Health services should collect feedback from inpatients at the point of service: opinions from patients and staff in acute and subacute facilities

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Abstract

Objective: Point of service feedback (POSF) enables patients to give health services feedback about their experiences during or immediately after care. Despite the increasing use of POSF, little is known regarding patients’ and staffs’ opinions of this practice and whether they consider it acceptable or useful. The study aimed to determine patient and staff opinions regarding POSF.

Design: A cross-sectional survey.

Setting: Acute and subacute healthcare facilities.

Participants: Two hundred and forty-seven patients and 221 staff.

Results: Participants indicated that patients should be invited to evaluate health services when they are in hospital or subacute care and improving services was the most important reason for doing so. Staff indicated that:

- collecting patients’ feedback during their stay was an important part of providing care and not an interruption to it (n = 187 of 221, 85%).
- collecting patients’ feedback was best done with a variety of methods; talking directly with patients during their stay was the preferred option (n = 161 of 219, 74%).

More patients preferred to:

- give feedback during their stay (51%) than after discharge from care (15%).
- give feedback by talking with someone (45%) than completing a questionnaire (31%).

Some patients (14%) were concerned about reprisal from staff if they gave negative feedback.

Conclusions: POSF can be acceptable and useful for evaluating health services and should be incorporated into a person-centred approach that allows patients to choose from a variety of feedback options both during and after their stay. To be most useful, feedback should be incorporated into a quality improvement system.

Key words: patient participation, healthcare evaluation mechanisms, patient experience, patient satisfaction, point of service
Introduction

Partnering with consumers is central to safe high-quality health care and is a driver of global healthcare reform [1, 2]. Consumers evaluating health services is now common, and point of service feedback (POSF) is popular [3, 4]. POSF enables consumers to give feedback about their experiences either during or immediately after an episode of care, enabling problems to be assessed and addressed as they arise. Methods and technologies used to collect ‘real-time’ consumer feedback have proliferated in the last 10 years and often include paper-based or electronic questionnaires that are distributed to patients by staff or community volunteers.

Despite the increasing use of POSF, patients’ opinions and preferences regarding POSF are largely unknown [5]. To provide person-centred care [6], it is important to understand what patients think and feel about POSF and whether it is considered acceptable to them. Patients might welcome the opportunity to comment on their care experience; alternatively, they might feel POSF intrudes on their privacy or is a distraction from their care. In addition, little is known about staffs’ opinions about POSF and what, if any, feedback methods they consider appropriate to use during a patient’s care experience. Staff acceptance of and engagement with POSF is necessary for data collection and for responding to feedback in a constructive and timely manner.

Preliminary research involving patients and staff in an inpatient rehabilitation centre identified a range of experiences and opinions regarding POSF [5]. Some patients wanted to give feedback during their stay and felt valued when their opinion was sought. Others felt it was inappropriate for patients to evaluate staff and found it stressful to evaluate their care experiences while being an inpatient. Staff were concerned that patients’ feedback might not be accurate, because it could be compromised by the individual’s health and cognitive status, ability to communicate and willingness to give honest answers, including negative feedback about their care. Opinions from a larger, representative sample are still required, despite these important insights about POSF.

The current study aimed to understand staff and patient opinions regarding POSF at acute and subacute inpatient facilities. We sought to determine whether patients and staff consider POSF to be an acceptable method of evaluating health services and their preferred methods of collecting and using feedback.

Methods

Setting

The study was conducted in the acute and subacute inpatient centres of a large regional health service that provides government funded care to a community of ~500 000 people. The 432-bed tertiary acute-care facility provides services across a broad range of specialties with the exception of neurosurgery and organ transplantation. The 100-bed subacute facility provides rehabilitation to people following acute injury, illness or elective surgery. Approximately 1600 acute clinical staff and 250 rehabilitation clinical staff work at the acute and subacute sites, respectively.

