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Case Study

Patient Experience Rounds (PER): Real-time feedback to improve the patient experience and quality of care

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Abstract
While patient feedback is critical to improving the patient experience and clinical care, we are currently limited in our ability to collect feedback in real-time from hospitalized patients. This paper describes our experience and outcomes implementing Patient Experience Rounds (PER). Our model uses trained former patients or family members as volunteers to collect feedback in real-time. Through this feedback, we were able to identify areas for improvement, make adjustments in the moment, and provide targeted feedback to providers. A total of 321 patient encounters were recorded by eight PER advisors. Nursing staff received the highest percentage of positive comments. 49% of patients offered a special mention to recognize a staff member. 33% of patients offered a comment in response to the question, "What is one thing that would improve your experience." In 16% of encounters, the advisor identified an issue or concern that required near-term follow up. This work has the potential to improve the patient experience and may be beneficial to hospitals seeking novel methods for rapidly improving the patient experience.

Keywords
Feedback, patient experience, patient engagement, quality improvement, high value care

Introduction

Feedback from patients is critical to improving hospital care, however current approaches to assess the patient experience are limited. The HCAHPS survey is one of the most ubiquitous and standardized methods of collecting patient feedback, but it is limited in several ways. Responses are anonymous and collected weeks after a hospitalization; therefore, they cannot be used to address concerns in real time to improve the patient experience and may be limited by recall bias. The survey also only captures data from a select number of patients who respond to the survey. It is not linked to individual providers and, therefore, cannot be used to provide targeted feedback.[1]

Moreover, collecting and responding to feedback in real-time has important implications for the patient experience.[2,3] Hospitalized patients and their family members often feel vulnerable, confused, and do not have an objective, third party to whom they can communicate their concerns. When patients are unable to express their needs in real time or our responsiveness falls short, we risk causing preventable harm and putting our patients' dignity, respect, and ability to heal at risk. Low satisfaction scores or "after the fact" complaints are only captured in the post-hospitalization survey, impairing our ability to address shortfalls as they occur. Additionally, a venue for providing feedback while a patient is hospitalized creates an opportunity for patient support, which is an unmet need for many hospitalized patients.[4] Furthermore, there is data to suggest that patients' perceptions of care are in fact related to objective measures of hospital quality, suggesting that improving these perceptions may improve the measures that have implications for hospital reimbursement.[5,6]

Collecting and responding to feedback in *real-time* may overcome some of these problems, however, also presents a unique set of challenges. Most hospitals do not have a systematic method for collecting feedback during a hospitalization. Patients may be reluctant to provide negative feedback directly to their care providers or hospital employees due to fear of retribution. Using hospital providers to elicit feedback and respond appropriately is limited due to lack of training, time, and resources. Additionally, a provider's ability to understand the patient's perspective is approached through the lenses of medical training and experience and, therefore, may limit their ability to offer the full spectrum of support needed for patients while in the hospital.

To address some of these issues and limitations, we developed the Patient Experience Rounds (PER) program

to collect and respond to real-time feedback using trained patient advisors. In this paper, we describe its development, characterize the types of feedback and show preliminary data on how we responded to patient concerns emanating from this feedback.

Methods

We developed our model for PER by first examining similar models at three institutions: Dartmouth-Hitchcock, Vidant Medical Center, and University of Massachusetts Memorial in spring of 2015. At the time of the interviews, these were the only programs identified through an internet search that were implementing a similar program. Our model for advisor rounds was informed by interviews with key stakeholders (generally leaders in patient experience within the medical center) and site visits. The purpose was to better understand several key components: who conducted the rounds, logistics (where, when, how), and what patient experience outcomes were measured. Using this information, we developed a model for rounding at our institution, outlined in the following paragraphs.

