

Capturing patient experience for local quality improvement

Abstract

The value of gathering feedback from people using health services is multi-faceted, but the primary purpose is to hear, value, reflect and act upon people's feedback to improve people's experiences and health outcomes and healthcare interactions. Nurses use feedback, to guide patient-centred care or to inform healthcare decisions. However, when charged with improving the quality of care, there can be a lack of process clarity, clear measurement, and evidence of the intended improvement success. This article will provide an overview of the strategies available and offer guidance on how nurses can capture and make use of patient experience feedback to inform healthcare improvement.

Introduction

The feedback patients, families and carers give about their care experience is central to understanding, evaluating, and improving healthcare at an individual, operational, and strategic level. Over recent decades, improving patient care experiences has been prioritised by healthcare services (Flott et al., 2017). Patient experience programmes and patient and public involvement teams have now become commonplace throughout the NHS in the UK (NHS England, 2022; NHS Scotland, 2022; NHS Wales, 2022).

Patient experience feedback involves formal, for example surveys and informal interactions for example, conversations (Davis, et.al., 2022) and can be effective in improving care (Boogaard et al., 2018), recognising and enhancing excellence, identifying problems and improvements and measuring or evaluating care provision. In essence, listening to patients result in positive healthcare interactions (Holt 2018). Nurses are at the forefront of quality improvement (QI) activities, but often patient experience feedback is not used to its full potential, both for technical and organisational reasons, including clarity of roles, time constraints, lack of training and support (Wong, et al., 2020). This article gives an overview of strategies to illicit feedback for QI, their related strengths and the identification of potential barriers nurses may face. This supporting nurse's confidence when capturing and using patient feedback.

Patient Experience Explored

Patient experience is defined as what people say about specific aspects of their healthcare (Burt et al, 2017). The term is used interchangeably alongside, “patient opinion”, “patient satisfaction” and “patient perspectives” the variations reflect what is being communicated or measured. For example, patient experience relates to important interpersonal aspects of the quality of care delivered and the impact upon the person, whereas patient satisfaction is more subjective, indicating how the care provided met with the patient’s expectations (Bull et al., 2019). Wong, et al. (2020) reported that patient experience measures assess aspects of care (for example communication) which are eventually associated with measures of clinical outcomes for that patient. In essence, actively seeking feedback creates a positive patient experience, as it increases nurse/patient communication and the opportunity for involvement, leading to care that is more person-centred and improved patient outcomes (Davis et al., 2022; Wong, et al., 2020).

Wong et al. (2020) highlights the lack of evidence and associated challenges with measuring patient experience using Patient Reported Experience Measures (PREMS) which are often highly variable. While Holt (2018) in her concept analysis of patient experience, identified key moderators (influencers) and mediators of patient experience that are dependent upon the policies, organisations and staff providing care. Patient experience can be influenced by patient characteristics (e.g., age or gender); access and timeliness of care; communication skills and cultural awareness of care providers (Holt 2018). The experience itself may be perceived (mediated) through trust; communication; shared decision making; patient expectation, values, beliefs, knowledge; patient perceived power, respect and acceptance, important to consider when gathering feedback to improve care quality.

Quality improvement

QI programmes are considered the vehicle to actualise person-centredness and quality care, with patient experience feedback forming the key data on which improvement ideas are generated, and outcomes measured. NHS Improvement developed a Patient Experience Framework, proposing a whole-systems approach to collecting, analysing, using and learning from patient feedback (NHS Improvement, 2018). Without this, the tracking, measurement, and promotion of QI becomes challenging.

QI is an appropriate approach when tackling process problems, such as staff not following guidelines or patients not receiving test results in a timely manner. In the UK, The Health Foundation defines QI as the application of a systematic approach that incorporates specific techniques to improve quality (Jones et al., 2021). Previously, QI approaches (e.g. Lean or Model for Improvement, which are related methods for planning and evaluating progressive cycles of change) have focussed upon process. Ensuring success of any change involves understanding the problem, current system and recognising why the change is needed (Langley et al., 2009). QI then encourages small “tests of change” at the local level, building evidence to drive change. These small “tests of change” are often based upon sequential cycles of Plan, Study, Do, Act (PDSA) (Langley et al., 2009). These approaches aim to empower staff to drive locally meaningful change, but this has been difficult to achieve due to lack of processes to prioritise change, lack of appropriate resources and failure to collaborate with people using services (Scottish Government, 2019). The Scottish Quality Management System (Glassborow, 2022), to address these issues, has focussed attention on organisational support to achieve successful change. Without feedback and collaboration from people using services, QI is not possible.

