International Practice Development Journal

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CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

Medical students volunteering in hospital: a novel method of exploring and recording the patient experience

Monica Lorraina Hytiris*, Fraser Prentice and Deborah Baldie

*Corresponding author: Ninewells Hospital, Dundee, Scotland
Email: m.hytiris@dundee.ac.uk

Abstract
Background: Patient experience is increasingly recognised as an important feature of healthcare quality improvement. However, many of the methods implemented for its collection have significant limitations and reliability issues. This article describes how a UK healthcare organisation worked with medical student volunteers to build capacity for the collection of patient feedback in evidence-informed ways, and summarises student reflections on this process.
Aims: To improve the quantity and quality of inpatient feedback, and in doing so provide new learning opportunities for medical students.
Conclusions: Patient feedback gathered by volunteers is beneficial to the service and to medical student volunteers. As the feedback gathered is ward-specific, opportunities are created for practice improvements to be identified and acted on. It is feasible for medical students to be trained effectively as volunteers in gathering patient care experiences with adequate support mechanisms in place.
Implications for practice:
- Healthcare services should consider the use of personnel independent of the care team for the collection of patient feedback
- Patient feedback needs to be shared with practitioners in a timely manner
- Medical schools should consider this type of volunteering as a unique opportunity for medical students to improve understanding of patients' experiences of healthcare, and of how care can be person-centred

Keywords: Reflection, person-centred care, practice development, medical student volunteers, acute inpatient settings, patient experience

Introduction
Patients' experiences of care are positively associated with healthcare quality outcomes, including patient safety and clinical effectiveness (Doyle et al., 2013; Ahmed et al., 2014). In most healthcare systems patient experience is expected to be an element of quality monitoring and improvement (Ahmed et al., 2014). In Scotland, where the practice innovation described in this article was undertaken, patient rights to provide feedback and understand how this has influenced services are now enshrined in law (Scottish Government, 2011). However, opportunities for patients to give feedback on their hospital experience in meaningful and timely ways are often lacking (Reeves, 2008), meaning opportunities to improve healthcare experiences are potentially missed.

Traditional approaches to understanding patient experience have significant limitations. Much patient feedback is collected using surveys; such tools tend to have ceiling effects and little discretionary power, and to mask dissatisfaction. Thus they are seen to have limited utility for informing practice (Williams et al., 1998; Skea et al., 2004; Ahmed et al., 2014). Written surveys risk excluding a large number of patients with visual impairment, low literacy or poor command of the English language (De Silva, 2013). Much patient feedback is gathered by practitioners themselves, which is not always conducive to honest and critical responses due to power imbalances between professionals and patients (Jenkinson et al., 2002; De Silva 2014). The sustainability of the burden on practitioners of undertaking patient surveys/interviews has also been questioned (De Silva, 2013). Furthermore, although health professionals in principle have positive attitudes to patient feedback, they may raise objections if presented with results critical of their care (Edwards et al., 2011); this can be somewhat ameliorated through the use of valid and reliable tools (Jenkinson et al., 2002; Davies and Cleary 2005; Davies et al., 2008). Local baseline evaluation conducted in advance of the innovation described in this article indicated that the collection of feedback was sporadic, carried out by staff and conducted without validated tools. Therefore it was not viewed as helpful by practitioners.

This innovation sought to address such issues. We aimed to enhance the ways in which inpatients' experiences are gathered and shared with practitioners. We describe here how we used practice development principles to improve the quantity and quality of inpatient feedback, and to what extent doing so was reflected in useful new learning opportunities for medical students. We also detail how we, as volunteers with medical student backgrounds, worked with the project leads to co-design our roles. We share our own process evaluation of the project so far, as well as that of patients and practitioners, and discuss our personal reflections of being involved.

The innovation
In January 2015, we worked with a project team consisting of a senior nurse for practice development, a clinical governance facilitator and two ward-based senior charge nurses. We were third-year undergraduate medical students whose experience of engaging with patients was mainly restricted to simulated encounters.

