Guidance on how to develop a Patient Relations Process

The ECFAA requires that all Ontario hospitals have a patient relations process, and make information about that process available to the public. Hospitals also need to ensure that their patient relations process reflects the content of their patient declaration of values. For information on how to develop a declaration of values, please see the guidance material on the ecfaa.ca/excellentcare website.

In addition, hospitals need to consider patient relations in the development of their quality improvement plans (QIP). The ECFAA requires that the QIP be developed having regard to data relating to the patient relations process.

Why patient relations is important:

A well-established patient relations structure and process, supported by the right personnel, is key to identifying gaps between patient expectations and experiences of care, and managing perceptions of patient expectations and quality of care (Gilly et al, 1991).

An impartial, confidential, easily accessible and robust patient relations process will ensure that patients and their family members have a clearly identified process and mechanism to raise concerns about their experiences and provide feedback.

As well, the patient relations process will provide hospitals with a way of tracking the quality of their patients’ experience, and identify opportunities for process and system improvements that meet the needs and expectations of patients. Organizations should take advantage of the valuable insights provided through patient engagement, use this information to identify common failure points, capture service excellence, and identify opportunities for improvement.

The patient relations process should be the responsibility of all staff and physicians in the hospital, and wherever possible the concerns of patients and their families should be addressed at the point of communication.

Best practice recommendations for designing a patient relations process:

The following best practices have been identified to help guide hospitals in the development of a patient relations process:

1. Role
   - Hospitals should (where possible) have a dedicated patient relations role. Some hospitals may be constricted due to size and thus, in the absence of a dedicated role, there must be a clearly defined patient relations process.
   - Responsibilities should include:
     - coordination of patient and family feedback
     - consultation with staff, physicians and leadership
Facilitation, mediation and conflict resolution of patient and family concerns
Reporting of patient relations processes and outcomes (metrics, trends, etc)
Coaching staff and physicians on communication styles and stakeholder perspectives, mediation, conflict resolution
Educating patients/families, visitors on current policies, protocols, rights and responsibilities
Advising on quality improvement opportunities and system changes.

2. Process
• Patient relations must be supported by senior leadership
• Patient relations person or process should regularly report to senior leadership and clinical leadership
• Patient relations person or process should link to quality committee through the senior leadership
• Patient relations should have a strong link to departments responsible for patient satisfaction surveys, risk management, ethics, and quality improvement
• A well documented and communicated policy and procedure should be developed (see example below)
• Patient concern resolution process should contain consistent core elements reflecting best practice
• Process should reflect the content of the Patient Declaration of Values
• Standardized process and tool to collect information should be developed
• Mechanism to monitor the status of concerns should be implemented

3. Measurement and Evaluation
• Minimum data set for patient relations should be developed that is simple and well defined. Suggestions:
  o Method feedback was received
  o Types of feedback (including # inquiries, concerns, compliments, requests for support from staff)
  o Feedback aligned with program, service and staff group involved
  o Total # concerns (by type and severity)
  o Resolution summary (outcome)
  o Resolution time/ response time.
• Develop methods to evaluate effectiveness of process
• Report regularly to senior leadership and board quality committee on metrics, trends, critical incidents, pt. stories, recommendations, etc
• Develop timely process and methods (written, verbal) for responding to patients/families
An example of a patient relations policy:

Patient / Family Feedback Process
PART ONE – Resolution within 24 – 48 hours

PART ONE

Staff, administration or physician receives patient/family feedback. Written or verbal. → Acknowledge and thank patient/family member for feedback.

Yes → Complimentary Feedback?

No → Concerns promptly resolved?

Yes → Concerns promptly resolved?

No → Complimentary Feedback?

Yes → 1. Explain concerns process. 2. Clarify issues & details. 3. Refer to appropriate manager or physician lead who will facilitate resolution. 4. Provide timeline and contact information to patient/family member. May also provide Patient Relations contact information. 5. Indicate to patient/family member when to expect follow-up from manager.

No → Update Team Leader asap

Potential to escalate or needs addressed asap?

Yes → Client wants to speak with someone right away?

No → Update Team Leader asap

Manager/physician follow up with patient/family member.

Concerns promptly resolved?

Yes → Go to PART TWO of resolution process

No → Go to PART TWO of resolution process

Inform manager and Patient Relations of service recovery, service excellence and/or quality initiative opportunities.

Acronyms:
COS = Chief of Staff
PRC = Patient Relations Coordinator
PRA = Patient Relations Assistant
PART TWO

Unresolved Concerns* received by Patient Relations Coordinator (PRC). Written or verbal.

Acknowledged in writing by an administrative assistant if letter or email addressed to Exec, before forwarding to PRC.

PRC gathers related documents for review (medical record, risk or security incident report).

PRC contacts client to clarify issues. Confirm expectations.

PART TWO

Risk, legal or reputation?

NO

YES

Director, VP Chief and COS notified.

Liaise with Risk, Legal and Public Affairs

Executive leads kept apprised and updated on case by PRC.

PRC forwards case summary with timeframe to program/service manager or physician involved in review.

PRC can assist as facilitator where possible to assist in team pre-meeting and family/patient meeting to mediate effective resolution.

PRC collaborates with manager/physician about response and action plan (phonecall, visit to client on unit, written response or meeting).

Patient/family member contacted for follow up.

Able to resolve* case concern?

NO

YES

"Final PRC Summary to include resolution, service recovery** & proposed quality initiatives" identified.

PRC contacts patient/family member to clarify issues, confirm expectations and propose new action plan & timeline.

PRC can assist as facilitator where possible to assist in team pre-meeting and family/patient meeting to mediate effective resolution.

Response rec’d from manager/physician within 48 hours?

NO

YES

Chief, COS and/or Director of Service to assist.

PRC collaborates with manager, physician lead, Director, COS for escalated action plan including final response.

PRC collaborates with manager, service coordinate, program manager for considerations of Quality initiative.

Patient/family member contacted with follow up.

"Final PRC Summary to include resolution, service recovery & proposed quality initiatives" identified.

Documentation updated in database by PRC. Quality proposals forwarded to Program Mgr/Director for consideration of Quality initiative.

Feedback categorized and included in quarterly reports.

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