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The authors would like to acknowledge the staff of the LHD for agreeing to be part of this study. This article is associated with the Policy & Measurement lens of The Beryl Institute Experience Framework. (<http://bit.ly/ExperienceFramework>). You can access other resources related to this lens including additional PXJ articles here: http://bit.ly/PX_PolicyMeasure

Patient feedback: Listening and responding to patient voices

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Abstract

The study aim was to identify key strategies to improve organisational systems and care experiences, to confront the challenges of achieving effective patient feedback throughout a large healthcare organisation. A mixed methods exploratory approach was used. Purposive and snowball sampling, semi-structured interviews with key stakeholders, and document analysis of existing feedback processes was utilised. The setting was a large metropolitan Local Health District in Sydney, Australia. Data was examined using thematic and content analysis. Participants identified no single feedback process was able to adequately gather all feedback necessary to reflect the patient experience. Patient feedback processes that are most useful: are in alignment with patient centred care principles; and, promote the return of information in a timely manner. Two types of patient feedback and their value was identified: proposals for resources; and, suggestions for improvements in processes. The optimal approach to gathering patient feedback requires: a combination of approaches; questioning about patient centred domains; and structured/unstructured and open/closed formats. Guidance and coordination from a central unit is imperative if improvement is to be integrated and effective across a large organisation. The study reveals that the key to achieving an effective patient feedback system is to utilise a multifaceted approach. A combination of approaches provides a comprehensive, adaptive strategy to address patient experience, satisfaction and outcomes. This approach, implemented throughout the organisation, enables relevant and actionable patient feedback to be gathered and implemented in a timely manner.

Keywords

Patient feedback, patient centred care, patient experience, patient satisfaction, patient engagement, qualitative methods, healthcare, health management

Introduction

As the end users of healthcare services, patients provide unique insights into the system (dis)functioning through firsthand experience.¹⁻⁵ Patient feedback can improve future patient experiences and produce tangible benefits to the system and organisations.^{1, 6-8} Gathering and using patient feedback aligns directly with the universal principles of patient centred care, particularly respect for patients' values, preferences and expressed needs.⁹

Optimal patient feedback should encompass patient experience, satisfaction and outcomes.^{5, 10} Utilising patient feedback results in the identification of service gaps¹¹ and improved clinical processes.¹² Clinically, patient feedback leads to increased patient engagement, adherence to provider instructions⁶ and subsequent improvements in care outcomes.⁷ Economically, patient feedback results in improved facility financial performance⁶, decreased malpractice risk⁶ and increased patient loyalty.¹³ Socially, patient feedback results in increased staff satisfaction¹³ and greater patient engagement.⁶ Patient feedback, in short, can transform practice and drive overall system transformation.^{1, 14-18}

Feedback mechanisms regularly take the form of structured, guided feedback, such as surveys with set questions¹⁹, or open, unguided feedback, in descriptive form of patient stories, compliments or complaints.^{3, 20} The benefits of structured, guided processes for gathering patient feedback are documented, and include the ability to capture large samples and standardisation in data gathering.¹ However, structured, guided feedback processes tend to have a narrow focus, allow limited opportunity for further exploration of issues raised and exclude unique patient insights being reported.^{1, 21} Conversely, open, unguided feedback processes allow patients to provide information on any area of their choosing related to their experience.¹⁹ Open feedback processes elicit diverse and detailed patient specific information.²² This feedback humanises the patient experience for staff, creating bonds and opening communication lines.²³ Nevertheless, there has been limited investigation into the benefits of open, unguided feedback processes.

Patient experience is influenced by the structure of the organisation.⁵ Typically, the array of facilities, departments and professional disciplines within a large organisation results in a siloed, disjunctured approach to the development of processes and procedures,²⁴⁻²⁵ including patient feedback.²⁶ Silos reinforce and contribute to the division of organisational products and interactions.²⁷⁻²⁸ Development and evolution of managerial and care processes is therefore often incremental, reactive and specific to the context from which they have arisen.²⁹ A consequent outcome is a variety of uncoordinated and unrelated patient feedback processes with differing governance, implementation and utilisation structures. This lack of organisation and communication makes patient feedback throughout the institution difficult to govern, variable for patients, non-comparable, and produces potential non-transferrable outcomes or solutions to common problems. There is a need for research into how to address these challenges and more effectively use patient feedback.³⁰ Hence, the study sought to identify local insights applicable to the broader healthcare context, developing transferable ideas to support the collection and utilisation of patient feedback. Through investigating patient feedback processes in a large, complex healthcare organisation we sought to answer four questions: what are the strengths and weaknesses of patient feedback processes; what patient feedback is most useful for the healthcare organisation; is there an optimal approach - of structured and unstructured processes - to gather patient feedback; and, what enables and promotes the integration of patient feedback processes?

