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2 **Title page**

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4
5 **Implementing a survey for patients to provide safety**
6 **experience feedback following a care transition: A feasibility**
7 **study**

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9
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29 **ABSTRACT**

30 **Background**

31 The aim was to determine the feasibility of implementing a patient safety survey which measures patients'
32 experiences of their own safety relating to a care transition. This included *limited-efficacy testing*,
33 determining *acceptability* (to patients and staff), and investigating *integration* with existing systems and
34 practices from the staff perspective.

35

36 **Methods**

37 Mixed methods study in 16 wards across four hospitals, from two English NHS Trusts and four clinical
38 areas; cardiology, care of older people, orthopaedics, stroke. Limited-efficacy testing of a previously
39 validated survey was conducted through collection of patient reports of safety experiences, and thematic
40 comparison with staff safety incident reports. Patient acceptability was determined through analysis of
41 survey response rates and semi-structured interviews. Staff acceptability and integration were
42 investigated through analysis of survey distribution rates, semi-structured interviews and focus groups.

43

44 **Results**

45 Patients returned 366 valid surveys (16.4% response rate) from 2,824 distributed surveys (25.1%
46 distribution rate). Older age was a contributing factor to lower responses. Delays were the largest safety
47 concern for patients. Staff incident report themes included five not present in the safety survey data
48 (*documentation, pressure ulcers, devices or equipment, staffing shortages, and patient actions*). Patient
49 interviews (n=28) identified that providing feedback was acceptable, subject to certain conditions being
50 met; *cognitive-cultural* (patient understanding and prioritisation of safety), *structural-procedural*
51 (opportunities, means and ease of providing feedback without fear of reprisals), and *learning and change*
52 (closure of the feedback loop). Staff (n=21) valued patient feedback but barriers to collecting and using
53 the feedback included resource limitations, staff turnover and reluctance to over-burden patients.

54

55 **Conclusions**

56 Patients can provide meaningful feedback on their experiences and perceptions of safety in the context
57 of care transitions. Providing this feedback was acceptable to some patients, subject to certain conditions
58 being met. Safety experience feedback from patients was also acceptable to staff; quantitative data was

59 perceived as useful to identify potential risks, and qualitative data informed types of changes required to
60 improve care. However, patient feedback was not integrated into any quality improvement initiatives,
61 suggesting there are still significant challenges to healthcare teams or organisations utilising patient
62 feedback, particularly in relation to care transitions.

63

64 **Key Words**

65 Patient safety, care transitions, feasibility, patient experience

66

67 **BACKGROUND**

68 Patient transitions across organisational boundaries are high in risk[1-4] and haphazard,[5] often as the
69 result of inconsistent care coordination between healthcare organisations or teams,[6] and lack of patient
70 involvement in the planning process.[7] This is particularly problematic when different health and social
71 care organisations, and their accompanying structures and processes, are required to work together in
72 order to provide integrated, patient-centred, high-quality care.[8] In England, healthcare policy is placing
73 an increasing emphasis on greater integration between health and social care services.[9 10] However,
74 there are many challenges associated with delivering safe, integrated care, including a lack of alignment
75 between health and social care organisations in their understanding of, and approaches to, safety.[11]
76 Furthermore, providing safe care during discharge from hospital, which is just one stage of a patient's
77 transition, is rarely perceived by clinicians to be a linear or causal occurrence. Safety is instead the result
78 of communication and collaboration within a complex system of multiple organisations and
79 boundaries,[12] which can also include the patient themselves.

80

81 The patient is often the only point of continuity across the care pathway and therefore has a unique
82 perspective of the transition that is not otherwise available to clinicians or staff.[7 13 14] When willing and
83 able,[15] patients are believed to have a role in improving their own safety during transitions, which includes
84 the identification and reporting of their own safety[16] and increased involvement in the handover process
85 itself.[17] Patients should be involved at all levels in their own safety,[18] with this involvement falling into
86 three categories: informing a management plan, monitoring and ensuring safe delivery of treatment, and
87 making systems safer,[19] the latter of which includes reporting on experiences of safety. Efforts are now

88 being made to implement or test the implementation of various systems to obtain patient reports of safety
89 incidents.[20 21] However the efficacy of such systems is limited, particularly due to the challenges of
90 making these systems routine for patients to complete, which can require considerable staff input,[22 23]
91 and limited evidence of successfully using patient feedback for organisational learning.[24 25] An
92 alternative approach has been to link data sets at the patient level from across the patient's journey, which
93 provides a more holistic picture of safety than analyses of individual events,[26] but this still does not fully
94 take into account the patient's experience.

95
96 By involving patients in their own safety, healthcare professionals can encourage them to act as an extra
97 safeguard within the healthcare system,[16 27] which is in line with the systems approach to safety.[28]
98 However in doing so, it is important to acknowledge that the definitions of safety differ between the patient
99 and healthcare professional.[29-31], and it is only the patient who can identify and report on feeling safe
100 or unsafe in relation to their own definition of safety. There is also an important distinction to make between
101 reporting safety incidents and providing feedback on experiences of safety. The former is based on
102 medically-defined events that have led or had the potential to lead to harm to the patient, whilst the latter
103 is based on the patients' own feelings of how safe they felt, regardless of the risk of harm. There is a
104 strong link between patient experience, safety and clinical effectiveness,[32] and it is proposed that patient
105 feedback on safety experiences can provide a source of data that highlights latent conditions within care
106 transitions. As such, there is a need to explore how patients can be enabled and supported to provide
107 feedback on their safety experiences relating to their care transition.

108

109 **METHODS**

110 **Aims and objectives**

111 The aim of this study was to determine the feasibility of implementing a patient safety survey which
112 measures patients' experiences of their own safety relating to care transition, and in particular the
113 discharge, journey and arrival stages of a transfer out of hospital. Three 'areas of focus' that have been
114 identified to be important to feasibility studies[33] were explored: *limited-efficacy testing*, *integration*, and
115 *acceptability* (to patients and staff). Specific research objectives included:

- 116 1. Test the limited-efficacy of the survey by measuring experiences of safety relating to a
117 care transfer following discharge from hospital, including a comparison of how these
118 experiences relate to staff safety incident reports.
- 119 2. Determine acceptability of the survey to patients using response rates as an indicator,
120 and reflecting on semi-structured interviews with patients that were previously
121 published[34]
- 122 3. Investigate the integration of the survey with existing systems and practices, and
123 acceptability of the survey amongst healthcare teams to the reporting tools and reports
124 of safety, and the limited-efficacy of using feedback for organisational learning.
125

126 **Study Design**

127 The study utilised a mixed-methods approach, with quantitative (surveys, distribution rates, response
128 rates) and qualitative (semi-structured interviews, focus groups, staff incident reports) data collected.
129 Distribution of the survey was split into two distinct cycles consisting of six months of data collection each.
130 Cycle 1 was conducted from March 2014 to August 2014 and cycle 2 was conducted from January 2015
131 to June 2015. Data collection was split into the two cycles to allow for changes to be made to the survey
132 as a result of patient feedback (figure). Information regarding membership of the survey co-design team
133 and the processes of development and validation of the survey have been published elsewhere, including
134 how the survey was amended between cycles 1 and 2.[35]
135

136 **[Insert figure around here]**
137

138 **Setting**

139 The study was conducted in four hospitals (two general hospitals and two teaching hospitals) from two
140 National Health Service (NHS) Trusts in England. Four clinical areas were chosen in collaboration with the
141 NHS Trusts as the wards that best represented the older population with whom the survey was initially
142 developed,[16 35] and as older patients are at increased risk of safety incidents[36] and are recognised as
143 high priorities in healthcare policy.[9] The four clinical areas, cardiac, care of older people, orthopaedics,
144 and stroke, were represented across 16 wards. Access to the wards was negotiated by site facilitators on

145 behalf of the research team, who discussed the research with ward sisters approximately three months
146 before distribution of the survey began.

