Keywords Feedback/Change/Ward team/Charge nurse/Nurse managers

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In this article...

- Importance of listening to patient feedback to improve care
- Stages of the patient feedback response framework
- Examples of successful and failed changes on three hospital wards

How can we use patient feedback more effectively to improve care?

Key points

Patient feedback is widely collected, but much less often acted upon

A study has examined how ward teams use patient feedback to change practice

Change requires a willingness to act, autonomy and organisational readiness

Ward sisters/charge nurses and senior nursing teams have a key role to play in making change happen

If it is listened to and used wisely, patient feedback can be a powerful tool

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Abstract Patient feedback is an important source of information that should help staff implement changes that will improve care quality and patient safety. A recent study exploring why staff might find it difficult to use patient feedback constructively found there are a number of prerequisites to effective and lasting change. Achieving such change requires: a willingness to act; staff at ward level having autonomy, ownership of the problem and resources to act; and the organisation being ready and able to support change. This article discusses findings from the study and gives examples of successful and unsuccessful change. It not only highlights what is needed at ward level to make change happen, but also illustrates the need for corporate nursing and senior management to get involved and facilitate change.

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Patient feedback is a valuable source of information and should be used to improve the quality and safety of the care we deliver, but do nurses use it to make improvements in service areas? If not, what are the barriers that are stopping us from doing so? This article highlights what is needed – but also often lacking – to make lasting change that is based on patient feedback, as found by Sheard et al's (2017) study.

Collecting feedback is not enough

After the publication of the Francis report (2013) in the wake of care failings at Mid Staffordshire Foundation Trust, organisations delivering healthcare could no longer afford to prioritise meeting targets and cutting costs over the needs of patients (National Advisory Group on the Safety of Patients in England, 2013). The publication of *The NHS Constitution for England* (Department of Health, 2015) and the pledge to put the patient "at the heart of everything the NHS does" have led to a proliferation of methods and tools to help patients give feedback about their healthcare experiences (Coulter et al, 2009).

This does not mean patient experience questionnaires are new – the national inpatient survey has been running since 2002 and the Friends and Family Test since 2013. However, the questions we need to ask are:

- What do we do with all the feedback we receive from our patients?
- Why is it so hard for the feedback to be acted on?

In the 2015/16 NHS staff survey (NHS Survey Coordination Centre, 2016), 62% of respondents from acute trusts believed that service user feedback was collected in their department, but only 14% strongly agreed that it was used to inform decisions within the department or directorate. Have we become focused mainly on collecting and measuring feedback and

Table 1. **Stages of the Patient Feedback Response Framework**

Stage	Leading to action	Leading to no action
Normative legitimacy	Team actively listens to patient feedback and want to make changes	Team do not value or are not interested in patient feedback; they see no need to change
Structural legitimacy	Team have ownership of the problem and have the autonomy and resources to make changes	Lack of ownership or understanding of the problem. This can be due, for example, to lack of leadership, low morale within the team or poor staffing
Organisational readiness	There is support from the organisation to make changes. This may be from a matron or service manager, from corporate nursing or even from the trust's board, or may require interdepartmental working	There is no commitment from the organisation to make the required changes. Reasons for this can include bureaucracy and inflexibility, as well as a lack of resources and unwillingness from outside the team

Source: Adapted from Sheard et al (2017)

performance, rather than on using the data to make positive changes for our patients (Coulter et al, 2014)?

According to the NHS Confederation (2010), in some trusts, there have been "unspoken but widely held beliefs" that providing good patient experiences is "nice but not necessary" or "nice but too expensive". However, if we are merely measuring and monitoring, how can we be working within the NHS constitution's promise that "NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers" (DH, 2015)?

Patient Feedback Response Framework

Sheard et al (2017) examined how ward teams use patient feedback to influence change in their clinical areas. Their work was part of a large clinical trial of a complex intervention conducted in 33 wards across three trusts in the North of England (Lawton et al, 2017).

