The Ultimate List – 65 Digital Tools and Apps to Support Formative Assessment Practices

There is no shortage of strategies, techniques, and tools available to teachers (and students) who use formative instructional practice in their classrooms. We’ve compiled an extensive list of 65 digital tools, apps, and platforms that can help teachers use formative assessment to elicit evidence of student learning. These tools and apps for formative assessment success give teachers (and students) many options and opportunities for classroom success. To get the most out of formative instructional strategies, check out our NWEA® formative practices workshops (https://www.nwea.org/formative-instructional-practice/). You’ll gain a better understanding of the role formative practice plays within your instruction and about the four foundational practices to use in the classroom.

And, share your tools, ideas, and thoughts with us, so we can keep this list growing and current! You can tweet me directly @kdyer13 (https://twitter.com/kdyer13).

- **AnswerGarden** (http://answergarden.ch/) - A tool for online brainstorming or polling, educators can use this real-time tool to see student feedback on questions.
- **Animo** (https://animo.to) - Gives students the ability to make a short, 30-second share video of what they learned in a given lesson.
- **Answer Pad** (http://www.theanswerpad.com/) - A graphical student response system with the ability to poll and leave feedback. The blank pad functions like an individual whiteboard for each student.
- **Backchannel Chat** (https://backchannelchat.com/) - (Now MasteryConnect Student.) Like TodaysMeet, this site offers a teacher-moderated version of Twitter. An extension of the in-the-moment conversation might be to capture the chat, create a tag cloud, and see what surfaces as a focus of the conversation.
- **Biblionasium** (https://www.biblionasium.com) - This online, safe, and simple book network allows teachers to view books students have read (a digital reading log), create reading challenges for students, and track progress. Students also can review and recommend books to their peers on the site.
- **BookSnap** (https://itunes.apple.com/us/app/booksnap/id440806676?mt=8) - While currently this app is only available for iOS, it truly provides a digital way for learners to interact with text and with other learners.
- **Buncee** (https://www.edu.buncee.com/) - A creation and presentation tool that helps students and teachers visualize, communicate, and engage with classroom concepts and ideas.
- **Chatzy** (http://www.chatzy.com) - Use Chatzy like you would use TodaysMeet to support backchannel conversations in a private setting. These live chats make great companions to classroom discussion, provide exit tickets, or keep a discussion going after the class is over.
- **ClassKick** (http://www.classkick.com/) - This app allows teachers to post assignments for students, so both the teacher and peers can provide feedback on the assignment. Students can monitor their progress and work.
- **Coggle** (http://coggle.it/) - A mind-mapping tool designed to understand student thinking.
- **Conceptboard** (http://conceptboard.com) - This software facilitates team collaboration in a visual format – similar to mind mapping, but using visual and textual inputs. Compatible on tablets and PCs, Conceptboard can work from multiple devices.
- **Dotstorming** (https://dotstorming.com/) - A whiteboard app that allows digital sticky notes to be posted and voted on. This tool is best for generating class discussion and brainstorming on different topics and questions.
- **Educreations Interactive Whiteboard** (https://itunes.apple.com/us/app/educreations-interactive-whiteboard/id47861706?mt=8) - A whiteboard app that provides students the tool to share understanding and comprehension.
The Ultimate List – 65 Digital Tools and Apps to Support Formative Instructional Practice

