Patient and colleague feedback for anaesthetists
Revalidation guidance series

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Introduction and acknowledgements

In February 2011, the Royal College of Anaesthetists (RCoA), together with the Faculty of Intensive Care Medicine (FICM) and Faculty of Pain Medicine (FPM) set up a working group to look at how anaesthetists could obtain and act upon feedback from patients and colleagues. A series of guidelines were published.

Following the introduction of revalidation in December 2012 it has now been possible to look at how the processes have worked in practice. A working group of the RCoA Revalidation Committee has developed a patient feedback questionnaire, specific to the needs of anaesthetists, and piloted it in four hospitals across the UK.

This document details the experiences gained from the pilot and is intended to provide guidance for anaesthetists and their appraisers.

We would like to thank the doctors who took part in the pilot for their co-operation and support.
Members of the RCoA Patient Feedback Pilot Group

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† Until September 2013
The purpose of patient and colleague feedback

Feedback from patients and colleagues can provide doctors with information about their work through the eyes of those they treat and work with. It provides the opportunity for patients, non-medical co-workers and medical colleagues to comment on the professional skills and behaviour of a doctor, and in turn allows the doctor to reflect on this information for his or her professional development.

Professional behaviour in doctors is central to quality of care and there are a variety of measures which may be used to assess it. In addition to patient and peer feedback, clinical outcome measures are clearly important for evaluating the practice of anaesthetists for quality improvement purposes.¹

Licensed doctors are required to seek feedback from patients and colleagues using structured questionnaires at least once in each revalidation cycle (normally every five years). Results from both patient and colleague questionnaires should be included in a doctor’s revalidation portfolio and discussed at appraisal.

How much feedback is required?

All doctors should collect patient feedback using a structured questionnaire.

The GMC does not require a specific or minimum number of responses to be collected. The feedback that is collected should provide the doctor with information about all aspects of his or her practice.

Most anaesthetists should be able to get feedback from between 15 and 30 patients.

Anaesthetists who only carry out small numbers of complex-major cases may have less opportunity to collect feedback from patients. They should make every effort to obtain as much as is practically possible. They may also be able to get feedback from surrogates (including patient relatives).
Not all questionnaires given to patients will be completed or returned. Doctors and their appraisers should take into account the expected return rate.

# Questionnaires for gaining patient feedback

The College has developed, piloted and validated a questionnaire tailored specifically for the interaction between patients and their anaesthetist in the surgical setting.

Following the completion of the study and analysis of the results this questionnaire was presented to the GMC who are satisfied that it meets their criteria. It is available on the RCoA website at [www.rcoa.ac.uk/reval-feedback-practice](http://www.rcoa.ac.uk/reval-feedback-practice).

The College questionnaire seeks information from patients using the same domains as the standard GMC patient questionnaire. However the questions are framed in a slightly different manner. The questionnaire does not ask the patient to comment on whether they felt their doctor could maintain confidentiality – our pilot study found that patients could not provide a reliable and informed answer in the context of their engagement with the anaesthetist.
The logistics of collecting patient feedback

Timing of patient feedback

Our pilot study found that the optimum time for gaining feedback on surgical patients is after the pre-operative consultation with the anaesthetist. The immediate post-operative period is not a good time because of the residual influence of anaesthetic drugs.

Patients attending out-patient clinics (e.g. pain, pre-assessment) can be asked for feedback following their consultation.

Questionnaires should be given to the patient as soon as possible after the consultation with the doctor that they are being asked to provide feedback on. Electronic versions of the questionnaire, e.g. using tablets or portable computers in the ward or clinic, should be given to patients as soon as possible after the consultation to achieve optimum returns.

Questionnaires may also be emailed or posted to patients but return rates may be reduced especially as the interval post-consultation increases.

We recognise that other hospitals have developed local methods of collection. For example, in Northern Ireland a generic patient feedback form is administered centrally which is usually given to in-patients at the time of discharge and filled in by relatives/carers/parents for day cases.

Obstetrics

Patients having caesarean section can provide feedback after the pre-operative consultation. If the procedure is carried out under regional block without sedation then they could provide feedback in the immediate post-operative period.

Feedback could be sought from mothers after epidural analgesia in labour the next day on the follow-up ward round, or by the midwife co-ordinator.
Feedback from relatives and carers
The GMC recognises and encourages seeking feedback from relatives and carers – for example the parents of young children or the carers of patients with dementia or impaired consciousness. Elderly patients may require assistance in completing the form.

Administration, collation and privacy of feedback
A third party, such as an administrator, should carry out the administration and collection of patient feedback questionnaires, and the collation of responses. Individual doctors and appraisers should not have any involvement in the collation of the results or be able to identify which patient made any particular comment or reply. Trusts and employers should provide the necessary support and resources to facilitate this.²

Anonymity for the patient must be demonstrably ensured.