The aim of this innovation was to:
- Improve the quantity and quality of inpatient feedback by using 'trained' medical student volunteers
- Explore if this volunteering opportunity provided new and meaningful learning opportunities for medical students

Our evaluation questions were:
- How effective is our strategy of using volunteers to build capacity for the collection and sharing of patient feedback?
- What are the stakeholders' views of the methods used by volunteers to collect and report patient feedback?
- What learning opportunities does volunteering for this role provide for medical students?

Our key stakeholders were patients, ourselves as volunteers, the project leads and the senior charge nurses in the pilot wards.

Our educational preparation included a combination of active learning workshops exploring key principles of gathering feedback, and roleplay. Two independent methods for collecting feedback were used.

Method 1: Two face-to-face, semi-structured interviews per month for each ward
Nurses helped us identify suitable patients, guided by the following exclusion criteria:
- Hospital stay of less than one night
- Age under 18
- Cognitive impairment
- Inability to take part in an interview in English

We approached eligible patients at random, and interviewed the first two who consented to participate. Patients were informed prior to consent that their responses would be anonymised, and that we were working independently of the ward.

Face-to-face, semi-structured interviews were conducted with patients while they were still on the ward. We used a topic guide informed by a systematic review of what matters to patients (Entwistle et al., 2012) and captured patients' feedback through note taking, using direct patient quotations when possible. Notes were shared by email with the senior charge nurse within a week of collection.

Method 2: Five post-discharge telephone surveys per month for each ward
Ward practitioners shared details of patients who were willing to be contacted post-discharge to complete a telephone survey. We sought verbal consent from the patients who were telephoned, after assuring them of their anonymity. Exclusion criteria for this method mirrored those in method 1 apart from command of English because we could, if necessary, book an interpreter in advance to conduct the survey; this would not have been possible for the face-to-face interviews because these were conducted on the same day as patients were selected.

Telephone surveys using the 'Picker Patient Experience 15' (Framework for Measuring Impact, 2012) survey (Jenkinson et al., 2002) were undertaken 10-14 days after discharge. The use of the telephone allowed us to include people who had literacy difficulties. This survey has four domains:
- Information and education
- Respect for patient preferences
- Involvement in care
- Emotional support

Survey responses were entered into the organisation's clinical quality dashboard, and shared with practitioners within 24 hours of collection.

Evaluation methods
After three months of testing we collectively reviewed the methods, using feedback from patients, the two pilot ward senior charge nurses and ourselves. We sought feedback using the claims, concerns and issues (CCI) tool (Dewing et al., 2014) as it helps to capture stakeholders' evaluation of changes in practice and to identify priorities for action in democratic ways. At the end of each telephone survey we asked patients how they had found the process and for their preferred ways of providing feedback. We did not seek similar feedback at the end of face-to-face interviews, perceiving patients might find it difficult to critique the process, or us, in a face-to-face discussion; undertaking this would, however, have strengthened our evaluation. Additionally, we, as volunteers, reflected on our involvement in the project and its impact on us and our learning.

Process evaluation: feedback from patients, practitioners and volunteers
Patient evaluations
Patients told us that they found the questions relevant, felt it was nice to talk to someone in person, liked having the option to add detailed feedback as well as ratings, and found the survey to be convenient.

Practitioner and volunteer evaluations
Claims, concerns and issues are detailed in Table 1.

Table 1: Claims, concerns and issues	
Claims	
Practitioners' claims	*Volunteers' claims*
• Having volunteers makes it happen	• We have the time and commitment do do this work
• Getting feedback boost morale	• Lots of positive feedback from patients means good things are already happening so teams do not need to make drastic changes
• Independent people asking patients for feedback is useful and balanced – fresh pair of eyes	• Lots of patients willing to take part. Telephone surveys have been well received, patients seem to like them
• Feedback is passed on to staff relatively quickly	• Feedback gathered gets back to the team quickly
• Volunteers we have are reliable	• We feel prepared and well supported
• Volunteers engaged in this work are benefiting from seeing how complex care is	• We get experience of what is going on in the ward, understand how it works, how to speak with patients, what they have been through
Concerns	
Practitioners' concerns	*Volunteers' concerns*
• Bias of data – practitioner might be selecting "good patients", patients may be saying what they think the volunteers want to hear	• Are practitioners giving us specific patients?
• Data – information back has been sporadic, so difficult to get momentum going. Amount of data and how it is presented could be better	• We sometimes don't get enough patients identified by the practitioners. We still don't have access to IT systems so all paper based at the moment
• Getting practitioners engaged is difficult and they don't necessarily understand why we are doing it	• Practitioners don't know who we are
• 'Impact – we don't yet know the difference it is making'	
	• Will other volunteers be as reliable?
Issues	
Volunteers' and practitioners' issues	
• How do we improve staff engagement? • How might we improve the quality of data collection, for example reduce bias? • How might we support the wards to connect with this work? • How might we capture and report the difference this feedback makes? • How do we scale up the work?	