- **Five Card Flickr** (http://5card.cogdogblog.com/index.php) – Designed to foster visual thinking, this tool uses the tag feature from photos in Flickr.
- **Flipgrid** (https://info.flipgrid.com/) – This tool has been recently updated. Students can use 15-second to 5-minute videos to respond to prompts; teachers and peers can provide feedback.
- **ForAllRubrics** (https://www.forallrubrics.com) – This software is free for all teachers and allows you to import, create, and score rubrics on your iPad, tablet, or smartphone. You can collect data offline with no internet access, compute scores automatically, and print or save the rubrics as a PDF or spreadsheet.
- **Formative** (https://goformative.com) – (https://ttt.ec/BI_28) This online, all-student response system provides teachers the opportunity to assign activities to students, receive the results in real time, and then provide immediate feedback to students.
- **Formative Feedback for Learning** (https://itunes.apple.com/us/app/formative-feedback-for-learning/id467523537?mt=8) – An iPad app that is designed to foster and encourage communication between students and teachers. Through a conference setting, it uses icons to prompt discussions.
- **Google Forms** (http://www.google.com/drive/apps.html) – A Google Drive app that allows you to create documents that students can collaborate on in real time using smartphones, tablets, and laptops.
- **GoSoapBox** (http://www.gosapbox.com/) – Free for less than 30 students, this all-student response system works with the Bring Your Own Device (BYOD) model, so no charge for a clicker. One of the most intriguing features for me is the Confusion Meter.
- **iBrainstorm** (https://itunes.apple.com/us/app/ibrainstorm/id382252825?mt=8) – An iPad app that allows students to collaborate on projects using a stylus or their finger on screen.
- **Kahoot** (https://getkahoot.com/) – A game-based classroom response system, where teachers can create quizzes using internet content.
- **Kaizena** (https://kaizena.com) – An online tool for providing students with real-time feedback on their digitally-uploaded work. Teachers can highlight or speak to give verbal feedback and attach teacher-created, reusable resources to student work.
- **Lino** (http://en.linoit.com/) – A virtual corkboard of sticky notes so students can provide questions or comments on their learning. These can be used like exit tickets or during the course of a lesson.
- **Mentimeter** (https://www.mentimeter.com) – Allows you to use mobile phones or tablets to vote on any question a teacher asks, increasing student engagement.
- **Naiku** (http://www.naiku.net) – Teachers can easily and quickly create quizzes that students can answer using their mobile devices. Great for checking for understanding before and after a lesson.
- **Nearpod** (http://www.nearpod.com) – This tool is nice in that you can not only gather evidence of student learning, like an all-student response system, but you can also create differentiated lessons based on the data you collected. The basic version (30 students or less) is free.
- **Obsurvey** (http://obsurvey.com) – Create surveys, polls, and questionnaires quickly and easily.
- **Padlet** (http://padlet.com) – Provides an essentially blank canvas for students to create and design collaborative projects. Great for brainstorming.
- **Pear Deck** (https://www.peardeck.com) – Plan and build interactive presentations that students can participate in via their smart device. Limited free usage, and it offers unique question types.
- **Peergrade** (https://www.peergrade.io) – A platform that allows teachers to create assignments and upload rubrics. Students upload work and are anonymously assigned peer work to review according to the rubric.
- **Plaza** (https://plaza.com) – A platform that allows teachers to upload lectures, assignments, and homework; pose and respond to student questions; and poll students about class content. This tool is better suited for older students as it mimics post-secondary class instructional formats.
- **Pick Me** (https://itunes.apple.com/us/app/pick-me%21/id444045099?mt=8) – An easy to use app for an iPod, iPad, or iPhone that facilitates random student selection. Can be organized by class for convenience.
- **PlayPosit** (https://www.playposit.com) – An interactive video and assessment tool that allows teachers to add formative assessment features (pauses and questions) to survey what students know about the topic. Teachers choose from a library of video content from popular sites such as YouTube, Vimeo, and others.
- **Plickers** (https://www.plickers.com) – Allows teachers to collect real-time formative assessment data without the need for student devices. Perfect for the one-device classroom.
- **Poll Daddy** (http://poll daddy.com) – Quick and easy way to create online polls, quizzes, and questions. Students can use smartphones, tablets, and computers to provide their answers, and information can be culled for reports.
- **Poll Everywhere** (http://www.polleverywhere.com) – Teachers can create a feedback poll or ask questions. Students respond in various ways, and teachers see the results in real-time. With open-ended questions, you can capture data and spin up tag clouds to aggregate response. There is a limit to the number of users.
- **ProProfs** (http://www.proprofs.com) – Build and test knowledge with quick quizzes, polls, and surveys.
- **RabbleBrowser** (http://appadvice.com/app/rabblebrowser/432616026) – An iPad app that allows a leader to facilitate a collaborative browsing experience.
- **RealtimeBoard** ([https://realtimeboard.com/education/](https://realtimeboard.com/education/)) - Teachers can invite students and collaborate with the whole class in real-time.
- **The Queue** ([https://letstreasure.com/queue/](https://letstreasure.com/queue/)) - Free educational chat tool that mirrors Twitter and allows teachers to post questions and students to respond via the thread. Students can respond via text or video, and the tool allows “journeys” in which teachers introduce a topic via video and connect students to participating resources. Great for gathering formative assessment data at the beginning, middle, or end of units.
- **Guia** ([http://www.guia.com/](http://www.guia.com/)) - Teachers can create games, quizzes, surveys, and more, and access a database of existing quizzes from other educators.
- **QuickVoice Recorder** ([https://itunes.apple.com/us/app/quickvoice-recorder/id284675296?mt=8](https://itunes.apple.com/us/app/quickvoice-recorder/id284675296?mt=8)) - Another free voice recording app for the iPhone or iPad that allows you to record classes, discussions, or other project audio files. You can sync your recordings to your computer easily for use in presentations.
- **Quizlet** ([http://quizlet.com/](http://quizlet.com/)) - Create flashcards, tests, quizzes, and study games that are engaging and accessible online and via a mobile device.
- **Random Name/Word Picker** ([http://www.class_tools.net/main_area/template_loader.php?fruit_machine](http://www.class_tools.net/main_area/template_loader.php?fruit_machine)) - This tool allows the teacher to input a class list and randomizes random name picking. You can also add a list of keywords and use the tool to have the class prompt a student to guess the word by providing definitions.
- **Seesaw** ([https://web.seesaw.me/](https://web.seesaw.me/)) - This tool helps parents improve parent communication and makes formative assessment easy, while students can use the platform to document their learning.
- **SMART Response VE** ([http://smarttech.com/us/Solutions/Education+Solutions/Products+for+education/Complementary+hardware+products/SMART+Res](http://smarttech.com/us/Solutions/Education+Solutions/Products+for+education/Complementary+hardware+products/SMART+Res)) - A cloud-based software that enables students to respond to planned and spontaneous questions and take quizzes using any of their favorite Internet-enabled devices, from anywhere.
- **Tagui** ([https://tagui.com/](https://tagui.com/)) - This word cloud generator has an added feature that allows the user to make each word an active link to connect to a website you determine.
- **Tagxedo** ([http://www.tagxedo.com/](http://www.tagxedo.com/)) - A tag cloud generator that allows you to examine student consensus and facilitate dialogue.
- **TitanPad** ([https://titanpad.com/](https://titanpad.com/)) - This unique tool for collaborative work offers 8 colors to choose from so that each contributor may use a different color. You can easily imagine how group work, be it peer review or peer editing for starters, can be made interactive.
- **Today's Meet** ([http://todaysmeet.com/](http://todaysmeet.com/)) - This online collaboration tool allows educators to create a “room” in which students can share ideas, answers, and thoughts to lectures and lessons. Educators can view student responses in real time for evidence of learning.
- **Verso** ([http://versoapp.com/#/verso](http://versoapp.com/#/verso)) - Described as a feedback tool, this app allows teachers to set up learning using a URL. Space is provided for directions. Students download the app and input their responses to the assignment. They can then post their comments and respond to the comments of others. The teacher can group responses and check engagement levels.
- **VoiceThread** ([https://itunes.apple.com/us/app/voicethread/id465159110?mt=8](https://itunes.apple.com/us/app/voicethread/id465159110?mt=8)) - Allows you to create and share conversations on documents, diagrams, videos, pictures, or almost anything. This facilitates collaborative student discussion and work.
- **Vocaroo** ([http://vocaroo.com/](http://vocaroo.com/)) - A free service that allows users to create audio recordings without the need for software. You can easily embed the recording into slide shows, presentations, or websites. Great for collaborative group work and presentations.
- **Voxer** ([http://voxer.com/](http://voxer.com/)) - Consider using this voice recording tool as a way to let students listen and self-assess their ideas and assignments. You can send recordings to parents so they can hear how their students are doing, let students chat about their work, or provide feedback to students.
- **Wordables** ([https://itunes.apple.com/us/app/wordables-word-cloud-guessing/id771308667?mt=8](https://itunes.apple.com/us/app/wordables-word-cloud-guessing/id771308667?mt=8)) - The Word Cloud Guessing Game. This app allows you to elicit evidence of learning or determine background knowledge about a topic. These word clouds are pictures composed of a cloud of smaller words that form a clue to the topic.
- **WordSalad** ([http://wordsaladapp.com/](http://wordsaladapp.com/)) - This app generates word clouds from the text you provide, and they can be exported and shared.
• **XMind** (http://www.xmind.net/download/win/) - A mind-mapping software for use on computers and laptops.
• **Yacapaca** (http://yacapaca.com/) - Allows teachers to create and assign quizzes with ease.

