

ENHANCING COMMUNICATION

IN OUTPATIENT DEPARTMENTS
MAY 2008

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INTRODUCTION

Right Management was engaged by the Department of Human Services, Victoria (DHS) to research, design, pilot and evaluate a communication skills training program for Outpatient Department staff and make recommendations for the way this program should be rolled-out across Victorian Public Hospitals.

The goals of the program are to:

- enhance the communication skills of Outpatient Department staff
- facilitate improvement of the patient experience
- build positive interactions between staff and patients.

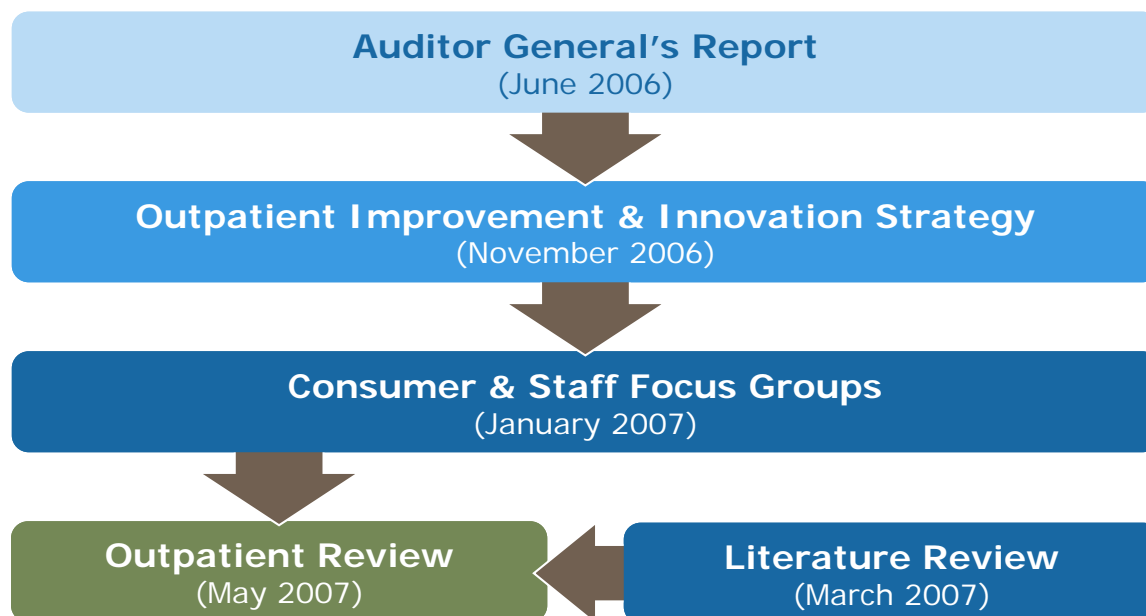
This document summarises:

- program details
- module content
- participant feedback on the Pilot Program
- recommendations for state – wide roll out.

EXECUTIVE SUMMARY

- Initial research to understand the nature of the Outpatient department environment, and the context for the communication skills training was undertaken through a desk top review of relevant reports and research, four site visits and interviews with staff.
- A Focus Group including representatives from a range of hospitals was organised to discuss and chart the journey of the patient through the Outpatient system. This work provided a key piece of content in designing the training materials.
- The key premise underlying the content and delivery methodology is that participants can have a major impact on the way others communicate with them through empowering them as “communication professionals” in their work environment.
- The Right project team reported on the findings of their research, key differentiators between Emergency Department and Outpatient departments and recommended program content to the DHS project Team, the Outpatient Improvement & Innovation Advisory Committee, and Benchmarking Sub-Committee. This was followed by a “Test Workshop” held to evaluate proposed workshop content.
- Pilots of the program have been run at four sites and feedback from participants is extremely positive. Based on data collected directly from participants following the workshops, 94% rated the content as useful or extremely useful.
- In depth telephone interviews conducted with 15% of participants following the pilot confirmed this with **50% of those interviewed advising that their participation had led to a behaviour change**. This is a remarkable outcome for a very modest four hour investment in staff development.
- Given the participant response, it is recommended that the program is delivered to all Outpatient Department nursing and clerical staff across Victorian Public Hospitals.
- A two x two hour format is recommended for state-wide program delivery to maximise learning outcomes and also to best match the needs of the participant group.
- The use of high quality, experienced facilitators is a critical part of the successful program delivery. The context for delivery is a challenging participant group, and maintaining consistency as far as possible with facilitators/ facilitation style used for the pilots is recommended.
- Having DHS funding of staff attendance will ensure that there is management buy-in at the public hospitals for the program. Prior experience with Emergency Departments and experience in organising the pilot demonstrates this. In this context DHS funding may cover paying staff to attend sessions on rostered time off; payments to staff from the casual bank brought in to cover for staff attending the sessions; staff staying beyond/starting before normal work hours to attend sessions.
- Establishing a “champion” at each hospital is critical in ensuring the program is positioned positively with Outpatient Departments, and that there is someone onsite taking accountability for hospital-end logistics and scheduling. Both of these components are very important in managing a successful roll out.
- DHS has a real opportunity to demonstrate strong RoI (return on investment) for this program. One of the most effective ways of doing this is through comparison of patient satisfaction levels pre and post workshop. We strongly recommend developing a patient satisfaction tool to enable this to occur.

CONTEXT



The above graphic depicts the broader context for this project. The “Outpatient Improvement & Innovation Strategy (OIIS)” was developed by DHS in 2006 to address findings in the Victorian Auditor General’s report (*Access to specialist medical outpatient care 2006*). The underlying purpose of the OIIS is to improve the quality and accessibility of outpatient services, with a priority being to improve the patient experience. The OIIS is informed by considerable research into both staff and consumer experience of Outpatient departments.

In May 2007, DHS commissioned an outpatient review at twenty three metropolitan and five regional hospitals with the following aims:

- observing the current state of physical amenities, information materials and communication practices in Victorian public hospital outpatient departments
- identifying good design and practice
- identifying areas where improvement may be desirable.

Following the review, one of the areas recognised as a priority for targeted improvement was communication training.

It is also acknowledged that the broader context is one of significant change afoot within Outpatient departments, which became as clear Right undertook initial research before commencing design of the training program.

Within this context Right Management was able to leverage experience obtained by Principal Consultant Fiona Robertson in developing and implementing communication skills training in public hospital Emergency Departments.

APPROACH



The graphic shows the process steps used to undertake this project. Steps one, two three four and five have now been completed within the agreed timeline and within budget. To follow is a brief outline of work undertaken up to this point.

