Generations Review - Journal of the British Society of Gerontology. March 1999

"You can't ring the bell"

A proposal to develop 'Mystery Visitors' as a Quality Audit system using the experience of older people who use Health and Social Services

A research project grant aided by The Averil Osborn Fund of the British Society of Gerontology in conjunction with The Centre for Applied Gerontology, University of Birmingham

There are three starting points:

- **Empowerment / user involvement of older people**

Whilst the terms 'user involvement' and 'empowerment' have become embedded into guidelines and policy practice is still more rhetoric than reality. Averil Osborn (1991) neatly captures the situation, her statement at the end, is profound:

> There are pitfalls present in the simple notion of consulting users - and the public - about community care planning. These include the use of jargon such as 'seamless', diversity of views, vested interests, the dilution of professional judgement, the danger of tokenism, the question of representation and accountability, and finally, the whole question of what is meant by empowerment.
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> Empowerment means a change in the balance of power, a transfer of power from one group of people to another. This requires a sea change which is unlikely, and therefore the proper meaning of empowerment has actually changed, when talking about ***"empowerment - and by indulging in tokenism and representation - we are actually talking about disempowerment?"***

- **Using older people as researchers**

The Centre for Applied Gerontology (CAG) has developed a distinctive way of working with older people as researchers and has built up a database of people - the 'Thousand Elders' (though nearer 5,000 in number) - willing to take part in research and questionnaires. The initial focus of the centre's work was on the (design and) evaluation of products for commercial companies, and this remains a key component. However, more recently, work has been undertaken in monitoring general services for shops and banks, e.g. Tesco, Lloyds TSB, Midland Bank.

- **Quality audit, consumer satisfaction**

Whilst these are important activities which must continue, in terms of user empowerment, there are drawbacks in that audit is usually an organisational and professional activity. Satisfaction surveys are retrospective and tend to have predefined options giving little opportunity for respondents to give their true feelings. There is also the whole question of acquiescence and the reluctance of (older) people to complain.

An interesting parallel within the commercial world is the Mystery Shopper:

> Mystery or secret shoppers are trained people who audit an operation (shop, bank, office etc) through its normal activity - i.e. a shopper testing the system by shopping, asking for information, presenting a complaint etc. Mystery shoppers are recruited by a market research organisation and work independently of the contracting (host) organisation; they are unknown and operate 'secretly' - hence the term.

The project draws together these three starting points by:

- creating the opportunity for greater user empowerment of older people
- using older people and their experience as researchers and operators of the system
- developing the concept of Mystery Visitors in hospitals

The heart of the project was a couple of focus groups, but before then a literature review was undertaken, and a discussion group took place. The literature search was conducted around the key words 'audit' AND 'user involvement'. A disappointingly small number of direct references were identified, and generally referred to either specific conditions or to the principles of user involvement.

Older people identify topics

In order to identify the topics for the focus groups, a discussion was held with four long standing members of the CAG. We quickly focused on hospital visits as the subject for discussion, since this is where people had the greatest experience, either as patients or visitors. Inevitably familiar topics were identified; that the hospital experience was sometimes good, sometimes bad, that staff often displayed poor attitudes towards older people and that ageism is rife. The group identified the various aspects about hospital stays which affect the quality of the experience: going into hospital, information received, transport arrangements and whether the visit was planned, routine or an emergency. Again, once in hospital, different elements all affected the overall experience:

- life (meal times, visitors, places to go, getting up and going to bed, night time)
- treatment (did it work, do patients know what is happening?)
- general care (food, washing, cleaning, staff attitudes)
- intermediate stages (convalescence) - if any
- going home (any plans made or help given)

The poor facilities in hospitals received much criticism, for example the poor washing facilities, the (too) high level of basins for people using wheel chairs. Mixed wards were not liked, nor having to share toilets (men always seem to get the blame for making a mess!). Day rooms were found to be dirty. Members recognized the wider NHS environment, the impact of finances and 'political' pressures on hospital services (and partly excused poor care because of this).