POSF was routinely collected at both sites prior to and during the current study using locally designed paper-based or electronic questionnaires. Questionnaires varied according to the site and service and typically had 5 to 10 Likert-style questions that evaluated aspects of patient-centred care with questions such as ‘Did each staff member treat you with respect?’ (an example of a questionnaire is published elsewhere [5]). Community volunteers collected POSF after staff had trained them to collect feedback in a standardized manner that respected each patient’s health status and encouraged honest and constructive answers. Providing POSF was voluntary, and nurse managers excluded patients whom they deemed too unwell. Managers distributed summaries of the feedback to staff according to the communication processes on each unit.

Participants

Inclusion criteria were:

- inpatient of the acute or subacute facility
- over age 18
- able to communicate in English
- not cognitively impaired
- able to provide informed consent and understand the questionnaire
- well enough to complete the questionnaire as determined by each unit nurse manager. Patients who were not present on the ward at the time of data collection were excluded.

Patients could participate irrespective of whether they had previously provided POSF. Two researchers S.D.G., J.R.-H. and two trained research assistants collected patient questionnaire data for the current study. Researchers spent blocks of 1–4 h in each unit and invited all patients who met the inclusion criteria to participate.

The researchers obtained informed consent from patients and asked them to consider the first two questions on the questionnaire and whether they could read and understand the questions. Patients who could not read or understand the questions were excluded from the study. Patients could complete the paper-based questionnaire by themselves or with the researcher’s assistance. The researcher’s presence at data collection enabled patients to clarify the meaning of questions if it was uncertain. The researchers emphasized that there were no right or wrong answers, and that they wanted complete and honest opinions.

All clinical staff in the acute and subacute facilities were eligible to participate. Leaders of each profession, nursing, medicine and allied health were informed about the study and asked to disseminate an invitation to participate to their staff. Invitations were disseminated via email and during staff meetings. Staff could complete a paper or electronic version of the questionnaire.

Questionnaire design and content

The researchers designed the patient and staff questionnaires (see Supplementary Appendix for questionnaires). Previous qualitative research on POSF in the subacute facility informed the design and content of the questionnaire [5]. The questionnaire underwent multiple iterations through repeated consultations with patients and staff so that questions were understood as intended. The questionnaire allowed comments for some closed-ended questions so participants could explain or expand on their responses. When patients made verbal comments, they were transcribed verbatim by the researcher.

Sample size and data collection

Previous research suggested strong support for POSF [5]. We assumed a priori that 80% of staff and patients would answer ‘yes’ to the binomial question ‘Should health services collect feedback from patients who are in hospital (rehabilitation)?’ and determined that 246 patients and 246 staff were required to estimate the proportion to within ±5%.

Data collection occurred between April and December 2014.
Data analysis process
Descriptive analysis was carried out using Microsoft Excel. For the principal patient question ‘Should health services collect feedback from patients who are in hospital (rehabilitation)?’ responses from hospital patients were compared with rehabilitation patients using the χ² test. For the principal staff question, ‘Collecting patients’ feedback during their stay is an important part of providing care, not an interruption to it’ responses from hospital staff were compared with rehabilitation staff using the χ² test. Confidence intervals of proportions were calculated for the primary patient and staff questions to allow inference to population estimates.

Free-text comments were inspected using content analysis to determine and count frequently occurring ideas [7]. Data for each free-text question were examined by S.D.G. and A.J.H. who independently created a list of frequently occurring ideas. S.D.G. and A.J.H. then agreed upon a common list of ideas for each free-text question. The number of times each idea appeared in response to a question was counted.

Ethical considerations
The organisation’s Human Research Ethics Committee approved the study. Participation was voluntary.

Results

Participants
Two hundred and forty-seven patients and 221 staff participated (see Tables 1 and 2 for demographic information). In addition, 13 acute and 17 subacute patients were invited to participate and subsequently declined, typically citing lack of interest in completing questionnaires as the reason.

Patient results
Patients indicated that:

- Patients should be invited to give the health service feedback about the care they receive (n = 239, 97%, 95% CI 95–99%).