147

148 ***Description of safety survey***

149 Both iterations of the safety survey (available as supplementary materials or upon reasonable request
150 from the corresponding author) were co-designed by healthcare professionals and expert patients from
151 within the target population of older people, as reported elsewhere.[19,30] Both versions provided a brief
152 explanation of patient safety and captured patient reports of safety experiences across three stages of
153 the care transfer (*discharge, journey and arrival or admission*). The questions in surveys distributed in
154 both cycles (described in the study design) focused on six domains of safety; *communication,*
155 *responsiveness, waiting times, falls, medication and hygiene*. Patients or their carers were asked to report
156 three levels of safety; *safe* (green), *neutral* (yellow) and *unsafe* (red), and to leave any non-applicable
157 sections blank. Space for free-text comments was provided in both iterations. In the version of the survey
158 distributed in cycle 1 this came in the form of questions asking if there was another reason they felt safe
159 or unsafe, and if anything could have been done to make the patient feel safer. In the version distributed
160 in cycle 2 there was space provided alongside each domain of safety for respondents to expand upon
161 their answers in relation to that specific domain.

162

163 The safety survey was provided to patients at the point of discharge, by a member of the clinical team or
164 an administrator responsible for compiling discharge information, e.g. discharge coordinator or ward clerk.
165 Responsibility for distributing the survey was discussed and agreed with the ward sister prior to the start
166 of the study. Patients were provided a letter of invitation to the research study, the safety survey and an
167 evaluation form (table 1) within a pre-paid envelope, addressed to be returned to a named person from
168 the research team. Pre-paid addressed envelopes were used as they have been shown to improve
169 response rates to surveys.[37] Those distributing the safety survey were asked to prompt the patient to
170 complete and return the safety survey upon arrival at their next location.

171

172 **Table 1: Evaluation form items and response modes**

| Item number | Item | Response mode |
|-------------|------|---------------|
|-------------|------|---------------|

| | | |
|----|--|--|
| 1 | I understood the purpose of the Safety Survey | Likert scale, 1-5 (1= Agree, 3=Neither Agree or Disagree, 5= Disagree) |
| 2 | I understood what was meant by 'your recent transfer' | Likert scale, 1-5 (1= Agree, 3=Neither Agree or Disagree, 5= Disagree) |
| 3 | I understood each of the questions | Likert scale, 1-5 (1= Agree, 3=Neither Agree or Disagree, 5= Disagree) |
| 4 | The questions asked accurately captured what made me feel safe or unsafe | Likert scale, 1-5 (1= Agree, 3=Neither Agree or Disagree, 5= Disagree) |
| 5 | There was nothing missing from the Safety Survey | Likert scale, 1-5 (1= Agree, 3=Neither Agree or Disagree, 5= Disagree) |
| 6 | I did not experience difficulties completing the Safety Survey | Likert scale, 1-5 (1= Agree, 3=Neither Agree or Disagree, 5= Disagree) |
| 7 | I felt that the colour scheme was useful | Likert scale, 1-5 (1= Agree, 3=Neither Agree or Disagree, 5= Disagree) |
| 8 | The size of the text was appropriate | Likert scale, 1-5 (1= Agree, 3=Neither Agree or Disagree, 5= Disagree) |
| 9 | The Safety Survey allows me to provide useful feedback about the healthcare I have received | Likert scale, 1-5 (1= Agree, 3=Neither Agree or Disagree, 5= Disagree) |
| 10 | By receiving this form I feel I am more educated about patient safety | Likert scale, 1-5 (1= Agree, 3=Neither Agree or Disagree, 5= Disagree) |
| 11 | Please use the space to expand on your answers or say anything about the survey that you think is relevant | Free-text |

173

174 Participants opted-in to the study upon completion and return of the safety survey and/or an evaluation
175 form. The option to return either was designed to reduce bias from those who perceived the safety survey
176 negatively and did not wish to complete it, i.e. patients could complete the evaluation survey and opt-in to
177 interviews without returning the safety survey. In the invitation letter and survey, patients' family members
178 or carers were also encouraged to assist the patient to complete the survey where appropriate, or to
179 complete it on their behalf. Return envelopes contained a unique identifying number to track the ward
180 from which the patient was discharged, and the month of discharge.

181

182 **Quantitative data**

183 ***Patient reports of safety experiences (surveys)***

184 Responses to the safety survey were recorded at ward and clinical area levels. Descriptive statistics were
185 compiled for each cycle, the domains of safety, and the stage of the transfer. Non-parametric Kruskal-
186 Wallis and Mann Whitney U tests were used to test for differences in safety ratings based on the clinical
187 areas, and Spearman's rho correlations were used to determine correlations between age and gender of
188 respondents, and safety ratings.

189

190 ***Safety survey distribution rates***

191 At the end of each month, unused surveys were collected. Distribution rates were then calculated as the
192 proportion of all discharges (excluding deaths and in-hospital transfers) given a survey during each month
193 of distribution and are reported descriptively. Discrepancies in distribution figures that resulted in
194 distribution figures of >100% were identified for two wards. They were excluded from the analysis of
195 distribution rates as this was deemed to be the result of the research process (the use of numbered
196 envelopes to monitor distribution), and not relating to feasibility (acceptability of the survey to staff).

197

198 ***Safety survey response rates***

199 A response rate was calculated based on the proportion of surveys returned (numerator) to the number
200 of surveys distributed (denominator). Survey respondents' demographics (age and gender) and
201 demographic data from wards were combined into weighted clinical area-level data. Wards with only one
202 respondent were excluded from the weighting calculations. For age, data included minimum, maximum,
203 mean and standard deviation. As with distribution rates, two wards were removed from the response rate
204 calculation due to data discrepancies.

205

206 **Qualitative data**

207 ***Patient interviews***

208 Semi-structured interviews were conducted by EH (PhD, Research Associate) with 28 patients who
209 completed the safety survey and/or evaluation form. Participants were informed of the reason for the study
210 including the researcher's role on the project, and provided informed consent. Interview questions included

211 a focus on barriers and enablers to providing useful feedback on their own safety within care transfers and
212 also included general health questions, general safety questions and questions relating to their experience
213 of care transfers. Participants were not asked to comment on or review transcripts. The analysis of these
214 interviews has been published previously in relation to the barriers and facilitators to patients providing
215 feedback.[34] As such, only reflections on the implications of this data for feasibility will be discussed in the
216 findings.

217

218 **Staff interviews**

219 Semi-structured interviews using a topic guide (see supplementary materials), conducted in the
220 participant's place of work or via telephone, and a focus group were conducted by EH (PhD, Research
221 Associate), JS (PhD, Chief Investigator) and ADB (PhD, Research Associate) with 21 staff members who
222 were involved in the transfer of patients or who received the patient feedback. Interview length ranged
223 from 14 minutes 17 seconds to 50 minutes 24 seconds (mean 28 minutes 5 seconds) and focus group
224 length was 56 minutes 18 seconds. Participants were informed of the reason for the study including the
225 interviewer's / facilitator's role on the project, and provided informed consent. Participants were not asked
226 to comment or review transcripts. The inclusion criteria for staff were that they:

- 227 • Work on one of the included wards during the period where safety surveys were distributed,
228 where:
 - 229 ○ They were responsible for managing the ward, or;
 - 230 ○ They had been involved in distributing the safety survey, or;
 - 231 ○ They had responsibility for discharging patients
- 232 • Had responsibility for the management of patients or services relating to the transfer of the patient

233

234 Questions were structured into three themes; general questions (*job role/title, team, time spent in*
235 *role/qualified*), general patient safety questions (*understanding of patient safety, role of patients in patient*
236 *safety, and role of patients in providing feedback on their safety*) and questions about safety survey
237 *feedback (contact with feedback; how feedback had been used in practice (for the ward-based staff),*
238 *including the relevance and appropriateness of information provided; and the barriers or enablers to using*
239 *the feedback to learn about patients' perceptions of safety and improve services*). Where data was
240 collected post-survey distribution or in community care teams, a vignette based on patient feedback was

241 developed to facilitate these discussions. Data collection stopped when it was felt data saturation had
242 been reached.