We recruited patient/family advisors from the hospital's Patient and Family Engagement program. Advisors are volunteers who partner with us on advisory councils, committees, focus groups, and projects to ensure that the needs and preferences of patients and families are the most important considerations when we are making changes. After developing a curriculum, a series of training sessions were held to teach and enhance advisors' skills related to interviewing, active listening, understanding and protecting confidentiality, handling personal questions about the advisors own history and circumstance, dealing with positive and negative feedback and escalating concerns. In addition to the training sessions, advisors were provided with debriefing sessions after their initial experiences to troubleshoot problems and support each other throughout the process. For the first several months of the program, a member of the social work/patient engagement team was on location and available to advisors for the entirety of the visits to answer any questions or help problem solve any patient concerns which surfaced during the interactions.

Advisors rounded on patients between one and three times per month, for approximately two hours each time, from November 2016 to September 2018. Rounds occurred on three inpatient units: general medicine, cardiology and cardiothoracic surgery; these units were chosen because of nursing director interest and engagement. At the start of each session, nurse supervisors selected which patients were appropriate for rounds, excluding patients with altered mental status (delirium, psychosis), those who were off the floor for a procedure or treatment, patients experiencing a great deal of pain and discomfort, patients unable to communicate in English, or those who were on precautions. Advisors would then see as many patients as possible during their allotted time period, with the number of patients seen on any given shift varying depending on the amount of time spent with each patient. Advisors asked open ended questions in several pre-specified categories including: physician care, nursing care, responsiveness, communication, care transitions, care experience, environment, and food (see Appendix A for interview guide). Advisors were also asked to indicate if the patient's overall experience in each category was positive or negative based on their conversation with the patient. Given the free-form nature of the conversations, not all questions were addressed in every conversation and, therefore, responses were left blank if not addressed. Patients were also asked to specify one change that would improve the hospital experience and were given the opportunity to provide recognition to individual staff members. Results were documented during or after the encounter using an electronic form on an iPad, which was provided to all advisors. Any immediate patient concerns were relayed to the nursing leadership on the floor. At the end of each month, de-identified responses were also relayed to nursing directors on the floors as well as a physician leader on the project team. These leaders were responsible for collating data and relaying feedback to physicians and nurses.

This study was approved by the BIDMC IRB as exempt.

Results

A total of 321 patient encounters were recorded by eight advisors. The patients rated their experiences as generally positive or negative in seven categories: physicians, nurses, responsiveness, communication, care transitions, environment, and food. Some patients chose to respond that they had both positive and negative impressions within a category (hereafter denoted as "mixed"). If this was the case, the advisor listed both responses. Table 1 shows the number of positive, negative, or mixed responses in each category. Representative comments for each category are listed. The majority of patients reported a positive experience. The nursing staff received the highest percentage of positive comments, with patients citing advocacy, communication, and respect as outstanding qualities. The food and care transitions categories garnered the lowest percentage of positive comments. 49% of patients offered a special mention to recognize a staff member. 33% of patients offered a comment in response to the question, "What is one thing that would improve your experience." In 16% of encounters, the advisor identified an issue or concern that required near-term follow up. The most common issues that required follow up included requests to involve additional consultants in care (e.g., social work), requests for clarification of the care plan or improved

communication, treatment of pain or other medical needs, repositioning, and requests for food, drink, linens or other equipment for the hospital room.

Discussion

To address the problem of obtaining real time feedback, we instituted the PER model. In implementing this program, we found that training non-medical volunteers to collect feedback is feasible and valuable. Advisors participating in this program collected feedback in seven different categories and assisted in responding to a variety of common patient concerns in real time. Anecdotally, advisors found the work to be satisfying overall, and floor staff generally reported that the advisor role was useful in relaying patient concerns in real time.

