Patient Experience Reporting System

District Wide Report

For the period April 1, 2012 to March 31, 2013

February 2014

Capital Health

A different today. A better tomorrow.

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Introduction

As a new category of the Patient Safety Reporting System (PSRS), the Patient Experience Reporting System (PERS) was launched on November 1, 2011. This system allows the Patient Representative Service to record and track patient and family concerns and compliments about their health care experience with Capital Health. The data compiled in PERS is information gathered from direct reports of people who have experienced care in our midst. Their feedback provides opportunity for review, partnership and quality improvement.

The system allows all Capital Health staff to enter concerns and compliments. PERS provides real time reporting to administrative, clinical and physician leads who are linked to the system so that at any time, data on patient experience in their individual service areas can be accessed and used as evidence for quality improvement.

This report from the Patient Representative Service represents a district wide summary and analysis of PERS data from April 1, 2012 to March 31, 2013. The summative data of the 2012/2013 fiscal year provides Capital Health with opportunities for a comparative snapshot of the various service locations. A previous report was prepared on the first three months after the initial launch of PERS from 2011/2012. Some annual comparative measures are available but the 2011/2012 data sets only capture the last five months of the fiscal year.

This report highlights the quantitative data collected from across the district and evaluates trends in location, time, and severity. Additionally, a qualitative analysis from samples of the case records highlights several key trends including themes about communication, customer service, mental health, and staff empathy.

Methodology

Quantitative

The quantitative data analysis component in this report includes all 1875 cases reported from April 1, 2012 to March 31, 2013, representing Capital Health's fiscal year. Using a statistical analysis program embedded in the PERS online system in combination with statistical summaries created by manipulating the data sets, this report provides insight into the trends around the total number of incidents reported, reports by location, reports by type, and reports by level of severity.

Because PERS has only been in use since November 2011, only a portion of the data from the fiscal 2012/2013 was able to be used as a means of an annual comparison and analysis. Moving forward, the data set will be enriched every year and a better long-term analysis will be much more relevant and feasible.

Qualitative

The qualitative data analysis component in this report was conducted using a recursive abstraction technique. This qualitative analysis method involves coding the sample cases into

summary categories based on identified themes in each case. As the cases are themed, they are progressively broken down into broader summaries until general themes emerge. For this analysis, 100 reports were selected at random to represent the entire data set. These 100 reports were randomly selected using a ratio that accurately represents the entire data set in terms of the proportion of both the level of severity and location.

Each case report in PERS includes information on the initial complaint/comment by the patient or caregiver, response and comments about the event from the staff and physicians accountable, and the steps and communications processes that ensued in the resolution process. This information is the qualitative data used in the analysis. In recursive abstraction, the qualitative data sets are summarized and themed which ultimately illustrates any trends and common elements between the reported cases.

Notes on Data

Approximately six months into the 2012/2013 fiscal year, a change in the interpretation of the levels of severity occurred.

Initially, the impact level recorded by PERS was dictated by the patient's expressed level of concern such that one patient may experience an event at level 1 (little impact) while another patient might experience the same event at level 5 (higher impact). It was felt that this method of classifying concerns represented the patient's unfiltered perception of the experience and provided important data for consideration.

This method of classifying complaints likely caused an increase in the number of cases reported at a higher severity (Levels 5-6-7-8) and a lesser number of cases reported at lower severity (Near Miss, Levels 1-2-3-4), until the point of adjustment. This method also caused disconnect with the manner in which the same impact scale is applied to other quality measures in the organization.

Adjustment was made to align the method of classification with other quality measures in the organization and to allow for consistent interpretation of the types and levels of concerns.

This Service continues to believe in the importance of reporting the unfiltered patient experience and will endeavour to develop a method of reporting this alongside the current method.

It is positive and exciting to note that some services enter their own data around compliments or concerns obtained by way of a "comments box" or other manner in their service area. In this way, some areas appear to have higher numbers in relation to other areas. We want to highlight that this is an excellent way to record data for quality review. In particular, these areas capture concerns that have been resolved without patient representative involvement and have the option of entering the myriad of compliments received at the unit level and thus, providing for a balanced look at what works well and what needs improvement.