243

244 Interviews were recorded and transcribed verbatim, then coded and analysed systematically using
245 qualitative analysis software. Quotations are reported verbatim and only corrected for spelling and
246 grammar where the meaning is not ambiguous. Staff data were thematically analysed using a deductive
247 and iterative approach by one researcher (ADB), with themes and codes independently verified by the
248 rest of the research team. Drawing on the approaches outlined by Braun and Clarke,[38] all transcripts
249 were closely read and initial codes generated and recorded using NVivo software. After initial coding,
250 codes were refined and combined into overarching themes. The themes were refined and finally arranged
251 into larger conceptual groupings. The final codes and themes were verified by all authors. Participants
252 were not invited to provide feedback on the final themes.

253

254 ***Staff incident reports***

255 Staff safety incident reports relating to discharge were identified from the Trusts' Datix incident reporting
256 system for the sixteen wards participating in survey distribution. This included reports that had been
257 assigned 'failure/delay of discharge' and 'admission/transfer problems'. A keyword search developed in
258 conjunction with the patient safety teams was also used to identify incident reports relating to discharge
259 but not included in the pre-existing categories. The keywords were 'discharge', 'transfer', 'handover' and
260 'hand-off'. Staff incident reports were provided to the research team in a spreadsheet that contained an
261 incident number, the incident report, action taken, date of incident, category, severity and ward name.
262 Identifiable patient information was removed by the Trusts prior to sharing with the research team.
263 Analysis consisted of JS thematically coding the content of the incident reports and actions taken. The
264 original themes were then grouped into meta-themes and revised to remove any duplication. The final
265 meta-themes and themes were discussed with and approved by JW and PD.

266

267 **Mixed methods analysis**

268 To incorporate the qualitative and quantitative data into a single analysis to provide a triangulated account
269 of the findings, the results from all individual analyses were compiled into a convergence coding matrix,
270 which displays findings from each component on the same page.[39] For both the qualitative and

271 quantitative data, the findings were entered into the matrix as a brief summary by JS. The matrix allowed
272 for an analysis of (dis)agreements, partial (dis)agreements or silences across the different components
273 of the study, which were discussed and populated by JS and ADB before wider discussion amongst all
274 authors.

275

276 **RESULTS**

277 The findings are presented in relation to the three areas of focus of the feasibility testing: *limited-efficacy*
278 *testing, acceptability, and integration.*

279

280 **Limited-efficacy testing**

281 ***Patient reports of safety experiences via the survey***

282 A total of 366 patients completed and returned a valid safety survey, defined as one or more complete
283 questions. Analysis of all questions revealed similar patterns amongst all three stages of the transfer
284 (discharge, table 2; journey, table 3; arrival, table 4), suggesting that patients did not differentiate between
285 the stages. Delays were often the largest safety concern for patients, which was reflected in accompanying
286 free-text comments which, where provided, contextualised the ratings provided by the patients.

287

288 **[Insert tables 2, 3, and 4 around here]**

289

290 There were no significant correlations between safety ratings and age of respondents across any domain
291 or stage of the transfer. Gender was significantly correlated with safety in relation to delays during journey
292 and arrival, and in relation to falls during arrival, with men more likely to feel safe. Notably, this correlation
293 was non-significant during discharge. The clinical area of discharge also showed no significant correlation
294 with safety ratings. Transport type was correlated with safety ratings; patient transport service (rather than
295 ambulance or private car) was frequently associated with lower perceptions of safety in relation to all six
296 safety domains. Statistics are reported in tables 2, 3 and 4.

297

298 **Staff incident reports**

299 375 staff incident reports submitted during the study period were identified. Following screening by JS, 92
 300 (24.5%) incidents were deemed eligible for inclusion; the remainder of reports examined did not pertain to
 301 the patient’s discharge. Thematic analysis of the incident description resulted in eight themes being derived
 302 from the data; *communication failures, delayed discharge, documentation, medication, pressure ulcers,*
 303 *devices or equipment, staffing shortages* and *patient actions*. Table 5 presents the staff incident report
 304 themes. Of the eight themes, five were novel, in that they were not presented in the safety survey, nor
 305 mentioned by any patient participants in the free text sections (*documentation, pressure ulcers, devices or*
 306 *equipment, staffing shortages, and patient actions*).

307

308 **Table 5: Themes and sub-themes of staff incident reports (n=92) relating to patient discharges**

| Major theme | Sub-theme |
|-------------------------------|--|
| Communication failures | <ul style="list-style-type: none"> • Care home not informed of discharge • Difficulty booking transport • Discharge letter contained incorrect information • Handover not completed properly • Referral to other services not made • Discharged without test results |
| Delayed discharge | <ul style="list-style-type: none"> • Result of communication error during booking of transport • Family cause of a delay • Internal delays to medication • Patient transport service aborted or late |
| Documentation | <ul style="list-style-type: none"> • Missing documentation • Incomplete documentation • Mistake in documentation • Received wrong patient’s documentation (data breach) |
| Medication | <ul style="list-style-type: none"> • Inappropriate medication • Incomplete medication • Incorrect dosage / prescription / dispensation • Missing or lost medication • Patient received someone else’s medication |
| Pressure ulcers | <ul style="list-style-type: none"> • Identified prior to discharge • Identified after discharge |
| Devices / equipment | <ul style="list-style-type: none"> • Device left in situ after discharge • Incorrect equipment given to patient |
| Staffing shortages | <i>No sub-theme</i> |
| Patient actions | <ul style="list-style-type: none"> • Verbal/physical aggression or harassment • Self-discharge against advice • Patient refused discharge |

309

310 **Using feedback for organisational learning**

311 Staff who participated in interviews or focus groups (n=21; see table 6 for participant characteristics) felt
 312 that the specific feedback from this survey could be used for learning on both an individual and
 313 organisational level, though no evidence of organisational learning was identified during the study.

314

315 **Table 6: Staff participant characteristics**

| Participant | Participated during or post- survey distribution | Data collection method | Demographics | | |
|-------------|--|------------------------|--------------|----------------------------|--------------------------------|
| | | | Gender | Clinical area / Speciality | Role |
| 1 | During | Interview | Female | Orthopaedic | Senior Ward sister |
| 2 | During | Interview | Female | Stroke | Discharge co-ordinator |
| 3 | During | Interview | Female | Cardiology | Ward sister |
| 4 | During | Interview | Female | Stroke | Discharge co-ordinator |
| 5 | During | Interview | Female | Cardiology | Ward administrator |
| 6 | During | Interview | Female | Orthopaedic | Ward sister |
| 7 | During | Focus group | Male | Stroke | Ward receptionist |
| 8 | During | Focus group | Female | Orthopaedic | Apprentice |
| 9 | During | Focus group | Female | Orthopaedic | Nurse (band 5) |
| 10 | During | Focus group | Female | Orthopaedic | Deputy Sister |
| 11 | Post | Interview | Female | Care of Older People | Ward manger |
| 12 | Post | Interview | Male | Site facilitator | Patient safety lead |
| 13 | Post | Interview | Male | Site facilitator | Senior Research Nurse |
| 14 | Post | Interview | Female | Care of Older People | Ward Sister |
| 15 | Post | Interview | Male | Site facilitator | Senior Research Nurse |
| 16 | Post | Interview | Female | Ambulance service | Patient relations co-ordinator |
| 17 | Post | Interview | Female | Care of Older People | Nurse (band 6) |
| 18 | Post | Interview | Female | Cardiology | Discharge co-ordinator |
| 19 | Post | Interview | Female | Cardiology | Ward sister |
| 20 | Post | Interview | Female | Community Care | Occupational Therapist |
| 21 | Post | Interview | Female | Community Care | Community Matron |

316

317 Recognising that most of the safety domains were reported as safe by patients, staff described themselves
 318 encouraged by the feedback and found it to be a useful indicator of patient perceptions of safety. The
 319 feedback data was also perceived as having the potential to provide a valuable insight into the impact of
 320 discharge processes of which staff would otherwise be unaware.

321

322 *“I think it would be nice to see ‘cos if a patient has had a good experience on the ward... it*
 323 *would be nice to know that it has carried on afterwards. Cos as I say we try to put everything*

324 *in place for when they get home or where they're going, so it would be nice to know that that*
325 *has carried on, actually worked.”* (Participant 2)

326

327 Furthermore, one individual reflected that feedback contained information that addressed issues that had
328 not been considered from a safety perspective, in particular by taking a proactive approach to safety by
329 involving the patient in a meaningful discussion.

