the existing protocols. It should be viewed as an integrated part of treatment. It will improve the service as a whole and also add value to the patient journey. The author hopes that it will embed itself easily and require little integration when fully established.

Clear transparent lines of accountability in decision making are required to fully implement and “bed-down” the “Helping Hand” system. A collaborative approach from the Front Desk staff, dental nurse and dentist will be key to success. While it is envisaged that the dentist will have ultimate responsibility for introduction of its use, the dental nurse will be responsible for carefully monitoring the patient for use of the system. Together, as a healthcare providing team – from front desk, through to dental chair and back, the patient journey is underpinned by clear communication from all members.

3.4.4.2 Evaluating and Learning

This final step is core of putting closure on the old way and is a good indicator for readiness for continued change. According to the HSE Change Model it is comprised of three distinct steps:

(a) Build a system to refine and continuously improve

(b) Learn from the change process and establish best practice

(c) Review the temporary change support structures, systems and roles

<u>Pilot Implication</u>

In looking at these three parts as a whole, it is envisaged that a continuous feedback loop of information will occur. Feedback from the dental team “on the ground” coupled with patient satisfaction reports will inform this.

This is the final phase of the OD Model. It is anticipated that the project-led aspect of this change will now be complete and that indeed the new practice has been adopted as the “norm”.

3.5 Summary and Conclusion

In reviewing the proposed change model, it is evident that the dynamic aspect of the HSE Change Model with built-in checks should prove useful in engaging all stakeholders. The nature of this proposed OD, with its obvious improvement of services and projected increased patient satisfaction should help to win significant support and build momentum throughout the process. In detailing the model, it has been useful to identify key areas where resistance may occur and developing strategies to overcome same. The next chapter will examine the crucial aspect of evaluation which will underpin this change.

Chapter 4

Evaluation

4.1 Introduction

Lazenbatt (2002) states that evaluation is a method of measuring an extent to which an intervention achieves its stated objectives. In examining Healthcare Evaluation in particular, the WHO European Working Group on Health Promotion Evaluation (1988) states that evaluation is the systematic examination and assessment of the features of an initiative and its effects in order to produce information, that can be used by those who have an interest in its improvement or effectiveness.

This chapter will discuss the crucial significance of evaluation in healthcare and of the Helping Hand system in particular. The chapter will further explore the evaluations impact on the stakeholders – with particular emphasis on clinician-patient communication and satisfaction with same.

4.2 Significance of Healthcare Evaluation

Green and South (2006) describe six key reasons for evaluation:

(1) To establish whether or not interventions have worked

(2) To improve health programme implementation

(3) To provide accountability to funders

(4) To increase support for sustaining or expanding an intervention

(5) To contribute to the scientific base for interventions

(6) To impact policy decisions

At its core, any planned evaluation needs to account for two fundamental aspects :

(a) From which stakeholder perspective is the evaluation going to take place?

(b) Which stakeholders are to be included?

The Health Foundation (2015, p. 32) state that "….a well-designed intervention will include for evaluation from the outset".

In an evidence-based and evidence-informed science, evaluation is king. On that basis, this author would suggest that the degree to which an intervention is faithfully evaluated is a powerful influencer for implementation.

Parry *et al*. (2013) suggest it is assumed that people act according to their degree of belief that an intervention will be effective in their setting. In looking at Figure 8 below, we can see that belief in an idea has three phases of improvement. To that end, Parry *et al.* conclude that only ideas that are linked with a high degree of belief should be widely spread. **CF FIGURE 4**

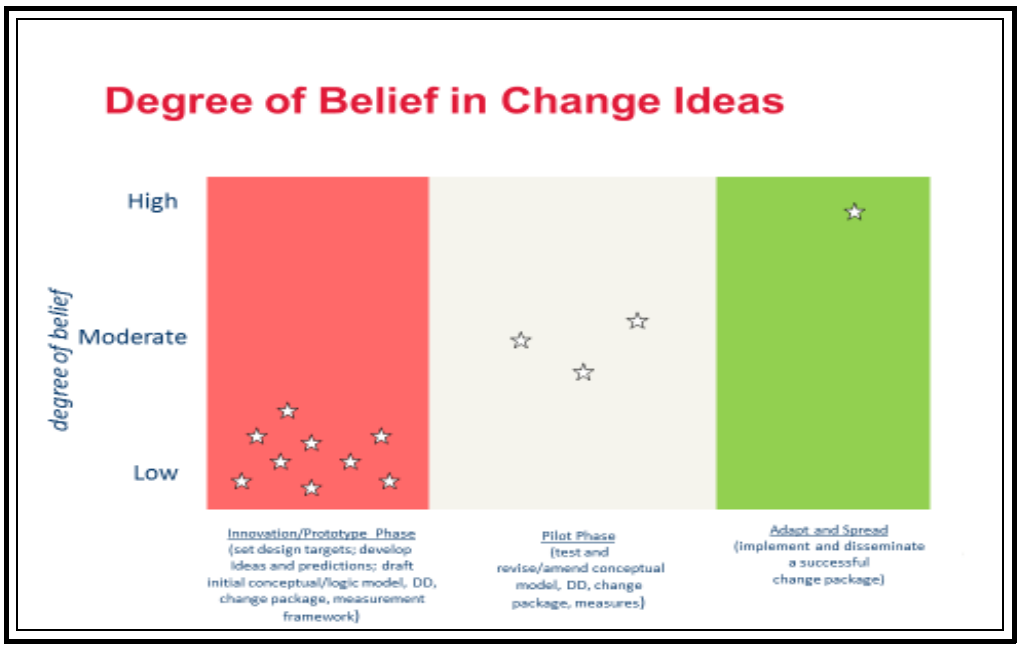


FIGURE 4 – Degree of Belief in Change Ideas (from Parry et al. 2013)

In any improvement methodology, Parry *et al*. (2013) also suggest that success or failure of an improvement model will ultimately depend on a number of disparate factors including : contextual factors (e.g. setting), time frame, leadership, support (momentum), resources, culture and an organisational ability to scale up and spread.