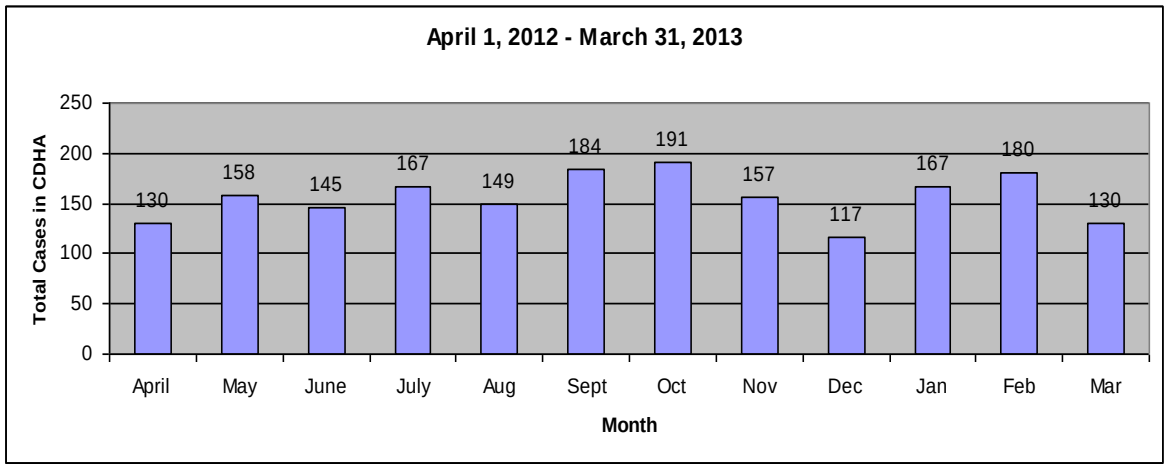
Statistical Analysis

The statistical analysis of PERS includes every report submitted between April 1, 2012 and March 31, 2013. The following data sets and tables will give insight into the distribution of reported cases among the various sites at Capital Health, the classifications of patient experience impact, and a look at the distribution in an annual, monthly basis in comparison to the PERS' inaugural year.

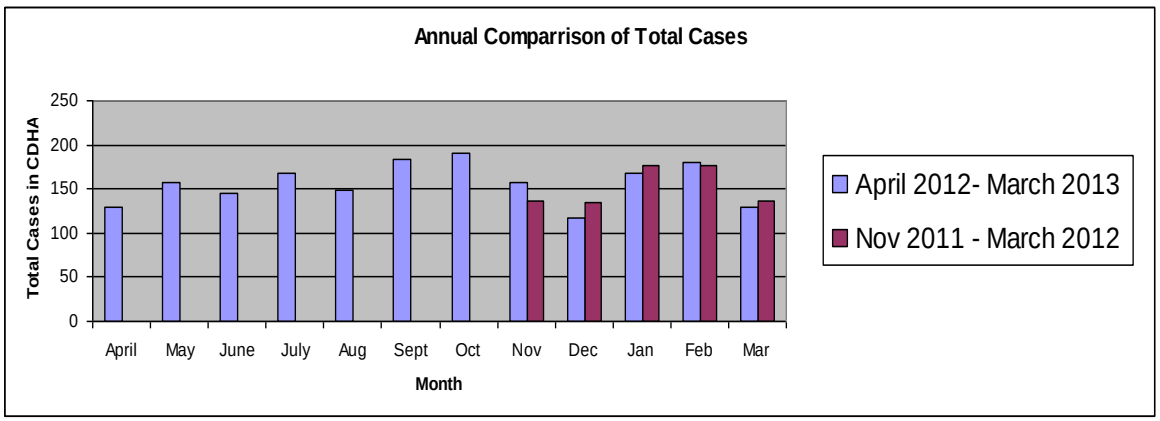
Total Number of Incidents Reported

The total number of incidents reported in all of Capital Health for the 2012/2013 year was 1875. The 1875 cases were distributed over the course of the year on a month-to-month basis peaking in October of 2012 (191) with the lowest number (117) recorded in December 2012.

As demonstrated in the graph below, the figures are relatively consistent throughout the fiscal year. The monthly mean for 2012/2013 was 156.25 cases. There was no indication in the PERS data as to why December was the lowest and October the highest.



The 2012/2013 numbers were also consistent the latter half of the 2011/2012 year; those figures did not start until November of 2011. (See below)

