Quality of Interaction Schedule (QUIS)

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

What is a quality of interaction audit (QUIS)?

This is method of systematically observing and recording interactions whilst remaining a non-participant. It is a technique first developed for use in long term residential mental health settings, but the tool has undergone substantial revision has been adapted for more general use in residential and general hospital settings (Dean, Proudfoot, & Lindesay 1993). It can be used as both a qualitative and quantitative tool to provide a measure of the quality of interaction between staff, patients and visitors. It is designed to develop the therapeutic and more sensitive communication within a ward or department.

It should be used sensitively and discreetly with full knowledge of senior managers, staff, patients and relatives. It is not a clandestine activity!

How useful is this activity?

- Can be used as a introductory diagnostic tool for problem solving
- As a management tool
- As a training tool
- Best used as part of a multi-method approach to quality improvement

Getting started

- Be prepared – let the ward/department know in advance the audit is arranged, discuss with the team and patients in the bay/point of observation what you are doing. Always observe in a communal area.
- Ideally do the observation with a team member. Prepare the team member on what to do etc
- Select your observation point and find somewhere that is unobtrusive to sit and record for 20 minutes.
- Do not following patients out of the observation area.
- Be happy to explain/ chat – “but after I have finished this, in a few minutes”
- No harm in a ‘dummy run’ to get you tuned in

Rating the interactions

When rating the *quality* of the interaction, bear in mind:

- Consistency
- Your agreed consistency with your colleagues
- Your discretion when rating each part of a multiple interaction. Use common sense but give a fair picture
- Negative interactions even as part of a 'better' whole must be identified. A sharp instruction or command, belittling, or inappropriate behaviours or endearments stick in the mind of patients and relatives.
- Discuss your thoughts with your colleagues, some activities or events just need extra thought
- Rate straight away – this is essential

Equipment

- Watch with second hand
- Observation sheets – usually at least 5 sheets per person per observation (enclosed within the portfolio)
- Highlight pen for events (optional)

Finishing the audit:

- Provide feedback on the observation to the staff involved
- Be thoughtful and considerate in your feedback and let staff explain their perceptions
- The tool is NOT designed to give an individual feedback on his or her performance and should not be used in this way. Give group feedback and discuss overall findings
- Say goodbye to the patients
- Future audits should be repeated at an agreed future date.

Observation time periods

This tool can be used at any time but may be useful during:

- Early morning for personal care
- Lunchtime
- Early evening with visitors present – for noise/ busyness
- Late evening

Each observation is to be 20 minutes in duration.

Interactions to record

All *staff/patient/relative* interactions to be recorded during the period of observation.

Patient/ patient or *relative/visitor/patients* interactions are not recorded (if you feel there is something significant to record, then use the events column to make a note of the interaction.

Coding categories

The coding categories for observation on general acute wards are:

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.

Examples include:

- Caring conversations e.g. what sort of night did you have, how do you feel this morning etc
- Encouragement and comfort during care tasks (moving and handling, walking, bathing etc) that is more than necessary to carry out a task
- Offering choice and actively seeking engagement and participation with patients
- Explaining, offering information e.g. medications etc
- Smiling, laughing together, personal touch and empathy
- Offering more food/ asking if finished, going the extra mile

Basic Care: (BC) – basic physical care e.g. bathing or use if toilet etc with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.

Examples include:

- Brief verbal explanations and encouragement, but only that the necessary to carry out the task
- No general conversation

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.

Example include:

- Putting plate down without verbal or non-verbal contact
- Undirected greeting or comments to the room in general
- Makes someone feel ill at ease and uncomfortable
- Lacks caring or empathy but not necessarily overtly rude

Negative (N) – communication which is disregarding of the residents' dignity and respect.

Examples include:

- Ignoring, undermining, use of child like language
- Being told to wait for medication or attention without explanation or comfort
- Told to do something e.g button dress without discussion, explanation or help offered
- Being told can't have something e,g a cup of tea without good reason/ explanation
- Being rude and unfriendly
- Bedside hand over not including the patient

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

Record and highlight as an event on the observation sheet.

An example of an omissions of care may be a resident repeatedly calling for attention without response, a patient left inadequately clothed, a meal removed without attempts made to encourage the patient to finish it, or a patient clearly distressed and not comforted.

Feedback and presentation of the results

Suggest giving immediate feedback after each observation and a written summary on all the 20 minute observations

Simple percentages of the quality of interactions are perfectly acceptable for straightforward evidence of the quality of verbal and non verbal communication e.g. 20% of observation were positively social (n=20), 70% were basic care interactions (n=70), 5% were neutral interaction (n=5) and 5% were negative interaction (n=5).

Presenting this information visually as a Venn diagram (pie chart) is clear and helpful.

References

Dean, R., Proudfoot, R., & Lindesay, J. 1993, "The quality of interactions schedule(QUIS): development, reliability and use in the evaluation of two domus units", *International Journal of Geriatric Psychiatry*, vol. 8, pp. 819-826.