Table 1 Patient characteristics

<table>
<thead>
<tr>
<th>n</th>
<th>Age median years (IQR)</th>
<th>Female</th>
<th>Previously completed POSF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute site</td>
<td>111</td>
<td>70 (61–80)</td>
<td>Yes 33 (30%), Unsure 8 (7%)</td>
</tr>
<tr>
<td>Subacute site</td>
<td>136</td>
<td>80 (68–87)</td>
<td>Yes 35 (26%), Unsure 6 (4%)</td>
</tr>
</tbody>
</table>

IQR, inter-quartile range; POSF, point of service feedback.

Table 2 Staff characteristics

<table>
<thead>
<tr>
<th>n</th>
<th>Female</th>
<th>Discipline</th>
<th>Median number of years worked as a health professional (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute site</td>
<td>137</td>
<td>107 (78%)</td>
<td>Allied Health 33 (24%), Allied Health 8 (5–15)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nurse 55 (40%), Nurse 14 (5–21)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Doctor 48 (35%), Doctor 3 (1–6)</td>
<td></td>
</tr>
<tr>
<td>Subacute site</td>
<td>79</td>
<td>64 (81%)</td>
<td>Allied Health 36 (47%), Allied Health 8 (5–16)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nurse 39 (51%), Nurse 10 (5–28)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Doctor 2 (3%), Doctor 23 (21–25)</td>
<td></td>
</tr>
</tbody>
</table>

IQR, inter-quartile range.

*Total number of staff = 221, not all staff answered all demographic questions, proportions were calculated from the number of staff answering the question at each site.

- Health services should collect feedback from inpatients (n = 218, 88%, 95% CI 84–92%). There was no significant difference in the proportion of acute versus subacute patients who thought health services should collect feedback from inpatients (P = 0.07).
- Giving feedback during their stay was preferred (n = 126, 51%) to after discharge from care (n = 36, 15%), though 85 patients (34%) indicated they had no preference.

When giving feedback during their stay, the most popular method was talking with someone (n = 112, 45%), because it enabled two-way communication about the issues raised and the prospect of having their issue resolved (Table 3).

Patients most commonly indicated that they did not mind who collected POSF (n = 112, 45%) though some preferred to give feedback to staff caring for them (n = 63, 26%), managers (n = 41, 17%) or community volunteers (n = 23, 9%). Patients indicated that:

- Would give different feedback depending on who collecting it (n = 73, 30%)
- Would feel uncomfortable giving feedback directly to staff caring for them (n = 61, 25%)
- Preferred to give anonymous feedback (n = 78, 32%)

Patients’ need for anonymity depended on the type of feedback being given. Some patients commented that anonymity was preferred when giving negative comments to avoid embarrassment or reprisal; 34 patients (14%) were concerned about reprisal from staff if they gave negative feedback. Some patients thought providing their name with feedback was useful for resolving issues, because ongoing dialogue could occur with staff over time. One patient described the tension felt between wanting to provide his name to allow follow-up, yet at the same time being concerned about reprisal: ‘I prefer to give my name so that my feedback can be followed up. I also fear being mistreated’. Participants indicated that completing POSF would make them feel valued (n = 145, 59%) (Table 3).

Overall, patients indicated relatively few things they did not like about completing questionnaires during their stay. The most common ‘dislikes’ were that questionnaires in general were confusing (n = 36, 15%), and there were too many questionnaires (n = 35, 14%).