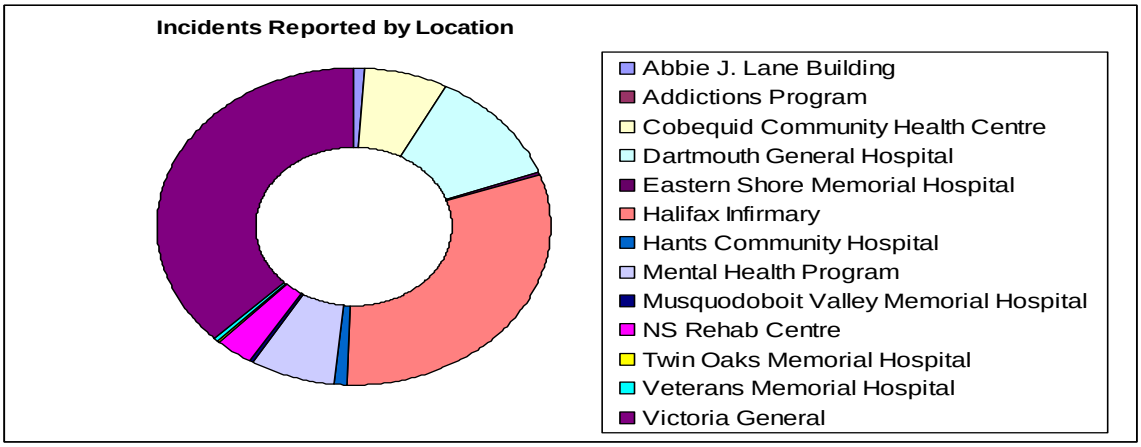


Distribution of Reports by Location

PERS includes reports from 12 different locations in Capital Health:

- Abbie J. Lane (not mental health)
- Addictions Program
- Cobequid Community Health Centre
- Dartmouth General Hospital
- Eastern Shore Memorial Hospital
- Halifax Infirmary
- Hants Community Hospital
- Mental Health Program
- Musquodoboit Valley Memorial Hospital
- Nova Scotia Rehab Centre
- Twin Oaks Memorial Hospital
- Veterans Memorial Hospital
- Victoria General

There was some discrepancy among the 12 locations for 2012/2013. However, these facilities vary significantly in their use and services and higher number of reported incidents in certain locations is expected.



The facility with the greatest number of reported incidents is the Victoria General (702), followed by the Halifax Infirmary (580), and the Dartmouth General Hospital (219). Eastern Shore Memorial Hospital (4), Addictions Program (4), Musquodoboit Valley Memorial Hospital (6), Twin Oaks Memorial Hospital (7), and Veterans Memorial Hospital (7), were significantly lower than all other facilities.

The large number of incidents reported related to the VG is higher than one would expect. This is because the central intake office for the Patient Representative Service is at the VG and the highest category of inquiry is General information and Assistance generally managed by the Service Intake Coordinator. As these inquiries are reported, they are traditionally captured as a concern related to the VG site, creating a higher number of incidents as illustrated above.

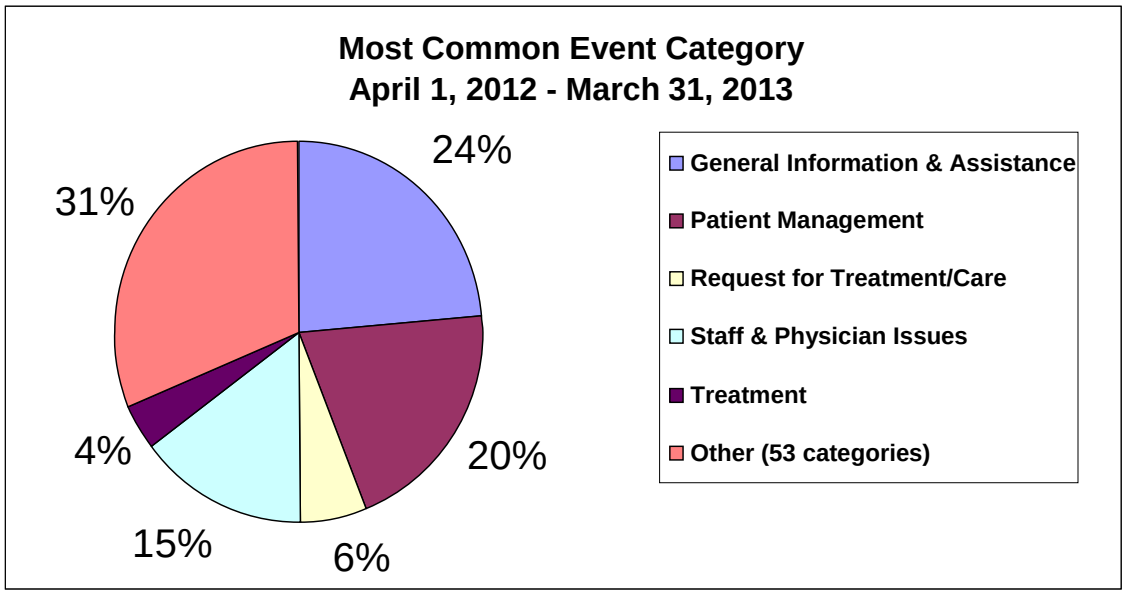
The incidents reported by location were also consistent with the latter half of the 2011/2012 fiscal year. The distribution of incidents was nearly identical to the 2012/2013 year.

For complete figures on the number of incidents reported by specific location, please refer to **Appendix A.**

Distribution of Reports by Type

Each case is classified using a case "type" describing the nature of the concern or compliment. These types include such things as interpersonal issues with staff and physicians, care and treatment concerns, and breakdowns in communication among the parties involved.