Patients completed an 'experience of safety' questionnaire and reported safety concerns, which were then fed back to ward teams so they could make changes based directly on those concerns. There were two phases in this cyclical process (undertaken six months apart) and patient feedback was given to 17 wards in the intervention arm of the trial.

Using staff interviews and observing how the ward teams used and acted on the feedback, Sheard et al (2017) developed a conceptual framework – the Patient Feedback Response Framework (PFRF) – to explore why staff might find it difficult to respond to patient feedback. The framework comprises three stages of action that are required to make effective and lasting change:

- A willingness to act to address an issue (normative legitimacy);
- The necessary autonomy, ownership of the problem and resources to be able to act (structural legitimacy);
- The organisation being ready and able to support change (organisational readiness).

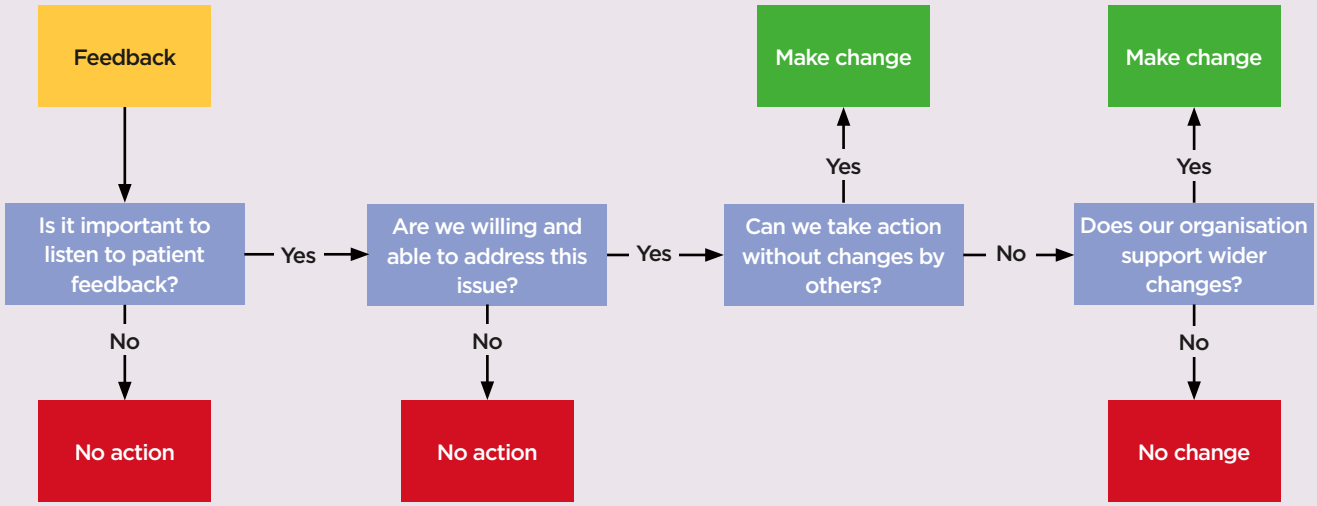
These concepts are detailed further in Table 1 and illustrated as a simple flowchart in Fig 1.

Normative legitimacy

Among the 17 wards in their study, Sheard et al (2017) identified that, during the two phases of feedback and action planning:

- The willingness to address an issue (normative legitimacy) was part of the culture in 11 ward teams – however, in two of these, the focus was on managing patients' expectations rather than looking at making any changes that would address the underlying issues that had been raised;
- Of the six remaining ward teams, two had developed an understanding and

Fig 1. **Patient Feedback Response Framework process flowchart**



Source: Adapted by Munro (2017) from Sheard et al (2017)