In line with the work of Green and South (2006), the earlier work of Solberg *et al*. (1997) is important when one considers the different facets (or faces) of performance management – namely – measurement for improvement, accountability and research. Solberg *et al*. (1997) define process as an action or as series of actions (by a processor) that converts an input from a supplier to an output for a customer. Solberg *et al.* further suggest that the work undertaken to improve a process is itself a process. Their Seven-Step Process Improvement Model examines the following steps:

(1) Identifying the problem

(2) Collecting data to understand the current process

(3) Analysing the data to understand root cause

(4) Choosing an approach

(5) Developing a process

(6) Implementation

(7) Evaluate and Improve in an iterative cycle through the steps

An advantage of this “systemisation” of improvement, particularly in the healthcare arena is that it is data-driven (evidence based) which usually leads to better buy-in from stakeholders. Also, according to Solberg *et al*. (1997) by focussing on process, it removes the fear and blaming from the equation. This feature is important when examining evaluation in healthcare improvement, particularly where a culture of blame may have historically been evident.

The work of Solberg et al (1997) is summarised in TABLE 7 below.

The Three Faces of Performance Measurement

Aspect	Improvement	Accountability	Research
Aim	Improvement of care (efficiency & effectiveness)	Comparison, choice, reassurance, motivation for change	New knowledge (efficacy)
Methods: • Test Observability	Test observable	No test, evaluate current performance	Test blinded or controlled
• Bias	Accept consistent bias	Measure and adjust to reduce bias	Design to eliminate bias
• Sample Size	"Just enough" data, small sequential samples	Obtain 100% of available, relevant data	"Just in case" data
• Flexibility of Hypothesis	Flexible hypotheses, changes as learning takes place	No hypothesis	Fixed hypothesis (null hypothesis)
• Testing Strategy	Sequential tests	No tests	One large test
• Determining if a change is an improvement	Run charts or Shewhart control charts (statistical process control)	No change focus (maybe compute a percent change or rank order the results)	Hypothesis, statistical tests (t-test, F-test, chi square), p-values
• Confidentiality of the data	Data used only by those involved with improvement	Data available for public consumption and review	Research subjects' identities protected

TABLE 7 – adapted from "The Three Faces of Performance Management" (Solberg et al. 1997)

4.3 Evaluation

Basic evaluation design may be thought of as in **Figure 5** below.

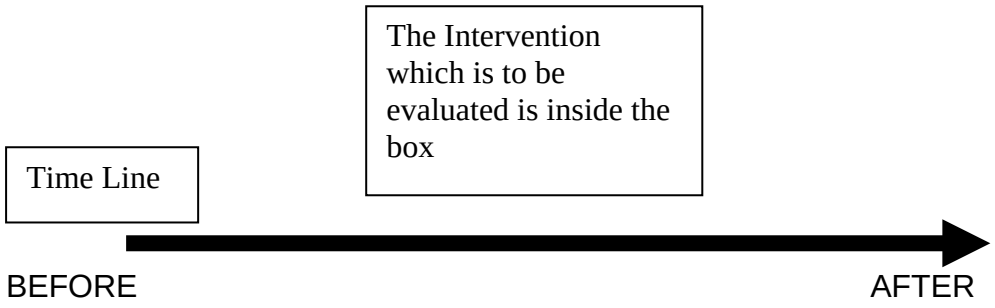


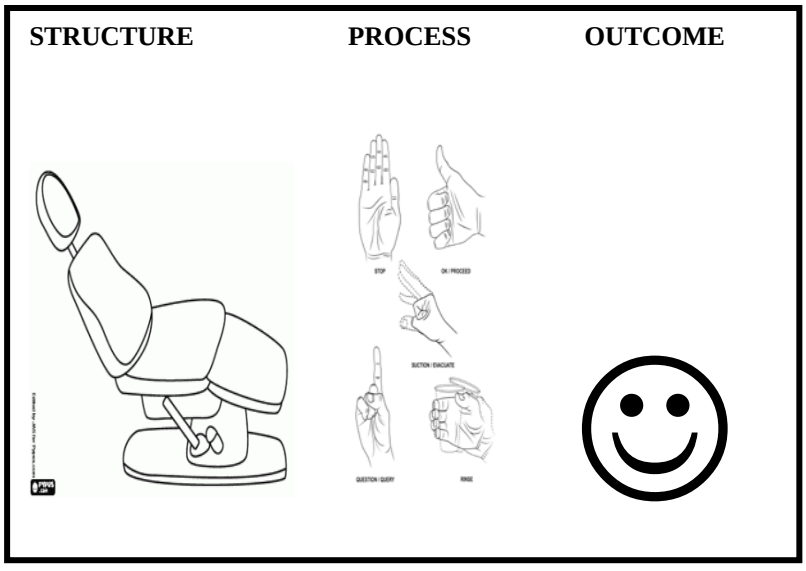
FIGURE 5 "The Box" Evaluation – adapted from Øvretveit (1998)

In his seminal work on assessment, Donabedian (1966) defines an approach to assessment which has 3 pillars, namely : Structure, Process and Outcome.