There are many Twitter chats related to formative instructional practices that could be considered tools, as well. One that is exceptionally lively and focused is regularly hosted by David Kwan (@davidwkwan) and Rachelle Dene Poth (@Rdene915) Monday evenings at 4:30 p.m. PT at #formativechat. I often tweet about formative instructional practices and you can follow me @kdyer13.

**ABOUT THE AUTHOR**

Kathy Dyer is a Manager of Professional Learning Design for NWEA, designing and developing learning opportunities for partners and internal staff. Formerly a Professional Development Consultant for NWEA, she coached teachers and school leadership and provided professional development focused on assessment, data, and leadership. In a career that includes 20 years in the education field, she has also served as a district achievement coordinator, principal, and classroom teacher. She received her Masters in Educational Leadership from the University of Colorado Denver. Follow her on Twitter at @kdyer13.

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Arts Observation Scale (ArtsObS) Manual

Introduction

The Arts Observational Scale (ArtsObS) is a tool for the evaluation of performing arts activities in healthcare settings. This manual intends to explain to users exactly how to use ArtsObS. Users are advised to read the manual alongside the evaluation form itself and practise applying the scale before testing it in a live setting. For more information on the tool or details on its validity, please refer to Fancourt & Poon (in progress).

1. Quantitative data

a. Demographic data

The scale captures basic demographic data on the activity and participants. Prior to starting the activity, observers should provide the ward name, date and activity being observed. During the activity, it will be necessary to find a way to identify participants. If participants are bed-bound, this identification can be their bed number. If they are in a communal space, it may need to be a unique descriptor, such as their colour clothes. Sex and age can also be approximated, such as M60s (male aged 60-70) or F20s for (female aged 20-30). Demographic data can also be recorded on the number of patients and clinical staff who attend (Qs 14 and 15). And an overall rating can be given for whether it brought a positive effect to a ward using the following scale:

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>The activity brought no benefit or even negative effects to the ward, causing complaints, missing its target audience or getting in the way of staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes, a little</td>
<td>The activity helped lift the mood of the ward, bring a sense of calm or have a small beneficial effect on patients, relatives or staff</td>
</tr>
<tr>
<td>2</td>
<td>Very much so</td>
<td>The activity was almost universally liked, or made a significant difference to the feel of the ward.</td>
</tr>
</tbody>
</table>

b. Mood scores

See Qs 1-2 and 7-8 on the evaluation form.

The mood scores allow you to tell whether an activity made a participant happier than they would have been without the activity. Participants should be rated both before and after the activity as somewhere on the scale from 1 to 7. Ratings should be made based on the faces, headline words (in bold) and other associated words:
c Set criteria

Set criteria are aimed to be constant across all activities in a centre to enabling activities to be compared during evaluations. For healthcare settings, these set criteria are recommended to be ‘relaxation’ and ‘distraction’.

i. Relaxation

*See Qs 3 and 9 on the evaluation form.*

Participants’ reactions should be rated 1, 2 or 3 depending on how many relaxation ‘signs’ they are exhibiting.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>No change evident.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes, a little</td>
<td>One or two changes evident.</td>
</tr>
<tr>
<td>2</td>
<td>Very much so</td>
<td>Multiple changes or pronounced changes obvious.</td>
</tr>
</tbody>
</table>

**Signs to observe**

- Muscular relaxation in the face or limbs
- Slow breathing
- Jaw relaxation
- Shut eyes
- Soft lips and resting tongue
- Falling asleep

ii. Distraction

*See Qs 4 and 10 on the evaluation form.*

Participants’ reactions should be rated 1, 2 or 3 depending on how many distraction ‘signs’ they are exhibiting.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Attention entirely focused on hospital or current medical state</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes, a little</td>
<td>Attention split between hospital / current medical state and the arts activity</td>
</tr>
<tr>
<td>2</td>
<td>Very much so</td>
<td>Attention entirely focused on the arts activity</td>
</tr>
</tbody>
</table>

**Signs to observe**

- Direction of sight line
- Level of engagement with the arts activity
- Topic of conversation with relatives/staff
- Use of other distractions (e.g. books or TV)
- Visible expression of unpleasant sensations (e.g. pain)

d Flexible criteria

*See Qs 5-6 and 11-12 on the evaluation form.*

Flexible criteria can be added depending on the activity being evaluated. These could include level of engagement, improvements in confidence or other similar measures. For each flexible criterion, a rating table and a ‘signs to observe’ table should be created.