Most patients (76–78%) indicated that clinicians and managers should have access to their feedback. A minority (20–23%) indicated that patients or patients’ families should see their feedback. Some patients thought reviewing feedback was tedious or irrelevant to patients. One patient commented that ‘reviewing feedback’ is not relevant to them [patients]’ and another said ‘I don’t think [patients] care [about reviewing feedback]’. Patients indicated that the most important reason to give feedback was improving services (n = 101, 41%) (Table 3).
Staff results

Staff reported that:

- Patients should be invited to give the health service feedback about the care they receive ($n = 218$ of $221$, 99%, 95% CI 98–100%), and they should have the option of providing feedback during and after their stay ($n = 192$ of $220$, 87%, 95% CI 83–92%).
- Collecting patient feedback during their stay was an important part of providing care, rather than interrupting it ($n = 187$ of $221$, 85%). There was no difference between acute and subacute staff responses ($P = 0.46$).
- Patients want to give feedback during their stay ($n = 157$ of $221$, 71%).
- Patients vary their feedback depending on who collects the information ($n = 169$ of $215$, 79%).
- The most important reason for inviting patients to give feedback is improving services ($n = 139$ of $219$, 63%).

Staff preferred multiple methods of collecting feedback depending on patients’ preferences and capabilities (Table 4). Feedback methods should allow the use of interpreters or staff with advanced communication training such as speech therapists and include questionnaires, comment cards, informal conversation between patients and/or family and staff, and interviews with individuals and groups. One staff member wrote: ‘A range of feedback methods should be available, especially for people who have issues with literacy, speak a language other than English, have a disability, etc.’ Staff reported that the most useful method of obtaining POSF was talking directly with patients ($n = 119$ of $220$, 54%), followed by completing questionnaires ($n = 65$ of $220$, 30%). Staff preferred that community volunteers collected inpatient feedback ($n = 90$ of $218$, 41%) more than managers ($n = 35$ of $218$, 16%) or staff who care for patients ($n = 29$ of $218$, 13%) (Table 4).

Most staff indicated that patient feedback should be available to staff who care for patients ($n = 196$ of $219$, 90%) and managers ($n = 193$ of $219$, 88%). Less than half the staff indicated that feedback should be seen by patients ($n = 93$ of $219$, 42%) or patients’ families ($n = 86$ or $219$, 39%).

Staff indicated relatively few things they did not like about POSF, most commonly:

1. There are too many questionnaires ($n = 46$ of $221$, 21%)
2. They did not think anything would be done with the responses ($n = 34$ of $221$, 15%)
3. Questionnaires do not address the issues that are important to patients ($n = 29$ of $221$, 13%).

Table 3 Patient questionnaire responses to selected questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Response options</th>
<th>Responses, $n$ (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>When giving feedback during your stay, would you prefer to: (select only one option)</td>
<td>Talk with someone</td>
<td>112 (45)</td>
</tr>
<tr>
<td></td>
<td>Complete a questionnaire</td>
<td>77 (31)</td>
</tr>
<tr>
<td></td>
<td>I have no preference</td>
<td>46 (19)</td>
</tr>
<tr>
<td></td>
<td>Place a note in a suggestion box</td>
<td>9 (4)</td>
</tr>
<tr>
<td></td>
<td>Write a letter</td>
<td>3 (1)</td>
</tr>
<tr>
<td>When in hospital, how would completing a questionnaire about your experience make you feel? (select as many options as apply)</td>
<td>Valued</td>
<td>145 (59)</td>
</tr>
<tr>
<td></td>
<td>Stressed</td>
<td>18 (7)</td>
</tr>
<tr>
<td></td>
<td>Empowered</td>
<td>17 (7)</td>
</tr>
<tr>
<td></td>
<td>Intimidated</td>
<td>13 (5)</td>
</tr>
<tr>
<td></td>
<td>Bored</td>
<td>12 (5)</td>
</tr>
<tr>
<td></td>
<td>Harassed</td>
<td>9 (4)</td>
</tr>
<tr>
<td></td>
<td>Embarrassed</td>
<td>7 (3)</td>
</tr>
<tr>
<td>For you, what is the most important reason to give feedback? (select only one option)</td>
<td>Improve services</td>
<td>101 (41)</td>
</tr>
<tr>
<td></td>
<td>Help staff understand the patient’s perspective</td>
<td>68 (28)</td>
</tr>
<tr>
<td></td>
<td>Give patients a chance to voice their opinions</td>
<td>49 (20)</td>
</tr>
<tr>
<td></td>
<td>Let patients know their opinion is valued</td>
<td>23 (9)</td>
</tr>
</tbody>
</table>