Structure relates to the setting in which the care is given. Process denotes the actual giving and receiving of care. Outcome relates to the effect on the health status of the patient. Donabedian also suggests that patient satisfaction is itself a desired outcome of care and potentially an element of the health status itself. He further suggests that this expression of satisfaction (or dissatisfaction) is the patient's judgement on the quality of care – but particularly the interpersonal process.

Of particular note is that Donabedian (1966) further posits that information pertaining to patient satisfaction is crucial to assessments of quality of design and management in any healthcare system. Simply put: If a patient is unhappy/dissatisfied with their care, they will not return – no matter how successful the potential clinical outcome.

FIGURE 6 – STRUCTURE, PROCESS & OUTCOME



In considering the Helping Hand System, the insertion of the hand signals encompassed into the routine dental treatment flow is part of the process (Figure 6). It embeds itself into the structure of the clinic,

presents itself as a process for the team and the patient. The outcome here should be increased patient satisfaction, particularly with clinician-patient communication.

As the Helping Hand system is an innovation, the author is particularly mindful of the literature in the area of healthcare evaluation and the success/failure of innovative ideas. Specifically, the literature alludes to Rossi's Iron Law of Evaluation (Rossi,1987). This suggests that, akin to the law of diminishing returns, a healthcare improvement while promising in a small number of settings is found to be ineffective when replicated across a broad range of contexts.

Given that this innovation is to be replicated in almost identical context, the author would argue that Rossi's Iron Law should not apply. However, as a framework for the evaluation, the author suggests careful evaluation across the following steps to better capture, adapt and refine the impact of the Helping Hand system:

(1) Innovation

(2) Testing

(3) Scale Up and Spread

This framework lends itself to the innovative nature of the intervention and also the broader group of clinics, where conditions are almost identical.

In the discussion that follows, the work of Parry *et al*. (2013) will be used to demonstrate a prescribed course of evaluation which meets the criteria for accurate evaluation of the Helping Hand System.

4.3.1 Aims

The aims of the evaluation for this innovative hand-signal system, the Helping Hand are as follows:

(1) To evaluate the training of the dental staff following instruction of the Helping Hand system.
(2) To evaluate the implementation of the Helping Hand system by the dental team (specifically in pilot at the start)
(3) To evaluate patient satisfaction following introduction the system into the dental clinic
(4) To use the results of evaluation to feedback into a PDSA (Plan-Do-Study-Act) Cycle for continual improvement, particularly to feed into Testing and furthermore Scale Up and Spread.

4.3.2 Methods and Measures

In reviewing methods and measures for a healthcare improvement, Parry *et al.* (2013) suggest an approach which asks simply, does the new model work or can it be altered to work?

The exact approach will be informed by two considerations: the degree of belief in the innovation and whether the model for testing is at the innovative, testing or scale-up and spread phase.

The Kirkpatrick Framework is very useful at this juncture.

Kirpkpatrick (1959) developed the Kirkpatrick model for training evaluation. This seminal work is used to observe and evaluate training. There are four levels of this evaluation tool.

Level 1 – Reaction – Measuring participants reaction to and satisfaction with the training. Did participants have an excellent experience working on the improvement initiative?

Level 2 – Learning – Measuring the learning and improvement in the imparted knowledge and skills. What did they learn?

Level 3 – Behaviour – Measuring changes in the task behaviour and progress with the planned actions. Have they adopted the Helping Hand?

Level 4 – Result – The degree to which targeted outcomes occur as a result of training and subsequent reinforcement. Did the organisation's performance improve?

The model was furthered by Phillips (2008) to include return on investment.
This is a significant adjunct, particularly for the private sector where "time is money".

