Patient feedback: the missing link in patient safety intelligence

Presented by:
Deborah Schaler, MHPol, PhD Candidate
Menzies Centre for Health Policy
University of Sydney
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

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

- *Title page image courtesy of stockimages at FreeDigitalPhotos.net*
- King, A; Daniels, J; Lim, J; Cochrane DD; Taylor, A; Ansermino, JM; (2010). Time to listen: a review of methods to solicit patient reports of adverse events. *Qual Saf Health Care* 2010;19 148-157
References (cont)

- Coulter, A; Fitzpatrick, R; Cornwell, J; (2009) The Point of Care: Measures of patient’s experience in hospital: purpose, methods and uses. London. The King’s Fund