Box 1. **Successful change: examples**

- One ward team extended their visiting hours to prevent a rush of relatives all requesting information at the same time. The visiting hours had previously been 2-4pm and 6-8pm, as in most of the hospital, but were changed to 2-8pm. Staff involved in the action plan considered it "radical", as it was a major change to the ward's structural processes. However, the action planning group had the necessary autonomy and ownership, and very little resources were required to make this change happen
- On one ward, patients had reported frustration at receiving conflicting information about the discharge process. The ward team decided to modify the role of the discharge nurse so each patient would be given dedicated time to discuss discharge and, most importantly, be kept informed if their discharge was going to be delayed
- On one ward, five patients had reported to researchers over a three-week data collection period that they had waited a long time for staff to answer their call buzzer (Lawton et al, 2017). This had often happened at night and had resulted in patients becoming incontinent because staff were not available to help them with toileting. The ward manager wanted an extra qualified nurse for three nights a week to address the staffing problems and the team made an action plan to achieve this. The ward manager reported the patients' concerns to the corporate nursing department (via an electronic system that records patient safety incidents) and escalated them to the hospital board. Senior management responded and authorised the ward manager to go over budget to ensure there were three qualified nurses on the ward every night.

Source: Adapted from Sheard et al (2017)

had begun to appreciate the importance of acting on patient feedback by the second phase of action planning;
- The remaining four ward teams (of the six previously mentioned) were not interested in patient feedback – they dismissed it and displayed some hostility towards both the researchers and their data.

This behaviour is not unusual. Reeves et al (2013) cited examples of nurses deciding that feedback from the NHS survey at hospital level was not relevant to them because "that never happens on my ward".

Lessons can be learnt from *The Report of the Morecombe Bay Investigation* (Kirkup, 2015), which shows that midwifery staff repeatedly denied that there were problems and rejected criticism from patients. At a time of pressure on the nursing workforce, it is positive to see that the majority of ward teams in Sheard et al's study did have normative legitimacy – they wanted to listen to their patients.

Structural legitimacy

Sheard et al (2017) identified that eight out of the 11 ward teams with normative legitimacy also possessed some degree of structural legitimacy; four of these eight teams chose to make changes where they had the autonomy and resources to do so successfully. For example, one team decided to modify the role of the discharge nurse to stop patients being given conflicting information about their discharge. However, some of the plans were stalled because ownership, autonomy and/or resources were lacking. As an example, three teams made action plans to implement new initiatives and gave the task to a particular staff member, who then either left the ward or went on long-term sick leave or maternity leave; the task was not delegated to someone else – usually because there was no one who had the capacity to attend to it. Ward staff lacked collective ownership of the problem and the resources to carry out their action plans.

Another example shows that a lack of autonomy can delay change. One of the ward teams developed a patient information leaflet that they could not use until the hospital reading panel had approved it. That panel did not meet regularly, so the leaflet still had not been implemented six months after being written. This team did not have the autonomy to roll out the leaflet on their ward until it had been approved by someone else.

Nurses at all levels will know examples of changes that have been stalled. Would these changes have been successful if nurses had been given support by senior members of the trust's nursing team? In 2009, the Royal College of Nursing identified the role of ward sister or charge nurse as key to the delivery of high-quality, safe patient care and positive patient experience. Sheard et al's study raises questions about the authority of these roles to actually "manage the ward and staff" (RCN, 2009). It shows that, although it is the ward sister/charge nurse who is accountable and responsible for standards and delivery of patient care, they do not always control the resources to manage that care. In some cases, signatures and/or approval from staff with more seniority are required even for minor changes in the ward sister/charge nurse's service area.

During the study, the researchers noticed a higher-than-anticipated level of ward staff movement. They described this as "staff flux" and observed that it often led to ward teams focusing on care delivery until stability returned, which delayed the completion of any action plan. From the perspective of a ward sister/charge nurse, resources to act also include having:

- A stable team;
- Time to meet to discuss patient feedback and plan actions to be taken.

The first two examples of successful change described in Box 1 illustrate this; interestingly, neither of these had cost implications.