Don't make a fuss

Of greater interest in relation to the focus groups were the attitudes of older people themselves. The issue of acquiescence and gratitude was expressed in terms of not wanting to be a nuisance or make a fuss. Some useful insights were gained:

the language of confrontation was often used *" they are all my enemies" (referring to staff)*

a patient saying to a visitor who was upset at the treatment received by the patient *" don't you dare make a fuss"*

as a patient, feeling that you are a sitting target, and that '*You can't 'ring the bell'* ~ hence the title

at the same time, one way of being noticed was to make a fuss *" he (the consultant) remembered my name because I had made a fuss"*

The system of mystery shoppers was discussed and whilst members could see the value of the system for commercial organisation and shopping, they were not so sure as to how the system could be applied to hospital, but thought it might be more useful if visitors 'reported back' rather than patients. They also felt more comfortable with the idea of looking for specific items, rather than just looking for problems in general. The project thus started to focus on mystery visitors rather than mystery patients.

The focus groups

Two focus groups took place, one with 12 participants in the morning, the other with ten members in the afternoon. Participants were selected from the CAG 'Thousand Elders' database, essentially that they had been in hospital or visited someone in hospital regularly (once a fortnight) within the past 6 months. Overall there were 10 males and 12 females, the majority were in the age range 70 to 79, the oldest being over 90. Participants revealed a wide range of experience of being a patient for major surgery or day surgery, of being an out-patient at clinics and specialist hospitals - e.g. the eye hospital, and of having someone close to them being a patient or visiting someone in hospital and escorting others. In contrast, one member claimed to be nice and healthy having had not been in hospital between being a child of 9 (tonsils out) and the age of 82!

It was good to see several participants whose prime involvement had been as a visitor. In this context they have the potential of bringing a more objective perspective (compared to being a patient) to life and care in a hospital. As already discussed, and seen later, this is likely to be of greater relevance to the concept of 'mystery shoppers'

The full report comments on the focus group findings in more detail, but in summary:

- Many comments illustrated the need for better QA systems and that people's comments, views and experiences would be of value to improve the system. Despite the recognised acquiescence and reticence in complaining ~ these groups showed no hesitation in identifying problems within hospitals!
- There was, as is to be expected, lots of praise and appreciation for services and specific actions of individual staff
- The quality and availability of information was a frequent comment and illustrates that whether a hospital visit is a good or poor experience often depends on the quality of the information available to the patient.
- having confidence in the person who was treating them, and how you find that person
- there were many comments about the care in hospital rather than the treatment of a medical condition. Again, there was a range of experiences, but when things went wrong, participants' comments tended to be more vehement than those concerning medical treatment ~ perhaps illustrating that care is just as, if not more, important than the treatment.
- An additional point arose relating to security, partly due to awareness of babies being abducted from hospital, but more generally reflecting older people's fears ~ a parallel with the housing world.

Following the topics from the pre-discussion, a major topic was that of making complaints, or of not being a nuisance.

"I think complaining is a dodgy subject - I don't know the procedure, but I would be very wary about complaining for myself or someone else for fear that somehow they might be some repercussion - you'd suffer for it. Fine to complain about all sorts of things, buses, shops, services generally, but when it comes to something medical - I don't know, better not to say anything in case."

A number of reasons were offered as to why this is so and some disturbing evidence for not making yourself a nuisance

"There is a lot more good than bad, and people tend to let the good override the bad. The overall picture is coloured by the good, and the bad is pushed to one side, but when you are really dissatisfied the bad comes to the fore and you can talk about it."

"I got the impression that the ambulance service have code words for people who 'bother' the service. You don't get such quick call out if you have been a nuisance."

Despite the natural reluctance to complain, some members recognised that it is sometimes necessary to 'make a fuss', and that it is also not easy to do. For some, it is a matter of course:

"Although we wish to be good patients and visitors, we do have to fight for ourselves ~ those that shout, get!"

"I think you should complain about anything, even if it is small. If I get some fruit from the shop and it isn't right, I take it back and get some fresh or a refund. If we all did it we would get better service from - and better food in - the shops. They wouldn't sell us a lot of rubbish in the hope that we won't bother to take it back."