Patient experience in quality improvement: an overview

Nurses are well placed to gather patient experience data; but they require knowledge, skills and confidence to engage in the measurement, analysis and implementation of improvement processes to ensure the trustworthiness of the data gathered.

Effectively gathering data for improvement starts with key questions:

- Why is the data being gathered?
- Who should gather the data and from whom?
- How will the feedback be gathered?
- Will the feedback gathered be formal, informal, or both?

These questions will be discussed, and then qualitative and quantitative feedback will be explored.

Why is data being gathered?

The Model for Improvement (Healthcare Improvement Scotland, 2023) outlines a group of measures (their Family of Measures) which are gathered for different purposes in QI:

- Outcome measurements – used to determine the effectiveness of the change.
- Process measurements – the activities needed to achieve the change.
- Balancing measurements - possible side-effects of the change which may occur in a complex, inter-related healthcare system, such as staff now not completing other care processes because time is spent completing the new care process.

Who should gather the data and from whom?

Nurses frequently gather feedback for improvement, but patients can be reluctant to be honest, or critical, when giving feedback to those providing care (Davis et al, 2020), or expressing concern about “getting anybody into trouble” (Burt et al. 2017: p25) and adversely affecting therapeutic relationships, leading to a lack of trust in the feedback provided.

In this context, bias is where there is intentional or unintentional influence on the feedback gathered. To avoid biasing feedback, consideration should be given to who gathers the data and their role and relationship to the patient. There is inadequate evidence in the literature to guide QI data collection. As a minimum, we should make data collection independent of staff providing direct care to individuals or staff with invested interest in the QI project, while still providing support when needed.

Wherever possible, individuals should self-report experiences; they have first-person insight and should be empowered to provide their own feedback, free of influence. Where a patient lacks capacity, a proxy may be necessary, for example family members; but consideration is needed to avoid potential biases, given the proxy will have their own interpretation of the experience.

How will the feedback be gathered?

Marsh et al. (2019) highlight the variety of patient feedback formats, but with limited guidance on their use for QI activities. This lack of guidance, coupled with concerns about reliability, biases, representativeness, anonymity and confidentiality, the usability and potential lack of action, can limit the usability of feedback gathered (Patel et al., 2015). Better

understanding of the validity and reliability of different forms of feedback should build nurses confidence around gathering feedback.

Validity

The validity of a patient feedback tool or instrument is an assessment the ability of the instrument to measure what it aims to measure and how it reflects the outcome or process, as well as the variation of what is being measured. There are different types of validity: content, criterion-related, and responsiveness (Devellis, 2012). *Content validity* evaluates how well a measurement tool covers all key elements of the construct it aims to measure. If measuring the experience of nurses' communication, then it would be important to identify the most important elements and measure all that are necessary and indicative. *Criterion-related validity* is an estimate of the extent to which a measurement tool agrees with a gold standard test. When available, these can include other relevant measures of communication, for example, the CARE measure (Mercer, 2004).

However, for QI, we need to be able to show change over time. *Responsiveness validity* is the ability of the measure to show change when the underlying construct changes, this is an essential for evaluating improvement. In a review of PREMs, Beattie et al. (2015) noted the limited reference to responsiveness, impairing the demonstration of QI impact, therefore undermining the value of patient feedback.

Reliability

Reliability is the ability of an instrument to produce consistent results or scores, under similar circumstances (Bull et al. 2019) these are tools that have been published and tested and can include for example, calibrated devices for health monitoring. Reliability also relates to how well data is managed. A highly reliable measurement tool has a lower risk of errors and process failures.

Utility

Utility relates to the usability of the data. For example, the use of national survey data can be valuable, but can lead to delays between the experience and report/publication, or not specific enough for the population/service (Gleeson et al., 2016).

Following their scoping review of the methods used to capture patient experience outcomes and patient feedback types, Marsh et al. (2019) offer 4 categories compatible with in-patient QI processes:

- (1) Hospital-initiated (validated) quantitative surveys: e.g. the NHS Adult Inpatient Survey
- (2) Patient-initiated qualitative feedback: e.g. complaints or twitter comments
- (3) Hospital-initiated qualitative feedback: e.g. Experience Based Co-Design or care specific interviews
- (4) Other: e.g. Friends & Family Test

Will the feedback gathered be formal, informal or both?