A photograph of the doctor (both in ‘scrubs’ and regular clothing) may be helpful to patients to ensure they give feedback on the correct individual.

The administration of patient feedback is easier if a pan-departmental approach is adopted.
Colleague feedback

Feedback from colleagues should be collected using a questionnaire that complies with the GMC’s *Guidance on Colleague and Patient Questionnaires.*

Feedback from colleagues should be sought from across the range of clinical and professional practice. It should also take into account the range of places that a doctor works, including multi-site working and private practice.

The choice of colleagues to provide feedback should include representatives from the following professional groups (as appropriate).

- Academic and research staff
- Consultant anaesthetists
- Critical care staff – medical and non-medical (e.g. pharmacists, physiotherapists)
- Managerial or administrative staff
- Midwives
- Nurses working in theatre and recovery
- Operating department practitioners and anaesthetic nurses
- Pain or pre-assessment clinic staff – medical and non-medical
- Surgeons
- Trainee anaesthetists

This list is not exhaustive, and individual doctors may seek feedback from other colleagues with whom they work.

It is essential that doctors seek feedback from a broad range of colleague groups, rather than any one particular group, in line with the breadth of their clinical work.
Doctors working in intensive care medicine

Doctors who work in intensive care medicine should look at the guidance provided by the Faculty of Intensive Care Medicine.

Acting on the results of patient and colleague feedback

Patient and colleague feedback is intended to be formative.

It should therefore be given to doctors prior to their appraisal to allow them to reflect and to plan or take appropriate actions, which should then be reviewed at appraisal.

The results from patient and colleague feedback should be given to individual doctors by trained facilitators. In many cases this will be the doctor’s appraiser.

If specific concerns are identified it might be that the doctor should undertake a second patient and/or colleague feedback exercise within the same revalidation cycle.

Appraisers should primarily be interested in the actions that have been planned or taken as a result of the feedback, not merely that feedback has been collected.
Collecting patient feedback – examples

Obtaining patient feedback at Glasgow Royal Infirmary

Glasgow Royal Infirmary (GRI) is a teaching hospital with a large maternity unit and regional plastic surgery and burns service.

Obstetric anaesthesia: Feedback was sought after pre-operative assessment for elective caesarean section; this was straightforward. Some feedback was sought following elective caesarean section in the recovery room; this is a group of patients who have usually received only regional anaesthesia. It is possible that patient feedback could be modified by intraoperative events outside the anaesthetist’s control, e.g. if the obstetrician exteriorises the uterus there may be intraoperative discomfort. It would be more difficult to seek feedback for category 1 or 2 sections, as there are time constraints, and likely maternal anxiety.

General: The majority of GRI anaesthetists asked members of staff to distribute the patient feedback questionnaires immediately after their pre-operative assessment. This meant the distribution of questionnaires was not random, and offered the opportunity to avoid giving a questionnaire to a patient with whom there was poor rapport. At least one anaesthetist left the questionnaires with the ward staff for them to be distributed randomly. This anaesthetist had a lower return rate, 50%, and there was a possibility of error, i.e. that some of the forms could have been given to patients that that doctor had not seen.

Pain medicine: Pain medicine doctors were able to leave the questionnaires with clinic staff who distributed the forms on their behalf.

The GMC recommends that a third party should distribute the questionnaires. However, at GRI the patients for any one theatre list may be admitted to a number of different wards areas, so it was not feasible to leave all forms in one place. The department has limited secretarial assistance – there is currently no capacity for secretarial staff to assist with this process. The solution of the anaesthetist asking a third party to deliver the form shortly after patient assessment was a pragmatic approach, which resulted in reasonable return rates.
Consultant anaesthetist: electronic return

I have successfully obtained patient feedback for patients seen in the pre-assessment clinic of a small district general hospital. We used an electronic version of the RCoA patient feedback questionnaire created using secure online questionnaire and survey software. The questionnaires were distributed to 35 consecutive patients by the pre-assessment clinic administration staff. Of these patients 15 completed the questionnaire in the pre-assessment clinic immediately afterwards, 10 patients were given the web address of the questionnaire and asked to complete it at home and 10 patients completed a paper version of the questionnaire which were then uploaded to the online site. Patients were also surveyed about the acceptability of the use of electronic media to complete the form.

There was a very low return rate of only 40% from patients who were asked to complete the questionnaire at home. Administration staff had to undertake significantly more work to upload the paper responses onto the online survey software. 89% of patients who completed the electronic format of the questionnaire found it to be acceptable and none found it unacceptable. 74% of patients would not have preferred a ‘paper-format’ of the questionnaire, or were neutral, and only 26% would have preferred a paper format. 60% of the patients who completed the paper version included obviously incorrect information or did not complete ‘compulsory’ fields. This did not happen in any of the electronically completed questionnaires due to the electronic processes requiring an answer before progressing to the next page.