In PERS there are currently 58 different types of concerns, however many of the items listed are easily blocked together to avoid redundancy. Additionally, and for the sake of analysis in this report, an 'Other' category has been included and groups together over 50 different categories that make up 31% of the case types. (See graph below)



Note: Of the 53 event categories included in the "Other" category, none had significant impact and were not above 2% of the total cases.

General Information and Assistance (24%) was the single most common type of case in the 2012/2013 fiscal year. Issues stemming from Patient Management were the second most (20%), followed by issues with Staff and Physicians (15%), Requests for Treatment/Care (6%), and finally, issues of Treatment (4%).

Both the Patient Management and General Information and Assistance case types will be reviewed in depth over the coming months to further refine what we can learn from these case types. This will enhance future reporting and benefit the end user through greater specificity.

For a full and comprehensive list of all case types please refer to **Appendix B.**

Distribution of Reports by Severity

In addition to categorizing the cases by location and type, each case is given a distinct level of severity. Level of severity is objectively determined by the nature of the incident, its context and relationship to other types of concerns, and our understanding of the issue. (As noted previously, we believe in the importance of the actual unfiltered patient experience and plan to also record the more subjective level of impact the situation had on the person as described by the individual)

In total, there are ten levels of classification available for each case:

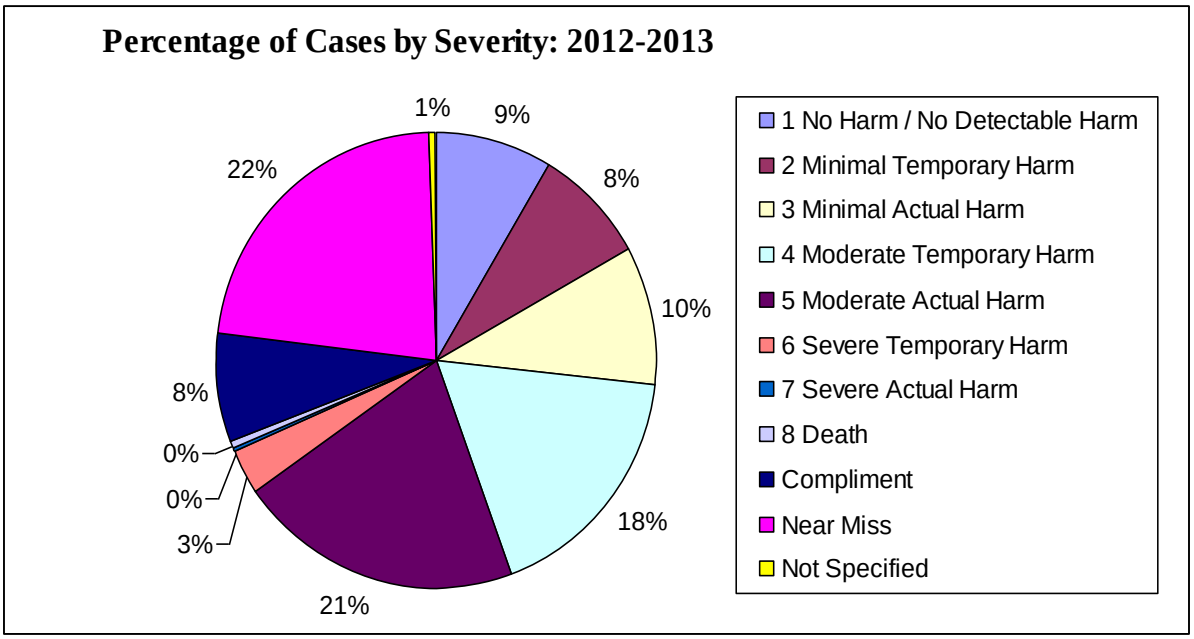
- *Compliment*
- *Near Miss*
- *2 Minimal Temporary Harm*
- *3 Minimal Actual Harm*
- *4 Moderate Temporary Harm*
- *5 Moderate Actual Harm*
- *6 Severe Temporary Harm*
- *7 Severe Actual Harm*
- *8 Death*

For a complete review and description of each level of classification, please refer to **Appendix C.**