Step One – Project Set up

Project scope was confirmed and a work plan agreed with the DHS project team outlining respective roles, critical milestones and timelines. This was supplemented by project meetings as required and attendances and presentations on draft content by Right project team members to the Outpatient Improvement and Innovation Advisory Committee, and Benchmarking subcommittee.

Step Two – Research and Fieldwork

Desktop research was undertaken by Right prior to commencement of the fieldwork. This included reviewing:

- The Auditor General's Report 2006
- The Outpatient Improvement and Innovation Strategy (OIIS)
- Research commissioned from Open Mind by DHS into the Outpatient Experience.

This was followed by visits to four Outpatient Departments where the physical environment was scoped and a range of clerical, nursing and medical staff interviewed. The sites visited were:

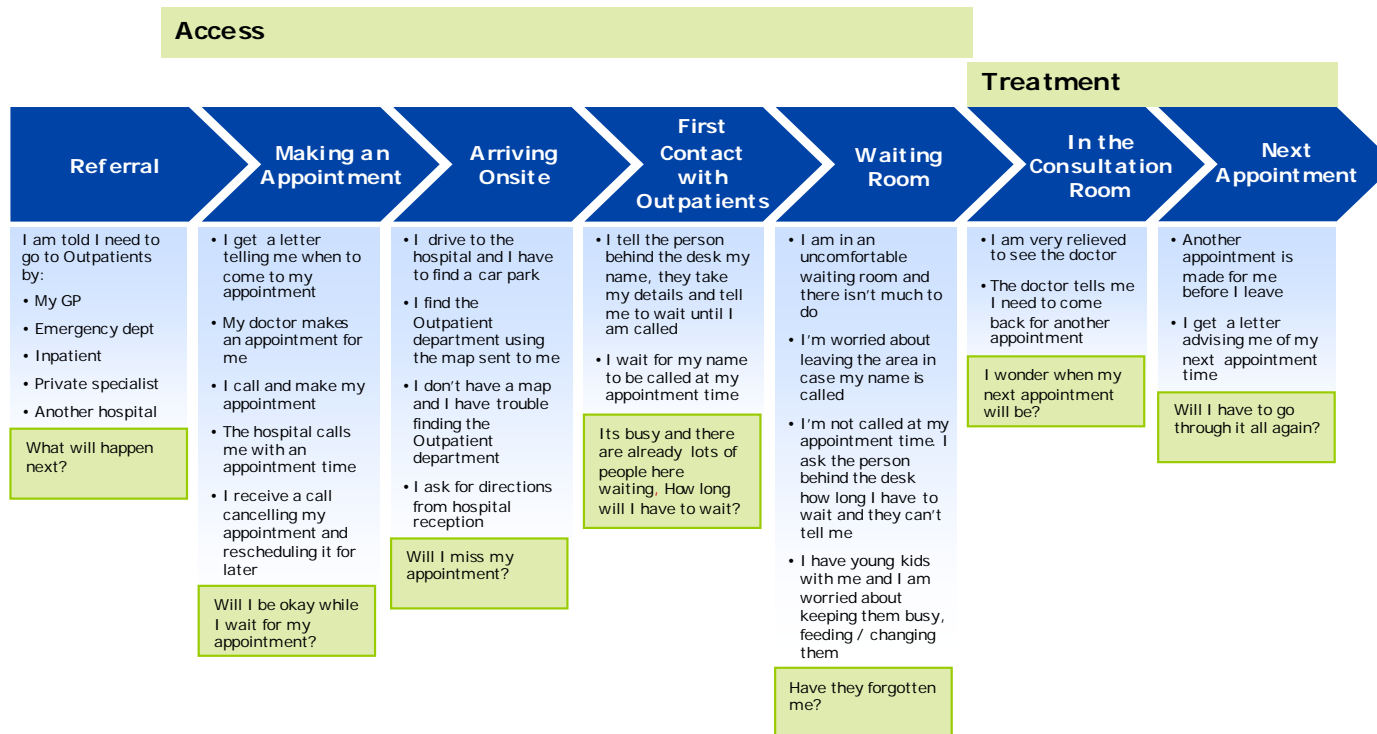
- Bendigo Hospital
- Austin Hospital
- Monash Hospital
- Box Hill Hospital

A focus group was then convened with around 10 Outpatient staff from a range of sites to chart a generic Outpatient journey from the patients' perspective to use as part of the workshop content. The output from that focus group is included on the next page.

MODULE ONE CONTENT- THE PATIENT JOURNEY

A critical part of the content developed is the process depicting the Patient journey through the Outpatient department.

Key research insights - the patient experience



Step Three – Design

The pilot program content was then developed and presentations made to the DHS Project Team and then the Advisory Committee identifying key differentiators between Emergency Departments and Outpatient departments, key themes from the Right Research listed below), and recommended content for the sessions.

Key themes from the Right research

- There continues to be significant and increasing demand for Outpatient services
- Outpatient departments see more patients than any other department in the hospital and as a result become the face of the hospital within the community and are critical to the brand and reputation of the hospital.
- Outpatient staff experience negativity from patients both in telephone interactions and directly from patients in waiting rooms/consulting room, as well as pressure on administrative systems and processes (clerical staff in particular are affected by this)
- There is scope to improve communication between all stakeholder groups involved in the Outpatient departments
- There is currently a significant focus by health services on the recruitment and retention of staff with appropriate knowledge, skills and capability to Outpatient Departments
- There is work underway at all four sites visited to improve systems and processes within Outpatient departments (e.g. stand alone call centres, queue management, role redesign, improved induction processes etc.) This is creating the need to manage change effectively as well as maintaining business as usual.

Program Content

The program was designed using a framework(outlined on page 8) with four key focus areas, creating a flow from examining and understanding the patient journey and needs, to understanding the impact that each individual can have through every interaction, and then to some tools and models that enhance effective communication.

