Measuring the quality of care: using patient experience trackers in a neonatal unit

Assessing patient experiences is now a vital part of ensuring quality care. One trust used electronic devices to track relatives’ experiences of the care they received.

AUTHORS
Johnette Brown, MSc, RN, is neonatal sister, neonatal unit, Homerton University Hospital Trust, London; Narendra Aladangady, PhD, FRCPCH, is consultant neonatologist and honorary senior lecturer in child health, Homerton University Hospital Foundation Trust and Barts and The London School of Medicine and Dentistry.

ABSTRACT

Measuring patient experience is a crucial part of improving care. This article describes how a neonatal unit used patient experience trackers to measure and record relatives’ views on whether their needs were met. It outlines how the survey was undertaken, the obstacles encountered, and how the process could be improved.

INTRODUCTION
There is growing interest in patient satisfaction as an indicator of healthcare outcome and quality of care. The NHS next stage review stated that quality would be judged using a range of measures including patient reported experience measures (PREMs) together with patient reported outcome measures (PROMs) (Department of Health, 2008).

The DH (2009) guidance made it clear that collecting and understanding patient satisfaction data and using it to improve care is a mark of best practice.

The neonatal unit
The neonatal unit at Homerton University Hospital in London is a typical example of a multidisciplinary teamwork setting. We deal with babies who are extremely sick and often unstable. Our patients include babies born prematurely from 23 weeks’ gestation (17 weeks early), weighing as little as 500g, who require full intensive care followed by prolonged periods of high dependency and special care. Some babies born at full term in poor health also require intensive care. This can be an extremely shocking and upsetting time for parents as they are unprepared for this situation unlike parents of premature babies.

The unit also provides full palliative care support to babies and their families after withholding or withdrawing life sustaining treatment in the best interests of a baby. The decision to withhold or withdraw treatment must be made with parents’ agreement (Nuffield Council on Bioethics, 2006; Royal College of Paediatrics and Child Health, 2004).

Babies can be admitted to the unit for a few hours for observations, or for several days for minor treatment, such as nasogastric tube feeding, intravenous antibiotics or continuous positive airway pressuresupport. Medium to long term treatment may require them to stay in hospital for several weeks and sometimes months. As part of our commitment to improving care for both babies and their families, we were interested in new ways of assessing and evaluating their experience.

PATIENT EXPERIENCE TRACKER
The Dr Foster patient experience tracker (PET) device is a small wireless electronic handset used to gather information from patients (Dr Foster Intelligence, 2008). The PET survey is both a quality improvement and performance management tool and can be used to promote good practice by encouraging patients and relatives to be more actively engaged in healthcare delivery.

The PET device enables people to express their views on the service they receive. This data provides feedback in order to identify potential improvements and review progress. The feedback, in the form of graphs and pie charts, is sent to all departmental clinical and non-clinical staff via email fortnightly. It is displayed on posters that are updated every month, giving the headline messages and scores.

The neonatal unit survey
The trust was already carrying out a PET survey in other wards when we decided to introduce it in the neonatal unit. We approached the trust PET lead, whose team gave us full support to start the project in September 2007.

A neonatal consultant, neonatal sister and the unit’s operational manager were involved at the start. We discussed the project with the senior nursing and medical teams, and then with junior nursing and medical staff, as well as other members of the
multidisciplinary team. The neonatal staff unanimously agreed to adopt the PET survey, which was also approved by the PET lead and corporate team.

Preparing questions
We prepared the first draft of questions before consulting with senior staff, and then prepared a second draft after consultation. We decided to have five similar questions in line with the rest of the hospital. The final draft was decided after consultation with all staff (Fig 1).

Positioning the PET device
Parents and relatives were informed about the PET device and survey by neonatal unit staff as well as through the use of signs and poster displays.

However, we did not anticipate the difficulties involved in positioning the device in the unit. Initially it was placed in the parents’ waiting room but uptake and entry was minimal, often with reports that no data was reaching the PET office or that the device was disabled.

We discovered it was sometimes switched off – on one occasion it was unplugged – or used for putting visitors’ coats on. We felt this might be happening because parents were unaware of its intended use. Members of staff were asked to tell parents about the device and how to use it, but this did not improve uptake.

The device was then placed in front of the nursing desk, where staff frequently gather, but uptake dropped further. We were concerned that parents might feel self-conscious about answering questions in front of staff, so we moved the device further down the corridor. Initially this appeared to work, but quickly we were informed that data was not reaching the PET office. We discovered the device was not working due to an electrical fault.

After it was repaired, we decided that the only place that was safe and could ensure parents’ privacy was the waiting room. An information poster was placed near the device with a caption “Help us to get better.” This marginally improved the survey device with a caption “help us to get better”.

CONCLUSION
Frontline staff can improve patients’ and relatives’ experiences by understanding how people cope with stress. This can only be achieved by actively listening to their experiences and acting promptly on both positive and negative aspects to ensure appropriate care.

It is essential that all staff take responsibility and ownership of patient experience surveys to achieve overall success. However, good uptake and accurate responses depend on the clarity of information provided to patients and relatives. The questions should be appropriate to each department; generic questions can “muddy” the issues and confuse clients.

Staff should not feel defensive about the findings but should be prepared to respond to them to improve patient satisfaction and, therefore, patient care.

REFERENCES