So you want to write a patient information leaflet?
Introduction

Research has shown that patients given adequate information about their test, operation or care are less anxious and more satisfied with their care than patients who are not.

Remember that information leaflets are only intended to back up and reinforce verbal information and discussion. They are not a substitute.

This leaflet is intended to give some general advice about developing written patient information materials.

1. **Is there a need for the information?**
   - Do patients always seem to be asking the same questions or expressing the same concerns about a test or operation?
   - Do you know of other hospitals where information leaflets on the subject you are interested in are already in use? (i.e. is there a ‘gap’ in the information we provide?)
   - Have medical staff in your ward or department asked for more information to be developed for patients?

   If the answer to any of the above is ‘Yes’ you should be thinking about developing further information for patients.

2. **Does the information leaflet already exist?**
   - There is always a possibility that someone has already developed a leaflet on the same or a similar subject (maybe in a different hospital, ward or department, in an Out-Patient Clinic, or from Physiotherapy, Speech and Language Therapy, Occupational Therapy, Dietetics, Pharmacy etc).
To check you could:
   i. Contact colleagues in other areas
   ii. Contact the Clinical Governance Support Team as we hold a list of patient information sites.

- Perhaps a charity or support group provides very good leaflets already. If these comply with Board guidelines then this might mean you do not have to develop information of your own, or you can adapt these leaflets to suit your own needs (but always ensure that you are not in breach of copyright).

3. How can I make sure the information will be read or understood?

- **Involves patients:** Involve patients in the preparation of your leaflet. What do they want to know? How would they like the information presented? Don't forget to involve patients in the evaluation of the leaflet you produce.

- **Layout and design:** The way the information is laid out on the page can influence whether or not people will read it. Patients will be more likely to read information if it is arranged in short, concise sections so break up your information into different paragraphs.

For example, for a leaflet about a test, you could have paragraphs headed:

- *What is an XYZ test?*
- *Why do I need it?*
- *What preparation is needed?*
- *How is the test carried out?*
- *Are there any after-effects?*
- *When and from whom do I get the results?*
- *Who do I contact if I have any questions or problems?*

When information is broken up into paragraphs like this, it will be much easier to read than if the same information was presented as one continuous piece of text.
• **Highlighting text:** You could use **bold**, *italic*, **bold italic**, CAPITAL LETTERS to highlight important words or phrases. Use these carefully, as you can go overboard. If over-used these features can be off-putting to the reader.

• **Readability:** Various studies have shown that the average reading age of a British ADULT is between **9 and 12 years**. So if you are writing a leaflet it might be an idea to get an average nine or ten year old to try to read and understand it!

Readability is simply a measure of how easy a piece of text is to read. Readability can be calculated in lots of different ways, but basically the following applies:

Short words + short sentences = information that is easy to read.

The Clinical Governance Support Team can do a readability test for you or you can do one yourself if you have access to Microsoft Word 6.0 (or a later version). For further information on how to do this just give us a call.

• **Medical jargon and long words:** Because of the type of subjects your information covers, it will be necessary to use some medical language, however some suggestions on alternative ways of writing are given in Appendix 1.

• **Amount of information:** Try not to overload patients with information, but do try and answer common questions and concerns. Aim for not too much but not too little.

• **Abbreviations:** The Health Service is full of abbreviations (e.g. NHS, GBH, HDU)! Remember patients may not be familiar with these. If you use abbreviations make sure you define them when you first use them.

For example: “Your relative has been admitted to HDU (The High Dependency Unit). In HDU…….”
• **Personal Pronouns:** Use personal pronouns ("you", "your") instead of "the patient" or "patients". This makes the tone of the information friendlier and more personal.

• **Passive sentences:** Try to avoid writing everything in the passive voice. (This means where something is being done to somebody.)

  For example:

  PASSIVE “The dressing should be changed everyday.”

  ACTIVE “Change the dressing every day.”

  Active sentences tend to be shorter, more direct and so easier to understand.

4. **Are there any other tips I need to know?**

• **Actions:** If your information includes describing an action (e.g. an exercise to aid recovery) get a friend or colleague who does not know how to do the action to read your information and to try and do the action correctly. This ‘dry run’ will help to highlight any shortcomings in your instructions.

• **Be consistent:** Remember patients may receive information from other sources (e.g. GP, Health Promotions, Out-Patient Clinic, other Ward, other hospital). Try to ensure your information does not clash or contradict information from other sources (always assuming this information is correct!).

• **Up - to - date:** Is the information you are developing in line with current thinking? You should look at recent research and literature to see if this is the case. As healthcare professionals, we have a responsibility to ensure all information we provide is evidence based, accurate and up to date. It must also identify treatment options, possible outcomes, risks, and possible side effects and provide further sources of information.