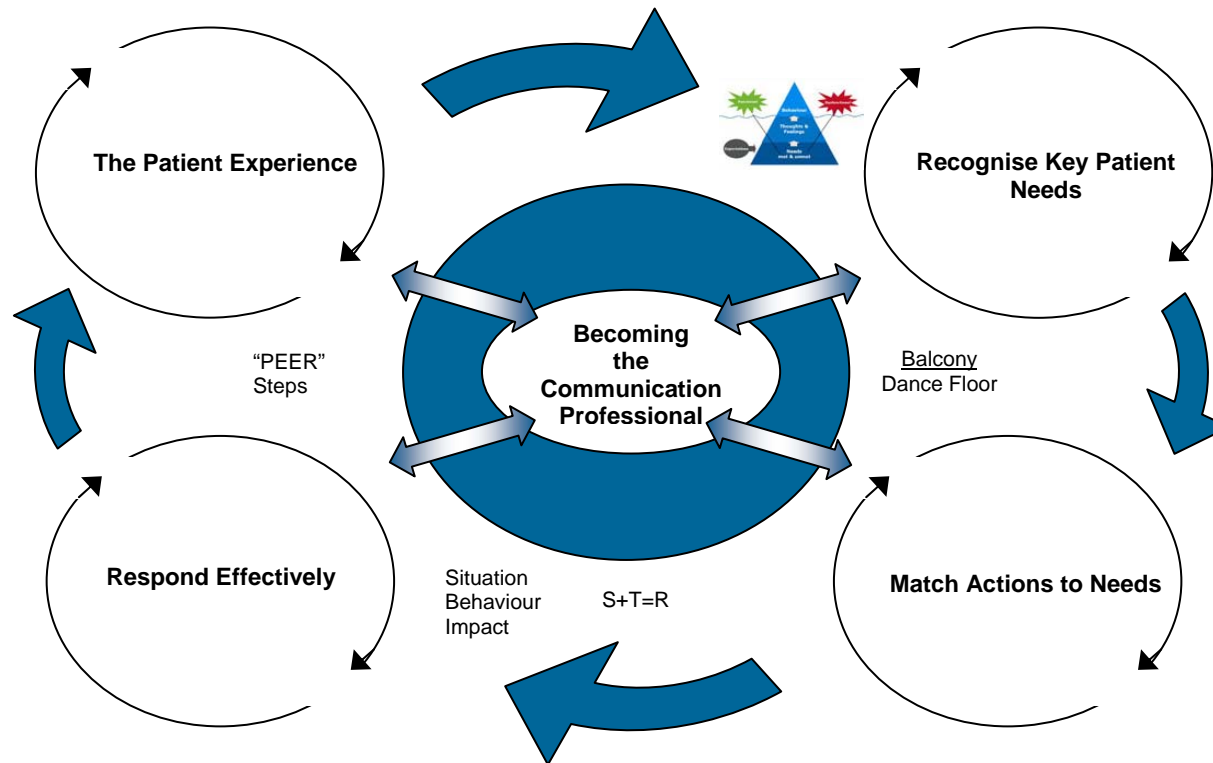
The four areas of focus are:

- The Patient Experience
- Recognising Key Patient Needs
- Matching Actions to Needs
- Responding Effectively

The program is positioned as an opportunity for participants to share their experience with each other about what they know works well from the communication perspective. There is discussion and acknowledgement about the challenges that their work environment creates. A small amount of theory supported by models is shared to stimulate discussion and participants are provided with tools and opportunities to practise positive communication. The positioning and program style is inclusive, non-threatening, and draws on and acknowledges participants experiences as a key contributing part of the content. The premise underlying the content and delivery is that participants can have a major impact on the way others communicate with them through empowering them as “communication professionals” in their work environment.

PROGRAM FRAMEWORK

The program was developed using learning from the Emergency Department program, research by Open Mind Research Group, Right research from site visits and interviews, input from a Focus Group convened to discuss the patient journey through the Outpatient department, a Test Workshop and feedback on proposed content. The program follows this framework:



Step Four – Pilot and Evaluations

Format

The program was piloted using two different formats at four sites. The two formats used were a single longer session (4.5 hours), and two shorter modules (2 hours and 2.5 hours) separated by a period of at least one week. The content of the single longer session was the content of the two shorter modules run together.

Pilot Sites and Participants

SITE	NURSING	CLERICAL	OTHER	TOTAL	DATE
Bendigo Hospital – single session	5	5	1	11	5 March
Peter MacCallum – two modules	3	11	1	15	7,14 March
Box Hill Hospital- two modules	5	5		10	12,19 March
Austin Health- single session	24	17	2	43	25 March

The 79 participants were a mix of nursing and clerical staff, with a very small number who identified themselves as “other”, and one who did not select a category. Selection of participants at Bendigo, Peter MacCallum and Box Hill was undertaken on a voluntary, self selecting basis. At Austin Health **all** Outpatient Department staff were required to attend as part of a staff development day. The way staff were invited to attend is relevant when reviewing the feedback. Groups that self-select tend to be more positive, whereas those compulsorily required to attend can demonstrate resistance.

Feedback

Feedback was collected through feedback forms completed by participants following the workshop and by follow up interviews conducted by telephone. A summary and analysis of all feedback is included later in this report.

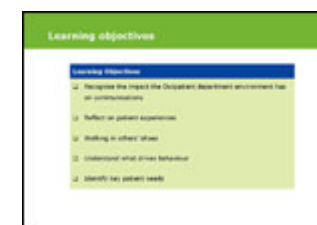
MODULE ONE CONTENT



The communications workshops are positioned as one of a cluster of initiatives in an overall strategy to improve Outpatients for patients and staff



The learning model is used to explain that the intention to bring participants back from a state of “unconscious competence” to “conscious competence” to examine what it is that they are doing well so they can do more of it

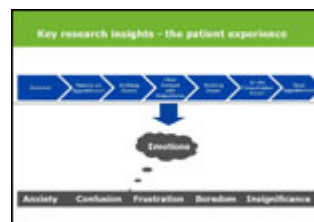


Learning objectives for Module One:

- Recognising the impact the environment has on communications
- Reflecting on the patient experience
- Understanding what drives behaviour
- Identifying key patient needs



The patient journey through Outpatients is charted to remind staff of the experience through the eyes of a first time patient



Accompanying emotions are discussed, followed by discussion of staff experience of Outpatients as a patient, or other situation where there was lack of control and dependence on others



Participants are introduced to the “iceberg model” identifying drivers of behaviour



Participants work in pairs on a worksheet with typical patient scenarios provided to practice identifying the drivers of behaviour, then contribute a recent scenario of their own.