2. Qualitative data

a Feedback

*See Qs 16-17 on the evaluation form.*

Alongside quantitative data, ArtsObS enables the collection of personal feedback and quotations from patients, relatives and staff. Observers should undertake a combination of discreet observation and active engagement with participants in order to gather both informal comments shared between participants and more formal statements from those involved in the project. Depending on the more detailed questions behind the evaluation, observers may wish to prompt participants to talk about certain aspects of the project, but questions should remain as open as possible. Precise questions or semi-structured interviews should be conducted separately. No personal data need be recorded, but observers should record basic data on the role of the person being quoted, e.g. ‘parent of paediatric patient’, or ‘staff nurse.’

b. Case studies

*See Q 18 on the evaluation form.*

Observers can also gather more detailed accounts of responses to activities. For example, if any participants show a particularly strong response such as singing along to a music session or being distracted from a painful treatment, this can be recorded here. If potential case studies are observed, these can be supplemented with more facts from staff and relatives to provide a better picture of the impact.
### Arts Observation Scale (ArtsObS)

#### PATIENTS

<table>
<thead>
<tr>
<th>ID</th>
<th>Sex/Age</th>
<th>Mood score</th>
<th>Did it help to relax patients?</th>
<th>Did it help to distract from hospital?</th>
<th>Flexible criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>1-3</td>
<td>1-3</td>
<td>1-3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>1-3</td>
<td>1-3</td>
<td>1-3</td>
</tr>
</tbody>
</table>

#### RELATIVES

<table>
<thead>
<tr>
<th>ID</th>
<th>Sex/Age</th>
<th>Mood score</th>
<th>Did it help to relax patients?</th>
<th>Did it help to distract from hospital?</th>
<th>Flexible criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>1-3</td>
<td>1-3</td>
<td>1-3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>1-3</td>
<td>1-3</td>
<td>1-3</td>
</tr>
</tbody>
</table>

13. Did it have a positive effect on the ward?
   - 1-3

14. How many patients took part?
   - 1-3

15. How many clinical staff looked in?
   - 1-3
Please add any positive feedback or quotations from patients, relatives or staff on the wards.

Please add any negative feedback or quotations from patients, relatives or staff on the wards.

Please add any anecdotal evidence or case studies from the responses of patients, relatives or staff to the activity.
Validation of the Arts Observational Scale (ArtsObS) for the evaluation of performing arts activities in health care settings

Daisy Fancourt & Michelle Poon

To cite this article: Daisy Fancourt & Michelle Poon (2016) Validation of the Arts Observational Scale (ArtsObS) for the evaluation of performing arts activities in health care settings, Arts & Health, 8:2, 140-153, DOI: 10.1080/17533015.2015.1048695

To link to this article: https://doi.org/10.1080/17533015.2015.1048695

Published online: 29 Oct 2015.

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Validation of the Arts Observational Scale (ArtsObS) for the evaluation of performing arts activities in health care settings

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\textit{Background:} As the number of arts-in-health programmes globally continues to increase, there is an growing need for a systematic approach to evaluation both to provide evidence of the efficacy of projects and support continuous quality improvement. The Arts Observational Scale (ArtsObS) is proposed as a mixed-methods tool to evaluate performing arts activities in health care settings. \textit{Methods:} The tool was developed over two years involving a consultation process with 1,500 patients, relatives and staff, and validated over a six-month period with 805 patients. Construct validity was assessed through extensive literature reviews, and score distributions, inter-rater reliability and concurrent validity were assessed using Pearson’s/ Spearman’s coefficient. \textit{Results:} Organising constructs were grounded in both empirical and theoretical research. Data collected with the tool were well distributed. Inter-rater reliability was very strong ($r = .721$, $p < .001$) and concurrent validity was strong ($r = .641$, $p < .001$). \textit{Conclusions:} ArtsObS is a reliable way of evaluating the impact of arts programmes in health care settings and is recommended to practitioners, project managers and researchers.

\textbf{Keywords:} arts; psychology; evaluation; methods; health

Introduction

The last decade has seen a burgeoning in arts-in-health programmes, in acute and community settings, both across the UK and internationally (Clift et al., 2009). These programmes have generally met with positive receptions because of the growing recognition of how the arts can contribute to improving the experience and outcomes of patients (MacDonald, Kreutz, & Mitchell, 2012). Evaluation of such activities is paramount to ensuring that they continue to meet the demands of patients and staff, and in order to provide evidence to funders and commissioners of the value of arts in health interventions (Staricoff, 2006). Furthermore, within health services clinical governance, quality monitoring and improvement are recognised as critical to maintaining standards, so there is increasing pressure on all interventions within health care to demonstrate the establishment and monitoring of their own standards. Consequently, arts interventions are increasingly in need of their own system for evaluation and auditing purposes.

However, evaluation of arts activities is not yet being routinely or consistently carried out within health care settings. Frequently, evaluations are only carried out on an ad hoc basis at the end of time-bound projects, often merely to satisfy the requirements of project...
funders. Partly this is due to a lack of understanding of what evaluation is and how it can benefit projects; something noted as problematic in a report from the Royal Society for Public Health (RSPH, 2013). Partly it is due to a lack of time amongst staff to dedicate to carrying out an evaluation. Partly, it is due to a current dearth of evaluation scales specific to arts activities in health care settings, meaning that arts organisations are unsure how to carry out a transparent evaluation without hiring external evaluators.

Indeed, reports in the literature have outlined four main options for evaluating arts-in-health projects:

1. Use of self-created questionnaires either exploring how individuals respond to activities based on their own assessments of their mood (Haake, 2013; Lipe et al., 2012) or asking individuals to comment on their satisfaction with an arts project (Chang & Chen, 2005; Puig, Lee, Goodwin, & Sherrard, 2006).
2. Use of validated psychology scales such as the Wong-Baker FACES pain rating scale or the State-Trait Anxiety Inventory (Colwell, Edwards, Hernandez, & Brees, 2013), the Beck Anxiety Inventory along with demographic surveys (Walsh, Radcliffe, Castillo, Kumar, & Broschard, 2007) or visual analogue scales (Ferrer, 2007).
3. Adoption of semi-structured interviews supplemented by self-report measures (Preti & Welch, 2013).
4. Use of qualitative techniques to observe patient behaviour (Colwell et al., 2013).

However, all of these techniques carry with them a variety of problems when used as the sole method of evaluation. Self-created questionnaires can lack rigour, contain unintentional bias and cannot be benchmarked against any other data. Self-created questionnaires, validated scales and semi-structured interviews require time commitments from patients which may not be appropriate if patients are short-stay, are only involved in an arts activity for a short amount of time or are more seriously ill. And both interviews and qualitative techniques require significant staff time to undertake, and can be difficult to compare across time, making it hard to assess progress.