Organisational readiness

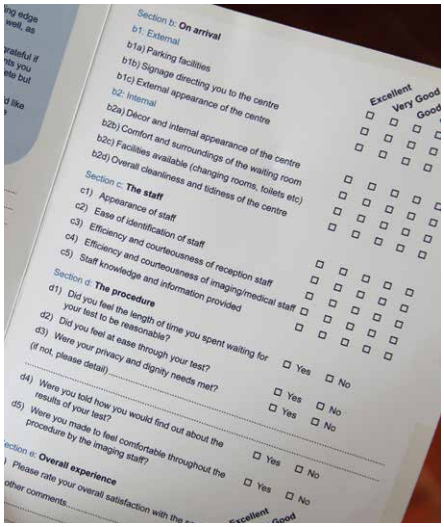
The third stage of the PFRF highlights two types of organisational support required if the ward team does not have the autonomy and resources to act:

- Interdepartmental working;
- Senior hospital manager/board-level support.

Box 2. **Failed or stalled changes: examples**

- One ward team needed assistance from the pharmacy department to change procedures around dispensing controlled drugs, but the pharmacy department was not willing to help
- One ward team found that a leaflet they had written had been awaiting approval from the hospital's reading panel for several months; six months after having been written, the leaflet had still not been implemented
- One ward team wanted to improve communication with theatre staff, but theatre management was not interested in helping them achieve that change

Adapted from Sheard et al (2017)



As well as being collected, patient feedback also needs to be acted on

The examples of failed or stalled changes in Box 2 show a lack of organisational support, both at interdepartmental and at trust committee level.

In the third example of successful change (Box 1), concerning low staff levels at night, because the ward sister lacked the financial resources to employ more staff, she used the patient feedback in a different way and highlighted the staffing issues to the corporate nursing team and senior management. She gained organisational support and was given approval to overspend on staffing, which supported the team to deliver safe care at all times. The ward sister was able to retain responsibility for care that is inherent in the role.

The evidence about low staffing on the night shift had been given by patients and was used to support a request for safe staffing made in a structured report, which is much more difficult to ignore than constant complaints from teams. This also demonstrates the need to keep collecting patient feedback after changes have been made – in this way, it is possible to demonstrate whether those changes have made a difference.

In large-scale projects such as The Productive Ward (Morrow et al, 2012), organisational support from board level down is a key to success. In that instance, both kinds of organisational support were available where needed. One of the drivers for organisational support for The Productive Ward was that the change could be measured and outcomes seen from an early stage. This is worth remembering when seeking organisational support.

In this final stage of the PFRF, corporate nurses/matrons have the power to support teams to make meaningful change for patients. Would the third example of unsuccessful change (Box 2), in which ward staff wanted to improve communications with theatre, have failed if the senior nursing team in both areas had facilitated the initial communication?

It is important that change is planned with staff at team/ward level rather than imposed on them (Morrow et al, 2012). Although some support may be required, it must be given with care and consideration.

> *"How can we, as nurses, ensure that organisations support our initiatives?"*

Conclusion

To be able to make meaningful and lasting change as a result of patient feedback, we need to focus on the role of the ward sister/charge nurse and senior nursing team, as well as on the relationship between them. Sheard et al (2017) have illustrated that organisational readiness is vital to enable change to happen and is often the missing link that leads to failed change and unsuccessful innovation.

How can we, as nurses, ensure that organisations support our initiatives? For patients to be truly listened to, the PFRF should not only apply to teams at a ward level but also be adopted by nurses at corporate level. Corporate nursing teams within organisations need to have the capacity to respond to ward teams' requests for changes that will improve patient care. If the culture at a senior level is such that there is no interest in enabling improvement at ward level, we can only ever expect small-scale changes to happen. Box 3 summarises the key factors that must be in place for change to be implemented successfully in response to patient feedback.

Nurse leaders are key to engaging staff across all disciplines and areas of care to work together to support positive change based on patient feedback. Patient feedback can be a powerful tool, if we all listen to it and then use it wisely. **NT**

● Sheard et al's (2017) report is available in full at: Bit.ly/SheardPFRF

Box 3. **Key factors for successful change in response to patient feedback**

- Ward teams need to want to change
- Ward teams need to actively listen to patients
- Ward teams need to have ownership, autonomy and resources
- Ward sisters/charge nurses need to have the authority to enact changes
- Nurses leaders need to empower teams and provide organisational support as and when required

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