Feedback is encouraged via a broad range of mechanisms, both formal and informal. Feedback can be captured through formal surveys or interviews, or informally through social media and verbal interactions (Burt et al., 2017). Many services now direct people to independent websites to share their experiences, e.g. Care Opinion (Care Opinion, 2023). These are open, accessible websites where people can share their personal experiences of health and care services. These are helpful in identifying improvement opportunities, but consideration should be given to the usability of feedback for QI activity and the influence others' perceptions has on patient expectations.

More formal data does have some advantages for QI. It can be planned to answer specific questions and test planned changes and to recognise small incremental change/improvement (Gleeson et al., 2016).

Qualitative and Quantitative Data

As Marsh et al. (2019) described, feedback data can be qualitative (words and stories rather than numerical data) or quantitative (numbers or words represented by numbers, such a scale running from strongly agree to strongly disagree), both with a valid role in QI. Care quality problems often arise from qualitative experience and then backed-up and broadened with quantitative data. Qualitative data can be a useful in understanding early cycles of "tests of change", when nurses attempt to understand the nature of the problem and the impact of small changes for patients. Quantitative data is helpful when monitoring change over time

(e.g. after changes to processes), to compare groups, to compare with larger datasets or to prepare for scale-up of successful QI projects.

When gathering patient feedback for QI, it is essential that the data is specific, measurable, aligned to the improvement initiative and usable (NHS England & NHS Improvement, 2021).

Qualitative Feedback

As outlined, qualitative experience data can come from a range of sources, including formal interviews, online fora, complaints, thank you correspondence, even informal verbal feedback. There are multiple reasons for using qualitative data, from improving team creativity to generating teaching tools ([Lesson 5 - Ready to Lead Toolkit - ihub - Lesson 5 - Storytelling](#)) (Health Improvement Scotland, 2023). It is useful for gaining insight into experiences, particularly where validated quantitative tools are not available or suitable.

Qualitative data can be valuable in exploring unanticipated or ignored aspects of an experience. This is useful in the early stages of improvement, for example in Five Whys exercises which can help teams understand the root cause of problems (Model for Improvement) or for examination of peoples and cultures, customs and habits, as well as approaches in the early stages of Experience Based Co-design ([EBCD: Experience-based co-design toolkit](#)) (The Point of Care Foundation, 2023).

Collecting qualitative experience data

It is important to consider whose experiences we want to represent with qualitative data. Are we wanting to understand a diversity of experiences or focus on specific groups, for example, people with learning disabilities attending oncology follow-up appointments?

The “good enough” principle of improvement is to use the minimum amount of data needed to gain the understanding required at that point; but how much is enough? QI reports rarely indicate how many people were interviewed, despite reporting guidance (SQUIRE, 2023). However, a general guide, for focus group participants is six – ten (Moule et al., 2017) to be manageable and encourage interaction. For individual interviews, consider the range of experiences that you want to understand. A rule-of-thumb may be to interview three people from each group you are interested in gaining insight from. It is important to consider under-represented populations, for example, those with learning disabilities, dementia and those

with sensory impairment, who may be overlooked due to assumptions about capacity, accessibility or staff confidence.

Focus groups allow for interaction between participants, generating unanticipated insights, while individual interviews can illicit the unique experience. Data collection for QI is more flexible when compared to formal research studies, but questions should be planned to address the needs of the project, limiting bias and power imbalances, while maintaining confidentiality.

Larger QI projects may require resources e.g. time to transcribe interviews and conduct analysis. Smaller projects may try to rapidly find answers to specific questions, or to draw out themes. Identifying themes or patterns of significance to the topic being explored (Braun & Clarke, 2013) helps to draw relevant learning to drive change.