Consequently, there is a clear need for the development of a tool which:

1. allows for entirely non-intrusive monitoring and evaluation of the impact of performing arts activities on participants for whom it is not possible or inappropriate to be administering paper questionnaires;
2. permits the capturing of both qualitative and quantitative data that can be benchmarked against organisational standards and used as the basis for cycles of quality improvement;
3. is fast and simple to complete so can easily be carried out with minimal training by staff in busy work environments.

This paper describes one proposed solution to this need. The first part of the paper outlines its purpose, design and procedures for use, while the second part describes how it has been validated.

**Purpose of ArtsObS**

The Arts Observational Scale (ArtsObS) has been specifically created to meet the needs identified. It has involved over two years of development over the period August
2012–December 2014, during which time it has been tested on an estimated population of 1,500 patients and undergone a number of iterations to achieve its current form. It is a practical data collection tool that can be used in a wide variety of settings, including hospital wards, care homes and in community settings with a broad range of ages, from babies up to care of the elderly. It is suitable for use with a wide range of arts projects, from monitoring patient reactions to live performances of music, theatre or dance to monitoring active patient participation in arts interventions or therapies. The tool permits supervisors or staff members to observe unobtrusively participants and relatives, concentrating on the direct effect that the arts activities are having on a range of measures, including mood scores, set criteria specific to the priorities of organisations, flexible criteria specific to each project, and qualitative feedback and case studies. Such data can then be used to demonstrate the value of an arts activity, benchmark its success against other projects within the same organisation, make informed changes to the project design where appropriate, and monitor its continued application to ensure it remains both high quality and high impact.

Framework

ArtsObS uses a mixed-methods approach, allowing for the gathering of both quantitative and qualitative data. The entire scale can be completed by an observer without requiring patients to fill in any paperwork, making it a time-efficient and non-intrusive process. The scale is split into six sections (Table 1):

<table>
<thead>
<tr>
<th>Type of data</th>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantitative</td>
<td>Demographic data</td>
<td>The main form records activity details, such as location of activity (whether a specific hospital ward, care home or other health care institution), date, and basic details on the activity. It also captures information on the number of patients and staff involved in an intervention</td>
</tr>
<tr>
<td></td>
<td>Mood scores</td>
<td>A seven-point scale allows observers to rate the moods of participants before and after their involvement in an arts intervention. In order to clarify the different points on the scale, visual depictions and a selection of adjectives are provided for each so observers can confirm an appropriate selection</td>
</tr>
<tr>
<td></td>
<td>Set criteria</td>
<td>These are criteria deemed to be of particular relevance to the use of arts in health care settings and applicable across a range of arts interventions, for example, relaxation, distraction from the hospital setting, level of boredom and level of engagement. Criteria can be set by each institution and observers given a simple three-point Likert-type scale to select from, ranging from 0 (not at all) to 1 (yes a little) to 2 (very much so)</td>
</tr>
<tr>
<td></td>
<td>Flexible criteria</td>
<td>These are criteria that can be selected specific to each project within an organisation. This might include criteria such as degree of socialisation, improvements in confidence, tolerance of pain, etc.</td>
</tr>
<tr>
<td>Qualitative</td>
<td>Feedback</td>
<td>Both positive and negative feedback from staff, patients and relatives can be captured on the reverse of the form. This can also be supplemented by photographs or videos or other forms of participant response</td>
</tr>
<tr>
<td></td>
<td>Case studies</td>
<td>The observer can also record noteworthy events within the intervention or responses to activities from individual participants</td>
</tr>
</tbody>
</table>
Procedures for use
ArtsObS is freely available for use. The tool consists of a user guide (Appendix 1) and a form for completion (Appendix 2).

Rating observed indicators
The scores calculated by ArtsObS for each project evaluated are anticipated to be different depending on the nature of the intervention and the participant group. Some projects that are well designed and specifically target their participant group may achieve high scores in using the tool. For other projects that are just starting and undergoing a period of adjustment, or projects with more acute patient groups, scores may be lower. However, the tool allows organisations to set their own benchmarks, for example, a target of a 20% lift in mood or 90% of participants being either a little or very relaxed by an activity. This means that scores will be relative to the rest of the organisation’s own performance rather than relative to any wider “gold-standard”. As this is an evaluation rather than a research tool, results are not anticipated to be compared outside of organisations. Instead, the focus is on internal consistency and quality improvement.

Training
Prior to using ArtsObS, observers should ensure they are familiar with the user guide. The scales included within the tool are deliberately simple to ensure ease of use and minimum time requirement. However, in order to make meaningful observations, observers will need to comprehend fully the constructs behind the scales. This is also an essential step in order to achieve inter-rater reliability, meaning that multiple different observers can use the tool and still produce the same data that accurately reflects the experiences of participants (see Section 5.3).

Data analysis
Once data have been inputted, simple analyses can be carried out to asses average responses for each criteria. This might include averages specific to the patient group involved, such as for all live music events involving dementia patients in a hospital, or averages specific to the arts intervention, such as all theatre performances from a specific arts organisation across multiple care homes.

This template spreadsheet can then be used for the generation of graphs and tables to assess whether activities are meeting their benchmarks and maintaining constant quality.

Validation process
Yohalem, Fischer, Shinn, and Wilson-Ahlestrom (2014) outlined seven ways of validating scales, of which four are appropriate to the design and methodological background to ArtsObS. These have been applied in a series of studies validating ArtsObS. Table 2 outlines these measures of validity and summarises the results from the validation process. Results are then described in detail in the following sections:
Construct validity

Mood ratings

Social cognition literature has identified mood as a key factor in patient experience in health care settings, finding demonstrable links between mood and both motivational state and behaviour. People experiencing positive moods are more likely to notice positive aspects of their surroundings, whereas those experiencing negative moods tend to notice more negative aspects of their surroundings, including noticing stress more and judging services to be of poorer quality (Routhieaux & Tansik, 1997). As such, it is of importance in health care settings to maintain more positive moods in order to support a calmer state amongst patients and avoid inadvertently undermining trust in services.