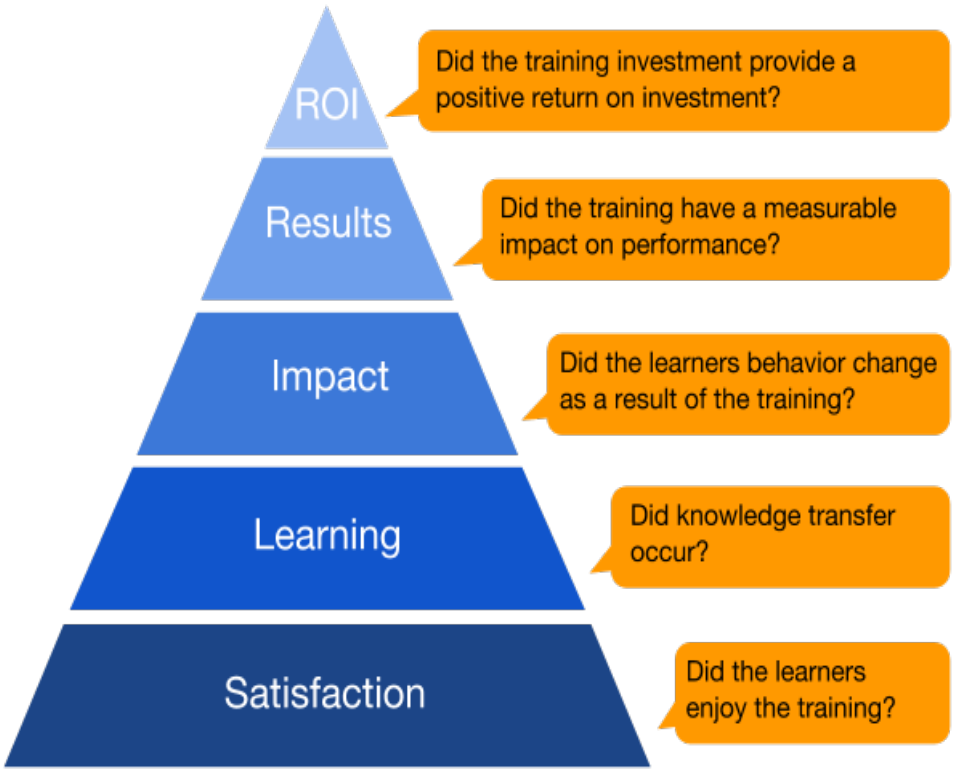


FIGURE 7 – Kirkpatrick's Model (Kirkpatrick, 1951 ; Modified by Phillips, 2008)

As the Helping Hand is at the innovative stage, the evaluation will look closely at this particular phase. However, broader discussion will include provision for testing and scale-up and spread.

With reference to the table below, Parry *et al.* (2013) suggest methods for evaluation at various stages of an improvement, from innovation through to scale-up and spread.

As described in this table, and given that the Helping Hand system is in the innovative stage, the author will discuss this section in particular. For completion however, reference is made to anticipated testing and further scale-up and spread.

Table 8 Summary of Evaluation Aims and Approaches by Improvement Phase

- specifically adapted for the pilot of Helping Hand System from Parry *et al.* (2013)

Innovation	Testing	Scale-Up and Spread
What is the aim of the improvement phase?	**What is the aim of the improvement phase?**	**What is the aim of the improvement phase?**
To introduce the Helping Hand System in a pilot setting.	To engage a broader number of dentists within the pilot site – from 1 dentist to 7.	To engage the organisation as a whole with a high degree of belief.
What is the aim of the evaluation?	**What is the aim of the evaluation?**	**What is the aim of the evaluation?**
Provide an estimate of the improvement achieved to better inform the future application	*Provide an estimate of the improvement achieved across the greater number of participants* .	*Provide an estimate of the improvement achieved across the entire group.*
Increase the degree of belief that the content theory will apply in similar contexts.	*Increase the degree of belief in these similar contexts and/or describe any amendments to theory.*	*Increase the degree of belief.*
What evaluation approaches may be helpful?	What evaluation approaches may be helpful?	What evaluation approaches may be helpful?
A quantitative measurement system that focuses on Kirkpatrick levels 3 and 4, to provide estimates of the impact of variations in development of the content theory.	*A quantitative measurement system that focuses on Kirkpatrick levels 1 to 4*	*A quantitative measurement system that focuses on Kirkpatrick level 3 and level 4.*
Regular rapid-cycle feedback to the leads of the innovation phase (author)	*Randomised cluster and stepped-wedge designs.*	*Longitudinal quantitative data analysis.*
	Regular, rapid-cycle feedback	*Rapid cycle feedback*

Execution Theory and Content Theory – their place in Evaluation

Execution Theory, as posited by Parry *et al.* (2013) is the rationale of how the experience provided by improvement initiative (Kirkpatrick level 1), the instruction delivered (Kirkpatrick level 2) and the learning achieved will lead to improvement in the process measures (Kirkpatrick level 3).

Content Theory (Parry *et al*., 2013) is defined as the rationale for how improvement in process measures associated with applying the new model (Kirkpatrick level 3) leads to organisational performance improvement of patient outcomes. In the case of the Helping Hand system, the author would suggest that both outcomes are desirable – a reduction in complaints and an increase in patient satisfaction.

Innovation Phase

As the Helping Hand is a planned OD with a pilot phase, the author looks at this phase in particular.

Specifically, the instruction in the Helping Hand system and its intended improvements, as described in previous chapters.