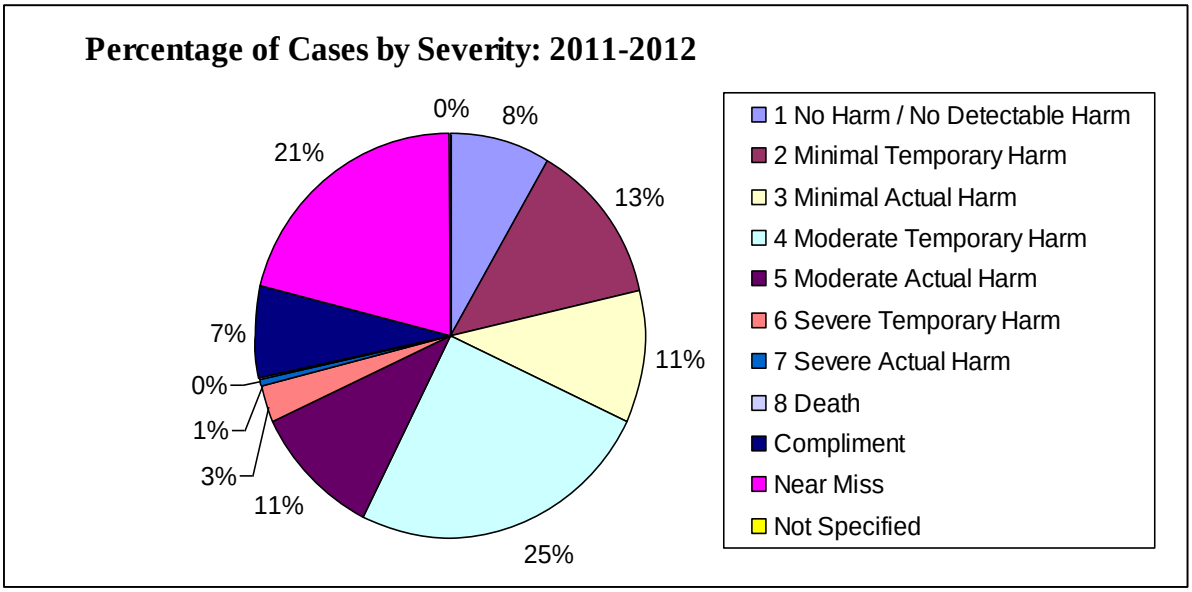
The distribution of incidents among the locations by severity was proportional to the number of cases logged at each location. The most frequently reported levels of severity in the 2012/2013 year were:

- ‘Near Miss’ (22.56%);
- ‘4 Moderate Temporary Harm’ (17.92%); and
- ‘5 Moderate Actual Harm’ (20.85%).

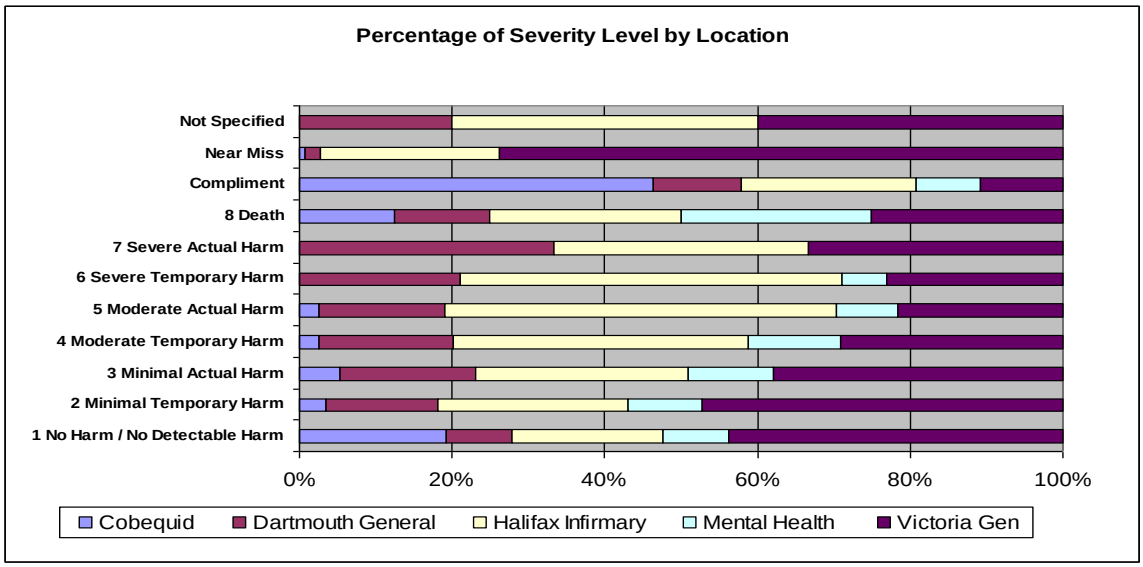
Both ‘8 Death’ (0.46%), and ‘7 Severe Actual Harm’ (0.32%), were the most infrequent. See graph below.



These figures are relatively on par with those from the partial data for the 2011/2012 year. See graph below.



A few discrepancies did present in the levels of reported severity based on the location of the event. The graph below uses the five most common sites for all 1875 reports. In an ideal situation, each color bar representing the five sites, would take up the same proportion in each Severity Level category.



