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Developing a Strategy for the Improvement in Patient Experience in a Canadian Academic Department of Surgery

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Abstract

Patient experience (PE) is recognized as a key component in the quality of health-care delivery. Public reporting of hospital, division, and physician-specific PE results has added to the momentum of adopting strategies to augment this metric of care. The Ottawa Hospital embarked on a journey to improve PE as a pillar of its quality improvement plan. This article demonstrates the efforts of a single surgery department from one large urban center to improve in-hospital PE in the rapidly changing environment of medicine and surgery. A multidisciplinary group within the department and a focus group of previous surgical inpatients were organized to address immediate challenges related to inpatient PE issues. We identified concrete strategies to optimize pain control, perceptions of patient respect and dignity, perceptions of surgeon availability, discharge medication understanding, and overall experience. Also, we identified a need in our department for timely patient feedback, improved communication styles in our staff and trainees, and an internal curriculum offering additional training for our staff and residents. We anticipate that the current results would be of significant interest to other departments wishing to optimize their PE profile as part of the ongoing quality improvement process at hospitals across North America.

Keywords

quality improvement, pain management, patient feedback, surgery, clinician–patient relationship, communication, physician engagement

Introduction

Patient experience (PE) is recognized as a key component in the quality of health-care delivery. Public reporting of hospital, division, and physician-specific PE results has added to the momentum of adopting strategies to augment this metric of care. There is also evidence that improvements in PE may be associated with better patient outcomes in surgery including decreased perioperative mortality, readmission, and failure to rescue (1).

There is potential to improve PE in the Canadian health-care system, and this has now been voiced as a priority for provincial government agencies (2). The Ottawa Hospital (TOH) embarked on a journey to improve PE as a pillar of its quality improvement plan. This dedication was reflected by the establishment of the Elizabeth and Matthew (EM) policy, instituted in April 2011, in an effort to improve communication between patients and the health-care team to honor 2 patients who suffered needlessly from adverse events related to breakdowns in communication (3). This policy was resonant with TOH's vision "to provide each patient with the world-class care, exceptional service and compassion we would want for our loved ones."

We recognized the need to mount a strategy to change the culture in the Department of Surgery to target the highest level PE results to achieve world-class standing. Therefore, the purpose of this work was to engage a multidisciplinary collaboration within the Department to develop a unified

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definition of PE with an improvement strategy. We utilized the wide spectrum of expertise in the Department to address immediate challenges related to inpatient PE issues. This process was a valuable exercise with a unique working collaboration of leaders with disparate perspectives. We believe that our findings are highly applicable to other surgical departments in academic and nonacademic settings.

Methods

The first part of the project was a hospital staff retreat developed as a quality improvement initiative. The second part of the project, which involved patient participation, was approved by the Ottawa Health Science Network Research Ethics Board. Patient informed consent was obtained.

Staff Retreat

Issues were identified and prioritized using 3 methods. The first involved a survey of division chiefs to assess their current understanding of the principles of PE and of the EM policy as well as their understanding of the processes related to EM policy compliance (Appendix A). A second survey of frontline office workers was completed to understand their perception of the application of the EM policy (Appendix B). Finally, a review was completed using the patient satisfaction data for inpatients on the surgery service. These survey data are routinely collected from randomly selected patients postadmission by National Research Corporation (NRC) Picker. The content of the survey is similar to the Hospital Consumer Assessment of Healthcare Providers survey (4; Appendix C).

A multidisciplinary staff retreat was then assembled consisting of 9 clinical managers, 9 surgeons, 1 pain physician, and 8 administrators with representation from quality, risk, faculty wellness, information systems, and leadership (no invitee declined attendance at the retreat). The retreat session was divided into 4 parts. Each part started with a presentation of the issue followed by breakouts with groups of 8 participants. The participants were given 18 minutes for discussion followed by a 5-minute group presentation and a 5-minute retreat-wide discussion. Data were collated, summarized, and sent to participants for feedback and changes.

Patient Focus Group

We recruited patients to obtain their feedback on the staff recommendations made during the retreat. The same PE issues related to patient-centered care were discussed at the patient focus group as at the staff retreat (Appendix D). Nine patients were recruited from TOH Patient and Family Advisory Council, a coalition of patients and family members who have had experience with hospital care. The inclusion criteria were as follows: (1) surgical inpatient at TOH anytime between March 2016 to March 2017 and (2) adult older than 18 years. The participants were given 20 minutes for discussion for each question.