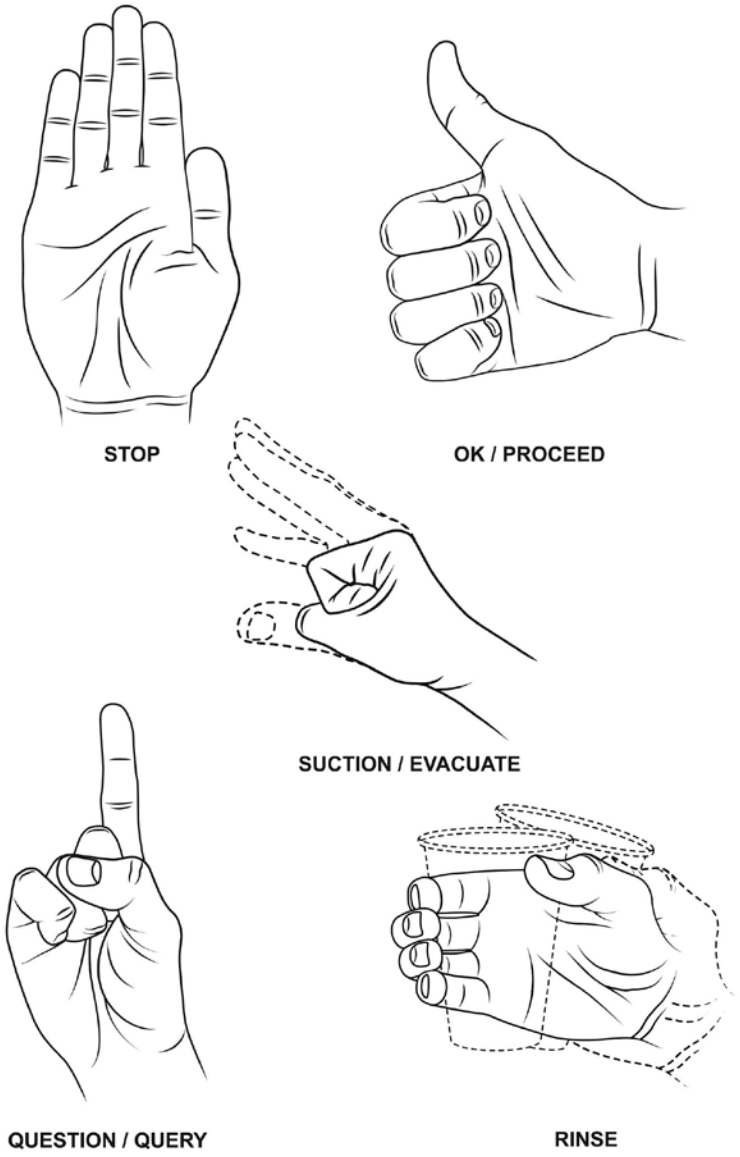
4.3.2.1 Evaluating training of staff after instruction of Helping Hand System

The A4 Sheet of hand-signals is distributed to dentist, dental nurse and receptionist. Each of these 3 is guided through the meaning of the signals.

Each participant is then encouraged to demonstrate the signals to each other. The session lasts 20 minutes to include a presentation on the rationale for the system itself.

It is timely to remind ourselves of the system at this juncture, in Figure 8 – which features English only labels.

FIGURE 8 – The Helping Hand System – (English only)



In evaluating the staff's reaction to the teaching (Kirkpatrick level 1), a questionnaire such as Table 9 is suggested.

Table 9 Evaluation of Training for Helping Hand System

Statement	Strongly Agree	Agree	Neither agree/ disagree	Disagree	Strongly Disagree
The Helping Hand System was clearly explained.					
I was encouraged to ask questions					
I am comfortable using the Helping Hand System and explaining it to patients					
I am more likely to use this system after this training programme					
I was happy with the teaching received.					

In further assessing the pilot dental team's learning of the material covered during the education piece – the following test is suggested. This test is ideally given after the instruction and before the first patients are attended to in the pilot clinic.

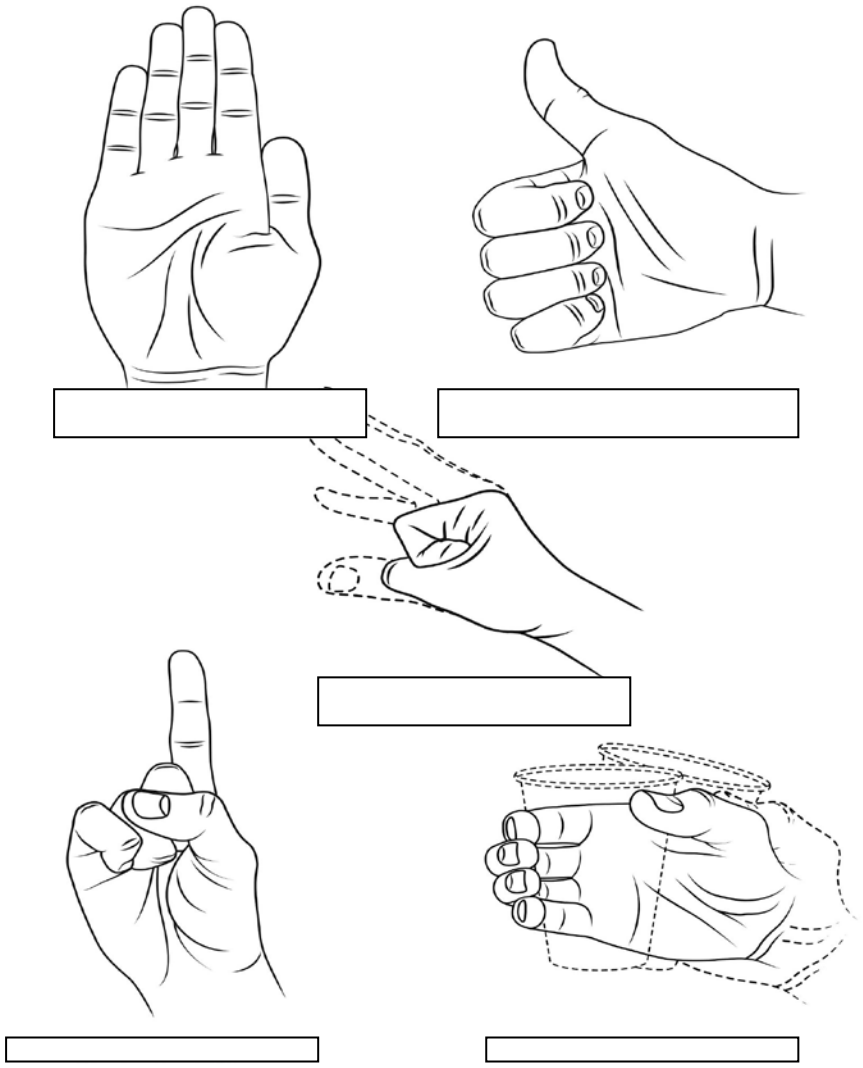


FIGURE 9 – TEST FOR PILOT TEAM – FILL IN THE SIGNAL

In assessing staff behaviour (Kirkpatrick level 3), this can be undertaken by observation and interview, specifically in the Pilot phase, attending the clinic at the initial roll out days that the dental team is introducing the system. There is also the potential for interview at this level to gauge and evaluate the success of use/ease of use. There is also a potential clinical note audit to check the system is being recorded in patients' notes.