330

331 *“Just because I know that something is safe, doesn't necessarily mean that it feels safe to*
332 *my patients. If it doesn't feel safe, then, to a degree, I've failed.... Even if something isn't*
333 *actually unsafe, the interpretation of it is just as important. It has to feel safe, it has to feel*
334 *like a safe environment.”* (Participant 17)

335

336 Survey feedback, specifically where it was positive, was recognised as an important opportunity to
337 commend staff for positive patient experiences of safety and as a tool to bolster and reinforce current good
338 practice. This was especially so as a persistent sentiment existed amongst staff that the wider health system
339 tended to focus attention on negative events and patient safety incidents, rather than also acknowledging
340 what works well. This negative focus, or deficit model of patient safety akin to Safety-I,[40] was described
341 as a limited and limiting perspective when there was often scope for sharing best practice among staff.
342 Consequently, this emphasis on mistakes and errors was said to impact considerably on staff morale.

343

344 *“It was encouraging to see that actually most people, most of the time - you're hearing*
345 *responses that are quite positive, and that's a good thing.”* (Participant 15)

346

347 *“Some of those things [that could be useful] are ones that I wouldn't have thought to ask*
348 *someone how safe do they feel about the possibility of falling. That's probably not something*
349 *that I would think to ask a patient who was going, to be honest.”* (Participant 11)

350

351 *“I think the problem is NHS, really isn't always interested in things that go well. Not to be too*
352 *negative, but people don't ever focus on the things that go well. People only ever seem to*

353 *be focused on things that haven't gone well, and they're the things that you hear about and*
354 *read about more."* (Participant 11)

355

356 Many participants commented that the results of the survey broadly reflected their expectations regarding
357 the issues that created most problems or concerns amongst patients. Overwhelmingly, it was agreed that
358 delays are the main issue for patients and participants felt this finding was representative of their experience
359 in the discharge process. Whilst some reported they were basing this assumption on anecdotal evidence,
360 some sites were conducting research to provide insight into this and confirmed that the survey findings
361 closely aligned with their investigations. This signifies that patients provided useful and valid feedback that,
362 as a minimum, provides confirmation of anecdotal evidence.

363

364 *"There are no big surprises there for me, to be quite honest. I would imagine that the delays*
365 *section is the biggest issue for everybody going home. That's not a surprise to me. Loads of*
366 *people, just anecdotally, complain about how long it takes to get the drugs up and all that*
367 *sort of thing."* (Participant 13)

368

369 However, several participants also stated there was limited value to only having quantitative data in
370 understanding important safety issues. It was expressed that, while the results were informative in
371 highlighting potential issues as well as areas of excellence, qualitative feedback in the form of patient
372 narratives and quotes was often more effective in resonating with staff and developing a better
373 understanding of the safety concern, issue or incident. This deeper understanding was considered a
374 crucial step in understanding the problem before changes could be suggested or made.

375

376 *"Yes, I think [quantitative survey data] adds an important dimension, but probably needs to*
377 *be not looked at in isolation... What it does is show that these are areas that we should*
378 *perhaps dig into more. I don't think it gives you enough information to understand what the*
379 *real issues are in order to then say, 'Right, well, we need to look at making these*
380 *improvements.'"* (Participant 12)

381

382 **Acceptability**

383 ***Patient acceptability of providing safety experience feedback***

384 The patient interview data, specifically relating to barriers and facilitators to providing feedback on safety
385 experiences, has been reported elsewhere.[34] To summarise, providing safety experience feedback was
386 acceptable to patients, subject to certain conditions being met. These conditions are represented by three
387 themes, which are combined into a staged model; *cognitive-cultural*, *structural-procedural*, and *learning &*
388 *change*. The first theme, *cognitive-cultural*, captured the notion that for safety feedback to be deemed
389 acceptable, patients had to understand and prioritise patient safety. The second theme, *structural-*
390 *procedural*, signified the need for patients to be provided with the opportunity, means and ease of providing
391 feedback, without fear of reprisals, while the individual patient needed the ability and inclination to do so.
392 The third theme, *learning & change*, represented the closure of a feedback loop with patients; they had to
393 feel that their feedback would be acted upon and make a difference to patient safety.

394

395 ***Patient acceptability as represented by survey response rates***

396 Estimation of response rates suggest a minimum response rate of 16.4%. Three clinical areas had similar
397 response rates (cardiology, 20.4%; orthopaedics, 22.4%; and stroke, 17.4%), whereas the care of older
398 people clinical area had a much lower response rate of 4.6%. Due to the method of recording distributions
399 these are likely to be an underestimate. This is due to identifiable discrepancies in distribution figures
400 (explained previously) for two wards, where the total number of surveys apparently distributed exceeded
401 the number of discharges.

402

403 From the valid surveys returned, 296 (80.9%) surveys were completed by the patient, ten (2.7%) were
404 completed by a carer and two (0.5%) were completed by both patient and carer. The remaining 58 (15.8%)
405 did not state who had completed the survey. 133 participants were female and 160 were male. Participants'
406 mean age was 64.9 (range=19 to 96, SD=15.4). Gender and age of respondents were largely
407 representative of the clinical areas from which they were discharged (table 7). The exceptions were care
408 of older people (respondents more likely to be younger and female) and stroke (respondents more likely to
409 be younger). Together with the lower response rates from the care of older people clinical area, this is
410 suggestive that older age was a contributing factor to lower responses.

411

412 **Table 7: Comparison of demographics (age, gender) between survey respondents and all patients**
 413 **discharged**

| | Age | | | | | Gender | | |
|--|--------------------|---|--------------|---|--------------|--------------------|----------------------------|-----------------------------------|
| | Survey respondents | | | All discharges | | Survey respondents | | All discharges |
| Clinical Area (total number of discharges) | Eligible | Weighted mean age, years (std dev) | Age Range | Weighted mean age, years (std dev) | Age Range | Eligible | Weighted gender | All discharges weighted gender |
| Cardiology (3,318) | 145 | 66.8 (12.4) | 28 to 96 | 66.2 (15.0) | 19 to 100 | 138 | 50% male 50% female | 54% male 46% female |
| Care of Older People (2,947) | 16 | 77.4 (5.7) | 68 to 93 | 84.6 (6.1) | 41 to 105 | 17 | 31.2% male 68.8% female | 52.7% male 47.3% female |
| Orthopaedics (3,859) | 108 | 60.1 (15.0) | 19 to 88 | 62.8 (17.5) | 16 to 105 | 115 | 66.1% male 33.9% female | 53.6% male 46.4% female |
| Stroke (1,260) | 22 | 62.1 (20.6) | 21 to 91 | 74.3 (13.9) | 21 to 103 | 21 | 45% male 55% female | 43.8% male 56.2% female |

414

415 **Staff acceptability of patients providing safety experience feedback**

416 Analysis of interview data showed that staff valued patient feedback on their safety experiences as serving
 417 to improve staff awareness of safety as well as acting as an additional barrier in the prevention and
 418 minimisation of harm.

419

420 *“I think, yes, obviously the more we know about things like [the patient’s experience of safety],*
 421 *the more we can do to reduce the risks of patients being injured or something happening*
 422 *with patient safety relating to our care, I think yes, it [their feedback] would be valuable”.*

423 (Participant 16)

424

425 Spending time and communicating with patients was perceived to encourage patients to provide feedback
 426 on their safety experiences. The quotation by Participant 15 demonstrates that resources are important to
 427 making meaningful connections with patients.

428

429 *“Of course that’s the big C word, communication. It’s all about making sure people have got*
 430 *the information in a format they can understand. That we’re not patronising, not making*
 431 *assumptions about what people know and don’t know. You have put up frank explanations*
 432 *for things, and we check out what people have understood.”* (Participant 15)

433

434 There was also a persistent belief among interviewees that older adults were generally less likely to report
435 any issues or concerns and were more likely to trust the care team without question. One individual stated
436 that some members of the older generation were *“inappropriately trusting of the system”* (Participant 15)
437 and reluctant to be perceived as causing a *“fuss”* (Participant 16) or to question the clinicians’ decisions.
438 There was also concern expressed that older adults were less likely to complain due to *“the thought of*
439 *having to take on a bigger organisation”* (Participant 16).