Table 1. Initial Patient Experience Definitions Generated by The Staff Retreat Participants.

"The sum of all clinical and nonclinical interactions throughout the patient/family care journey"
"Everything patient and loved ones sense, feel, and think about the interactions with the organization"
"What patient and loved ones feel and perceive from the first to the last interaction with The Ottawa Hospital Department of Surgery"
"The sum of all interactions shaped by the organization's culture of providing compassionate care that influences the patient's perception cross the continuum of care"

Table 2. "Journey," "Loved Ones," and "Perceive" Were the Most Popular Followed by "Care," "Feel," and "Whole."

Journey	11 votes	100%
Loved ones	9 votes	82%
Perceive	8 votes	73%
Care	4 votes	36%
Feel	3 votes	27%
Whole	3 votes	27%
Interaction with hospital	1 vote	9%
Think	1 vote	9%
Culture	1 vote	9%

In this article, we have selected key findings for broader dissemination based on the perceived generalizability of the issues to other surgical departments.

Results

What is the Definition of the PE in Surgery?

Retreat results. Participants were asked to generate their own definitions and 4 were initially created (Table 1). Key points included (1) the language used should be understandable to the general population; (2) "family" and "loved ones" should be included in the definition as they may influence the patient's interpretation of care received; (3) "journey" also should be included because patient care extends beyond admission and includes the transition to home; and (4) "perceive" and "feel" are essential key words that prioritize subjective experience over objective outcomes. The participants voted on the key words extracted from the definitions (Table 2), and 3 definitions of PE were created using the top key words (Table 3).

Focus group results. The patients had mixed opinions in response to the definitions generated. Key points included: (1) a broad definition may lack the specifics that could be used to introduce accountability; (2) PE should include all points of contact with the hospital and should extend beyond admission; and (3) "perception" and "perceive" might not be understood by the general population.

Table 3. Patient Experience Definitions Created Based on Top Key Words Selected by The Staff Retreat Participants.

"Everything the patient and loved ones feel and perceive from their interactions with the hospital throughout their care journey"
"The feelings and perceptions of the patient and loved ones shaped by the sum of all hospital interactions throughout their care journey"
"What the patient and loved ones feel and perceive in their interactions with the hospital on their care journey"
A final variant was then recommended: "Everything our patients and their loved ones feel and perceive throughout their care journey with the hospital"

Table 4. Modified Patient Experience Definitions Based on Patient Feedback.

"Everything the patient and their loved ones feel from their interactions with the hospital throughout their care journey"
"The feelings of the patient and their loved ones shaped by the sum of all hospital interactions throughout their care journey"
"What the patient and their loved ones feel in their interactions with the hospital on their care journey"

Summary recommendation. We modified our PE definitions to include patient feedback (Table 4), removing the words "perception" and "perceive" as suggested. It is our vision that one definition will be chosen for dissemination to all medical and nonmedical staff and trainees and become the foundation for future training and assessment of patient-centric behaviors across the hospital.

Patient-Centered Care

What strategies can be used to ensure best postoperative pain control?

Retreat results. It is essential to define pain control in order to manage patient and provider expectations. Pain control is not the absence of pain but pain that is well controlled. Key points included: (1) use the patient room whiteboard to document the patient's current level of pain; (2) the health-care team should consider the factors influencing postoperative pain such as the type of surgery and patients' preoperative pain (5); (3) pain management should be standardized across the Department and should be based on the graduated use of nonopioids, opioids, and adjuvants; (4) multimodal pain management including music, massage, and other nonpharmaceutical therapy may be utilized; (5) psychologists can help patients cope with surgical trauma through techniques such as cognitive behavioral therapy and strategies to lessen catastrophization (6); (6) improve pain management teaching to residents through collaboration with the surgical education office; (7) physicians also should have updated knowledge on the initiation, adjustment, and discontinuation of narcotics.

Focus group results. (1) Pain management teaching to residents can be improved, including complex issues such as narcotics tapering and stewardship; (2) medical directives can be extended to nursing staff, so pain medications can be administered when residents are not available and during emergency situations (eg, pain pump malfunctioning).