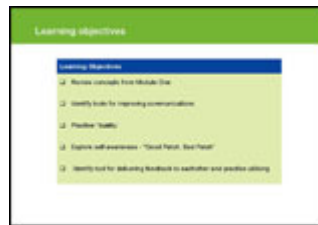


The key patient needs of knowledge and reassurance are identified as being the most important to flip behaviour from dysfunctional to functional



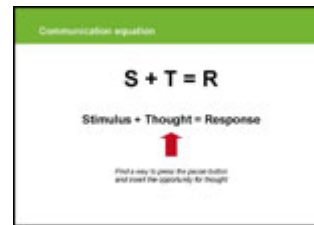
The "PEER" formula is introduced to remind participants of communication steps for first time patients in Outpatient department

MODULE TWO CONTENT

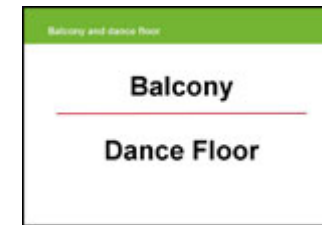


Module two learning objectives include: Reviewing Module one concepts and Introduced tools for enhancing communication including:

- Understanding and practicing “duality”
- Exploring self-awareness
- How to give each other feedback



The S+T=R equation encourages participants to give themselves space for thought before responding



Participants are introduced to the concept of duality – being able to simultaneously be in an interaction on the dance floor) and observing the interaction (on the balcony)



Participants complete a worksheet exploring self awareness through identifying their behaviours as they experience good patches and bad patches at work



Participants are introduced to the Situation- Behaviour- Impact model of giving feedback and practise using it



At the completion of Module Two participants are given a copy of the key frameworks to take away for future reference

PARTICIPANT FEEDBACK

A copy of the participant feedback form is included as appendix one.

MODULE ONE (2 HOURS) FEEDBACK

Participants

CLERICAL	NURSING	OTHER	TOTAL
8	16	1	25

Length of Service

LESS THAN 1 YEAR	1-2 YEARS	3-5 YEARS	6-10 YEARS	11-15 YEARS	16+ YEARS
8	6	6	1	1	3

Ratings

- **100%** of participants rated Module One as useful or very useful (20 as useful, 5 as very useful).
- **100%** of participants rated the facilitators as good or excellent (10 as good, 15 as excellent)

Most valuable concept?

In response to the question “what was the most valuable concept you were introduced to”, all concepts introduced were referred to. Some of the comments were:

- “The acknowledgement of the real storm we are facing every day. To remember what patients go through and how they feel”
- “Taking time initially to communicate well with the patient will enhance their experience and save time later”
- “How to see patient behaviour and use our knowledge and reassurance to change it”
- “Remembering we are all humans with needs and remember to put ourselves in their shoes”

What aspects of the workshop could be improved?

In response to the question “what aspects of the workshop could be improved?” responses indicated that the environment in which the workshop is held is important. One session was conducted in an open space, and participants noted that audibility was not good, and a better space was needed. Comments included the following:

- Smaller group or better room for presentation
- If it is done on a regular basis
- To have all staff attend
- So far, so good

MODULE TWO (2.5 HOURS) FEEDBACK

(The same participants attended Module Two as Module One)

Ratings

- **100%** of participants rated Module Two as useful or very useful (16 as useful, 9 as very useful).
- **100%** of participants rated the facilitators as good or excellent (11 as good, 15 as excellent)

Most valuable concept?

In response to the question “what was the most valuable concept you were introduced to”, again all concepts introduced were referred to. Some of the comments were:

- “Separating the behaviour from the person, focussing on the situation and how to resolve it with a positive outcome”
- “Being aware of my own moods/behaviour”
- “Choose your own behaviour – don’t react”
- “How to approach a situation so that there is a positive behaviour and the right impact/outcome for all”

What aspects of the workshop could be improved?

In response to the question “what aspects of the workshop could be improved?” responses included the following:

- “Maybe a little too long in the second session”
- “To be held as one session rather than two”
- “I enjoyed the 2nd better than the 1st because of the change of venue and I could see the screen better”
- “Not on a Friday afternoon when it is the only quiet time you have to catch up on things”

SINGLE SESSION (MODULES 1&2 COMBINED) FEEDBACK

Participants

CLERICAL	NURSING	OTHER	TOTAL
27	24	3	54

The 11 participants from Bendigo self-selected, and the 43 from Austin Health were compulsorily required to attend.

Length of Service

LESS THAN 1 YEAR	1-2 YEARS	3-5 YEARS	6-10 YEARS	11-15 YEARS	16+ YEARS
6	9	10	12	8	9

Ratings

- **89%** of participants rated the single module as useful or very useful (33 as useful, 16 as very useful.)
- **11%** of participants rated the single module as not very useful or not at all useful, (4 as not very useful, 1 as not at all useful.)
- **100%** of participants rated the facilitators as good or excellent (14 as good, 38 as excellent.)

Most valuable concept?

In response to the question “what was the most valuable concept you were introduced to”, all concepts introduced were referred to. Some of the comments were:

- “I liked the Iceberg, Balcony/Dance floor method of explaining behaviour and found these concepts easy to understand when explained in this manner”
- “Learning to take time to listen to what others are saying”
- “Putting the shoe on the other foot and remembering what the patient is going through and how they are feeling”
- “To know it is not only an “Austin” problem”
- “Awareness of how our behaviour impacts on patients”
- “Behaviour and how to work as a professional”
- “Identifying improved ways of communication with other staff members”

What aspects of the workshop could be improved?