Methods

The study setting was a large metropolitan Local Health District (LHD) in Sydney, Australia. There are six inpatient facilities provide services for a population of approximately 940,000 people located across 6,243 square kilometres. The LHD has a culturally diverse population with high numbers of refugees, high rates of fertility, a large ageing population and significant socioeconomic disadvantage. The LHD employs approximately 12,000 people throughout its facilities and within the community setting. The LHD was selected because of its accessibility by the researchers. Its accessibility enabled researchers to gather a richness of understanding within the available time and resources. The study was approved by the local research ethics committee (HE16/131).

A mixed methods approach was utilised, including interviews and document analysis. A purposive sampling process recruited key informants from the inpatient facilities.³¹ Key informants were identified as the six quality managers as they were deemed as being best able to provide a detailed and holistic view of the phenomenon under investigation.³¹ The quality manager role within each

facility encompasses the direct management of patient feedback processes at the respective site. Their roles are responsible for the governance and supervision of other frontline staff directly involved in gathering and reporting patient feedback. Snowball sampling was used to recruit three further participants known to have significant knowledge about patient feedback due to their unique roles, expertise and experience within the LHD.³² These participants occupied the roles of: patient feedback project manager; complaints manager; and consumer participation manager. Recruitment was ceased at nine as data saturation was reached.³³ Potential participants were recruited by email invitation and all agreed to participate.

Individual semi-structured interviews were conducted in person with each participant. Eleven interview questions focused on current patient feedback processes including: participant's role in organising and managing patient feedback; identification of current processes, and their strengths and weaknesses; areas of patient feedback considered most relevant and useable; preferred timing of patient feedback; and, additional processes or areas of feedback identified as important. Interviews ranged in duration from 15 to 40 minutes. They were recorded, transcribed verbatim and de-identified. Thematic analysis of transcripts was used to identify, analyse and report themes within the data.³⁴ Transcripts were combined into a single document by one investigator (SR) and read to gather an overall impression of participant responses.^{34, 35} The combined transcripts were then reviewed line-by-line by one investigator (SR) to identify codes.³⁵ The combined transcripts and initial list of codes were then reviewed together with another investigator (SR and KE) and a condensed list developed. The two investigators then grouped the codes by similarity to develop themes.³⁴ This list was then reviewed and discussed by all members of the research team (SR, KE and DG) to resolve any variance and agree on a final list of codes and themes. Themes were then collected together, compared and analysed by the team.

Interviews were complimented with document analysis of existing patient feedback tools utilised by participants within their institutions. Ten patient feedback tools – five paper and five electronic items - were provided by participants and examined. Items were reviewed utilising the format of delivery to patients, that is, paper, website and/or tablet. Content analysis of patient feedback tools involved examination of tool structure and identification of specific areas addressed and/or questions asked within the tool.³⁶ Examination of patient feedback tool structure focused on three areas: layout of tool, format of questions – open or closed, and number of questions. Examination of patient feedback tool content focused on identifying what patient experience domains the tool was asking about, and thematic comparison of similarities and differences. This involved one investigator (SR) tabulating

each patient feedback tool and the abovementioned characteristics applicable to each tool. These characteristics were compared between tools and similarities and differences recorded. This table was then reviewed together with another investigator (SR and KE). This table was then reviewed and discussed by all members of the research team (SR, KE and DG) to ensure all characteristics were correctly identified, compared and recorded.