The term “mood” is to be distinguished in this context from “emotions”, which are more intense and tied to overt behaviours. Moods are capable of changing quickly in direct response to external stimuli and can shift even if an underlying emotion, such as fear or sorrow, and the stimuli causing this emotion, prevail (Alpert & Alpert, 1990). Psychological studies have demonstrated that people are capable of gathering information relevant to moods from merely observing somebody, and this information is strengthened through situating it within a given context which can provide supportive information (Carroll & Russell, 1996). This suggests that the observation of patients in the context of a specific setting (such as a hospital ward) is a legitimate way of assessing their mood. This is supported by the number of observational tools already available for health care settings, including the Face, Legs, Activity, Cry, Consolability scale; the Paediatric Anaesthetic Emergence Delirium scale and the Yale Preoperative Anxiety Scale.

The use of faces for the mood scale within Arts ObS is based on the Wong-Baker FACES Pain Rating Scale (Wong & Baker, 2001). The use of faces has been identified by 90% of nursing professionals as easy to use and appropriate for administration by

<table>
<thead>
<tr>
<th>Table 2. Summary of procedures used to validate ArtsObS.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Element</strong></td>
</tr>
<tr>
<td>Construct validity</td>
</tr>
<tr>
<td>Score distributions</td>
</tr>
<tr>
<td>Inter-rater reliability</td>
</tr>
<tr>
<td>Concurrent validity</td>
</tr>
</tbody>
</table>
non-nursing professionals (Curtis, 2011), and seven-point scales have been suggested as one of the most reliable types of rating scales (Colman, Morris, & Preston, 1997). The use of five adjectives for each point on the scale follows the theoretical basis of the Multiple Affect Adjective Checklist which has been used in arts studies before (Stratton & Zalanowski, 1991). Watson and Tellegen (1985) defined mood as having a three-dimensional structure, focusing on the domains of pleasantness, arousal and attention. Consequently, ArtsObS incorporates adjectives for each point on the mood scale that incorporate all of these three dimensions.

**Set criteria**

The evaluation method behind both set and flexible criteria is the use of Likert-type scales. These are commonly used psychometric scales within questionnaires (Matell & Jacoby, 1971). As opposed to a binary choice between “yes” and “no”, the three-point Likert scale allows for the “yes” choice to split into “a little” and “very much so”, meaning that the degree of relaxation can be assessed by observers, but at the same time the choice is still very simple to facilitate both ease and speed of using the tool, and accuracy of assessment.

As outlined in Section 3, set criteria can be set by each organisation to reflect the organisation’s own goals. However, construct validity has been undertaken for two suggested set criteria felt to be recurring in health care settings:

**Relaxation.** Relaxation is an important factor for patients in hospital, both for its effects on patient experience and clinical outcomes. A number of studies have shown the negative effects of stress in hospitals, in particular both trait and state anxiety, anger and distress, linking them with slower wound healing (Broadbent, Petrie, Alley, & Booth, 2003) and more complicated recovery (Johnston & Wallace, 1990). However, there is a growing body of evidence showing that relaxation can reduce side effects such as nausea, improve emotional adjustment and also have positive ramifications for family members (Luebbert, Dahme, & Hasenbring, 2001). And relaxation has been associated with concepts of patient well-being, strength, competence and comfort (Syrrjala, Donaldson, Davis, Kippes, & Carr, 1995).

Relaxation can be measured both psychologically and physiologically, through tests on emotional state, heart rate, blood pressure, cardiac output, galvanic skin response, respiration rate, electroencephalographic alpha brain waves, muscle tension and mood profiles (Luebbert et al., 2001; Robb, 2000). However, in order to be able to assess relaxation through observation alone, researchers in the fields of psychology and stress psychophysiology have sought to find indices of these responses, including muscular relaxation of the face and limbs and softening of facial expressions (Good et al., 2001; Robb, 2000); jaw relaxation, tongue resting and lips soft (Good, 1996); slow respirations (Good, 1996; Good et al., 2001); and shutting of eyes or falling asleep (Robb, 2000). These studies have also been noteworthy in that they have used music as a means of effecting relaxation on participants, suggesting both the effectiveness of music and the appropriateness of these indices within the ArtsObS tool. Indeed, Robb (2000) discussed how many individuals automatically combine listening to music with physical relaxation techniques such as mental imagery or visualisations and free thoughts, suggesting the surface manifestations of relaxation to be an indication of a deeper effect.
Distraction. Distraction is a technique used within health care for a range of purposes, including reducing patient anxiety, fear around needles and medication, and pain levels. It works on the premise that our cognitive attentional resources are finite (the “limited capacity” model) so distraction can reduce the resources available to focus on negative sensations (Shiffrin, 1976). Consequently, positive stimuli can deliberately be introduced to reduce the perception of negative stimuli.

The ArtsObS tool uses Eccleston’s model (1995) to rate levels of distraction. This posits that when faced with two competing informational inputs, we can: (1) process the negative instead of the positive, (2) process both at the same time and (3) process the positive instead of the negative (Eccleston, 1995). Based on the same three-point Likert-type scale as the other criteria on the tool, the distraction scale asks observers to rate “no”, “yes a little” and “yes very much so” in line with options 1, 2 and 3, respectively. Level of distraction can be ascertained by observers from direction of sightlines, level of engagement with the activity, and reduction in visible perceptions of feelings of pain, depression, anxiety and hostility (Luebbert et al., 2001).

Distraction is distinct from relaxation in that the former is about changing the focus of concentration while the latter is to do with changing the affective dimension by influencing mood or emotions (Kwekkeboom, 2003).

Score distributions
In order to assess whether the rating scales developed were strong scales with even distribution across their scores, data were gathered from observing 203 patients and the distributions of these results were analysed. Mood scores prior to arts interventions demonstrated a normal distribution (Figure 1), with neither floor nor ceiling effects. Mood scores following arts interventions demonstrated a negative skew (Figure 2). This confirmed expectations that arts interventions can cause an increase in positive scores and demonstrated that the tool is sensitive to arts-induced mood changes.