Summary recommendation. Collaboration with the surgical education office is needed to improve resident education on pain management.

What strategies could a division use to improve the perception of respect, dignity, and courtesy?

Retreat results. Participants agreed that the quality of time with patients was more important than the quantity of time. Key points included: (1) surgeons should allocate time to address patient concerns and questions, (2) proper attire (eg, scrubs, white coats, and business attire) was an important aspect of respectful care, (3) inform patients when bedside teaching is occurring, and (4) explaining to the patient the concept of team-based care can help establish appropriate expectations of surgeon availability.

Focus group results. The patients agreed that respectful care means (1) being treated as an individual, (2) having adequate time with their surgeons to address their concerns, and (3) having their surgeons take time to explain the procedure to them.

Summary recommendation. Clinicians should be encouraged to take time with patients to ensure that patient concerns are addressed.

What strategies can be used to change patient's perception of "poor doctor availability"?

Retreat results. The group recommended better coordination between patients and providers such that the patient knows when the surgical team is available, and the surgical team knows when the patient or family would like to speak to them. Key points included (1) patients may be notified in advance on the timing of daily rounds and (2) the contact information of the surgeon and residents could be written on the whiteboards.

Focus group results. The patients found that good availability means having adequate opportunities to communicate with a health-care team member, be it a resident, nurse, or physician. Key points included: (1) being given a phone number that was a direct line to speak with a nursing staff, (2) the quality of discussion with a provider is more important than the duration, and (3) the resident's name can be added to the patient room whiteboard along with the names of the surgeon and nurse.

Summary recommendation. The patient room whiteboard can be used to communicate the timing of rounds, residents' names, and patient questions.

What strategies could be used to improve discharge medication understanding?

Retreat results. (1) Create a formal role for a team member to take charge of medication teaching at discharge; (2) the "teach-back" method can help confirm that the patient

understands what was explained; (3) allocate more teaching closer to discharge when the patient is more ready to learn; (4) drugs can be divided into the 3 categories "no change," "new," and "discontinued" to simplify medications at discharge; (5) distinguishing between generic and trade names and clarifying drug interactions are important areas for discussion with patients.

Focus group results. There is room for improvement in the way discharge medications are communicated to patients. Key points included: (1) inform patients of the nature and rationale of medication changes and (2) give patients a list of their medications at discharge with explanations for medication changes.

Summary recommendation. Strategies should be implemented to help patients better understand the reasons and nature of changes to their medications made during admission.

Barriers to Optimizing PE (Staff Only)

What could we standardize within the Department at the office level to comply with the Elizabeth and Matthew policy?

Key points included. (1) a real person should answer phone calls, and perhaps the use of a second number can help process simple requests and increase the patient's contact with a real person; (2) the referral request, consult triage, and appointment booking can be streamlined to take place within one phone call; (3) a triage staff, a centralized uptake guideline, or an electronic consult system can help address communication gaps with referring physicians.

What are the system issues we need to deal with to comply with seeing patient daily and making a note?

Key points included. (1) barriers included issues related to the outdated technology for documentation, increased physician workload, and the impact of a multicampus hospital network; (2) explaining to patients team-based care can help manage patient expectations of surgeon availability; and (3) emphasize to patients the value of understanding their perceptions throughout their care experience.

Future Plans (Staff Only)

How can we most effectively use the comments we are collecting to help build momentum?

Key points included. (1) addressing gaps in the current feedback process is a priority; (2) the NRC-Picker survey, while having the advantage of comparison against self and other institutions, is not timely enough to promote change; and (3) an iPAD may be used at the time of discharge to provide timely feedback.

What is our 5-year vision and strategies to improve PE? The group's vision was to improve excellence in PE by 20% and become a top 20% performer in North America in 5 years. To achieve this, (1) professional development courses and simulations were recommended to improve communication skills, (2) improved patient feedback to providers and the use of physician- and team-specific scores may encourage clinicians to pay attention to behaviors during interactions with patients and colleagues, (3) variances among divisions can be explored in order to share successes and failures among divisions.