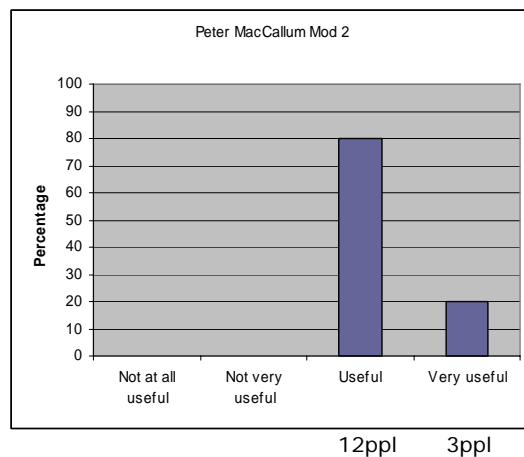
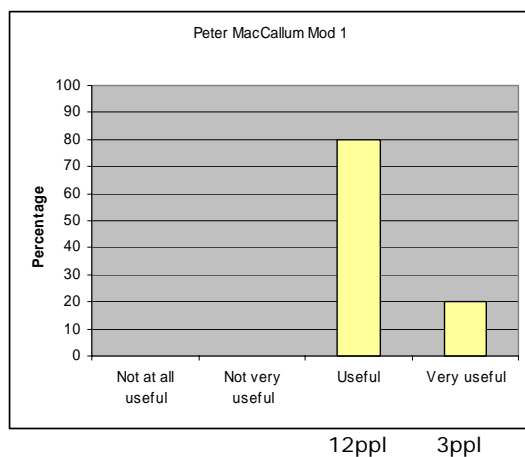
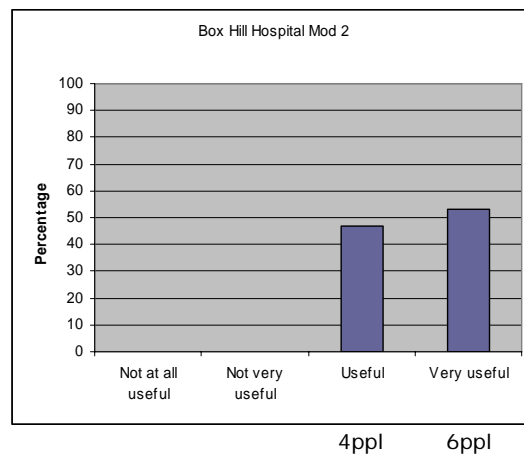
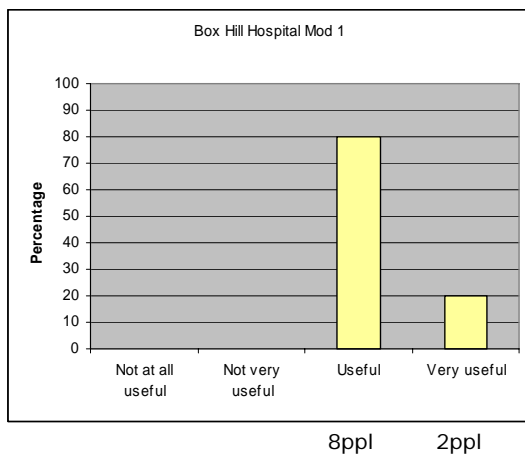
In response to the question “what aspects of the workshop could be improved?” responses again indicated that the environment in which the workshop is held is important. Comments included the following:

- “Better room - too small”
- “Ran very well – enjoyed the session”

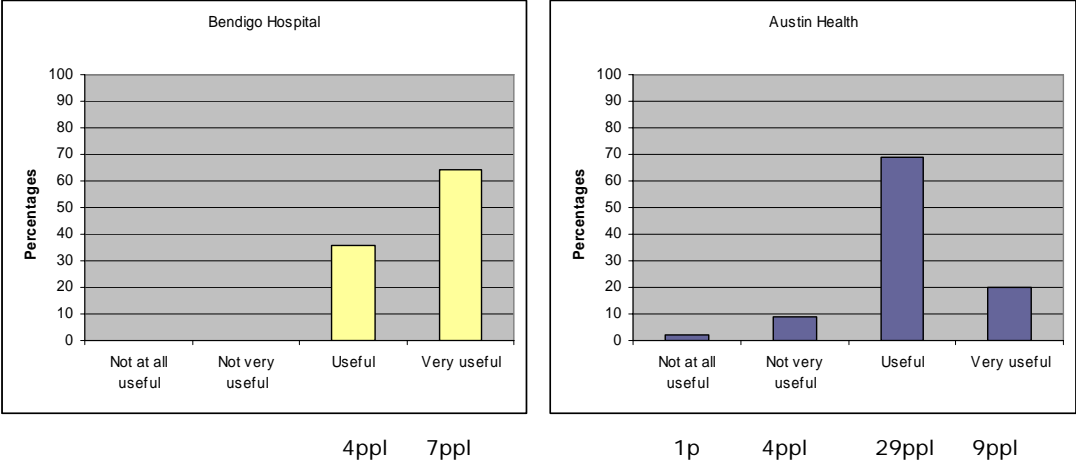
- “A lot more team building exercises so we don’t sit still for too long”
- “Less group activities more individual activities”
- “Perhaps too long”
- “Relevance to our issues as nurses”

SUMMARY FEEDBACK DATA

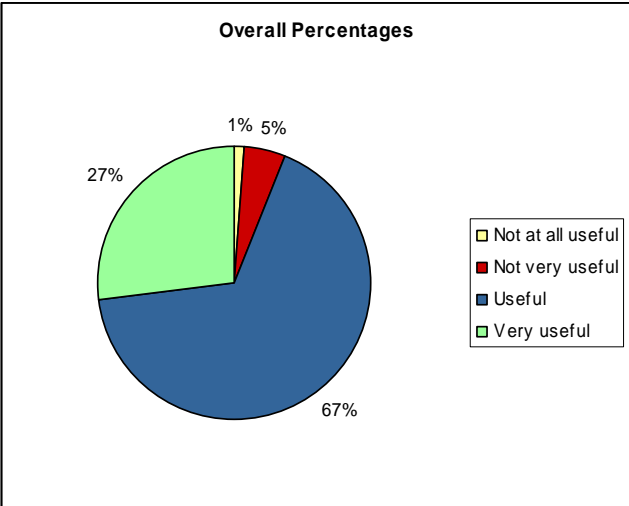
Modules One and Two by Location



Single Session by Location



Overall Percentages



TELEPHONE INTERVIEW FEEDBACK

As part of the work agreed by Right Management and DHS, and reflective of Right Management’s commitment to ensure the best possible outcomes for DHS, follow up feedback interviews were conducted with a sample of participants who attended the pilot communication skills workshops.

The purpose of these calls was to gather additional data to supplement the evaluation forms completed post workshop. The interviews focused on where the workshops were providing particular value to participants and where they could be improved. Reflective of Right Management’s approach to evaluation (outlined more fully in Appendix B), the questions were designed to gather increasingly rich sources of data starting with participant reactions, moving to participants learning’s, followed up with the behaviour change impact of these learnings, and then financially the impact of this behaviour change on the outpatient experience. This tiered approach to questioning allows DHS to obtain increasingly deep sources of information about the workshop.

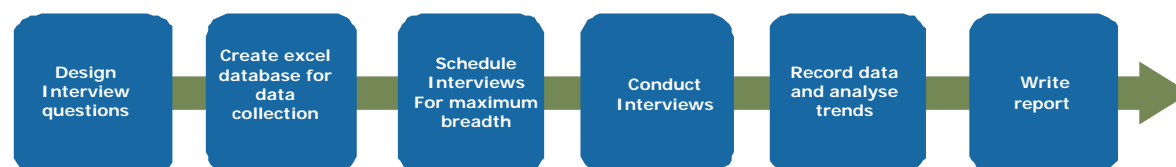
Interviews were spread across the pilot sites in the following way:

PETER MAC	BOXHILL	AUSTIN	BENDIGO	TOTAL
3 interviews	4 interviews	3 interviews	2 interviews	12

Not surprisingly, it was not easy to access time with participants. The most effective method proved to be ringing and scheduling a suitable time to call back and have the conversation. First contacts were made on 20 and 27 March, and most interviews were conducted on 31 March and 1 April, between 1 and 3 weeks after the pilots commenced (pilot dates being 5, 7,14,12,19, and 25 March.)