Our study provided three major insights. First, the majority of patients reported a positive experience overall, highlighting nurses, doctors, and environment as strengths of our hospital. Second, the majority of negative feedback was related to food service and transitions in care. Third, an unexpected benefit of the rounding was that it provided an opportunity to recognize staff for outstanding work. Whenever a patient named an individual and provided feedback, we shared that feedback (with the patient's permission) with the leadership on the unit. Both

Table 1. Summary of feedback received from advisor rounding

Category	N	Response type			Themes	Sample quotes
		Positive	Negative	Mixed		
Physicians	286	89%	5%	6%	-bedside presence -clarity of plan/goals, communication -patient inclusion in discussions -respect and dignity	"[I] wished that they could have taken the time to answer [my] questions and explain things to [me]"
Nurses	293	97%	1%	2%	-communication -advocacy -attentiveness -respect	"Appreciative of the dignity with which the nurse and PCT explained to [me] what they were doing"
Responsiveness	271	84%	9%	7%	-call bell response time -slow response to toileting requests leads to shame/embarrassment -how requests are answered is often as important as how quickly the response is	"If they had just told [me] that they were busy, it would have been better than just repeating 'we'll be there'"
Communication	255	82%	12%	6%	-white board communication is appreciated -delayed communication on testing results, procedure and discharge timing -communication can be fragmented between patient and care team as well as between providers	"waiting for hours without being offered an explanation makes you feel ignored and not cared for"
Care Transitions	191	81%	15%	4%	-long ED wait times -discharge planning is a period of high stress	"[I] have anxiety about discharge. [I] feel [I have] asked many different people if [I] will return to rehab after discharge, all of whom do not know"
Environment	224	87%	9%	4%	-noise level -frequency of cleanings -privacy -tv programming	"There is a lot of ambient noise throughout the entire day"
Food	239	67%	22%	12%	-food quality -waiting times -dietary restrictions unclear to patient or staff -missing or incorrect items delivered	"[I] had to wait 3 hours for breakfast on a morning when [I] was very hungry, had to call multiple times"

employees and floor leaders anecdotally found that this feedback enhanced staff engagement.

Our work further strengthens the body of literature supporting the value of patient feedback and peer-to-peer support. Unpublished verbal reports from similar programs at other institutions have suggested that using former patients and/or their family members to collect real time feedback is helpful to better understand and improve the patient experience. These institutions report that advisor rounding has been overwhelmingly embraced by unit staff members, who note vast improvements in identifying and efficiently addressing patients' concerns, boosts in staff morale and recognition, and practice changes that were a direct result of advisor rounding. Similarly we found that the information gained from these rounds can be used to recognize staff, guide improvement efforts and allow change to be implemented in real time. To our knowledge, we are the first to categorize the feedback received and document specific interventions that resulted from the feedback.

There are several limitations to this study. Our exclusion criteria, which were logistically necessary to conduct the study, may have skewed the results towards a more favorable impression. This same effect may also skew the HCAPS survey, but this is impossible to know. The data collection tool was completed by volunteer advisors rather than researchers and was thus less structured in format. To facilitate open communication, advisors did not necessarily ask about all domains, so some categories may be underrepresented. Finally, although advisors were introduced as volunteers, it is possible that they were perceived as employees who were part of the care team; this may have resulted in under-reporting of negative feedback.

The advisor rounding model is an important tool for collecting data and implementing change in real time. This work informs the national conversation on patient experience and may be beneficial to hospitals interested in improving the patient experience. A research agenda to further advance this work would include documentation the impact of this program on patient experience metrics, staff satisfaction and quality outcomes, including the HCHAPs survey. Additionally, further stratifying the results to understand which interventions would result in the highest impact for the lowest cost could help to focus improvement efforts. Finally, while several anecdotal comments suggest that patients value the program for the peer support it provides, further investigation is needed to better understand the supportive role that the advisors play in this role.

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Appendix A

Interview Guide

Date:		Advisor Name:
Unit:		Room/Bed:
Is there an issue that needs follow up?	○ No ○ Yes Please Describe:	
"Special Mentions" (complements)?		
Topic	Positive, Negative, or both?	Notes (use patient/family members words if possible):
Physicians	○ Positive ○ Negative	
Nurse	○ Positive ○ Negative	
Responsiveness	○ Positive ○ Negative	
Communication	○ Positive ○ Negative	
Care Transitions	○ Positive ○ Negative	
Environment	○ Positive ○ Negative	
Food	○ Positive ○ Negative	
What is one thing that would improve your experience?		