The two data sets were then compared and reviewed together. Two investigators (SR and KE) read the feedback tools, then documented features of each and data being collected through them. Participant views on patient feedback tools were compared to the tool used by the respective participant to determine where the features and content of tools aligned with themes produced from interviews. This involved comparing the list of identified themes with the table of patient feedback tool characteristics. The two data sets were then discussed with all investigators (SR, KE and DG) to develop the final comparison. The analysis was to derive explanation and insight into current patient feedback practices and potential improvements.

Results

Ten patient feedback tools were identified by participants in use within their facility. A standardised, state-wide survey administered by the Bureau of Health Information (BHI) and patient journeys/stories/interviews were both identified by seven participants. Written compliments, written complaints and Patient Experience Trackers (PETs) – tablet-based surveys, were each identified by five participants. Online complaints and online compliments were identified by three participants. A modifiable, local questionnaire – Communication with Purpose (COMPURS), was identified by two participants. A hospital-wide, paper survey and social media were identified by one participant each.

Some tools addressed key domains related to patient experience, such as health care worker communication, physical environment and patient involvement in care. Some tools allowed for unstructured, free-text responses without set focus areas. Other tools were a combination of both.

The results are presented in four sub-sections. First, the strengths and weaknesses, as identified by participants, of the 10 patient feedback processes used are reported. Second, the patient feedback topics considered most useful are noted. Third, the analysis of views for potentially an optimal approach to gather patient feedback is discussed. Finally, consideration is given to what enables and promotes the integration of patient feedback processes.

Strengths and weaknesses of patient feedback processes

Participants identified 10 patient feedback processes available. They reported that *“there’s no shortage of ways patients can let us know what they think”* (Participant 4) and, furthermore, that each had their strengths that gathered feedback that could be used to improve the services. In the words of one participant:

“Nothing we have in place is perfect by any means, but there are bits and pieces from the different processes that are really good that we can definitely take and use.” (Participant 6)

The feedback processes were grouped into two categories – principle and supplementary. Seven feedback processes were categorised as ‘principle’ and three as ‘supplementary’. Ten characteristics were identified as strengths and/or weaknesses by participants. Each of the processes were identified by participants as having individual and/or common strengths and weaknesses (Table 1).

Participants described principle feedback processes as those with the following characteristics: individualised to the patient, with the ability to be both standardised and modifiable; open format (free text, unguided, and unstructured); and, received and actioned in a timely manner (ideally immediately). Participants reported that, typically, principle feedback processes were implemented directly by individual services, were able to obtain high response rates from the activity, and that they could interpret and implement actions arising from suggestions quickly and simply. This idea was encapsulated by the statement: *“we need the feedback to be accurate and represent patient opinions but we also need to be able to do something with it”* (Participant 8).

Conversely, other feedback processes, defined as supplementary processes, had the following characteristics: population-based; non-standardised and non-modifiable; closed format not allowing for further explanation or investigation (survey-type); received and actioned in an untimely manner; and, resource-intensive to implement and action. Supplementary patient feedback processes were implemented centrally or external to the organisation, and received poor response rates. The feedback ideas were delayed returning to the service and were, by comparison to the principle feedback processes, difficult to implement. Participants explained their frustration with this in the following ways: *“What can you do with it [feedback] when only five percent complete the survey and we get it 12 months later?”* (Participant 1); and, *“A simple tick-a-box that doesn’t let the patient expand or explain what the issue is just isn’t enough.”* (Participant 2)

Table 1. Feedback processes assessed by category and characteristics

Category	Feedback process	Characteristics									
		Open format	Timely	Standardised	Modifiable	Actionable	Closed format	Untimely	Resource-intensive	Non-standardised	Poor response rates
Principal	Patient journey/story/interview	S	S		S	S			W	W	
	Social media	S	S		S	S				W	
	Written complaints	S	S		S	S				W	
	Written compliments	S	S		S					W	
	Online complaints	S	S		S	S				W	
	Online compliments	S	S		S					W	
	Communication with Purpose (COMPURS)	S		S	S	S			W		
Supplementary	Bureau of Health Information (BHI) survey			S			W	W			W
	Patient experience trackers (PETs) - tablets		S	S	S	S	W		W		W
	Hospital-wide paper survey			S		S	W		W		