Our personal reflections:
We both engaged in a reflective discussion using Gibbs' (1988) reflective cycle to guide our conversation. Two key points that arose were:
1. We identified that we often felt anxious when approaching patients in the earlier stages; as time progressed we were more confident talking to them
2. We found it challenging to engage with practitioners on the ward

Approaching patients
We initially signed up to volunteer for the project with no real idea what to expect, and were daunted by the expectations of the role. Although we had gone through a developmental process, gaining skills in approaching and communicating with patients, there was still a sense of trepidation during our first volunteering sessions. As medical students, we have communication skills training, but this is often in simulated patient encounters. The patient does not have any acute condition or any 'real' feelings about their healthcare to convey to us. We are also permitted to try again if we do not quite know how to word or react to something. This training, as well as our volunteer training, is useful preparation, but you never know quite how you are going to react when faced with reality.

Our first few real-time interviews were a bit stop-start as we familiarised ourselves with the questions and how best to prompt patients to elaborate on their responses. As time has progressed, we have both realised how important a good first impression is when speaking to a patient. Having confidence in what you are saying and speaking clearly to the patient helps engage them and leads to a more productive interaction. This experience has also taught us to slow down and take our time during a consultation. When we first started we rushed through the questions, which, on reflection, was due to nerves and a lack of familiarity with the interview questions. We now notice that the process is a lot smoother and that the patient mainly guides the interaction. Similarly, we raced through the early telephone surveys; now we make sure to ask the patient at the beginning of the conversation if they have time to talk to us, and probe more into their experiences, gathering richer and more detailed information. This has highlighted the need to negotiate time with patients when we are seeking information from them – this makes conversations easier and helps elicit useful information. Taking part in this process has also taught us about non-medical issues that are important to patients while they are in hospital. Issues such as privacy and being talked to rather than talked about were strongly emphasised by patients. Having an understanding of this has helped us reflect on behaviours we see in practice, and that we are potentially at risk of adopting ourselves, which is likely to make us more mindful about including patients in all communication relating to their care.

Now on our fourth-year clinical attachments, we have the confidence to approach patients, something that used to make us quite nervous. We have a better understanding of social cues, and have the skills to gain more specific information from patients. We have heard from patients what matters to them about their hospital experience, and therefore have a greater understanding of the manner in which we need to act as future doctors. We understand that the patient journey is multidimensional and we feel able to take on board patients' comments, confident that we can use them to improve our future patient care.

Engaging with ward staff
The second main issue that arose from our reflective dialogue was our relationship with ward practitioners, and in particular how we interacted with them. It often felt as if our communication was disjointed and we did not really feel part of the team. When we first started out we were accompanied by a senior member of the team who introduced us to staff and explained the process to them. However, once left to our own devices, we experienced difficulty. It often seemed that staff knew nothing about the project or how they could help us. This, on occasion, became quite frustrating. Apart from feeling undervalued by these teams, we found the teams had often failed to identify sufficient patients for our telephone surveys with, thus limiting opportunities for data collection.

Now, on our clinical attachments we understand the pressures faced by practitioners within the healthcare system. We can see that any difficulty we felt in interacting with practitioners did not stem from deliberate action on their part. Understandably, given how busy they are, they would prioritise caring for patients over engaging with a volunteer. Moving forward with our careers has taught us the importance not only of helping practitioners when possible to alleviate some of their workload, but also to consider the manner in which we interact with them. Interacting with practitioners sympathetically, acknowledging their pressures, was new to us but is now something we deal with on a daily basis. We now have greater insight into how wards function, the routines and time pressures practitioners face, and how the healthcare team works as a unit to provide care. We have also identified opportunities to engage effectively with staff – a skill critical to being an effective team member.