PROCESS

The process for the evaluation was fairly straightforward, reflective of the relatively small sample of participants thus far, and the pilot nature of the programmes delivered to date. The process, in summary, is outlined in the diagram below.



The first step was to design a series of interview questions which would meet the following criteria:

- Be short and to the point – given interviewees other myriad commitments
- Gather data in a way that reflects Best Practise in evaluation, that is assessing reactions, learning, behaviour and impact
- Assure interviewees that all data is completely confidential
- Be flexible enough to gather valuable data from participants who attended the full day, two half days and participants who found it more or less useful.

Once the interview guide was written (see Appendix A), an excel data collection sheet was written to ensure that the information gathered in the interview could be analysed in the most meaningful yet efficient manner.

One this was done interviews were scheduled by calling all participants and booking in – with those available - a time. This was done after first calling participants for interviews direct without scheduling times, however this was found to be extremely inefficient. A key consideration nonetheless when booking times in was to ensure that between 10 and 20% of all participants were interviewed (for maximum feedback value), and that participants from all the different participating hospitals, different facilitators, and time frames (i.e. either full or half day sessions) were interviewed. This would allow an examination of whether there were different experiences for staff form different hospitals etc.

The interviews were then conducted, with data gathered and written up. Finally data was examined for summary themes and trends and this report produced as a result.

RESULTS

Overall the workshops received extremely positive feedback, with, even at this early stage many participants noting not only that they felt it was valuable but citing real world impact it has had for them on the job and thus for outpatients. There were few consistent areas for improvement. A summary of the results from the interviews is outlined below.

Best aspects of the workshop:

Participants mentioned several, diverse aspects as being the ones they found useful. These included (with specific comments):

- **The facilitators – in particular their flexibility, non-patronising approach, and activity led facilitation:**

“good”, “everybody participated” “comfortable learning environment” “the 2 ladies - used activities to get people out of chairs- which was good.” “Maria was excellent facilitator.” “Thought v well done and girls who did it were great. ”

- **Opportunity to bond with the team, learn from each other, share experiences:**

“Joint workshop with nursing and clerical staff. The clerical staff often don't get the opportunity to mix with the nursing staff.” “Way everyone communicated” “nursing, clerical staff ...all involved.” “having the group discussion and learning from each other.”

- **The design of the content - its relevance, simplicity and practicality**

“Simplified material”. “The practice”. “the topics ... content was good.” “not lots of detail but really related to what we were doing. Especially the conscious and unconscious competence”. “...relevant” “the ideas were great - especially on the first day.”

- **(Rare) Opportunity to reflect on work and approach (and refresh)**

“we don't have time to reflect.” “when you are working your butt off it helped you see that can you sit back and reflect” “It gets people into giving it a little more thought.”

Areas for improvement

As mentioned above there were very few consistent areas for improvement mentioned. Key comments were as follows:

- **None**

"Nothing" "I honestly don't think a lot could have been." "Not really anything." "Nothing didn't like" "not really - I found what I got out of it was very useful"

- **The process**

The main improvement mentioned was in the process – although different views were expressed by different participants. As such it appears (not unexpectedly) that the process is actually working well, but different specific elements of it were less effective for some people than others. The only comment that came up more than once was the need to ensure sufficient breaks- or preferably conduct the programme over two 2- hour slots rather than one 4-hour slot. Overall process comments included:

- "Need more practice - extra 1/2 hour more"
- "get more people to attend staff in different roles ... could have attended",
- "I'm not into drama roles but it worked well"
- "I would like to see that all people attend - all staff"
- "some bits felt like wasted time e.g. activity where one person talks and another listens - too unnatural...".
- "I think a full day is too much ...given the other work we have to do"
- "a 4 hour slotwas long time.... A break in the middle was good"
- "was end of week which was hard - as all tired."

Key 'take aways'

Participants said that different elements of the program were most useful to them. This is not surprising and suggests positively that each participant is taking out of the program those elements most relevant to them. A reasonably consistent comment was about spending a little more time or conscious energy communicating with, and understanding, patients. Key comments included:

- **Patient awareness:**

- "Will now take extra time to explain what will happen to new patients"
- "How a patient feels - keeping them informed. You don't realise a patient coming to us is apprehensive."
- "Understanding what's in people's (patients) backgrounds. Why they act the way they do.they may be anxious.."
- "Understand what patients go through... spend more time explaining to them."
- "discussing ways to reassure patients more"
- "reminded patients have problems tooGood to bring it back that we are providing a service to public."
- "people being non-confronting - whether staff or patients- especially when upset".

- “that patients have other things going on - be easy on them. Going that extra mile too...”.

- **General content**

- “The one about where does behaviour come from - thought it was extremely well done.”
- “The 'Balcony' exercise / concept”
- “Unconscious/ conscious competence”
- “balcony dance floor thing”
- “Formula of stimulus + thought = response.”

How are participants behaving differently?

Once again a variety of comments were made in this regard. Perhaps most pleasingly though, most people interviewed said that the workshop had led to behavior change (and one talked of it leading to a fairly major process change in their outpatients section.) The most consistent comments related to dealing with patients in a little more of an understanding way and not leading to change per se but being reminded of important behaviors. Comments included:

- **Treating patients differently**

- “Trying not to get uptight and to remain calm”
- “spend more time with elderly person. ...rather than rushing in automatic way spend more time explaining the process. Be more considerate - not just assume they know why they are here.”
- “Reinforced how I need to handle and talk to people. People can be aggressive. I try to keep the workshop ideas in mind and stay calm and understand their point of view..... It has helped when dealing with staff who are stressed.”
- “I'm more conscious of my responses”
- “I try more so now to really think more about this- have the eye contact more - rather than just deal with people automatically - try and smile a bit more - in a genuine way”.
- “I have to keep reminding myself as brain goes a million miles an hour so calming down a bit. Don't go on the offensive.”

- **No change – but reminder of how I already behave**

- “no - I think it was more relevant for the clerk role. I know to have a smile on my face - stops people getting angry.”
- “I don't think I am doing anything differently - as I have been here many years- maybe if you are new it would be helpful.”
- “probably not - but making me aware of the importance of it - I believe I have done it anyway. But good thing is talking about it and having it reinforced”

What is the impact on patients of these changes?