Table 4 Staff questionnaire responses to selected questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Response options</th>
<th>Responses, $n$ (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The most useful methods for collecting patient feedback are: (select as many options as apply)</td>
<td>Speaking with individual inpatients</td>
<td>161 (74)</td>
</tr>
<tr>
<td></td>
<td>Inpatient questionnaires</td>
<td>143 (65)</td>
</tr>
<tr>
<td></td>
<td>Post discharge phone calls</td>
<td>111 (51)</td>
</tr>
<tr>
<td></td>
<td>Post discharge questionnaires</td>
<td>107 (49)</td>
</tr>
<tr>
<td></td>
<td>Post discharge group interviews (such as focus groups)</td>
<td>38 (17)</td>
</tr>
<tr>
<td></td>
<td>Inpatient group interviews (such as focus groups)</td>
<td>29 (13)</td>
</tr>
<tr>
<td>The best person to collect patient feedback during the patient’s hospital stay is: (select one option only)</td>
<td>Community volunteers</td>
<td>90 (41)</td>
</tr>
<tr>
<td></td>
<td>Manager</td>
<td>35 (16)</td>
</tr>
<tr>
<td></td>
<td>Staff who care for patients</td>
<td>29 (13)</td>
</tr>
<tr>
<td></td>
<td>It does not matter</td>
<td>30 (14)</td>
</tr>
<tr>
<td></td>
<td>Other*</td>
<td>34 (16)</td>
</tr>
</tbody>
</table>

*Respondents who selected ‘other’ indicated that the collector needed to be independent of patient care to avoid biasing the patient’s answers or increasing clinical staff’s workload.
Staff (n = 41) provided additional comments that expressed concerns about POSF; most (n = 30) thought POSF might not accurately or comprehensively reflect that patient’s experience. For example: ‘patients feel pressure to provide positive feedback and may be concerned their care will suffer if they give negative feedback’ and ‘Can a very ill person have a balanced perspective during a stressful time?’. In addition to concerns about the validity of POSF, seven staff members were concerned that completing POSF could be burdensome or distressing for patients. For example: ‘more questions and strange people approaching the patient, it may be distressing’.

Discussion

Health services in many countries are encouraged or mandated to enable patients to evaluate the services they provide [2, 3, 8, 9]. The current study provides much-needed data to support the use of POSF with hospitalized patients.

Patients indicated that health services should collect POSF, and half of them preferred POSF than providing feedback following discharge from care. Earlier research indicated that patients preferred POSF, because it was more convenient, personal, accurate, constructive and timely than evaluating the service following discharge [5]. Doing it during the care experience, rather than after care might lead to: higher participation rates, more representative samples, and more accurate recall and assessment of experiences. POSF enables issues to be raised and addressed during the care experience, improving current and future patients’ experiences.

Health services are expected to continuously improve system performance and patient outcomes [10]. Quality improvement methods are variously defined, but almost all include a cycle of improvement comprising collecting data, describing/diagnosing problems, designing and implementing solutions and re-evaluating outcomes [11]. For maximum benefit, POSF must be embedded within a quality improvement cycle that facilitates efficient and effective collection and use of feedback [12–14]. Managers, staff, patients and families should have access to feedback and co-design timely and constructive responses [15]. Real-time feedback requires real-time responses for maximum benefits to be achieved.

Patients and staff in our study described a variety of preferences for the way patient feedback is collected. A suite of complementary tools used during and after admission might produce the most accurate and comprehensive evaluation of the patient experience and help overcome the limitations of each individual tool. Talking with someone was the preferred data collection method and has several benefits: it enables two-way communication; it is personable and flexible; and it enables each individual’s issues to be raised, clarified and, where necessary, immediately addressed. Questionnaires can be confusing, might not address issues that are important to patients and are most suitable for those who can read. However, questionnaires have advantages over conversation: standardized questions and response options enable data to be compared among people and over time, and anonymous answers are possible if patients fill out questionnaires independently. Questionnaires might be preferred if the goal is benchmarking and assessing change. Patients who find giving feedback stressful or are uncomfortable giving feedback directly to those caring for them would also benefit from the option of completing an anonymous questionnaire. We must be careful not to overburden patients with too many assessments, as the imperative to collect data increases.

