Patient feedback: the missing link in patient safety intelligence

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Background

- PhD research project:
  - investigating the relationship between patient feedback methods (complaints, surveys & narrative) and patient safety improvement.

- Methods:
  - Case Study. Mixed methods including grounded theory situational analysis, semi-structured interviews with 44 staff, review of literature and policy documents, analysis of patient safety data; development of method to aggregate patient feedback and adverse event data.

Overview of findings

- Patient feedback methods are not reaching their potential to improve patient safety. Core theme from qualitative analysis = Degree of separation.
- Patient safety culture could be improved through a patient safety intelligence system; however
- Silos in patient safety sources hamper improvement efforts.
- A common coding taxonomy across patient feedback and adverse event data sources would facilitate patient safety intelligence.

Patient safety intelligence – what is it?

Military and business worlds understand *intelligence* as:

- A **rich knowledge** gained by gathering information from a number of sources; AND
- Requires **aggregation and analysis of data** to determine responses, actions or future strategy.

(Patient) safety intelligence is:

- An 'error detection jigsaw'; that
- Integrates patient reporting.

When patient harm occurs:

The combination of patient safety elements that may activate:

- Adverse event (incident) report; risk management system
- Clinical review (could include root cause analysis)
- Open Disclosure process
- Patient or family complaint; other patient feedback through survey or collection of narrative
- Medico-legal claim

These data sources: operate in silos; are managed differently; have different data systems and coding taxonomies.

Example: staff reported and patient reported harm

ADVERSE EVENTS/INCIDENTS	PATIENT COMPLAINTS
Staff reported	Patient/family reported
About SAFETY	About QUALITY or SAFETY
Risk assessed, assigned a risk rating	Not routinely risk assessed
Escalation process related to seriousness	Escalation processes vary
Process inclines toward: • **System response: clinical review** • **Recommendations for service improvement**	Process inclines toward: • Individual patient response/resolution. • Tenuous links to service improvement
Staff trained and enabled to report adverse events (although voluntary system with problems of its own).	Patient capacity to report concern/incident is influenced by: health literacy; vulnerability; wellness., and other factors.

Silos in patient feedback methods

- **Patient complaints:**
  - Complaint data reports often quantitative - numbers with/without narrative i.e. losing the patient voice or what the complaint is 'about'.
  - Coding taxonomies don't entirely match with adverse event reports.
- **Patient surveys (satisfaction or experience):**
  - Quantitative reports; often report hotel type issues; results considered in isolation from other patient feedback.
- **Patient narrative:**
  - Qualitative; pure patient voice; little/no coding for themes; methods lacking to integrate with other patient feedback.

Patient safety intelligence is hampered by:

- Lack of aggregation of patient feedback data due to mix of quantitative and qualitative methods and data silos.

- Patient feedback and adverse event data systems - lack of method to aggregate and analyse data.

The **lack of a common data coding taxonomy** weakens the utility of patient feedback methods as an informant of patient safety intelligence.

Could the solution be….

Hypothesis: Patient safety intelligence can be achieved through application of a common taxonomy applied to patient feedback sources and adverse events based on:

- Patient SAFETY standards/domains e.g. ACSQHC National Standards; combined with
- Patient QUALITY standards/domains e.g. (international) Picker patient experience domains.
- Include risk assessment.
- Work in progress at case study site.

Policy implications

- Patient safety data sources are weakened by data ‘silos’.
- Patient feedback is a key informant of patient safety intelligence.
- New coding taxonomies are required to enable aggregation and analysis of patient safety data across sources to facilitate service improvement.

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