At the end of the survey period a report is generated by the online survey software and sent to the anaesthetist and their appraiser for inclusion in their appraisal documentation. This report provides an easily interpretable summary for each of the questions, along with anonymous open-ended responses.

I believe that electronic completion of the questionnaires is easier for patients, for staff (less forms to hand out and nobody is required to enter the results into a database and then analyse them) and also for the anaesthetists (who get a report at the end together with the comments made by the patients). It should make the system less open to abuse as data is collected securely online reducing the potential / opportunity to tamper with the results. Anonymity is well protected. Data collection is more complete with fewer
errors and incomplete sections. There are also environmental benefits of not using three sheets of paper for each questionnaire.

**Obtaining feedback at the Princess of Wales Hospital**

The Princess of Wales Hospital is a district general hospital within the Abertawe Bro Morgannwg University Health Board. The hospital is located on the outskirts of Bridgend town in South Wales, and provides acute health services to the local population of approximately 160,000 people.

For the purpose of the pilot study we included patients undergoing urgent and elective surgery in the main operating theatres, day surgery unit and the short stay unit (SSU). We also included those using obstetrics and paediatric services.

The feedback forms were handed over to the anaesthetists with instructions from the RCoA. We placed labelled boxes for the completed questionnaires in most of the above-mentioned sites. The nurses in the day surgery unit and the midwives on the labour ward were particularly helpful, and the response rates from these sites were quite good. Staff were instructed to hand over forms to the patients in a randomised fashion and to collect the completed forms in the boxes provided.

Our SSU turnover is very rapid as most of the patients for major and minor surgery are admitted here before their surgery. We found the staff here were hard pressed for time. To overcome this we asked the theatre receptionist to hand over the forms to patients in the pre-operative waiting area (excluding those who had a pre-med). Distributing the forms in this way led to a higher response rate. The receptionist reported that one of the patients had remarked that ‘It gave me something useful to do and I forgot my anxiety briefly’.

One of the anaesthetists has a dental GA list, which has a significant number of patients with learning difficulties. He obtained a 60% response rate from the carers.

We felt that although nurses and other health care providers wanted to help with the administration of the forms they did not have the time to do so. We all felt that the Trust administrative staff should be given specific time to do this, especially in view of the large number of forms involved.
We are looking at ways in which we can carry out the process electronically, which may be easier and more environmentally-friendly, and we are in consultation with our Patient Liaison Group to discuss this.

Most of us thought 15-20 completed forms per doctor was a reasonable number.

**Obtaining feedback at Wrexham Maelor Hospital**

Wrexham Maelor Hospital is one of three district general hospitals within Betsi Cadwaladr University Health Board. It is located in North East Wales and serves a population of 300,000. Wrexham is the regional centre for upper GI surgery and is supported by an intensivist-led 12 bedded critical care unit. The anaesthetic department comprises 24 consultants, 11 specialty doctors and 15 trainees.

We recruited 15 volunteers, which included both consultants and specialty doctors, to take part in the pilot.

The majority of surgical patients are admitted on the day of surgery to one of two wards. One is a self-contained day case unit. The other is an admissions ward – patients admitted here are transferred post-operatively to an in-patient ward. We placed collection boxes on these wards and liaised with the nursing staff to explain the project and their part in it as a ‘third party’. Anaesthetists were given a pack containing the patient feedback questionnaire, a covering letter from the RCoA explaining the project and a labelled collection envelope.

Following the anaesthetist’s pre-operative visit, the patient was given a questionnaire by one of the nurses. They emphasised that it would be anonymised and that the anaesthetist would only see a summarised report of all questionnaires. Completed questionnaires were placed in sealed envelopes into the collection boxes. A member of the Trust administrative staff collected the questionnaires twice a week and entered the data into a database. I then produced summaries of the feedback and emailed these to participants for discussion with their appraiser.

This system worked well. The timing meant that the pre-operative consultation was fresh in the patient’s mind. Identification of individual anaesthetists was easy because we are a relatively small department and the nurses know all the anaesthetists.
Doctors who worked in other clinical areas, such as the labour ward or paediatric ward, were asked to send the feedback forms collected in these areas in a sealed envelope to the secretaries in the anaesthetic department. Midwives and ward nurses were involved.

Some colleagues had difficulty in getting sufficient numbers of completed forms in the time available for the pilot. Reasons for this included management commitments and blocks of working in ITU. Those anaesthetists who did long cases that lasted all day found that there was not always time for the patient to complete the questionnaire before being taken to theatre. However, with time extended beyond the pilot, these anaesthetists were able to get at least 15 returns.

References and further reading

References

Further reading