A large proportion of the cases under 'Near Miss' were issued at the Victoria General, while a large proportion of all 'Compliments' reported were issued from the Cobequid site. This references earlier comments on location of the Patient Representative's Central Office and how some service areas use the database to effectively record compliments received at the unit level.

For the complete data set of all sites, and a more detailed view of each severity level, please refer to **Appendix D.**

Qualitative Analysis

Upon reviewing 100 reported concerns, selected randomly but proportionally to the location, month, and level of severity, the following themes emerged from the recursive abstraction analysis.

Contributing Conditions

Many things influence an individual's experience of healthcare. Things such as family dynamics, poor medical literacy, behaviourial issues, and other existing health conditions, including mental health issues, have impact on the complexity of the problem at hand as well as on the approach and response methods used in the resolution process.

These types of contributing conditions can adversely affect the patient – provider therapeutic relationship, and oftentimes, attempts to resolve the concerns by staff and physicians, as well as by the patient representative are hindered or sometimes exacerbated by this circumstance. In this type of scenario, complicated, long term resolution processes, and morally distressing events can occur and are sometimes unavoidable. The resulting stress creates vulnerability for both the patient and the provider which further complicates relationships and outcomes.

According to the Canadian Mental Health Association, 1 in 5 adult Canadians will experience a mental illness in their lives and there is no doubt that this as well as the other contributing conditions noted, can produce a number of challenges to a therapeutic relationship. While patients and families might perceive a lack of understanding and appreciation of their needs, our data also shows that providers themselves struggle to negotiate clinical and emotional care and support.

How we approach and communicate in these types of situations is critical to a good experience and it may be that education and training for staff in this regard would benefit and improve the patient-provider relationship and thus the patient's experience of healthcare.

Empathy

Patients and families consistently report a lack of empathy. They negatively report on interpersonal experiences with those in front-line customer service positions, on their interactions with physicians and nurses, and more generally on a lack of attention and understanding during times of crisis and vulnerability.

The lack of empathy appears to result from a difficulty experienced by staff and physicians in finding a balance between customer service and patient/family expectations. Many of the patients reported a lack of attention and care during their times of need. At times the lack of empathy seemed to be a result of the general processes and procedures in the hospital environment, and was not related to a single cause but generally related to poor communication and lack of information around same.

Patients and families also report that while they feel clinical treatment is very good, staff generally lack a sense of caring and understanding. In perceiving an absence of empathy and caring, patients and families indicate they remain hesitant to believe that 'everything that can be done is being, or was, done.'

Communication

Communication is the single greatest common theme throughout all 100 reports examined. This includes communication from the physician or nurse directly with the patient or from the physician and hospital staff with the family doctor. Additionally, the more severe cases were often a result of a breakdown between the staff treating a patient and the patient's family seeking information and advice in a manner and method that suited their level of communication.

The concerns described above, along with other issues such as medication and privacy concerns, were all often exacerbated by a lack of communication between parties. This includes communication between handover of staffs which resulted in treatment errors, and a lack of communication with family members of mental health patients who required additional supports.

Many patients and families come to Capital Health with preconceived ideas and uninformed expectations of health care and in many of these cases, despite best efforts, neither Capital Health nor the health care provider meet their needs. Unfortunately, the data shows that these patients and their concerns are frequently amplified by poor communication from staff, between staff, and between Capital Health staff and the patients' family physicians. Staff seemed to become uncomfortable and frustrated with patients who present as difficult to please, and less empathetic and communicative over the course of the patient's service.

Other

Other themes discovered in the qualitative analysis include:

- Patients feel there is a lack of explanation on diagnosis, procedures and treatment options.
- Patients feel there is a lack of Information around proper medication delivery
- Hygienic concerns – washing hands, housekeeping and especially bathroom and patient room cleanliness
- Wait Times generally
- Front-line customer service - General friendliness, empathy and clear communication at the first point of contact for patients and families entering Capital Health facilities.
- Trust – Patients and families were challenged in trusting Capital Health staff and physicians if prior experiences were negative or they felt previously misinformed.

Discussion

This report is an analysis of the first full fiscal year for the PERS system. The quantitative and qualitative sections highlight several key trends and themes that are relevant to Capital Health planning and quality improvement moving forward. PERS provides an excellent framework to collect useful data on patient and family experience and is accessible to leaders such that reports can be routinely extracted to provide decision support.

Based on the 1875 total cases examined from April 1, 2012 to March 31, 2013, it is evident that the sites that provide the greatest number of services to the greatest number of patients are predictably the sites who receive the greatest number of complaints. While there was an adjustment in the reporting of the level of severity over the course of the 2012/2013 year, it is evident that similar to the previous year, the most frequent levels reported were predominantly in the low to mid-range in terms of severity.