It was emphasized to adopt a few interventions and build momentum on "small wins" instead of implementing many changes at once and to select metrics that can be measured without additional personnel resources.

Table 5. Immediate Strategies to Improve Patient Experience.

- Department-wide rollout of a patient experience handbook to stay at the bedside that is available to both patients and staff
- Pain management teaching to resident as part of the Surgical Foundations curriculum
- Increase patient education efforts to introduce the concept of team-based care and to establish appropriate expectations of pain control and surgeon availability, while ensuring that individual concerns are addressed
- Use the whiteboards to indicate when rounds are happening and to communicate questions to the doctors. Include residents' names on the whiteboards
- Improve patient teaching about medications prior to discharge
- Develop guidelines to help primary doctors make appropriate referral requests and explore other options for screening surgery referrals
- Develop a short hospital-wide questionnaire disseminated to patients just before they leave the unit
- Explore business plans to develop communication skills training in the Department

Conclusion

Patient experience is a term that captures the perceptions of patients and their loved ones as they interact with the hospital staff and environment. Through the conversations with hospital staff and patients, we identified concrete strategies (Table 5) to optimize pain control, perceptions of patient respect and dignity, perceptions of surgeon availability, discharge medication understanding, and overall experience. Although this is not a short list, we believe it can be accomplished as part of an ongoing quality improvement process at the hospital through annual progress reports and tracking of our PE metrics.

This study is limited as the contributing leaders were recruited from a single surgery department from one large urban center. On the other hand, the demographic population served is very similar to other major areas. The overall outcome results for surgical therapy at TOH are also not dissimilar to other major academic centers; therefore, it is anticipated that the findings are representative. Moreover, while the focus group patients were recruited from the hospital advocacy group and thus are not representative of all surgical inpatients, their feedback provides a valuable first step in this quality improvement process.

We have complied a handbook of PE based on the discussion points at the retreat and have distributed the handbook to all participants at the retreat. In addition, we have researched communication courses that can be valuable for our surgeons and residents to improve patient–doctor communication. We have also organized a similar retreat for emergency physicians at the hospital in order to improve PE beyond the surgical department.

Although many hospitals have embraced institution-wide programs of PE optimization, surgical departments have not previously communicated their independent efforts in this area. We anticipate that the current results would be of significant interest to other departments initiating this type of program should they wish to duplicate the process or if they decide to initiate the same recommendations directly. Implementing a departmental retreat of this nature requires leadership skills and familiarity with quality improvement processes. We are not convinced that specific training would be required other than the ability to mobilize health-care teams and foster a drive to improve in-hospital PE in the rapidly changing environment of medicine and surgery.

Moving forward, we identified a need in our Department for timely patient feedback, improved communication styles in our staff and trainees, and an internal curriculum offering additional training for our staff and residents. Through the implementation of strategies to change the way we interact with our patients, we envision raising our PE profile and becoming a top performing hospital in North America.

Appendix A

Patient Experience Questions—Chiefs—Department of Surgery

1. What is your interpretation of the definition of the patient experience?
2. Do you think the patient experience is suboptimal?
3. How important is "fixing the patient experience"?
4. Do you think the patient experience could be improved?
5. How?
6. Do you know what the Elizabeth and Matthew policy is?
7. What are the key communication items that must be included in each patient encounter? (5)
8. What are the policy rules regarding Most Responsible Physician (MRP) visits and inpatients?
9. What are the factors that are inhibiting your division the ability to comply with the policy?
10. How do you think we could change the system to increase compliance?
11. Is physician-to-physician communication used during transfer of inpatients between or within services or from one MRP to another?
12. Are outpatient referrals being triaged within 2 weeks?
13. Once an outpatient referral is accepted, how quickly are the patients given a firm appointment date?
14. How is your division dealing with telephone calls from patients?
15. Do voicemails refer the patient to the emergency and if so, are you making sure that emergency consults are being seen quickly by your service?
16. For voicemails, are patients being called back before the end of the next business day?
17. Are you returning phone calls from patients who are not established patients who need advice?
18. How would you rate your division's response to in-house consults?
19. Are consults seen within 24 hours?
20. Are calls from outside the hospital answered promptly? How are these managed in your surgical specialty?
21. Are all emergency consultations seen within 3 hours?
22. Are you aware that consults that impact process of care and decisions on inpatient treatment and discharge must be completed the same day?
23. Are you currently using the patient survey data in the annual assessment of your division members?
24. What concerns do you have regarding the survey data?
25. What number of responses to the survey would you consider adequate to derive conclusions for an individual surgeon?