• **Distribution:** Think about when patients will receive the information (e.g. will they receive it before they come to hospital, at the Out-Patient Clinic, in the Ward, before they leave the ward to go home?). This will influence what you include and leave out.
• **Cultural, religious and other beliefs**: Ensure that your information does not discriminate against patients from backgrounds different from your own.

5. **Is there anything I should avoid?**

• **Scare mongering**: Trying to shock patients can be counter-productive and cause unnecessary distress.

• **Being over-authoritarian**: Although there may be some things patients will have to do, try not to sound like you are ordering them about!

• **‘Preaching’**: Being over-enthusiastic about trying to get your message across can be a turn-off!

• **Giving false hope or misleading information**: Be honest in your information. Do not raise hopes unrealistically if dealing with distressing information but when highlighting more positive aspects, strike an appropriate balance.

6. **How can I get my leaflet typed up?**

Don’t worry if you don’t have the time or the facilities to type it up yourself – the Clinical Governance Support Team can offer you secretarial assistance – just give us a call. Even if your leaflet is still in draft form or hand-written, we can get it typed up for you. This will give you a better idea of how your finished leaflet will look.

7. **Is there a Board policy on patient information leaflets?**

Yes. If you would like a copy we can send you one.

The policy recommends that leaflets should:

• be dated (to identify when they should be reviewed or if leaflet is an ‘older’ version).

• be copyrighted to NHS Shetland.

• have the name of the author(s) and their ward or department.
- be in a minimum type size of 14 points (for the style of typeface we use) although some leaflets (e.g. for Eye patients) should be done in a larger size.

- be reviewed regularly.

8. **How do I know my leaflet is any good?**

You should test your leaflet out on patients to see what they think!

You should send a copy to Ms Edna Mary Watson, Assistant Director of Nursing (Community), for the Patient Focus Public Involvement Steering Group to review and be prepared to attend the meeting to discuss it.

The Clinical Governance Support Team has developed a standard questionnaire for assessing written patient information. We recommend you use this questionnaire, which we can customise to suit your needs. We can also help with the administration and analysis of the questionnaires.

9. **Who needs to approve the content of my leaflet?**

Please make sure that your line manager has reviewed and approved the content of your leaflet. Don’t forget to liaise with other healthcare professionals in your ward or department and remember, depending on the content of your leaflet, staff from other disciplines should also be given the chance to review and approve it.

10. **How can I find out more?**

Contact the Clinical Governance Support Team. Details can be found on the back page.
### APPENDIX 1

**SUGGESTIONS FOR SIMPLIFYING INFORMATION**

<table>
<thead>
<tr>
<th>Term</th>
<th>Suggested Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesia</td>
<td>Painkillers, pain-relief</td>
</tr>
<tr>
<td>As a consequence of</td>
<td>Because</td>
</tr>
<tr>
<td>Due to the fact that</td>
<td>Because, as</td>
</tr>
<tr>
<td>Elevate</td>
<td>Raise</td>
</tr>
<tr>
<td>Fast</td>
<td>Nothing to eat or drink</td>
</tr>
<tr>
<td>In order to</td>
<td>To</td>
</tr>
<tr>
<td>Mobilise</td>
<td>Get up and about</td>
</tr>
<tr>
<td>On a daily basis</td>
<td>Daily, every day</td>
</tr>
<tr>
<td>Physician</td>
<td>Hospital doctor or consultant</td>
</tr>
<tr>
<td>Post-discharge</td>
<td>After you go home</td>
</tr>
<tr>
<td>Post-operative</td>
<td>After your operation</td>
</tr>
<tr>
<td>Pre-operative</td>
<td>Before your operation</td>
</tr>
<tr>
<td>Procedure</td>
<td>Test, treatment, operation</td>
</tr>
<tr>
<td>Proceed</td>
<td>Go ahead</td>
</tr>
<tr>
<td>Relating to</td>
<td>About</td>
</tr>
<tr>
<td>Sutures</td>
<td>Stitches</td>
</tr>
<tr>
<td>Thereby</td>
<td>So</td>
</tr>
<tr>
<td>Therefore</td>
<td>So</td>
</tr>
<tr>
<td>Via</td>
<td>Through</td>
</tr>
<tr>
<td>2-2½ hours</td>
<td>2 to 2½ hours</td>
</tr>
<tr>
<td>(could be read as 22 ½ hours)</td>
<td></td>
</tr>
</tbody>
</table>
Could you repeat that, please?

Instead of ......

The purpose of this is to facilitate the healing process subsequent to the operation and thereby contribute to the achievement of a successful result.

Try ......

This will help you get better.

Instead of ......

Post-operative analgesia (title)

Try ......

Pain relief after your operation

Instead of......

To ensure that you can mobilise safely before you go home

Try ......

To ensure you can get up and about safely before you go home
If you require further copies of this booklet, please contact the Clinical Governance Support Team on:

Tel: 01595 743000
ext 3234 or
Extension 3234

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