Patients and staff reported that patients vary their feedback according to who collects it. Choosing the data collector requires careful consideration, and the collector’s potential influence on the type of feedback received must be considered when interpreting results. Other researchers found that patient satisfaction with care was lower when community volunteers, not staff, collected feedback [16, 17]. The researchers suggested that patients feel safe with volunteers and can trust them, so are more willing to share their dissatisfaction. Staff consider ‘clinical care’ as their priority [5]; however, when volunteers collect POSF, patients provide information during conversation that is not always captured and passed on to staff [5]. Pragmatically, the person chosen to collect patient feedback depends on the human resources available (e.g. staff with time allocated), the method of collection (e.g. talking with patients versus questionnaire) and the type of information collected and its intended use (e.g. benchmarking versus service improvement). If community volunteers collect POSF, they require appropriate training to enable valid and reliable data collection and to understand how to work in clinical environments in a way that complements staff and services.

Participating with consumers is promoted and idealized as an opportunity to learn, inspire and improve health services [18, 19]; however, it is uncertain whether consumers or professionals want to accept all the responsibilities inherent to partnership [18]. Our data indicate that patients were willing to partner in evaluating health services, but less than a quarter of patients and less than half of staff thought patients or families should see patients’ feedback. The ideals of comprehensive consumer participation are unlikely to be realized unless patients and staff are aware of and accept the rights and responsibilities of full participation that includes patients’ giving feedback and co-designing appropriate responses.

Enthusiasm for POSF should be moderated against its potential negative effects. A small number of patients indicated that POSF could produce stress, intimidation, embarrassment and fear of reprisal. Patients’ distress and concern might be alleviated by not approaching patients for feedback who are already under significant stress, explaining to patients the purpose of POSF and how feedback will be used, providing assurances in word and deed that feedback, particularly negative feedback, will be used constructively, and allowing patients to decline POSF or provide anonymous feedback.

Strengths and limitations of the current study

To the best of our knowledge, the current study is the first quantitative assessment of patient and staff opinions regarding POSF. Patient data should closely reflect the opinions of the target population, because the recruitment strategy sought to invite all eligible patients on each ward and few patients declined. The sample included patients who had previously given POSF so the results include opinions formed through experience. Researchers were present for patient data collection and could clarify the meaning of questions increasing data validity. Because some people feel uncomfortable giving negative feedback, some participants might have withheld negative sentiments about POSF; the current results might overestimate acceptance of POSF. Staff opinions are from three major professional groups: nursing, allied health and medicine. However, the opinions of staff who volunteered for the study might not represent all staff’s opinions. Collecting data from acute and subacute facilities improves the generalizability of the findings; however, the results might not be representative of inpatient services elsewhere. We did not include: children, emergency department staff or patients, non-English-speaking patients, carers, and patients with poor cognition, communication-skills, or health status; the opinions of these people, some of whom are disadvantaged, vulnerable and need a ‘voice’, are important and remain unknown.
Conclusions

The current study provides evidence that POSF can be acceptable and useful for evaluating health services and the patient experience. The best methods for collecting patient feedback depends on the patient, the characteristics of the health service and how the data are used. Many patients preferred giving feedback during their stay, yet a person-centred method for evaluating health services allows patients to choose from a variety of options both during and after their stay. The most accurate and comprehensive patient experience evaluation will include multiple tools at different time points. POSF should be integrated into a quality improvement system to enable constructive responses.

Supplementary material

Supplementary material is available at INTQHC online.

Acknowledgements

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References