Appendix B

Patient Experience Questions—Office Assistants—Department of Surgery

1. What are the policy rules regarding MRP visits and inpatients?
2. Is physician-to-physician communication used during transfer of inpatients between or within services of from one MRP to another?
3. Are outpatient referrals being triaged within 2 weeks?
4. Once an outpatient referral is accepted, how quickly are the patients given a firm appointment date?
5. How is your division dealing with telephone calls from patients?
6. Do voicemails refer the patient to the ER and if so, are you making sure that emergency consults are being seen quickly by your service?
7. For voicemails, are patients being called back before the end of the next business day?
8. Are you returning phone calls from patients who are not established patients who need advice?
9. Are consults seen within 24 hours?

Appendix C

The Ottawa Hospital | L'Hôpital d'Ottawa

Your Hospital/Facility Stay
Votre séjour à l'hôpital

Please fill in the circle that best describes your experience during your hospital/facility stay at Alpha Hospital ending on March 3, 2013. Thank You!
S'il vous plaît remplir le cercle qui correspond le mieux à l'expérience que vous avez vécue au cours de votre séjour à notre centre hospitalier de/d'Alpha Hospital, se terminant 123ABC. Merci!

ADMISSION...

1. **How would you rate the courtesy of the staff who admitted you?** Comment évalueriez-vous la courtoisie du personnel qui a procédé à votre admission?

   ○ **Poor** Mauvais ○ **Fair** Passable ○ **Good** Bon ○ **Very Good** Très Bon ○ **Excellent** Excellent

DOCTORS... LES MÉDECINS...

2. **During this hospital stay, how often did doctors explain things in a way you could understand?** Pendant ce séjour à l'hôpital, les médecins vous ont-ils donné des explications simples à comprendre?
   ○ **Never** Jamais ○ **Sometimes** Parfois ○ **Usually** Habituellement ○ **Always** Toujours
3. **How would you rate the courtesy of your doctors?** Comment évalueriez-vous la courtoisie des médecins à votre égard?

   ○ **Poor** Mauvais ○ **Fair** Passable ○ **Good** Bon ○ **Very Good** Très Bon ○ **Excellent** Excellent
4. **How would you rate the availability of your doctors?** Comment évalueriez-vous la disponibilité des médecins?

   ○ **Poor** Mauvais ○ **Fair** Passable ○ **Good** Bon ○ **Very Good** Très Bon ○ **Excellent** Excellent
5. **Overall, how would you rate the care you received from your doctors?** Dans l'ensemble, comment évalueriez-vous les soins que vous avez reçus des médecins?

   ○ **Poor** Mauvais ○ **Fair** Passable ○ **Good** Bon ○ **Very Good** Très Bon ○ **Excellent** Excellent

NURSES... LES INFIRMIERS (ÈRES)…

6. **During this hospital stay, how often did nurses explain things in a way you could understand?** Pendant ce séjour à l'hôpital, les infirmières vous ont-elles donné des explications simples à comprendre?
   ○ **Never** Jamais ○ **Sometimes** Parfois ○ **Usually** Habituellement ○ **Always** Toujours
7. **How would you rate the courtesy of the nurses?** Comment évalueriez-vous la courtoisie de vos infirmiers (ères)?

   ○ **Poor** Mauvais ○ **Fair** Passable ○ **Good** Bon ○ **Very Good** Très Bon ○ **Excellent** Excellent
8. **How would you rate the availability of your nurses?** Comment évalueriez-vous la disponibilité de vos infirmiers (ères)?

   ○ **Poor** Mauvais ○ **Fair** Passable ○ **Good** Bon ○ **Very Good** Très Bon ○ **Excellent** Excellent

HOSPITAL STAFF... LE PERSONNEL HOSPITALIER…

9. **Did you have enough say about your treatment?** Avez-vous pu participer, autant que vous le vouliez, aux discussions concernant votre traitement?