The initial complaint reflects the patient or family member's story. Often, issues between patients and providers were a result of a lack of communication, where patients, not necessarily knowing what to expect, or having no information on what to expect, had unmet or unrealistic expectations of Capital Health. However, in the majority of those cases, patient and family concerns were not mediated by effective communication techniques from staff.

Since PERS is only in its second year, this data set is limited in its ability to analyze long-term trends. Yet based on the report from the first three months of operation in the 2011/2012 year

(January 31, 2012), many of the same themes have emerged, including issues of staff and physician behaviour and communication, as well as general patient mismanagement and poor communication. Future reports will undoubtedly be enriched by an increase in available data for comparison as well as by the development of more specific and in depth reports.

Appendix A

Total Number of Cases by Location

Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2012/2013 Total	2011/2012 Total
Abbie J. Lane Building	0	0	1	1	3	1	2	1	1	1	1	2	14	12
Addictions Program	0	1	0	0	0	1	0	0	0	0	1	1	4	1
Cobequid Community Health Centre	10	15	8	8	5	14	11	8	11	15	10	14	129	44
Dartmouth General	14	19	11	19	21	13	18	23	15	21	20	25	219	95
Eastern Shore Memorial	1	0	0	0	0	0	2	0	0	0	0	1	4	5
Halifax Infirmary	31	32	45	57	57	53	51	55	40	47	54	58	580	257
Hants Community	1	2	2	1	0	4	2	0	0	5	2	1	20	18
Mental Health Program	10	11	7	12	8	12	16	10	12	15	13	4	130	68
Musquodoboit Valley Memorial	0	0	0	1	0	0	0	1	0	0	1	3	6	0
NS Rehab Centre	2	6	2	5	3	9	14	3	1	2	4	2	53	13
Twin Oaks Memorial	0	1	0	0	0	1	1	0	0	2	0	2	7	6
Veterans Memorial	0	0	0	1	1	2	0	1	0	0	1	1	7	4
Victoria General	61	71	69	62	51	74	74	55	37	59	73	16	702	253
CDHA TOTAL	**130**	**158**	**145**	**167**	**149**	**184**	**191**	**157**	**117**	**167**	**180**	**130**	**1875**	**776**

Appendix B

List of Type of Event/Category

Accommodation Charges
Ambulance (EHS)
Appointment/Surgery Cancelled or Delayed
Behavior Attitudes: Other
Breach of Confidentiality
Cleanliness
Communication: Other
Compliments: Other
Consent Issue
Damaged/Missing Property: Other
Damaged/Missing: Patient Property
Discharge: Incomplete Info or No Discharge Plan
Discharge: Other
Discharge: Unhappy or Refusal by Patient/Family
Environmental Concern
Facility Cleanliness
Facility Equipment Failed/Broke
Family/Visitor Issues
General Information & Assistance
General Information & Assistance: Other
Hospital Grounds
Infection Control Concern: Procedures or Staff
Inpatient Surgery Waitlist
Left without Being Seen/LAMA
Meal Concerns
Medication Concern
Missed Diagnosis/Misdiagnosis
Missing/Unsecured Patient Records
Mixed Gender
No/Unclear Communication: Patient/Family
No/Unclear Communication: Staff
No/Unclear Communication: Team Members Service
Outpatient Surgery Waitlist
Parking Fee
Parking Lot Concern
Parking Ticket Concern
Parking: Other
Patient Issues
Patient Management
Patient Room Concern: Other
Patient/Facility Equipment: Other

Policy/Procedure Concerns
Preferred Accommodations
Privacy: Other
Release of Information to Wrong Party
Request for Physician Change/2nd Opinion
Request for Treatment/Care
Staff
Staff Issues
Telephone Concerns
Treatment & Patient Management
Treatment: Other
TV/Television Concerns
Unauthorized Access to Patient Info
Wait Period: Bed/Admission
Wait Period: Test Results/Documentation
Wait Period: Treatment
Wait Times/Cancellation
Wait/Cancellation: Other

Appendix C

Issues Management
Patient Experience Impact Classification

Near Miss, Level 1, Level 2

Generally, these matters will be handled by the Intake Coordinator. These issues may involve exploration via telephone inquiry and investigation by way of in-house IT systems. There may be occasional face to face meeting. These are non-clinical issues. On occasion the assistance of the Patient Representative may be required.

Near Miss
An individual is seeking information. No experience or emotion has occurred.

Patient Experience Examples:

Information
Explanation
Prevention
Resources

Level 1 – No Harm/Detectable Harm
An individual is seeking reassurance and support.

Patient Experience Examples:
Unsure
Upset
Worried
Unfortunate

Level 2 –Minimal Temporary Harm
An experience has occurred that has caused an individual to feel minimal concern. The individual is seeking acknowledgement, honor and minimal response. This is often achieved with minimal intervention.