In assessing Kirkpatrick level 4 - This could be reviewed by the potential of greater patient return, particularly at the 6 month recall marker. Simply put, the new patient, for whom the Helping Hand was part of their treatment on the very first visit to the clinic – this cohort could be reviewed by audit to see if they returned – and if the Helping Hand System was a driver in their return.

4.3.2.2 Evaluating Patient Satisfaction

The author feels that in this planned implementation project, a baseline level of overall satisfaction with the current service in advance of the pilot, would prove invaluable. This could serve as a measure of current levels of satisfaction with communication and service.

To that end, a simple questionnaire to measure patient satisfaction/user experience would prove necessary. With reference to **TABLE 10**, this simple questionnaire should capture patient sentiment in this regard.

Table 10 Evaluation of Patient Satisfaction before Helping Hand System

Statement	Strongly Agree	Agree	Neither agree/ disagree	Disagree	Strongly Disagree
I felt I could at all times communicate with my dentist and nurse.					
I felt I was involved in my own treatment management particularly during a procedure					
I am satisfied with the level of communication between my dentist and myself					
I could at all times indicate a query or concern					

Using the same questions with the addition of specific questions in relation to the Helping Hand System (**TABLE 11**) we can now compare (side-by-side) the results of the two patient questionnaires. It is envisaged that this will yield vital results data which will show the direct outcome of this OD process.

The specific additional questions would be:

Table 11 Evaluation of Patient Satisfaction after introduction of Helping Hand System

Statement	Strongly Agree	Agree	Neither agree/ disagree	Disagree	Strongly Disagree
The Helping Hand System was clearly explained					
I was comfortable using the Helping Hand System					
Because of the Helping Hand System, I felt at all times in control of my surroundings and part of the decision sharing process.					
I could indicate any query at anytime, even during a procedure.					

4.3.3 Results

As this is a planned project, the hard data of results from the proposed questionnaires is currently absent. The author takes this opportunity to examine two key aspects of the evaluation in detail. Firstly, the administration, analysis and reporting of the questionnaires. Secondly, the PDSA cycle and its use within the framework of this project to help predict the expected outcomes and their importance in this cycle.

4.3.3.1 Questionnaires

As evidenced above, questionnaires will yield the most information at the critical initial phase of the project. In reviewing the construction of these questionnaires, Boynton (2004) suggests that questionnaires tend to fail because participants don't understand them, can't complete them, get bored or offended or dislike how they look.

It is evident that care must be taken at the initial phase of questionnaire deployment that careful attention is given to:

(1) How long does it take the respondent to complete the form(s)?
(2) Are questions repeated?
(3) Are questions simple, easy to comprehend?
(4) Are the safeguards of data protection (as described by law) adhered to in the administration, collection and use of the questionnaires?
(5) Does the patient/particpant (dental team member) feel engaged with the process? Do they consider themselves to be stakeholder?
(6) Is the purpose of the questionnaire fully explained before the questionnaire is attempted?

With reference to the above criteria, the author suggests that by conducting an initial questionnaire (before implementation of the Helping

Hand System) that TABLE 10 will yield information, not just on the subject matter, but also help to refine the proposed questionnaire for post-implementation of the system.

From a practical standpoint, stakeholder engagement by the reception staff will be vital in facilitating patients completing the form after dental treatment.
Familiarity with the questionnaire by the staff, to facilitate completion by the patient will be of paramount importance here.

4.3.3.2 Plan Do Study Act (PDSA) Cycle

The original Plan Do Check Action (PDCA) cycle takes its origins from “Deming’s wheel”. The central premise of the PDSA cycle is that it holds many advantages, particularly in an improvement (QI) initiative as stated by Moen and Norman (2006).

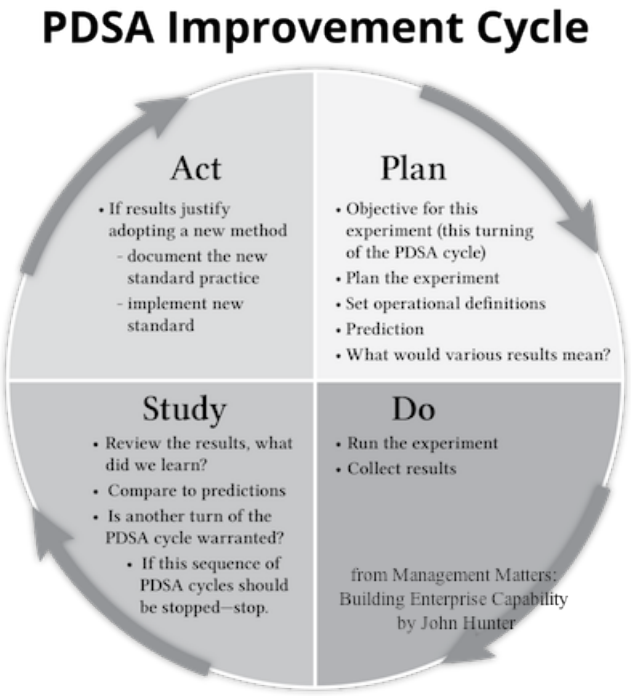


FIGURE 10 – PDSA Improvement Cycle

In their systematic review of the application of the PDSA cycle, Taylor et al (2013) made some interesting observations. The pragmatic nature of the PDSA lends itself to small scale interventions and implementations. By positing a hypothesis, collect data, analyse same and make the necessary adjustments. Using the PDSA provides opportunity to build evidence for change (Taylor *et al.* 2013) and further minimises risk to patient, organisation and the resources required for the change implementation.