   ○ **Yes, definitely** Oui, absolument ○ **Yes, somewhat** Oui, plutôt ○ **No** Non

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10. **How much information about your condition or treatment was given to your family or someone close to you?** Comment évalueriez-vous la quantité de renseignements fournie à votre famille ou à vos proches au sujet de votre état ou de vos traitements?

- ⬭ **Not enough** Insuffisante
- ⬭ **Right amount** Suffisante
- ⬭ **Too much** Excessive
- ⬭ **No family or friends involved** Ma famille/mes amis n'étaient pas impliqués
- ⬭ **Family did not want or need information** Ma famille ne voulait pas ou n'avait pas besoin d'information

11. **Was it easy for you to find someone on the hospital staff to talk to about your concerns?** Vous était-il facile de trouver un membre du personnel hospitalier à qui parler de vos préoccupations?

- ⬭ **Yes, definitely** Oui, absolument
- ⬭ **Yes, somewhat** Oui, plutôt
- ⬭ **No** Non
- ⬭ **Did not want to talk/no concerns** Je n'avais pas de préoccupations ou je ne voulais pas en parler

12. **When you needed help getting to the bathroom, did you get the help in time?** Lorsque vous aviez besoin d'aide pour aller aux toilettes, l'avez-vous eu à temps?

- ⬭ **Yes, always** Oui, toujours
- ⬭ **Yes, sometimes** Oui, parfois
- ⬭ **No** Non
- ⬭ **Did not need help** Je n'ai pas eu besoin d'aide

13. **How many minutes after you used the call button did it usually take before you got the help you needed?** Combien de minutes après que vous ayez appuyé sur le bouton d'appel, avez-vous habituellement obtenu l'aide dont vous aviez besoin?

- ⬭ **0 minutes/right away** Aucune attente
- ⬭ **1-5 minutes** De 1 à 5 minutes
- ⬭ **6-10 minutes** De 6 à 10 minutes
- ⬭ **11-15 minutes** De 11 à 15 minutes
- ⬭ **16-30 minutes** De 16 à 30 minutes
- ⬭ **More than 30 minutes** Plus de 30 minutes
- ⬭ **Never used call button** Je n'ai jamais utilisé le bouton d'appel
- ⬭ **Never got help** Je n'ai jamais obtenu l'aide demandé

14. **Did you feel like you were treated with respect and dignity while you were in the hospital?** Aviez-vous le sentiment d'être traité (e) avec respect et dignité durant votre séjour à l'hôpital?

⬭ **Yes, always** Oui, toujours ⬭ **Yes, sometimes** Oui, parfois ⬭ **No** Non

PAIN... LA DOULEUR...

15. **Were you ever in any pain?** Pendant votre séjour, avez-vous eu de la douleur?

⬭ **Yes** Oui ⬭ **No** Non (Passez à la question n^{o} 18)

If 'No' in #15, skip to #18. Si 'Non' dan #15, passez à la question #18)

16. **Do you think that the hospital staff did everything they could to help control your pain?** Pensez-vous que le personnel a fait tout ce qu'il pouvait pour aider à maîtriser votre douleur?

⬭ **Yes, definitely** Oui, absolument ⬭ **Yes, somewhat** Oui, plutôt ⬭ **No** Non

17. **During this hospital stay, how often was your pain well controlled?** Pendant ce séjour à l'hôpital, dans quelle mesure a-t-on soulagé la douleur que vous éprouviez?

⬭ **Never** Jamais ⬭ **Sometimes** Parfois ⬭ **Usually** Habituellement ⬭ **Always** Toujours

GOING HOME... RETOUR À LA MAISON...

18. **Did someone on the hospital staff explain the purpose of the medicines you were to take at home in a way you could understand?** Est-ce qu'on vous a expliqué, d'une manière facile à comprendre, pourquoi vous deviez prendre certains médicaments une fois de retour à la maison?

    ○ **Yes, completely** Oui, absolument
    ○ **Yes, somewhat** Oui, plutôt
    ○ **No** Non
    ○ **Did not need explanation** Je n'avais pas besoin d'explications
    ○ **No medicines at home** Je n'avais pas de médicaments à prendre à la maison

19. **Did someone tell you about medication side effects to watch for when you went home?** Est-ce qu'on vous a expliqué les effets secondaires éventuels associés à ces médicaments que vous deviez surveiller une fois de retour à la maison?