The most difficult question of all of course is to measure the impact of the pilot program (especially at this early stage) on the patient experience. Nonetheless it was reassuring that almost half the people interviewed felt that their attendance at the workshop had led to behaviour change that altered the outpatient experience. The primary comment made referred to the positive impact that a more understanding patient approach would have had. Comments included:

- “They are happy to get the information and to see I'm interested in them. They tend to ask more questions now.”
- “The patients are more appreciative (giving them explanations, acknowledging what they said).”
- “Not able to implement yet. But hopefully they would react better and have a better understanding.”
- “Its got to be better - if you are welcomed by someone and acknowledged and made to feel you are a person not just a number.”

Any other feedback?

Participants gave some extremely useful additional comments. In general these referred to either specific elements of the program they found useful or their desire to see a more regular occurrence. Comments made included:

- “It would be good to do every couple of years”
- “Should do a refresher every year as this would also pick up the new staff.”
- “The flip cards on the ring that we were given were useful”.
- “Perhaps a program that is more focused on dealing with ethnic patients would be good, we need training in that.”

ROLLOUT TO VICTORIAN PUBLIC HOSPITALS

CRITICAL SUCCESS FACTORS

Taking into account the feedback received and prior experience the following key learnings and critical success factors for successful state-wide rollout are identified:

KEY LEARNING	CRITICAL SUCCESS FACTORS
DHS sponsorship for staff attendance or to backfill while staff attend will help ensure participation	DHS funding of staff attendance will ensure management buy-in to the program
Participant feedback from the pilots confirms the usefulness of the program, with 94% of participants rating the program as useful or very useful, and content value being confirmed in telephone interviews where it had in some cases led to behaviour change	Attendance is compulsory for all Outpatient Department clerical and nursing staff
Visible support (and in some cases participation) from NUM's and OP Directors/Business Managers positions the program for success	Prior engagement with OP Directors/NUM's at the hospital sites is essential both in positioning the program successfully with staff, and for gaining commitment to scheduling
Two shorter sessions will suit this participant group better and achieve better learning outcomes	The program is delivered in two sessions of two hours with optimal time of 2 weeks between delivery of each session
The facilitators and facilitation approach used for the pilot program worked very well for the participants	High quality, experienced facilitation is essential, with the need to match attendee demographics and facilitators appropriately
The logistics of scheduling in this environment are challenging (e.g. a pilot site pulled out because of staff shortages arising within a 6 week period)	Central coordination of scheduling is a key function in rolling out the program
The optimum numbers for effective learning and full participation are 12-15 people	Program attendance numbers are limited to a maximum of 15 per session. Attendees organise and commit to attend in advance.
The venue is important in creating an appropriate learning environment	A closed space that is sufficiently large for a single row of seating for all participants is essential as a minimum for the program venue

RECOMMENDATIONS

- Following considerable tailoring through the focus group and test workshop, the pilot program content can be maintained without modification. There has been very positive endorsement by participants of the value of the content, and we recommend roll out to all Outpatient Departments of Victorian Public Hospitals.
- Given value expressed by participants in the pilot, compulsory attendance of all Outpatient staff (i.e. clerical and nursing) is recommended. If participants self-select, those who may benefit most may not attend. If attendance is at the request of the manager, then the program may be labelled “remedial” and resulting mindset will not be conducive to learning.
- Further thought is given to inclusion of medical staff with core Outpatient staff in the program. While communication between staff groups is clearly an issue within Outpatient departments, this needs to be balanced with the impact of attendance by medical staff on participation levels by clerical and nursing staff in what appears to be a rare group development opportunity.
- A two session format is recommended for rollout. While there are advantages from a scheduling and logistics perspective in presenting single module, our observations from facilitating the pilots are that there appear to be higher levels of engagement and therefore perhaps better learning outcomes from the two module format. Participants were unused to the workshop learning environment, and maintaining engagement and concentration for the longer session was challenging. Our broader experience also tells us that better learning outcomes are achieved where there is more than a single workshop intervention. The opportunity for reflection occurs, and the opportunity to reinforce concepts introduced in the first session.
- Continue with same facilitators or same facilitation approach. Provision of highly skilled and experienced facilitators is critical with this particular audience in gaining credibility and establishing rapport.
- Continue post workshop evaluation and expand to include where possible “return on investment” data to ensure maximum value from the programme (for example gather patient feedback pre and post workshop to examine differences)
- Where possible conduct workshops with intact teams to maximise value from team bonding, reflection time and learning from each other
- Issue participants with a completion certificate following attendance

Key Activities

In order to roll out the program to all Victorian Public Hospitals, the following key activities will need to be undertaken:

- **Stakeholder Liaison** with OP Directors and NUMs at each public hospital to ensure management support for the program and commitment to scheduling. The outcomes of this needs to be:
 - Senior hospital Outpatient staff are introduced to the program, comfortable with the content, and feel confident about their people attending the program
 - Agreement on number of workshops
 - Agreement on schedule for delivery i.e. identification of preferred dates/times

- o Identification of a “hospital champion” for the program who is able to coordinate logistics at the hospital, organise participant attendance, and act as liaison point with Right

This activity can be undertaken either by Right or by DHS but needs to deliver on the outcomes identified.

- **Centralised Scheduling and Logistics** to coordinate preparation and printing of materials, schedule and confirm times, dates, locations and venues, AV requirements materials, facilitators, and participant numbers. We envisage this would be undertaken by a Right Project Coordinator who would liaise with the hospital champion.
- **Program Delivery** by a pool of facilitators (including those used to deliver the pilot) supplied and trained by Right. Facilitator training would include a half day group session on the content, and a co-facilitating module one and module two with one of two primary facilitators from the pilot.
- **Reporting and Quality Assurance** through post workshop evaluation by participants, monitoring of feedback by Right, and reporting through on each individual hospital to DHS.
- **Evaluation of Return on Investment (ROI)** by implementation of a Patient Satisfaction survey tool prior to commencement of the roll out so that return on investment can be accurately assessed and reported once roll out is completed. Right can assist in development and delivery of this tool or DHS may wish to progress this independently