Taylor *et al.* (2013) also warn against regarding the PDSA cycle as a black box intervention.

In reflecting on the literature with regard to the proposed Helping Hand System, it is evident that a consistent approach to data collection,

analysis of this data and the consequent action it triggers, is essential to the verifiable results expected.

From a practical viewpoint, the collection of the data (questionnaires) at source (in the surgery/clinic) and their collation will be of vital importance to accurately demonstrate the success (or otherwise) of the project.

4.3.4 Dissemination Plan

The pilot study for the Helping Hand System is scheduled for activation in a very busy clinic. The clinic of choice has 7 dental chairs which are in use from 8am to 8pm. The projected pilot will see one dentist (a champion of change) recruited to implement the Helping Hand System, in concert with the dental nursing staff and the reception staff.

Following the steps outlined in Chapters 3 and this chapter, a clearer picture of the success and use of the system will emerge.

Assuming that the results are favourable and lessons are learned from the PDSA cycle, any improved version will then be scaled up and disseminated throughout the group.

With reference to Table 8, the methods of evaluation for the next phases – testing and scale-up and spread are listed in the table.

The initial dissemination process will initially occur via an email update (which the author will fold into the weekly group email). The updates,

along with real-time data will form the platform from which any group-wide roll out will occur.

It will be imperative that a Champion of Change is also recruited in the remaining 19 clinics who will have responsibility to ensure that the system is implemented. Working as a reporting structure back to the author, it is envisaged that this system can be closely monitored and finally adopted as practice.

4.4 Summary and Conclusion

Evaluation and assessment is at the heart of healthcare improvement. As clinicians, evidence-based practice is at the core of the day-to-day treatment offered to patients. Any innovative improvement to this quality of care will gain wider acceptance if baseline data and recognisable improvement can be demonstrated.

It is hoped that the proposed evaluation methodology above, in conjunction with the structured Organisational Development Model (Chapter 3) will yield a galvanising acceptance and belief in the Helping Hand System.

The various stakeholder groups will need regular updated information on the progress of the OD project to further belief and increase acceptance. The evaluation process itself should be seen, the author contends, as a

continuous cycle of improvement. Only by gathering ongoing data can the change be demonstrated to be of benefit to patient, clinician and management. The remaining chapter will discuss and conclude this dissertation.

Chapter 5

Discussions and Conclusions

5.1 Introduction

Attending the dentist for treatment has traditionally been an anxious time for most patients. Corah (1998) suggests that a review of the literature yields that the quality of the dentist-patient relationship was a significant factor in the reduction of anxiety and increase in patient satisfaction. Particularly, Corah (1998) continues to suggest that empathy, friendliness and a calm manner were important for patients over all experience.

Riley *et al.* (2014) further suggest that while dentists usually can predict a satisfied patient's journey, they conclude that for improved patient-centred care dentists should seek to understand patient values. A large aspect of the dentist-patient relationship is communication.

The author suggests that the Helping Hand System will improve communication, safe guard patient dignity and significantly reduce patient complaints by increasing patient satisfaction.

5.2 Project Impact

As this is a planned OD, the author will suggest ways in which this project will impact on the various stakeholders, the broader implications to the service and to the patient. In informing this discussion, the author will draw on the literature (as detailed in Chapter 2), the drivers for change (particularly the proposed legislative changes) and the author's own professional experience in his current administrative role and also as a clinician.

5.2.1 Stakeholders

Senior Management:

From management's perspective, the benefits of the "Helping Hand System" are obvious. The increased communication, which can be documented in the clinical notes, is a verifiable safeguard of patient dignity. It will add value to the patient journey and potentially fulfils any expected requirement to demonstrably show patient-centric care. From a financial viewpoint, the costs involved in introducing this system are minimal. The practical costs in training and distribution of the posters and questionnaires are cost effective and virtually negligible.

The evaluation protocol should yield accurate real-time feedback to better inform deployment and uptake.

Dentist:

Day to day dentistry is demanding. For patients, it is usually a rare and infrequent glimpse into the world of dentistry, as they usually attend with some specific oral health issue. The demands of diagnosis and treatment are high, particularly in attempting to address the presenting issue. The history and examination visit, the first visit, is the bedrock on which a successful and trusting relationship is built between dentist and patient. With the advent of four-handed dentistry, where the dental nurse (assistant) is relied upon to assist in the delivery of dental care, their observations in particular are of importance to delivery of care.

It is anticipated that the dentist will embrace the Helping Hand System. By working closely with the dental nurse, a more regulated, reproducible and observational communication can be established. This system can be annotated in the clinical record and verified by the dental nurse. In safeguarding the patient dignity it also safeguards against miscommunication and/or infringement on consent to proceed during a procedure.