Mystery patients or visitors

Some time was spent talking about the idea of mystery visitors and whether it would be possible to use the normal experience of going into hospital as a patient or visitor as a quality audit mechanism. Some members were enthusiastic about the idea:

"I'd love to be a secret shopper! Can I go and test pubs!"

Members recognised that they have a range of experiences that are going

unnoticed and it would be good to use that experience in a more systematic way to feed back information. Whilst, to a certain extent, it is open to anyone to comment on services, they felt it would be easier if there is a recognised system through which to observe and report back on the experience. Perhaps this should be through a group, so that there is the backing of other people and if necessary things can be pursued further and given publicity.

Members drew parallels with other situations; for example the work of the Community Health Councils (interestingly, two participants were members of a CHC), the police complaints authority, councillors visiting establishments, e.g. residential care homes, mystery guests staying in hotels and telephone sales or advice lines being recorded. They also mentioned that a Birmingham consumer group regularly monitors New Street Station and the plethora of consumer programmes on television programmes and media articles (though concern was however expressed at the way some information is obtained and used for sensational entertainment or just focuses on extreme cases.)

In the above, all those being 'inspected' know that it is happening, though sometimes after the visit as is the case with mystery hotel guests. By contrast with mystery shoppers, it is the mystery element which is different; recipients don't know who they are, or necessarily that they have been (though they will know that mystery shoppers may visit sometime).

Members quickly pointed out that you can't really have mystery patients, since people can't pretend to have a complaint and they would soon be found out! Which leaves visitors, though it was recognised that they would need training and information and a formal system surrounding the activity. Though, in some circumstances it might be possible to involve patients

"Perhaps if someone is having elective surgery, they might be able to take part, especially if you knew the sort of things the hospital is interested in , for example, 'How do the nurses talk to you?'"

Members also identified that it need not necessarily be patient's visitors, but that there are other people who have a valid reason to be in the hospital

"Library volunteers would be a good one, someone going in and out all the time, with another legitimate job to be doing - they could notice things which are happening."

One member confirmed that it is fairly easy to collect relevant information:

"I often used to go and ask people questions in relation to my work (providing home care). I asked patients about this and they would say that whilst they have been in hospital, this and that had happened - its surprising how much you learned that way and I was going in not as the NHS or nursing service. Some of information related to genuine complaints and I managed to get something done about it. Its amazing how when you are talking about one thing, how people talk about another or tell you how they're feeling. You'd be quite surprised."

Conclusion

The focus groups generally agreed that a mystery visitor scheme could work provided there was the proper support for it

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"I am very interested in this and am primarily interested in good health. I feel that through my visits over the last three months I could be an expert witness in commenting on the hospital. I always see something on my visits that is worthy of comment - not necessarily a severe criticism - so the idea of having observers go in would be excellent, provided they are familiar with the hospital. It could be either by form of report or could be someone actually interrogating the visitor on a friendly basis - as you are doing with us now!"

Quality indicators

Whilst the prime aim of the project is not to fully define a system and all its constituents, several indications as to what would make good quality indicators were made. These included (in no particular order and without further comment):

- made to feel welcome
- being given information and knowing what to expect
- opportunity to have information repeated and discussed in your own time
- being treated caringly
- good washing and toilet facilities
- general life in hospital (as distinct from medical treatment)
- things are dealt with speedily when there is a real problem
- seeing the same person on subsequent hospital visits
- not being asked questions that you've already answered
- given the same facilities as younger people
- measure travel distances in hospital
- the same standards across a hospital in different wards
- proper records so that other people know what has happened
- security - knowing that people have a valid reason for being in the hospital
- privacy in wards - not being disturbed by TVs or other visitors
- meals and the way they are served
- freedom over meal times, bed times etc
- ward sizes, gender, compatibility of patients

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Reference

Osborn, A. (1991) *Taking Part in Community Care Planning: The Involvement of User Groups, Carer Groups and Voluntary Groups.* Nuffield Institute for Health Services Studies and Age Concern Scotland

The full report is available from the author, cost £5