    ○ **Yes, completely** Oui, absolument
    ○ **Yes, somewhat** Oui, plutôt
    ○ **No** Non
    ○ **Did not need explanation** Je n'avais pas besoin d'explications
    ○ **No medicines at home** Je n'avais pas de médicaments à prendre à la maison

20. **Did they tell you what danger signals about your illness or operation to watch for after you went home?** Est-ce qu'on vous a expliqué les symptômes éventuels associés à votre maladie ou à votre opération que vous deviez surveiller une fois de retour à la maison?

    ○ **Yes, completely** Oui, tout à fait ○ **Yes, somewhat** Oui, plutôt ○ **No** Non

21. **Did the doctors and nurses give your family or someone close to you all the information they needed to help you recover?** Est-ce que les médecins et les infirmiers (ères) ont fourni les renseignements nécessaires à votre famille ou à vos proches pour qu'ils puissent vous aider à vous rétablir?

    ○ **Yes, definitely** Oui, absolument
    ○ **Yes, somewhat** Oui, plutôt
    ○ **No** Non
    ○ **No family or friends involved** Ma famille/mes amis n'étaient pas impliqués
    ○ **Family did not want or need information** Ma famille ne voulait pas ou n'avait pas besoin d'information

22. **Did you know who to call if you needed help or had more questions after you left the hospital?** Saviez-vous à qui vous adresser si vous aviez besoin d'aide ou aviez des questions après votre départ de l'hôpital?

    ○ **Yes** Oui ○ **No** Non ○ **Not sure** Je ne suis pas sûre

OVERALL IMPRESSION... DANS L'ENSEMBLE…

23. **Overall, how would you rate the care you received at the hospital?** Dans l'ensemble, comment évalueriez-vous les soins que vous avez reçus à l'hôpital?

    ○ **Poor** Mauvaise ○ **Fair** Passable ○ **Good** Bon ○ **Very Good** Très bon ○ **Excellent** Excellent

24. **Would you recommend this hospital to your friends and family?** Recommanderiez-vous cet hôpital aux membres de votre famille et à vos amis?

    ○ **Yes, definitely** Oui, absolument ○ **Yes, probably** Oui, probablement ○ **No** Non

AMENITIES... AMÉNAGEMENTS...

25. **How would you rate the quality of the food (how it tasted, serving temperature, variety)?** Comment évalueriez-vous la qualité de la nourriture (le goût, la température, la variété)?

    ○ **Poor** Mauvais ○ **Fair** Passable ○ **Good** Bon ○ **Very Good** Très Bon ○ **Excellent** Excellent

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26. **During this hospital stay, how often were your room and bathroom kept clean?** Pendant ce séjour à l'hôpital, à quelle fréquence a-t-on nettoyé votre chambre et votre salle de bain?
    ○ **Never** Jamais ○ **Sometimes** Parfois ○ **Usually** Habituellement ○ **Always** Toujours

ADDITIONAL QUESTIONS...
LES QUESTIONS SUPPLEMENTAIRE...

27. **During your recent hospital stay, did health care workers or doctors clean their hands when providing care to you?** Durant votre récent séjour dans l'hôpital, les travailleurs des soins de santé ou les docteurs se sont-ils lavés les mains pendant qu'ils vous ont prodigués des soins?
    ○ **Yes, always** Oui, tout le temps ○ **No** Non
    ○ **Yes, sometimes** Oui, parfois ○ **I did not notice** Je n'ai pas remarqué

28. **The hospital where you received care is actively encouraging health care workers to clean their hands. How confident does this make you in the care given to you at the hospital?** L'hôpital où vous avez reçu des soins encourage activement aux travailleurs des soins de santé à se laver les mains. Jusqu'où cela vous donne- t-il confiance dans les soins prodigués dans l'hopital?
    ○ **Very confident** Très confiant ○ **Not too confident** Pas trop confiant
    ○ **Somewhat confident** Un peu confiant ○ **Not at all confident** Pas du tout confiant

29. **Were you served in the official language (French/English) of your choice?** Avez-vous été servi dans la langue officielle (français/anglais) de votre choix?