The author would also postulate that this will have significant positive ramifications for record keeping, particularly where patients may later have issues with the standard of care received (Shaw, 2007).

Dental Nurse:

As the main observational participant during the use of the system, the nurse will be crucial to the success and implementation of the Helping Hand System. Familiarity with the signals and the encouragement of the patient to use them will be of the essence. It will also empower the nurse to increase their role in the provision of dental care as part of the team.

Reception Staff:

As the first point of contact, the administrative staff have a paramount importance. Their role will be in disseminating the relevant information (the laminated sheet of signals to the patient). Many of these staff are former (or practicing) dental nurses. Of particular note here will be there understanding of the importance of the system – particularly in light of the proposed added value to the patient journey. Being aware of the safeguard to the dignity of the patient is also key. The reception staff deal daily with multiple queries from patients – many clinical questions and in particular issues to do with delivery of care. It is anticipated that the reception staff, who also will be tasked with collecting the evaluation data will be the first to see the improvement this system will bring. They will play a decisive role in the implementation, feedback and refinement of the system.

Patient:

In the pilot phase of this system, the author is eager to learn of the patient experience. The evaluation methods should yield data which will better inform as to the progress of the system. The observational piece within the evaluation will also prove critical, as patients' body language and other non-verbal "tells" are of importance to gauge the over all success (or otherwise) of the system.

In particular, those for whom English is not their first language should notice a marked improvement in the service provided and (hopefully) tell others of their experience – thus boosting return custom and increased new patient referrals.

Other Stakeholders

The early agreement and endorsement by Foras na Gaeilge was an important step. A high level of communication with prompt response to queries on use of vocabulary was encouraging. At time of writing, the author is already in consultation with Foras na Gaeilge to determine a timeline for introduction at pilot stage.

The approaches to the various European embassies was also positive – with tentative agreement on endorsement and, from a practical standpoint, use of translation services to accurately assign correct words to the actions contained within the Helping Hand System.

At time of writing, Lámh had yet to fully endorse the system. The author feels that there may be a funding/sponsorship issue here. Every effort will be made to overcome any resistance before piloting in Autumn 2015.

5.2.2 Practice

From a clinical standpoint, the deployment of the Helping Hand System will have the following implications:

(1) A prominent position within the dental setting/structure.
(2) It will feature in the clinical duties and day-to-day management of patient treatment, adding to the patient journey and value to the patient experience
(3) The use of the system will also feature within the clinical notes of the patient underscoring its use and validating its potential as a communication method

These 3 kernel points should see an overall positive ripple effect within the dental team. By ensuring the Helping Hand System becomes the “way we do business”, (HSE, 2008) it has the potential to become a defining attribute of dental care with the company. This also will have implications as a marketable USP.

5.2.3 Theory

The theory behind the system, its conception, change management, evaluation and review has been important to fully elucidate and clearly define a vision. The preliminary works with the main stakeholders have proved invaluable in informing the author in how to better ensure implementation.

5.3 Strengths of the Project

The one-to-one nature of dental care makes this Helping Hand System an ideal bespoke communication pathway for patients and clinicians alike. It is easily understood, intuitive in design and readily evaluated. The emerging literature and prevailing regulatory ethos sweeping through the profession at the time of writing all signpost the obvious need for this system (Campbell & Tickle, 2013).

Many stakeholders will have an understandable incentive to see this system successfully launched and implemented. The duty of care to the patient remains the paramount goal of all clinicians. That this system also has attributes of marginal cost, minimal time constraint and maximum gain in patient safety is the essence of simple design.

5.4 Limitations of the Project

In reflecting on the limitations of the project, the question must be asked, is the system too elaborate? Surely a simple hand-raising will suffice rather than 5 separate signals? In answering this charge and in allaying doubt, it should be stated clearly here that while apocryphal evidence suggests that an informal "stop" system occasionally exists, it has never been noted in clinical notes, nor is it recorded in the literature. From the author's experience too, there is no existing protocol taught within the teaching hospitals at undergraduate level in this regard.

5.5 Recommendations

While developing this project, the author suggests that other recommendations for the project's scope could be considered. In particular, a colour-coded version of the Helping Hand System could be provided. For example, a French language version could be denoted by a blue-outlined graphic version of the system, perhaps red for Polish and so forth. In this way, the reception staff in particular could easily identify the correct instruction card for the requisite language of the patient attending.

Thought could also be given to providing a Braille version – where a raised or indented version of the signals is embedded in the laminate. Further research and work on this could be developed with the experts in

this field to deliver a viable alternative to the sighted version discussed in this project.

The idea of inclusivity is at the heart of this change. In attempting to provide for as wide a patient base as possible, it endeavours to cater for all. The tenet of patient care and patient dignity are at the core of the change.

5.6 Summary and Conclusion

The innovative nature of the Helping Hand System is designed for the patient journey. It is hoped that it will not only safeguard communication, but also safeguard patient dignity. In so doing, this establishment of patient empowerment during treatment will build trust and encourage patient interaction. The benefits of this could unlock greater patient cooperation and in so doing improve overall treatment delivery and patient satisfaction. The pilot phase of this project is due for roll out in Autumn 2015. The evaluation of this pilot will inform its future direction. Given the level of detail and the initial buy-in from the interested stakeholders, the author is confident that this will hearld a new era for the patient journey for his organisation and most importantly for safer, better patient care.

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7 APPENDICES