Patient Experience Examples:
Outrage
Escalated
Unacceptable
Disbelief
Shocked
Irritated
Annoyed
Frustrated
Flustered
Unsupported
Angry
Appalled
Venting

Level 3, Level 4 and Level 5

These matters can be handled by either the Intake Coordinator or the Patient Representative, depending on the type of intervention required. Clinical issues will be handled by the Patient Representative. All other issues could potentially be handled by the Intake Coordinator and if ultimately necessary, referred to the Patient Representative. These issues may involve exploration via telephone inquiry and investigation by way of in-house IT systems. These issues may also involve face to face inquiries, meetings, correspondence, contact with outside agencies, and longer term involvement.

Level 3 – Minimal Actual Harm
An experience has occurred that has caused an individual to feel minimal/moderate concern. The individual is seeking acknowledgement, honor and moderate response. This is often achieved with minimal/moderate intervention.

Patient Experience Examples:

Emotionally hurt/injured	Treated meanly
Feeling threatened/vulnerable	Over whelmed
Given ultimatums	

Level 4 – Moderate Temporary Harm
An experience has occurred that has caused an individual to feel moderate concern. The individual is seeking acknowledgement, honor and in-depth response. This is often achieved with moderate intervention.

Patient Experience Examples:

Distress/stressed	Roughness	Embarrassed
Fear/scared	Not caring	Compassion
Suffering	Empathy	

Level 5 – Moderate Actual Harm
An experience has occurred that has caused an individual to feel heightened concern. The individual is seeking acknowledgement, honor and an internal review and in-depth response. This is often achieved with moderate to intensive intervention.

Patient Experience Examples:

Disrespectful	Unprofessional	Dignity
Unheard/not listening	Attitude	Arrogant
Irresponsible	Civility/courtesy/	Trust
Ignored	rudeness	Confidence

Level 6, Level 7 and Level 8

These matters will be handled by the Patient Representative. These are multi-faceted, complex issues. These issues require coordination of process and conflict resolution. These are clinical or non-clinical issues that may be multi-facility and multi-service based with broader, district wide or system wide impact. These issues may involve exploration via telephone inquiry and investigation by way of in-house IT systems. These issues may also involve face to face inquiries, meetings, correspondence, contact with outside agencies, and longer term involvement

Level 6 – Severe Temporary Harm
An experience has occurred that requires an in-depth internal review and response. There may be intensive intervention which may include for example, Risk Management, Legal Services, Media Relations, and Clinical and Administrative Leadership.

Patient Experience Examples:
Harmed
Personal security/safety/fear
Humiliation

Level 7 – Severe Actual Harm
An experience has occurred that requires an in-depth internal review and response. There may be intensive intervention with internal remedies which may include, for example, Risk Management, Legal Services, Media Relations, and Clinical and Administrative Leadership. There may be intensive intervention with external agencies such as, but not limited to, governing Colleges, Department of Health & Wellness, and the Office of the Ombudsman.

Patient Experience Examples:

Abuse	Mistreated	Violated
Negligence	Lying	

Level 8 – Death

Interventions may include internal and external review.

Patient Experience Examples:
Grief
Loss

Appendix D

Level of Severity by Location

Severity Level	Abbie Lane	Addictions Program	Eastern Shore	Musquodoboit	NS Rehab	Twin Oaks	Hants Community
1 No Harm / No Detectable	0	0	1	0	4	4	3
2 Minimal Temporary Harm	0	2	0	0	5	1	3
3 Minimal Actual Harm	1	1	1	0	4	1	1
4 Moderate Temporary Harm	3	0	1	0	15	0	2
5 Moderate Actual Harm	7	1	1	0	17	0	3
6 Severe Temporary Harm	1	0	0	0	2	0	0
7 Severe Actual Harm	0	0	0	0	0	0	0
8 Death	0	0	0	0	0	0	1
Compliment	1	0	0	6	4	1	7
Near Miss	1	0	0	0	0	0	0
Total	14	4	4	6	53	7	20

Severity Level	Cobequid	Dartmouth General	Halifax Infirmary	Mental Health	Victoria General	Veterans Memorial
1 No Harm / No Detectable	29	13	30	13	66	1
2 Minimal Temporary Harm	5	21	36	14	68	0
3 Minimal Actual Harm	9	30	47	19	64	1
4 Moderate Temporary Harm	8	55	121	38	91	2
5 Moderate Actual Harm	9	60	185	29	78	1
6 Severe Temporary Harm	0	11	26	3	12	1
7 Severe Actual Harm	0	2	2	0	2	0
8 Death	1	1	2	2	2	0
Compliment	65	16	32	12	15	1
Near Miss	3	8	95	0	300	0
Total	129	219	580	130	702	7