440

441 *“[Older people] never really want to say anything negative, but I think that’s just because of*
442 *the age that they are. It’s that generation.”* (Participant 11)

443

444 **Integration**

445 ***Integration of the survey with existing systems and practices***

446 Staff discussed their role in facilitating the collection of patient feedback on safety, identifying numerous
447 facilitators and barriers to doing so. Staff prompting and reminding each other was deemed helpful to
448 facilitate distribution and maintain and boost distribution rates, as was making the survey visible and easily
449 accessible. Thus, those sites in which survey distribution was considered a team endeavour, with staff
450 working together to remind and encourage each other to distribute the survey, appeared to be most
451 successful in distribution.

452

453 *“I think it’s just trying to prompt each other sometimes... I mean it depends who’s on ‘cause*
454 *everybody’s different really, but I mean what I like to do is try and sort of prompt, you know*
455 *like, ‘Ooh you could’, you know, ‘have given them that as well’ and you kind of get people*
456 *who’ll remind you.”* (Participant 5)

457

458 Barriers to integration included resource limitations (especially nurses’ own time) and staff turnover.

459

460 *“I think it’s a bit unfair to ask the nurses to do anymore, personally, do you know what I*
461 *mean? But not everybody has a discharge co-ordinator and I think probably in the absence*
462 *of the discharge co-ordinator there’s probably the receptionist that could do it, but I think*
463 *nursing staff I just think sometimes they’ve got too much on the plate to ask”* (Participant 18)

464

465 Another barrier to integration was a reluctance amongst staff to overburden patients with paperwork,
466 particularly during discharge when they are deemed to be vulnerable.

467

468 *“I feel they get bombarded sometimes with information and things that they need to do and*
469 *all they want to do is just get home, and once they’re home, I don’t know, they might not want*
470 *to complete them, complete any surveys. I mean I’m sure if they thought it was going to help*
471 *patients in the future then they might think differently about it, but I know just from feedback*
472 *we’ve had about surveys, they do find it a bit much completing lots of paperwork.”* (Participant
473 6)

474

475 ***Integration as represented by survey distribution rates***

476 11,282 patients were discharged from the included wards. It was not possible to determine the exact
477 distribution rate as some surveys that had not been distributed may not have been returned to the research
478 team because, for example, they had been lost or thrown away on the ward. As such, there were a
479 maximum of 2,824 (25.1%) surveys distributed, though the actual number was likely lower. Distribution
480 rates varied amongst clinical areas (cardiology, 30.5%; care of older people, 28.3%; orthopaedics, 19.7%;
481 stroke, 20.0%). There was also large variation in distribution rates at ward level (9.2% to 46.3%) regardless
482 of the clinical area, suggesting that variables other than the clinical area or the NHS Trust were responsible
483 for variation.

484

485 **DISCUSSION**

486 The aim of this study was to determine the feasibility of implementing a patient safety survey which
487 measures patient experiences of their own safety relating to care transfer. In particular, the study explored
488 *limited-efficacy testing, acceptability* (to patients and staff) of the safety survey, and *integration* with existing
489 systems and practices from the staff perspective.

490

491 From the limited-efficacy testing, patient reports on their experiences of safety identified that delays relating
492 to departure from hospital made patients feel least safe. Where patients identified the cause of this feeling,
493 it was often associated with delays in obtaining medication or from the lack of explanation and reassurance

494 from staff about the delay. However, there were discrepancies between patient reports and staff reports,
495 with patients identifying aspects of their care that made them unsafe which staff did not report, and staff
496 identifying types of incidents that patients did not report, including incidents caused by patients. These
497 findings reflect existing evidence that patients and staff are able to identify some of the same safety issues,
498 but also identify different safety issues.[29-31] This study expands on the existing literature by
499 demonstrating this within the organisational care transfer setting, thus providing support for the notion that
500 patients can provide constructive feedback on their experiences and perceptions of safety in this context.
501 These findings also demonstrate that it is possible to collect meaningful data relating to safety experiences
502 from patients in relation to their care transitions.

503

504 Qualitative data from staff demonstrated a degree of staff acceptability to using the survey, including belief
505 that patient feedback from the survey could be used for service improvement, which in turn can contribute
506 to a culture of continuous learning. Quantitative feedback was seen to serve the purpose of indicating
507 where there may be problems, and qualitative feedback to inform the types of changes required to improve
508 care. However, staff within this study did not appear to engage in quality improvement activities based on
509 patient experiences of safety, and we are therefore only able to conclude that patient feedback on their
510 safety could lead to quality improvement, but that other individual, structural, procedural and cultural
511 conditions are required to be met first. This supports existing research that patients should be involved in
512 the improvement process, providing their involvement is managed correctly[41 42] and they welcome
513 having some responsibility for their safety.[43] For instance in one study[44] using a national patient
514 survey for quality improvement, it was identified that staff were largely receptive to the survey findings but
515 that there were a number of barriers. These barriers included survey results that were not directly
516 meaningful to individual wards or units, and limited resources or knowledge to make changes.[44]
517 Evidence also suggests that providing written feedback to wards is not sufficient for enabling quality
518 improvement, even if that feedback is specific to the ward.[45] We identified a similar barrier in the context
519 of distribution of feedback tools, in particular the time constraints that impacted upon the distribution of
520 the survey to patients. An additional barrier was the perception that patients would be overburdened with
521 paperwork, thus limiting the opportunity for patients to provide feedback on their safety experiences; this
522 formed a structural-procedural barrier to patients providing feedback.[34]

523

524 Staff interviews also identified that there was a systematic focus on unsafe or negative experiences of care,
525 which reflects the deficit approach to safety[40] and has been dominant throughout healthcare services
526 since the safety movement began in earnest at the turn of the century.[46] However, some healthcare
527 professionals in the study acknowledged that an appreciative approach to patient safety could help them
528 to understand what it is that they have done correctly. As such, they felt that sharing best practice can lead
529 to quality improvement. However, it was noted that any approach that relied on staff distributing surveys
530 and obtaining and collating feedback, carried a real risk of overburdening those staff, which in turn would
531 hinder any quality improvement efforts.

532
533 The findings are moderated by conceptual and pragmatic issues relating to the implementation of the
534 survey, which would need to be addressed before implementation - using the approaches taken in this
535 study - could be possible. Further testing to determine whether feedback can contribute to a change in care
536 is required. For instance, patients were able to highlight aspects of their care that had made them feel safe
537 or unsafe, but this was often conflated with other aspects of care (i.e. beyond the transfer from hospital),[34]
538 including the transfer *into* hospital or their experiences on the ward. Such conflation was also reflected in
539 patients often reporting the same ratings of safety across the three different stages of the transfer; based
540 on interviews and open text comments, this was not always representative of how they experienced safety
541 within those individual stages. This suggests that a safety experience from one location of care (for example
542 in the hospital setting) is remembered and reflected in the feedback on latter stages, including transfer.

543

544 **Study limitations**

545 There is considerable scope for a Type-I error within the statistics, given the number of variables that were
546 tested. There was consistency in the correlation between transport type and safety ratings across all six
547 domains of safety, which suggests this finding was not subject to a Type-I error. However, there was no
548 such consistency in relation to the three significant gender-safety rating correlations, and as such these
549 findings should be treated with caution.

550
551 There were a number of other limitations to the study, although many of these are indicative of the
552 feasibility nature of the study. The first of these limitations was that the number of responses to the survey
553 and the number and varied categorisation of staff incident reports meant that it was not possible to perform

554 statistical analysis to look for correlations or relationships beyond those that appear at a thematic level.
555 This was also reflected in some subgroups with a small number of participants, such as respondents from
556 care of older people wards (n=16).