Feedback topics considered most useful

Participants explained that patient feedback topics could be divided into two groups of ideas. One group were proposals for resources or care activities, which was expressed as: “Patients often see something at this hospital or that hospital that their mum or someone was in and tell us we should get this or that” (Participant 7). The other group of ideas were suggestions for improvements in care processes, including professional-patient communication, and the point was made like this: “The overwhelming majority of feedback we get from the survey tells us that we need to improve communication with patients and their families” (Participant 4). The former group presented a challenge for professionals as normally there were not resources to address them or they needed a long-term time frame for changes. However, the latter group were usually quickly and immediately actionable, as they focused directly on action under the control of professionals. Changes requiring resources were considered largely out of their control and, hence, this feedback was less useful for frontline staff, whereas process improvements were within their immediate control and immediately useful. That is:

“If we have patient feedback asking for a pool, we know that’s not going to happen, but if we have feedback about poor communication there are things we can put in place to address that.” (Participant 1)

Optimal approach to gathering feedback

Participants identified the need for a balance between the principle and supplementary approaches, considered complimentary, necessary to gather diversity and depth of views and topics. They needed to be applied intermittently

and regularly monitored, to form the optimal holistic approach to gathering patient feedback. For example: *“I think we need to start off with diagnostics and finding the problem through open patient interviews and surveys, determine what we’re going to do about it, implement it, then review if we have done it.” (Participant 2)*

Open format feedback processes that allow patients to explain their experience, using self-determined domains, were reported by participants as vital to gathering in-depth, patient centred information. They enabled the service to target and get to the patient experience quickly and directly, as reflected by this view: *“There’s nothing more patient centred than saying to the patient, ‘tell us what you think’ ” (Participant 6).*

Participants identified eliciting this type of information was achieved through processes including patient journeys, complaints and compliments. It was explained that the open, free-text nature of these processes allowed for contextualised feedback and suggestions for improvement and change to be provided by the patient. Staff, however, could particularly experience the complaint process confronting albeit a learning one for them. As one respondent stated:

“As much as people hate complaints they generate a lot of information around how we can make improvements, let us know when we have done something wrong and are a learning experience.” (Participant 9)

Participants placed significant emphasis on the importance of these processes that provided freedom to the patient to speak openly on topics of their choosing. As stated: *“You get a wealth of information when you let people tell you what they want to tell you”* (Participant 9).

However, it was acknowledged by participants that questionnaire surveys, using patient centred principles, are equally important. They are an approach which allows for standardisation and comparability of results by a service or between facilities, and at specific points and/or longitudinally over time. As expressed by one participant:

“[These] results let us know how we compare to other similar hospitals and can show us if we’ve made improvements from one year to the next” (Participant 3).

A further benefit of a questionnaire survey was mentioned by participants. They noted that the pre-defined approach of the survey, when based on recognised patient centred care principles, provided the potential to address all areas of the patient experience, albeit in limited depth. This approach ensured that patients were presented topics to answer they might overlook mentioning during other feedback approaches. This perspective was reflected as such: *“The survey, despite not being comprehensive, asks about areas the patient might not think to mention”* (Participant 5); and, *“You can’t deny that it [Bureau of Health Information survey] is based on the patient centred care principles and is evidence-based, so we can trust it”* (Participant 3).

The additional elements identified as imperative in an optimal approach were threefold, that is, the necessity to continually: apply diverse feedback approaches; review and implement the findings over time; and, monitor the impact of changes to practices. Participants stated these components, individually and together, as essential to ensure feedback is identified, understood, actioned and improvements are achieved. The following statement sums up the point:

“The hospital is always changing and implementing new ideas to fix [patient feedback] problems, so we need to know if they’re having the desired impact or if we’re just wasting our time.” (Participant 7)

Integration of feedback processes

Centralised governance, with ongoing oversight, was recognised by participants as essential to support integration of patient feedback processes across a multi-site organisation. As explained by one participant: *“We need guidance and coordination from the District. Set questions we should be asking based on BHI (Bureau of Health Information), structure for use of the PETS (Patient Experience Trackers) and things like that.”* (Participant 2)

Participants reported that due to facilities being widely geographically dispersed across the district, accompanied

by varying local processes, integration and conformity of patient feedback processes was often difficult. Comments were along these lines:

“A lot of the time we won’t hear about what they’re doing up the road, so we just do our own thing. We’re a long way away down here and things work a bit differently to the rest of the district.” (Participant 1)

“There are so many processes in place here and there and everywhere, how are we meant to combine and compare and come up with a complete plan when it could change at any moment.” (Participant 8)

To overcome these challenges, it was proposed that centralised governance structure and guidance was necessary. The point as succinctly expressed in this way: *“If they tell us what to do and how to do it we’d be happy to get on board”* (Participant 6).