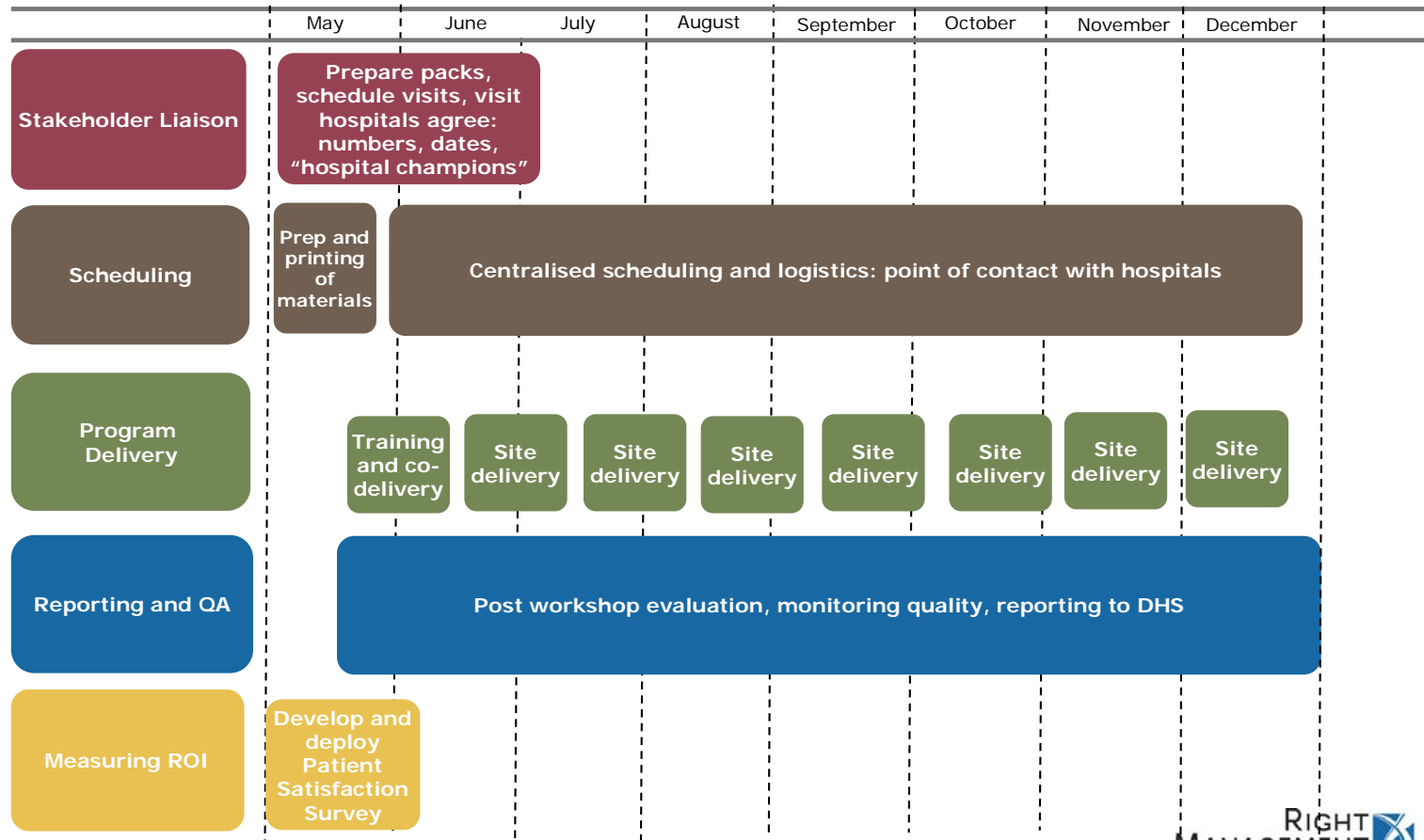
Assumptions

Based on the data available on the public hospital locations and numbers of Outpatient Department staff at those locations, a minimum of 90 workshops with 15 participants at 25 locations will need to be scheduled.

Phased Rollout

We understand the project would commence in the new financial year. As with the ED Program, a phased rollout is recommended commencing in June with the stakeholder liaison to enable workshop rollout to commence early in the new financial year. The process envisaged is illustrated overleaf.

Phased Roll Out May 2008 – December 2008



APPENDICES

APPENDIX 1 – POST WORKSHOP FEEDBACK FORM

ENHANCING COMMUNICATION IN OUTPATIENTS: Participant Feedback

Logistics			
Hospital:	L	Module:	
Workshop Date:		Workshop Time:	
My role			
Medical:	<input type="checkbox"/>	Length of service in OP:	<input type="checkbox"/>
Nursing:	<input type="checkbox"/>		Less than 1 year
Clerical:	<input type="checkbox"/>		1-2 years
Other:	<input type="checkbox"/>		3-5 years
			6-10 years
			11-15 years
			16 years +
Feedback			

How useful did you find this workshop:

Not at all useful	Not very useful	Useful	Very useful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What was the most useful concept that you were introduced to?

What aspects of the workshop could be improved?

How would you rate the workshop facilitators?

Poor	—————→			Excellent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

APPENDIX 2 – INTERVIEW TEMPLATE

Introduction

Hello, my name is [insert name] and I'm calling from Right Management. The reason for my call is to get your feedback on the Communications Skills Workshop conducted by Right that you attended recently. Do you have 5 -10 minutes to answer a few questions now? If not, when would be a better time for us to call?

1. Reaction level feedback

- What was the best aspect of the workshop?
- What could have been improved / done differently?

2. Feedback on Learnings implemented

- What were the one of two key points that you took away from this workshop?
- Were these ideas new to you? OR Were they a refresher?

3. Feedback on any behavioural change

- As a result of what you learned during the workshop, what if anything have you started doing differently?
- *(If nothing)* - what has prevented you from making any changes?
 - In what way do you think the workshop could be improved to convert what was learnt into actual changes on the job?
- *(If some)* How would you describe the impact on patients of these – in what way is the patient experience different as a result?

4. Feedback on any impact to the patients (customers)

(See above now)

5. Other questions/close

- You originally gave us anonymous feedback on the last day of the workshop. Now that you've had a chance to reflect on the workshop back in the workplace, is your feedback (today) different or the same as your previous feedback?
- Do you have any other feedback today?
- Thank you for your time today. We appreciate your feedback.

APPENDIX 3 - RIGHT MANAGEMENT'S EVALUATION PERSPECTIVE

Right Management currently has numerous resources available at its disposal with respect to evaluation and hence a number of perspectives have been adopted.

The model below provides an overview of Right Management's Point of View about measuring success. It is based on the Kirkpatrick and Phillips approaches utilising a number of reliable techniques and tools. It is the model on which the current report is based – although only a pilot and a small review rather than full evaluation.