557

558 A further limitation relates to the limited data obtained from existing measures and indicators of quality
559 and safety. Firstly, with the exception of staff incident reports, there were very few if any routinely collected
560 data that are directly relevant to the care transfer, or the discharge from hospital. Data on patient
561 complaints was obtained, however there were too few for any meaningful statistical analysis or for
562 inclusion in the thematic analysis due to identification concerns. The complaints data only contained a
563 single category, meaning any form of thematic analysis similar to the staff incident reports was not
564 possible. Other routinely collected safety data, such as from the Safety Thermometer,[47] was deemed
565 to be irrelevant to the discharge process and was therefore not obtained. Readmission and length of stay
566 data was obtained for eight of the 16 wards, but again there was insufficient data for inferential analysis.

567

568 As the research team were not involved in collecting the reports, with the exception of producing the
569 surveys and providing them to participating wards, we encountered a number of barriers to conducting
570 the research that were not specifically related to feasibility of implementing a safety survey. These
571 included a lack of awareness amongst staff on the wards, caused in part by high staff turnover, resistance
572 to change or a lack of motivation to engage, confusion between multiple surveys to give to patients and
573 time or resource constraints. Whilst a more resource-intensive approach could have been used, such as
574 having more research staff to facilitate the distribution of the survey or incentivising the distribution, the
575 findings provide a more accurate reflection of what would happen were the survey to be introduced into
576 routine practice.

577

578 Finally, the use of numerically-identified envelopes allowed envelopes to be tracked from distribution
579 through to response. However, there were some discrepancies in the distribution data as a result of using
580 this process, as described in the methods. This was usually isolated months rather than over a prolonged
581 period of time, and was accounted for to some extent in the analysis. However it is likely that distribution
582 rates and response rates were influenced by these discrepancies. Specifically, distribution rates will have
583 been lower than identified, and response rates will have been higher.

584

585 **Implications for research and practice**

586 Patient experience is recognised as a pillar of healthcare quality,[32] but there needs to be sufficient
587 resources to support the collection of experience data so that it does not become a burden for front-line
588 teams. However, removing the onus from front-line staff may generate suspicion of the system and staff
589 disconnectedness, as has happened with the Friends and Family Test in the English NHS.[48] Future
590 research needs to examine whether patient feedback in relation to their safety during transitions in care is
591 able to influence practice and drive quality improvement at the local level. Whilst there is some limited
592 evidence that this may be the case in single care settings,[24] and staff within this study reported that it
593 should be possible, there is still a requirement to identify how this can be done in practice where multiple
594 boundaries exist. There is also a need to investigate other factors that contribute to patients' experiences
595 of safety, such as where patients are transitioning to, and whether treatment is still ongoing or complete.

596

597 As patients struggled to differentiate between the different stages of their care, it is necessary to question
598 the assumption that patients are better placed than healthcare professionals - who only see parts of the
599 transfer relevant to their role[7 13] - to identify safety issues that span multiple boundaries and
600 organisations. Future research should aim to identify the unique aspects of the transition that the patient
601 and care provider can identify both individually and jointly, which would need to include developing a greater
602 understanding of how patients perceive boundaries within health and social care. Such research could
603 move towards providing more comprehensive datasets that link multiple types of feedback from patients
604 and healthcare professionals specific to single episodes of care or transitions, thus providing a more holistic
605 perspective. Current policy drivers towards improved health and social care integration[9] may help with
606 the system changes necessary to facilitate these data sets.

607

608 **CONCLUSIONS**

609 Limited efficacy testing suggests that patients can provide meaningful feedback on their experiences and
610 perceptions of safety in the context of care transitions. Furthermore, providing safety experience feedback
611 was acceptable to some patients, subject to certain conditions being met; *cognitive-cultural* (patient
612 understanding and prioritisation of safety), *structural-procedural* (opportunities, means and ease of

613 providing feedback without fear of reprisals), and *learning & change* (closure of the feedback loop).[34]
614 Safety experience feedback from patients was also acceptable to staff, with quantitative data serving the
615 purpose of indicating where there may be problems, and qualitative data informing the types of changes
616 required to improve care. However, patient feedback was not integrated into any quality improvement
617 initiatives, suggesting that there are still significant challenges to healthcare teams or organisations utilising
618 patient feedback, particularly in relation to care transitions.

619

620 **List of Abbreviations**

621 NHS – National Health Service

622

623 **DECLARATIONS**

624 **Ethics approval and consent to participate**

625 Ethical approval for the collection and analysis of incident reports for the included NHS Trusts
626 and wards was obtained from the Yorkshire and The Humber/Leeds West NHS Ethics
627 Committee (13/YH/0372). R&D approval was provided by the individual NHS Trusts. All
628 participants gave written, informed consent for the collection and analysis of qualitative data.
629 Survey participants were informed that return of the survey constituted consent to be included in
630 the study.

631

632 **Consent for publication**

633 Not applicable.

634

635 **Availability of data and material**

636 Participants did not provide consent to share their data beyond the original study team. The
637 study team would be happy to interrogate the data on behalf of others upon reasonable request
638 to the corresponding author. In line with the study's ethical approval, restrictions apply to the

639 availability of the data, and it will no longer be available for interrogation after 31st December
640 2021. Study materials required for replication are available as supplementary files.

641

642 **Competing interests**

643 The authors declare that they have no competing interests.

644

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649 design and conduct of the study, including the collection, management, analysis, interpretation
650 of the data, preparation, review or approval of the manuscript, and decision to submit the
651 manuscript for publication.

652

653 **Authors' contributions**

654 JS, JW and PD conceived and designed the study. JS, EH and ADB collected the data. All
655 authors contributed to data analysis, drafting of the manuscript and approved the final version.
656 JS agrees to be accountable for all aspects of the work.

657

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Table 2: Safety survey responses in relation to the departure stage of the transition.

| Departure | N (% of all 366 respondents) | Safety rating | | | Differences in Characteristics | | |
|----------------|------------------------------|------------------------|-----------------------|-----------------------|--------------------------------|---------|----------|
| | | Safe (%) | Neutral (%) | Unsafe (%) | Clinical area* | Age** | Gender** |
| Communication | 346 (94.5) | 304 (87.9) | 32 (9.2) | 10 (2.9) | p=0.808 | p=0.132 | p=0.607 |
| Responsiveness | 342 (93.4) | 303 (88.6) | 31 (9.1) | 8 (2.3) | p=0.075 | p=0.285 | p=0.807 |
| Delays*** | 257 (70.2) | Cycle 1: 118 (64.8) | Cycle 1: 51 (28) | Cycle 1: 13 (7.1) | Cycle 1: p=0.874 | p=0.097 | p=0.768 |
| | | Cycle 2: 34 (45.3) | Cycle 2: 23 (30.7) | Cycle 2: 18 (24.0) | Cycle 2: p=0.151 | | |
| Falls | 310 (84.7) | 268 (86.5) | 37 (11.9) | 5 (1.6) | p=0.874 | p=0.887 | p=0.184 |
| Medication | 335 (91.5) | 278 (83.0) | 36 (10.7) | 21 (6.3) | p=0.107 | p=0.650 | p=0.182 |
| Hygiene | 351 (96.0) | 319 (90.9) | 29 (8.3) | 3 (0.9) | p=0.841 | p=0.559 | p=0.322 |

801 * Kruskal-Wallis test comparing the four clinical areas: cardiac, care of older people, orthopaedics, stroke.