Discussion

Feedback from patients and practitioners, alongside our own reflections, has indicated that when there is practitioner commitment, patient feedback gathered using our methods is beneficial for all parties involved.

Patients welcomed the opportunity to give feedback via a telephone survey. While this was a small-scale pilot, on a larger scale the use of volunteers has the potential to provide patients with the opportunity to express their opinion in a safe, anonymised environment, with the chance to give honest remarks about their healthcare experience. By conducting telephone interviews we ensured that individuals with low literacy skills were able to have their views on their hospital experience heard and valued.

We believe that medical students can be supported to develop the skills to collect patient experiences of care. Our reflections have demonstrated that this learning opportunity has been useful in that it has supported us to gain confidence and skills in building relationships with staff and patients. It has developed our ability to listen actively to patients during discussions, to record accurately what they say and to explore their feedback in greater detail.

We have found that feedback shared with nursing staff in the two pilot wards has helped boost morale. However, as the process is in its infancy there is uncertainty about how practice will change as a result of receiving such feedback and whether any changes will be sustainable. Positive claims from practitioners include the reliability of volunteers in gathering feedback, the speed of communication of that feedback and the independent nature of the process. However, senior practitioners have found that it is often difficult to engage other members of the team. Getting this right at the outset is critical to meaningful adoption of such a change in practice. Ongoing work in this NHS organisation now involves ward teams developing a vision of what the patient experience should be, against which they can evaluate themselves using the feedback shared with them. This seems to be motivating staff around these issues.

One further concern practitioners raised was not knowing what the longer-term impact of the feedback and any resultant changes will be – an issue reflected in the wider literature:

> *'Despite data on patient experience being increasingly collected worldwide, there are still questions in regards to its uses and values'* (Ahmed et al., 2014, p 239).

While we continue to support the collection and reporting of patients' experiences, the project leads are now working with practitioners to explore how they can make sense of, and act on, the feedback they are routinely receiving and how its impact can be identified and reported. A study conducted in England showed that merely informing nurses of patient feedback is not enough to stimulate changes, but discussing it with staff during team meetings this has been shown to help (Reeves and Seccombe, 2008). Therefore, involving practitioners in regular meetings to discuss results can increase commitment, and make them more aware of the process and results.

Conclusion

Embarking on this patient experience innovation together has been of great value to us. We have built skills and confidence in communication with patients and ward practitioners. In addition to these skills, we have been offered the opportunity to learn more about the hospital structures, individual ward dynamics and, most importantly, the patient journey. This has allowed us to develop an appreciation of aspects of patients' hospital stay that are often not visible to us as medical students, or even as practitioners. We feel privileged to have been part of an innovative practice development, discovering what is involved in the process of co-designing, evaluating and implementing a new way of working in a complex system such as the NHS.

Both feedback methods – face to face and telephone – can be administered to a wide group of people within current hospital resources and produce useful insight into how patients experience healthcare. Care needs to be taken to share patients' feedback with practitioners soon after it has been collected, but further research is required to explore how staff can best be supported to use such information to improve their practice and consequently patients' experiences of care.

Using medical students as volunteers to gather patient feedback is a novel concept but one that has worked well. All healthcare students could potentially be involved in the process as it is a mutual relationship, benefiting both the organisation and the student.

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Monica Lorraina Hytiris (BMSc), Medical student, Ninewells Hospital, NHS Tayside, Dundee, Scotland.
Fraser Prentice (BMSc), Medical student, Ninewells Hospital, NHS Tayside, Dundee, Scotland.
Deborah Baldie (PhD, MSc Nursing, BSc Hons Nursing, RGN), Senior Nurse, Practice Development, NHS Tayside, Musselburgh, Scotland; Research Fellow, Queen Margaret University, Dundee, Scotland.