Quantitative Feedback

Quantitative analysis of experience is useful as it allows us to see wider patterns and to track changes over time. Surveys or questionnaires are often used as an economic way to gain self-report from large numbers (Gleeson et al., 2016). Questionnaires focus upon key, predetermined, and specific questions. To ensure that the survey findings reflect the realities of patient experience, questions need to be valid and reliable. This is challenging, because patient experience cannot be directly measured, it happens within the person. In their review of patient experience measures, Beattie, et.al., (2015) identified a range of scales that were designed for QI, indicating that a few had a good balance of validity, reliability and utility for use where resources are limited (i.e. Quality from the Patients' Perspective Shortened (QPPS) and Patient Experiences with Inpatient Care (I-PAHC)). Validity and reliability of measures can be limited in QI guidance, leading to an illusion of simplicity; driving calls for better use of measures in improvement projects and "quick (not dirty) tests of change" (Reed & Card, 2016).

Many measures are validated to be used as a whole (rather than individual questions) and are better suited to using traditional statistical approaches; an accessible guide is available in Practical Statistics for Nursing and Health Care (Fowler et al., 2021). When the aim is to test smaller changes with more focussed targets, it may be better to use quality process

approaches such as run charts; a comprehensive guide is available in The Healthcare Data Guide (Provost and Murray 2021).

Overview of Feedback Strategies

To support use of patient feedback for improvement, it is valuable to give an overview of strategies and their strengths. Table 1 offers such an overview, drawing from Burt et al. (2017) and Marsh et al. (2019), the strengths and use of each is identified, giving some direction for selecting the best approach for the specific QI initiative.

Quantitative Feedback Strategies	Strength and Use
Surveys / Questionnaires	Validated tools (accurate reliable data) Repeatable Good for measuring or evaluating care provision Large numbers Can be tested
Qualitative strategies	Strength and Use
Patient stories/narratives	Recognising and enhancing excellence
Verbal/written feedback	Identifying problems
Group discussion	Highlighting potential improvement areas
Complaints	Rolling out good practice
Social media	
Third party feedback – family, friends, advocacy services.	

Table 1: Overview of patient feedback strategies (Adapted from: Burt et al., (2017); & Marsh et al., (2019))

Barriers to using patient feedback

The barriers to using patient feedback, include anonymity, confidentiality, and security of the data. Elements like nurses’ confidence, knowledge, and skills, relating to analysing and measuring data, can get in the way of progressing improvements (Gleeson et al., 2016; Wong, et al., 2020), while other barriers relate to services or the patient population. Table 2 summarises these barriers.

Process issues	Barriers (Nurse)	Barriers (Service)	Barriers (Patient)

Concept confusion - patient feedback/patient satisfaction	Lack of Process Knowledge	Reputation of service	Health conditions
Timing/timeliness of seeking feedback	Lack of Confidence	Structures to facilitate feedback	Pre-judgment /pre-conceived ideas Fear of repercussions
Creating accessible feedback mechanisms	Bias/influence Fear of reprisal	Perceived value of informal feedback	Social and cultural norms
Selection of type of feedback (fit for purpose)	Attitudes Uncertainty about effective tools/methods	Mechanisms not in place to support processes	Expectations / accessibility
Lack of measurement	Engagement with feedback Resistance to change	Lack of resources to support processes	Poor previous healthcare experiences
Lack of valid and reliable data gathering methods	Leadership skills	Leadership expertise	Perception of choice
Lack of evaluation of responsiveness validity	Lack of Confidence/Knowledge	Lack of resources/mechanisms to support processes	Attitude, knowledge

Table 2: Process Barriers (Adapted from Bull et al. (2019); & Holt (2018))

While many of the solutions to the presented barriers relate to increased confidence, knowledge and skills, which come through education and practise, other solutions can be

found by identifying the resources required and engaging with people who use services to reassure, explain and create accessible ways for people to feedback. Whichever approach is adopted, patients and families have a vested interest in both the process, for example, how accessible, usable, and meaningful the measurement is; and the outcome potential of the feedback; how it could benefit them or others. Therefore, nurses should actively share outcomes to demonstrate the benefits of people's contribution, ensuring future/continued participation.

Conclusion

Patient care experience feedback is central to understanding, evaluating, and improving the healthcare experience at all levels. This paper offers an overview of strategies nurses can use to gather feedback for QI and identify and avoid potential barriers. Feedback is useful only if the gathered insights are transformed into actions, therefore nurses and other healthcare professionals are required to both make full use of the feedback people provide and ensure that actions taken are clearly communicated. This article offers some guidance on how to identify feedback strategies and potential barriers to help nurses navigate the use of patient feedback in QI.

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