802 ** Spearman's rho correlation with safety rating

803 *** Reported per cycle due to changes in the question

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Table 3: Safety survey responses in relation to the journey stage of the transition.

| Journey | N (% of all 366 respondents) | Safety rating | | | Differences in Characteristics | | |
|----------------|------------------------------|---|--|---|---|---------|---|
| | | Safe (%) | Neutral (%) | Unsafe (%) | Transport type* | Age** | Gender** |
| Communication | 231 (63.1) | 213 (92.2) | 14 (6.1) | 4 (1.7) | p<0.001 Safe Ambulance, 93.3% Private car, 91.0% Patient transport, 85.7% | p=0.121 | p=0.876 |
| Responsiveness | 230 (62.8) | 207 (90.0) | 20 (8.7) | 3 (1.3) | p<0.001 Safe Ambulance, 90.8% Private car, 83.3% Patient transport, 66.7% | p=0.911 | p=0.463 |
| Delays | 226 (61.7) | Cycle 1: 151 (73.5) Cycle 2: 34 (45.3) | Cycle 1: 29 (19.2) Cycle 2: 23 (30.7) | Cycle 1: 11 (7.3) Cycle 2: 18 (24.0) | p<0.001 Safe*** Ambulance, 71.4% Private car, 67.2% Patient transport, 58.3% | p=0.460 | p=0.038 (male more likely to report safe) |
| Falls | 230 (62.8) | 194 (84.3) | 29 (12.6) | 7 (3.0) | p=0.009 Safe Ambulance, 90.8% Private car, 83.3% Patient transport, 66.7% | p=0.420 | p=0.501 |
| Medication | 226 (61.7) | 197 (87.2) | 23 (10.2) | 6 (2.7) | p=0.001 Safe Ambulance, 87.7% Private car, 87.2% Patient transport, 91.7% | p=0.194 | p=0.444 |

| | | | | | | | |
|---------|------------|---------------|----------|---------|---|---------|---------|
| Hygiene | 232 (63.4) | 211 (90.9) | 18 (7.8) | 3 (1.3) | p<0.001 | p=0.536 | p=0.703 |
| | | | | | Safe Ambulance, 91.7% Private car, 92.4% Patient transport, 81.8% | | |

807 * Kruskal-Wallis test comparing the three categories with >10 responses: ambulance, private car, patient transport.
808 ** Spearman's rho correlation
809 *** Cycles 1 and 2 combined
810

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Table 4: Safety survey responses in relation to the arrival stage of the transition.

| Arrival | N (% of all 366 respondents) | Safety rating | | | Differences in Characteristics | | |
|----------------|------------------------------|---------------------|--------------------|--------------------|--------------------------------|---------|---|
| | | Safe (%) | Neutral (%) | Unsafe (%) | Arrival destination* | Age** | Gender** |
| Communication | 235 (64.2) | 219 (93.2) | 11 (4.7) | 5 (2.1) | p=0.980 | p=0.840 | p=0.122 |
| Responsiveness | 237 (64.8) | 210 (88.6) | 23 (9.7) | 4 (1.7) | p=0.315 | p=0.691 | p=0.207 |
| Delays | 223 (60.9) | Cycle 1: 118 (79.7) | Cycle 1: 21 (14.2) | Cycle 1: 9 (6.1) | p<0.001 | p=0.084 | p=0.039 (male more likely to report safe) |
| | | Cycle 2: 34 (45.3) | Cycle 2: 23 (30.7) | Cycle 2: 18 (24.0) | | | |
| Falls | 241 (65.8) | 204 (84.6) | 32 (13.3) | 5 (2.1) | p=0.052 | p=0.069 | p=0.001 (male more likely to report safe) |
| Medication | 239 (65.3) | 213 (89.1) | 21 (8.8) | 5 (2.1) | p=0.433 | p=0.404 | p=0.400 |
| Hygiene | 241 (65.8) | 219 (90.9) | 17 (7.1) | 5 (2.1) | p=0.779 | p=0.927 | p=0.351 |

813 * Mann-Whitney U test comparing the two categories with >10 responses: home, hospital.

814 ** Spearman's rho correlation

815 *** Cycle 1 only as too few respondents (n=2) reported going to hospital in cycle 2.

816

| | |
|-----|----------------------------------|
| 817 | Figure Legend |
| 818 | |
| 819 | Figure: Data collection overview |
| 820 | |

821 **Additional files**

822

823 Additional file 1: Supplementary Material - Patient Interview Topic Guide

824 *This file contains the interview topic guide used with patients.*

825

826 Additional file 2: Supplementary Material - Staff Interview Topic Guide

827 *This file contains the interview topic guide used with staff members.*

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829 Additional file 3: Supplementary Material - Safety Survey

830 *This file contains the final version of the safety survey distributed to patients as part of the limited efficacy*

831 *testing*

832

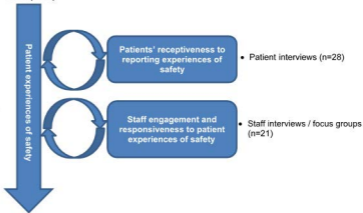
833 Additional file 4: Supplementary Material - COREQ checklist

834 *This file contains the COREQ checklist*

Distribution of safety survey

Safety survey distributed to patients
(n=2,824) at point of discharge from
wards (n=16)

- Valid survey responses
(n=366)
- Datix™ reports of safety
(n=92)



Mixed method analysis

Convergence coding matrix combining all
three components

HCP INTERVIEW SCHEDULE

Briefing

- The purpose of the interview
 - Talk about safety and patient reporting of safety
 - Understand how patient reports of safety can be used
- Interview will be recorded unless they ask otherwise
- Why they have been asked take part in the study
- How long the interview will last
 - Approximately 30 to 60 minutes
- Their rights as participants
 - Right to withdraw at any time
 - Ask questions at any time
 - Right to complain
 - What you tell me today will remain completely confidential and you will remain anonymous.
 - However if you tell me something that suggests yourself or someone else may be at risk of harm, I will have to break confidentiality. Again, doing so will not affect the care that you receive.
- Have they got any questions?
- Signing of the consent form

To begin with, I'd like to ask you some questions about yourself.

General Questions

1. **What's your role / job?**
2. **Which team do you work in?**
3. **How long have you worked in this role / been qualified?**

General Patient Safety Questions

1. **What do you understand by the term patient safety?**
2. **Do you think that patients should have a role in their own safety?**

Prompt

- What role should this be? Why?
- Who should ultimately be responsible for patients' safety? Why?
- Do you think that patients can make a difference to their own safety?
 - If yes, how? What would help this to happen?
 - If no, why not? What are the barriers?

3. **Do you think patients should be providing feedback on their safety?**

Prompt

- Will doing so make any difference? Why / why not?
 - If no, ask what would need to change

4. **Are there any reasons a patient wouldn't provide feedback on their safety?**

Prompt

- Reasons for being unwilling, unable or unready to provide feedback
- What can be done to change this?
 - For example what types of support might be needed or is it a wider issue?

Questions about Safety Survey Distribution

1. **How did you experience distributing the surveys to patients?**

Prompt

- Did you find that the survey was distributed to all discharges?
- Was there anything that prevented you or others from distributing the survey?
- Was there anything that helped increase distribution?
- Did distributing the survey interfere with any of your other tasks?
- Does your ward distribute any other surveys (e.g. Friends and Family)? If so, how did the distribution of this survey compare?

2. What would improve distribution rates of surveys like this one?

Prompt

- Do staff need more reminders, or a stronger motivation to distribute/explanation as to why distribution matters?
- Can you think of any ways that distribution of the survey could be embedded into regular practice?

Questions about Safety Survey Feedback

I'd like to now ask you some questions about the safety survey feedback

3. What sort of contact have you had with the feedback?

Prompt

- Were you responsible for receiving and using the feedback? If not, how were you in receipt of the feedback, and by whom?

4. Can you tell me what you think about the feedback?

Prompt

- Was it useful? Do you think it accurately reflects things? Were there other questions we should be asking patients?

5. Have you learned anything from the feedback?

Prompt

- Can you give some examples?
- [If appropriate] Do you have anything to support this?

6. Have you made any changes based on the feedback?

Prompt

- If yes, what changes have you made? How did the feedback help? What could be done better?
- If no, why not? What would need to be done to be able to make these changes?

7. Are there more appropriate ways for patients to provide feedback about their discharge?

Prompt

- If yes, what are they? How would they be better?
- If no, why not?

8. Is there anything else that you'd like to mention?

PATIENT INTERVIEW SCHEDULE

Briefing

- The purpose of the interview
 - To get an understanding of what they understand about patient safety
 - To get feedback on the reporting tool
 - To find out if it accurately captures their thoughts on safety
 - To get an understanding of how they think the reports of safety can lead to improvements
- Interview will be recorded unless they ask otherwise
- Why they have been asked take part in the study
- How long the interview will last
 - Approximately 30 to 60 minutes
- Their rights as participants
 - Right to withdraw at any time
 - Ask questions at any time
 - Right to complain
 - Anything that is said today will not affect your healthcare
 - What you tell me today will remain completely confidential and you will remain anonymous.
 - However if you tell me something that suggests yourself or someone else may be at risk of harm, I will have to break confidentiality. Again, doing so will not affect the care that you receive.
- Have they got any questions?
- Signing of the consent form

To begin with I'd like to ask you a few questions about yourself. Remember, if you don't want to answer a question please say.