Participants argued that this centralised approach would contribute to increased standardisation, comparability of feedback processes and common solutions to shared problems. Different locations but with a unified understanding and common resolutions to patient issues, that is: *“If we’re all asking about the same things, we can share ideas and solutions”* (Participant 5).

Discussion

Confronting the conundrum of how to identify and integrate appropriate patient feedback processes to enable continual improvement in healthcare organisations was the aim of our study. In doing so this study offers four interlinked findings to address this complex issue, that can be applied both locally and within other healthcare organisational contexts.

First, the study confirms that patient feedback processes that are most appropriate and useful to those at the frontline: are in alignment with patient centred care principles⁹; promote the return of information in a timely manner³⁷; utilise an open, flexible format^{19, 22}; and, give patient’s the opportunity to provide feedback on areas of their choosing. Conversely, in contrast, the study provided confirmation of the limited value of patient feedback processes that are externally managed. This is due to their three main characteristics: inflexible; closed format with predefined content¹; and, delayed return of information. Second, an original contribution has been the differentiating of two different types of patient feedback content and their perceived value. That is, one type of feedback being proposals for resources or care activities; and, the other, suggestions for improvements in care processes, including professional-patient communication. Previous literature identified that patient feedback is useful to an organisation in improving patient experiences and producing tangible benefits.^{1, 6-8} However, in specifying

different types of patient feedback greater understanding of the material is identified and the value to those at the frontline is exposed explicitly. This provides empirical evidence as to why they are more likely to engage with feedback processes implemented locally rather than by external agencies.

Third, the optimal approach to gathering patient feedback is revealed to require several elements, including: a combination of principle and supplementary approaches to address the breadth of patient experience, satisfaction and outcomes; questioning specifically about patient centred care domains to ensure comprehensiveness; and, structured/unstructured and open/closed formats tailored to suit different issues and modes of collection. This combination of elements draws upon the strength, and overcomes the weaknesses, of each individual approach. This optimal approach to patient feedback is endorsed from the synthesis of current literature.^{9-10, 19, 22, 38}

Fourth, patient feedback processes, within complex, networked healthcare settings, are subject to incremental development and implementation in silos, within services and by other central actors, and, simultaneously, external agencies.^{25, 27-29, 39} Consequently they may, but most likely are not working in union nor alignment.²⁶ Hence the imperative for guidance, coordination, governance and monitoring from a central unit if improvement from patient feedback is to be integrated, effective and maximised. The importance of a leadership focus on patient centred feedback is core to creating a successful culture of implementing, utilising and valuing patient feedback within a healthcare organisation.⁴⁰

Limitations

Limitations of this study, as in other localised studies, are sample size and transferability to other settings. However, because the study specifically addressed the LHD under investigation, and it is well documented that many healthcare organisations operate with a similar structure, the results are applicable elsewhere. Additionally, as this study was reliant on interview data, responder bias is always a risk. However, because the findings were consistent throughout the study, across multiple staff and sites, we consider it unlikely that this has occurred. Finally, due to the limited timeframe preventing confirmation of data saturation through an increased sample size, there is risk that additional results were not reported. As no new significant themes were reported by mid-way through the interview schedule the criteria for data saturation was met.

Conclusion

The key to improving complex and networked healthcare organisations through the use of patient feedback, is to utilise a multifaceted approach. The combination of

structured and unstructured approaches provides a comprehensive, adaptive strategy to address the breadth of patient experience, satisfaction and outcomes. Diverse, integrated elements enable relevant and actionable patient feedback to be gathered and implemented in a timely manner. Application of these learnings will produce tangible clinical, economic and social benefits for the healthcare system, organisations and patients.

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