    ○ **Yes, always** Oui, toujours ○ **Yes, sometimes** Oui, parfois ○ **No** Non

30. **During this hospital stay, did a clinical manager visit you?** Pendant ce séjour à l'hôpital, avez-vous reçu la visite d'un gestionnaire clinique?
    ○ **Yes** Oui ○ **No** Non ○ **Do not know** Je ne le sais pas

31. **Who completed this survey?** Qui a complété ce sondage?
    ○ **Patient** Patient ○ **Someone else** Une autre personne

The hospital will review your comments, however you will not be contacted directly regarding any comments or concerns. Should you wish to speak with someone directly regarding your care experience, please contact the Advocacy Department at 613-798-5555 extension 13377.
L'hôpital étudiera vos commentaires, mais personne ne communiquera directement avec vous au sujet de vos commentaires ou de vos préoccupations. Si vous désirez parler directement à quelqu'un à propos des soins que vous avez reçus ou si vous avez des questions ou des préoccupations, veuillez communiquer avec le Service de la représentation au 613-798-5555, poste 13377.

32. **Is there anything else you would like to tell us about your hospital stay?** Avez-vous autre chose que vous aimeriez nous dire au sujet de votre séjour à l'hôpital?

_____
_____
_____
_____
_____

Thank you for taking the time to complete this questionnaire! Your answers are greatly appreciated. When you are done, please use the enclosed, pre-paid envelope to return this questionnaire to National Research Corporation Canada, 7100 Woodbine Ave, Suite 411, Markham ON L3R 5J2
Merci pour le temps que vous avez mis à compléter ce questionnaire. Vos réponses sont grandement appréciées. Quand vous avez terminé s'il vous plaît utiliser l'enveloppe affranchie pour retrouner le questionnaire à National Research Corporation Canada, 7100 Woodbine Ave, Suite 411, Markham ON L3R 5J2.

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Appendix D

Focus group questions

1. [Give patients a list of definitions for Patient Experience proposed by the Ottawa Hospital staff] Do these definitions resonate with you?

> "Everything the patient and loved ones feel and perceive from their interactions with the hospital throughout their care journey"
> "The feelings and perceptions of the patient and loved ones shaped by the sum of all hospital interactions throughout their care journey"
> "What the patient and loved ones feel and perceive in their interactions with the hospital on their care journey"
> A final variant was then recommended:
>
> "Everything our patients and their loved ones feel and perceive throughout their care journey with the hospital"

2. What is your perception of the best postoperative pain control?
3. What do you need to feel that you have been treated with respect and dignity by your physician? Also, what are your thoughts on surgeons calling patients one day before the day of surgery to say "I am [name of the surgeon] and I am doing your surgery tomorrow, I am calling you to let you know I am sleeping early today in preparation for the surgery. I will meet you before and after the surgery to get your questions answered"?
4. What does good availability from your physician look like?
5. When you were discharged from the hospital, did you have a good understanding of the medications you were discharged with?

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References

1. Sacks GD, Lawson EH, Dawes AJ, Russell MM, Maggard-Gibbons M, Zingmond DS, et al. Relationship between hospital performance on a patient satisfaction survey and surgical quality. JAMA Surg. 2015;150:858-64.
2. Legislative Assembly of Ontario. An act to Amend Various Acts in the Interest of Patient-Centred Care. Legislative Assembly of Ontario, 1st Session ed; 2016. www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BilllD=4215
3. Elizabeth and Matthew policy on communication and access. In: Hospital TO, ed. Vol MED-RR-027; 2011. https://mytoh.ottawahospital.on.ca/dm/atom/library
4. Giordano LA, Elliott MN, Goldstein E, Lehrman WG, Spencer PA. Development, implementation, and public reporting of the HCAHPS survey. Med Care Res Rev. 2010;67:27-37.
5. Ip HY, Abrishami A, Peng PW, Wong J, Chung F. Predictors of postoperative pain and analgesic consumption: a qualitative systematic review. Anesthesiology. 2009;111:657-77.
6. Khan RS, Ahmed K, Blakeway E, Skapinakis P, Nihoyannopoulos L, Macleod K, et al. Catastrophizing: a predictive factor for postoperative pain. Am J Surg. 2011;201:122-31.

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