General Health Questions

1. **How old are you?**
2. **Do you consider yourself to have any disabilities**
 - a. **If yes, what are they?**
3. **What would you describe your ethnicity?**
4. **What sort of care, if any, are you receiving at the moment?**
5. **Roughly how often do you go into hospital?**

General Safety Questions

1. **In terms of the care that you receive, what do you understand by safety?**
2. **Have you ever been involved in something to do with your care that may have or did affect your safety?**

Prompt

- What about someone else's safety?
3. **Have you ever experienced something that made you feel particularly safe?**

Prompt

- Think back to the last time you were discharged from hospital

4. **Do you think that as a patient, you should have a role in your own safety?**

Prompt

- What role should you play and why?
- Who should ultimately be responsible for your safety and why?
- Do you think that you can make a difference to your own safety?
 - If yes, how? What would help this to happen?
 - If no, why not? What are the barriers?

5. **Do you think patients should be providing feedback on their safety?**

Prompt

- Will doing so make any difference? Why / why not?
 - If no, ask what would need to change

6. Can you think of any reasons why patients would or would not be willing to provide feedback on their safety?

Care Transfer Questions

I'd now like to ask you some questions about your recent transfer out of hospital. This includes when you were being discharged, the journey or transport to your next destination and when you arrived there.

1. Can you tell me about your recent transfer?

Prompt

- Where were you discharged from? Where were you transferred to? How did you get there?
- Who was involved in your transfer? (can be staff, family, friends etc)
- Relating to your safety, did anything of note happen?

2. In the survey, you said [...]. What was it that made you choose these answers?

3. Ask a question about feeling safe

4. Ask a question about feeling unsafe

5. Would you say that your experiences would make you more or less likely to report on your safety?

Safety Survey Questions

1. Can you tell me what you thought of the safety survey in general?

2. Did you feel you understood the point of the safety survey?

Prompt

- What do you think the survey was trying to find out?
- Why do you think we'd want to find out about this?
- Did you think it allowed you to provide useful feedback?

3. Did you feel that the survey provided you with any useful information about safety?

4. Did you experience any difficulties filling out the survey?

5. Did you feel you understood what all of the questions were asking you?

6. I'd like to go through the safety survey to see how you interpret(ed) it. Can you tell me what you understood by:

a. 'Your departure'

Commented [JS1]: I've moved this from general safety questions. Otherwise we'd start asking about the survey and then move away from it again. Delete this comment and it's good to go!

Prompt

- Departure from where?
- What sorts of events/places might this involve?

b. 'Your journey'

Prompt

- Journey from where to where?

c. 'Your Arrival'

Prompt

- Arrival where?
- What sorts of events/places might this involve?

7. In terms of your departure, what do you think we might have meant by the following? Can you give an example?

- Communication from staff
- Staff listening to you
- Departure running to schedule
- Falling or potential falls
- Medication problems or concerns
- Hygiene

8. In terms of your journey, what do you think we might have meant by the following? Can you give an example?

- Communication from staff
- Staff listening to you
- Journey running to schedule
- Falling or potential falls
- Medication problems or concerns
- Hygiene

9. In terms of your arrival, what do you think we might have meant by the following? Can you give an example?

- Communication from staff
- Staff listening to you
- Waiting times
- Falling or potential falls
- Medication problems or concerns
- Hygiene

10. Did you think the questions that it asked reflected what you think about safety?

Prompt

- Why or why not?



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Nottingham University Hospitals
NHS Trust



11. Was there anything that it missed?

12. Are there any other ways that you think would be more appropriate to provide feedback on your safety?

Prompt

- Other formats or questions?

13. Did you think that completing the survey may or may not affect the care that you receive in the future?

Prompt

- If no, why not? What are the barriers to this?
- If yes, how? What can make this happen better?

14. Is there anything else that you'd like to add?

SAFE AND SURE

Safety Survey

Dear patient and / or carer,

This survey is for you to tell us how safe you felt during your most recent transfer out of hospital, and what made you feel this way. Anything that you tell us will remain confidential and will not affect the care that you receive.



It is important for us to find out about your experiences so that we can improve our services. **Please complete the survey and return it in the prepaid envelope provided.**

Contact Jason Scott or Emily Heavey if you have any questions, would like help completing the survey or if you would like to receive the survey in large print.

01904 876 376

j.scott@yorks.ac.uk

e.heavey@yorks.ac.uk

What does safety mean?

We believe that for you to feel safe, healthcare staff should communicate with you, respond to your individual needs and ensure you are physically safe and secure. We are also interested in finding out if there is anything else that makes you feel safe.

How do I complete the survey?

For each question, please tick the face that best represents how you felt. The **green face** means you had no worries or concerns about your safety, the **red face** means you were worried or concerned about your safety, and the **yellow face** means you felt somewhere between the two.



Departure means planning and preparing for, and leaving hospital.

Journey means travelling from hospital to your next location.

Arrival means settling in at your next location.

What is your NHS Number? (optional) _____

Are these the opinions of: patient carer

What was the date of your departure? / /

Which ward did you depart from? _____

Where were you going to? _____




How did you get there? _____

Did someone go with you? Yes No




If yes, who? Family / Friend Carer Member of Staff

Only tick boxes for questions below that are relevant to you, for example the question on staff communication during your journey may not be applicable if you used your own transport.

How safe did the communication from staff make you feel? For example giving you clear and timely information or being polite.

| | | | | |
|----------------------------------|--|--|--|-----------------|
| |  |  |  | Comments: _____ |
| On your departure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| During your journey | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| On arrival at your next location | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

How safe did you feel with regards to staff listening to you and responding to your individual needs?

| | | | | |
|----------------------------------|---|---|---|-----------------|
| |  |  |  | Comments: _____ |
| On your departure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| During your journey | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| On arrival at your next location | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Did you experience any delays? Yes No

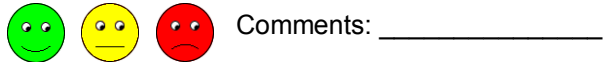
If yes, where was the longest delay during your transfer?

Departure Journey Arrival Comments: _____

How did this make you feel?



How safe did you feel about the possibility of falling? For example if you felt confident that you wouldn't fall or if you were you concerned that you might

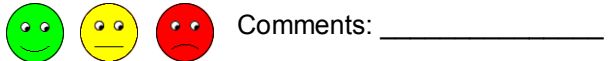


On your departure _____

During your journey _____

On arrival at your next location _____

How safe did you feel about your medication? For example receiving the correct medication, understanding the medication you were taking or delays in receiving your medication.



On your departure _____

During your journey _____

On arrival at your next location _____

How safe did you feel about hygiene and cleanliness? For example if staff washed their hands and if the surroundings were clean



On your departure _____

During your journey _____

On arrival at your next location _____

Overall, how safe did you feel throughout the whole transfer including the departure, journey and arrival?

Comments: _____



Thank you for taking the time to complete this survey. Please return it in the freepost envelope provided.

What will we do with your answers to this survey?

We will bring together feedback from patients and provide this anonymously to healthcare teams involved in your transfer. The purpose of this is to identify what is being done well, and areas where the quality of care that you receive can be improved.

What should you do if you want to make a complaint about your care?

By completing this survey you are **not** making a complaint. If you have felt unsafe at any other point during your care or would like to raise a specific concern please contact the Patient Advice and Liaison Service. If you contact us we can give you information on how to do this.

Would you like to receive a summary of the research findings?

Yes No

Please fill out your details below and we will send you this at the end of the study. All information will remain private and confidential in line with the Data Protection Act (1998), and will not be shared with anyone or used for any other purpose than to provide you feedback.

Name: _____

Address: _____

Could you please tell us your gender, age and how you define your racial / ethnic origin. This will tell us if we're reaching a wide sample of people. If you are a carer, please tell us the patient's details. You do not have to complete this part if you do not want to.

Gender: Male Female

Age: _____

Racial / ethnic origin: _____