As distraction and relaxation levels are ordinal rather than linear variables and only have three levels, reliability and validity tests were not conducted. However, a basic score distribution check demonstrated neither floor nor ceiling effects, suggesting the categories are well defined.

Inter-rater reliability
As well as assessing distribution, the mood rating from ArtsObS was assessed to see whether two observers using the scale would produce the same results, thus showing whether the scale is consistent irrespective of who is collecting the data. Two raters were provided with the manual prior to evaluation and then completed assessments on the same 119 patients. Inter-rater reliability tests were conducted using Pearson’s product–moment correlation coefficient. There was a very strong correlation between the data collected by the two observers ($r = .721$, $n = 119$, $p < .001$) indicating consistent, very high inter-rater reliability. This demonstrates that the tool is a reliable way of assessing patient mood, and that the manual effectively prepares observers for using the tool correctly.
Concurrent validity

The mood rating from ArtsObS was also assessed to see whether scores gathered by observers would align with patients’ own reported feelings and responses. One hundred fifty-eight patients were invited to answer surveys posing the same questions asked by the ArtsObS tool, and a rater independently observed their behaviour. Data were negatively skewed so concurrent validity tests were conducted non-parametrically using Spearman’ correlation coefficient. There was a strong correlation between the data collected by the observer and patients ($r = .641$, $n = 158$, $p < .001$) indicating consistent, high concurrent validity. This demonstrates that observations made using the tool are a

![Histogram](image1)

Figure 1. Score distributions pre-intervention.

![Histogram](image2)

Figure 2. Score distributions post-intervention.

**Concurrent validity**

The mood rating from ArtsObS was also assessed to see whether scores gathered by observers would align with patients’ own reported feelings and responses. One hundred fifty-eight patients were invited to answer surveys posing the same questions asked by the ArtsObS tool, and a rater independently observed their behaviour. Data were negatively skewed so concurrent validity tests were conducted non-parametrically using Spearman’ correlation coefficient. There was a strong correlation between the data collected by the observer and patients ($r = .641$, $n = 158$, $p < .001$) indicating consistent, high concurrent validity. This demonstrates that observations made using the tool are a
A reliable way of assessing patient response and can be used as a proxy for asking for patients’ own responses.

**Conclusion**

Overall, the background and consultation work involving 1,500 patients, relatives and staff demonstrated the need for a reliable way of assessing response to arts interventions in health care settings. The validation study involving 805 patients and relatives conducted on the subsequent tool developed to meet this need has demonstrated the very strong reliability and consistency ratings for the ArtsObS. Together, this evidence confirms that the ArtsObS tool is a valid way of assessing response to arts interventions in health care settings, and both the tool and the manual can be used with confidence by arts administrators, session leaders and clinical staff in health care settings. As stated at the outset, ArtsObS is an evaluation tool intended as a way of rating individual projects against themselves. If this tool is to be considered for research purposes, further validation will be necessary to ascertain how the tool performs when comparing different projects in different settings, and identify which further factors might need to be taken into account in order to enable meaningful comparisons of data to take place.

**Acknowledgements**

The authors are grateful to Katey Warran, Uberto Orlando, Rebecca Argyle and Melissa Hobbs at Chelsea and Westminster Hospital for their help with data collection.

**Funding**

This work was supported by CW+.

**References**


RSIPH. (2013). *Arts, health and wellbeing beyond the millennium: How far have we come and where do we want to go?* London: Royal Society for Public Health.


Appendix 1.

Arts Observation Scale (ArtsObS)

Manual

Introduction
The Arts Observational Scale (ArtsObS) is a tool for the evaluation of performing arts activities in healthcare settings. This manual intends to explain to users exactly how to use ArtsObS. Users are advised to read the manual alongside the evaluation form itself and practise applying the scale before testing it in a live setting. For more information on the tool or details on its validity, please refer to [the paper submitted].

Overview
1. Quantitative data
   a. Demographic data
   b. Mood scores
   c. Set criteria
      i. Relaxation
      ii. Distraction
   d. Flexible criteria
2. Qualitative data
   a. Feedback
   b. Case studies

1. Quantitative data

a. Demographic data
The scale captures basic demographic data on the activity and participants. Prior to starting the activity, observers should provide the ward name, date and activity being observed. During the activity, it will be necessary to find a way to identify participants. If participants are bed-bound, this identification can be their bed number. If they are in a communal space, it may need to be a unique descriptor, such as their colour clothes. Sex and age can also be approximated, such as M60s (male aged 60-70) or F20s for (female aged 20-30). Demographic data can also be recorded on the number of patients and clinical staff who attend (Qs 14 and 15). And an overall rating can be given for whether it brought a positive effect to a ward using the following scale:

|   | Not at all | The activity brought no benefit or even negative effects to the ward, causing complaints, missing its target audience or getting in the way of staff.
|---|---|
| 2 | Yes, a little | The activity helped lift the mood of the ward, bring a sense of calm or have a small beneficial effect on patients, relatives or staff.
| 3 | Very much so | The activity was almost universally liked, or made a significant difference to the feel of the ward.

b. Mood scores

See Qs 1-2 and 7-8 on the evaluation form.
The mood scores allow you to tell whether an activity made a participant happier than they would have been without the activity. Participants should be rated both before and after the activity as somewhere on the scale from 1 to 7. Ratings should be made based on the faces, headline words (in bold) and other associated words:

<table>
<thead>
<tr>
<th></th>
<th>Angrily</th>
<th>Frustrated</th>
<th>Sad</th>
<th>Calm</th>
<th>Satisfied</th>
<th>Happy</th>
<th>Excited</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Visibly expressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Visibly expressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Visibly expressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Visibly expressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Visibly expressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Visibly expressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Visibly expressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Angry</th>
<th>Frustrated</th>
<th>Sad</th>
<th>Calm</th>
<th>Satisfied</th>
<th>Happy</th>
<th>Excited</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Depressed</td>
<td>Restless</td>
<td>Bored</td>
<td>Reserved</td>
<td>Focused</td>
<td>Receptive</td>
<td>Delighted</td>
</tr>
<tr>
<td>2</td>
<td>Aggressive</td>
<td>Anxious</td>
<td>Listless</td>
<td>Quiet</td>
<td>Alert</td>
<td>Entertained</td>
<td>Appreciative</td>
</tr>
<tr>
<td>3</td>
<td>Distressed</td>
<td>Irritated</td>
<td>Tense</td>
<td>Still</td>
<td>Relaxed</td>
<td>Interested</td>
<td>Enthusiastic</td>
</tr>
<tr>
<td>4</td>
<td>Hostile</td>
<td>Upset</td>
<td>Distracted</td>
<td>Passive</td>
<td>Content</td>
<td>Amused</td>
<td>Friendly</td>
</tr>
</tbody>
</table>

Set criteria
Appendix 2.

Set criteria are aimed to be constant across all activities in a centre to enabling activities to be compared during evaluations. For healthcare settings, these set criteria are recommended to include ‘relaxation’ and ‘distraction’.

i. Relaxation

See Qs 3 and 9 on the evaluation form.

Participants' reactions should be rated 1, 2 or 3 depending on how many relaxation ‘signs’ they are exhibiting.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>Not at all</th>
<th>No change evident.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>Yes, a little</td>
<td>One or two changes evident.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Very much so</td>
<td>Multiple changes or pronounced changes obvious.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signs to observe</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscular relaxation in the face or limbs</td>
<td>Slow breathing</td>
</tr>
<tr>
<td>Jaw relaxation</td>
<td>Shut eyes</td>
</tr>
<tr>
<td>Soft lips and resting tongue</td>
<td>Failing asleep</td>
</tr>
</tbody>
</table>

ii. Distraction

See Qs 4 and 10 on the evaluation form.

Participants' reactions should be rated 1, 2 or 3 depending on how many distraction ‘signs’ they are exhibiting.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>Not at all</th>
<th>Attention entirely focused on hospital or current medical state</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>Yes, a little</td>
<td>Attention split between hospital / current medical state and the arts activity</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Very much so</td>
<td>Attention entirely focused on the arts activity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signs to observe</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Direction of sight line</td>
<td>Level of engagement with the arts activity</td>
</tr>
<tr>
<td>Topic of conversation with relatives/staff</td>
<td>Use of other distractions (e.g. books or TV)</td>
</tr>
<tr>
<td>Visible expression of unpleasant sensations (e.g. pain)</td>
<td></td>
</tr>
</tbody>
</table>

d Flexible criteria

See Qs 5-6 and 11-12 on the evaluation form.

Flexible criteria can be added depending on the activity being evaluated. These could include level of engagement, improvements in confidence or other similar measures. For each flexible criterion, a rating table and a ‘signs to observe’ table should be created.

2. Qualitative data

a Feedback

See Qs 16-17 on the evaluation form.

Alongside quantitative data, ArtsObS enables the collection of personal feedback and quotations from patients, relatives and staff. Observers should undertake a combination of discreet observation and active engagement with participants in order to gather both informal comments shared between participants and more formal statements from those involved in the project. Depending on the more detailed questions behind the evaluation, observers may wish to prompt participants to talk about certain aspects of the project, but questions should remain as open as possible. Precise questions or semi-structured interviews should be conducted separately. No personal data need be recorded, but observers should record basic data on the role of the person being quoted, e.g. ‘parent of paediatric patient’, or ‘staff nurse.’

b. Case studies

See Q 18 on the evaluation form.

Observers can also gather more detailed accounts of responses to activities. For example, if any participants show a particularly strong response such as singing along to a music session or being distracted from a painful treatment, this can be recorded here. If potential case studies are observed, these can be supplemented with more facts from staff and relatives to provide a better picture of the impact.
### Arts Observation Scale (ArtsObS)

#### Patients

<table>
<thead>
<tr>
<th>ID</th>
<th>Sex/Age</th>
<th>Mood score</th>
<th>Set criteria</th>
<th>Flexible criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Happiness score at start</td>
<td>/7</td>
<td>3 Did it help to relax patients?</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Happiness score after</td>
<td>/7</td>
<td>4 Did it help to distract from hospital?</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Did it help to relax patients?</td>
<td>0-2</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Did it help to distract from hospital?</td>
<td>0-3</td>
<td>6</td>
</tr>
</tbody>
</table>

#### Relatives

<table>
<thead>
<tr>
<th>ID</th>
<th>Sex/Age</th>
<th>Mood score</th>
<th>Set criteria</th>
<th>Flexible criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td></td>
<td>Happiness score at start</td>
<td>/7</td>
<td>9 Did it help to relax patients?</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Happiness score after</td>
<td>/7</td>
<td>10 Did it help to distract from hospital?</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Did it help to relax patients?</td>
<td>0-2</td>
<td>11</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Did it help to distract from hospital?</td>
<td>0-3</td>
<td>12</td>
</tr>
</tbody>
</table>

13 Did it have a positive effect on the ward? | 14 How many patients took part? | 15 How many clinical staff looked in? | 1-5 | □ | □ | □ |
17 Please add any positive feedback or quotations from patients, relatives or staff on the wards.

18 Please add any negative feedback or quotations from patients, relatives or staff on the wards.

19 Please add any anecdotal evidence or case studies from the responses of patients, relatives or staff to the activity.
Community Engagement: Determine needs/goals in common with your company, community partner and funder.

A. What are you trying to achieve in your program?
   1. 
   2. 
   3. 
   4. 
   5. 

B. What are the needs of your community partner? Ask them! Don’t make assumptions.
   1. 
   2. 
   3. 
   4. 
   5. 

C. What is your funder interested in supporting?
   1. 
   2. 
   3. 
   4. 
   5.
Community Engagement: Determine needs/goals in common with your company, community partner and funder.