Guidelines for manual classification of patient feedback

This document reports the procedure for manually coding the patient feedback. The manual coding was done to investigate the validity of the algorithm (RQ1) for detecting safety incidents (coding 1a & 1b) and to examine the extent of unnoticed (coding 2a & 2b) and unresolved (coding 3a & 3b) safety incidents (RQ2).

The coding frame used binary no/yes (recorded as 0/1) coding. Here we define each classification, with inclusion and exclusion criteria.

1a) Safety incident: all

Does the feedback report a safety incident? Coded as '0' (no) or '1' (yes).

Safety incidents are defined as any unintended or unexpected incident that could have led or did lead to harm for one or more patients.[1,2]

Includes any description of errors by clinical or administrative staff that could have led or did lead to patient harm. For example, medication error, misdiagnosis, a consequential delay in treatment (e.g., 'why walking gets worse each day', 'now I am unable to go to work'), hospital acquired infections, failure of important equipment, food poisoning, delay for a critical or urgent procedure (e.g., test described as 'urgent' or 'emergency'), delays causing adverse consequences, preventable falls, discharging a patient with dementia without informing carers, parents of upset child leaving hospital with no understanding of what is wrong, patients being left with emotional upset or trauma, and safety risks on ward (e.g., abusive or drunk patient).

Excludes dissatisfaction that does not point to an error that could cause patient harm. For example, vague references (e.g., 'poor treatment', 'rude staff', or 'poor communication'), inconsequential delays, inconsequential miscommunication, staff not answering calls during lunch, frustrations with online or telephone booking systems, cancellations and delays for non-emergency appointments and tests, inconvenient appointment times, cold waiting rooms or wards, out-of-date reading material in waiting room, poor-quality information leaflets, lack of contact with staff, cancelled surgery or appointment (inconsequential), car-parking, unappetizing food, poor cleanliness not related to patient neglect (e.g., dirty ward or toilets), fire doors being propped open, weak data protection (e.g., patient file visible in public area), and indirect or inconsequential issues ('The sanitizer dispenser was empty'). The defining feature of these excluded cases is that there is no clear route to patient harm.

1b) Safety incident: severe

If there is a safety incident, is it severe? Coded as '0' (no) or '1' (yes).

Severe safety incidents are the severest subset of safety incidents. They are defined as unintended incidents that caused, or potentially caused, either severe harm with permanent or long-term impact, or death.[1,2]

Includes any severe harm or death that the patient attributes to medical error. For example, serious medication error, misdiagnosis of a fatal illness, surgical error (e.g., punctured intestine leading to infection), patient unable to contact staff in an emergency, patient fall that leads to serious deterioration or death, or extreme neglect (e.g., 'left unwashed, covered in excrement and urine which led to ulcers which you could put your fist in') leading to or contributing to permanent harm or death.

Excludes severe harm and death not attributed to medical error (e.g., patient died of illness despite medical intervention), patient terminally ill but not reported as having died (e.g., patient described as 'terminally ill' or having 'terminal cancer'), extreme (but short-lived) suffering due to lack of pain relief, premature discharge without severe consequence (even if re-admitted).

2a) Safety investigation: all

Is there any mention of a safety investigation in the patient feedback? Coded as '0' (no) or '1' (yes).

To understand the relationship between the safety incidents reported online and the safety incidents captured by hospital staff, all patient feedback reporting a safety incident was also coded for whether there was any mention

of a past, present, future, or even potential/threatened safety investigation, whether carried out by the hospital or a third party (e.g., newspaper or ombudsman).

Includes any mention of a previous, ongoing, or future investigation. For example, 'an investigation found', 'ongoing inquiry', 'is being investigated', 'are looking into my complaint', 'I will be taking this further', 'I am making a formal complaint', 'I went to PALs', 'was classified as a serious incident', and 'acknowledged it was a safety incident'. This includes unacknowledged investigations ('I have contacted the hospital and as yet had no response on the outcome of the investigation') and threats to involve politicians or newspapers.

Excludes all feedback that does not explicitly mention a past, present, or future investigation. For example, a safety incident that is so severe (e.g., patient death) that one would assume the hospital is aware of the problem, but that does not explicitly mention an investigation. An isolated member of staff being aware of a problem does not constitute an investigation; it must be a formal process (e.g., negligence claim, formal complaint, PALs issue). Any staff responses to the online feedback are also excluded.

2b) Safety investigation: patient-initiated

If there is a safety investigation, is it initiated by the patient (or friend, family)? Coded as '0' (no) or '1' (yes).

To assess the extent to which patients (or friends, family) are involved in bringing safety incidents to the attention of hospitals, all feedback mentioning a safety investigation was also coded for whether the patient (or friends, family) initiated the investigation.

Includes references to complaints lodged, letters sent to the ombudsman or Department of Health, any reference to a 'complaint investigation', 'formal complaint', 'negligence claim', and statements such as 'I will be taking this further'.

Excludes all mentions of safety investigations where it is not clear that it was initiated by the patient (or friends, family). For example, 'the investigation found', 'they reported that', and 'they told us'.

3a) Report safety question dismissed

Does the feedback mention any failed attempts to bring the safety incident to the attention of the hospital or staff? Coded as '0' (no) or '1' (yes).

Patients (friends, family) reporting that their questions or concerns about a safety incident were rebuffed or ignored suggests that the hospital may not be aware of the safety incident.

Includes any claim that concerns were dismissed ('dismissed', 'they ignored me', 'did not listen'), inadequate responses to complaints ('they denied this in a complaint reply', 'tried complaining but they talked their way out of it'), raising safety issues without any follow up ('I told them I had unsterilized injuries from self-harm, but they were forgotten about'), resisted suggestions ('we voiced our concerns about this but…'), and seeking a second consultation and being dismissed.

Excludes actions carried out without the patient's consent ('examined against my will'), patients bringing things to staff attention ('we had to continually chase staff') without any explicit mention that staff ignored or dismissed concerns.

3b) Asking safety question

Does the feedback ask (not report asking) questions relating to the safety incident? Coded as '0' (no) or '1' (yes).

Patients asking questions online indicates that there has been either no or no satisfactory investigation of the issues raised. Reports of asking questions to staff are not included. This only includes questions being asked in the feedback itself (presumably because no satisfactory response has been received through other routes).

Includes any safety-related question directed at staff or the organization. For example, 'why did this happen?', 'who is responsible?', and 'when will I get a response?' This includes statement questions without an explicit question mark, such as 'I would like to know why my wife was turned away'.

Excludes questions directed beyond the staff or hospital (‘why don’t the government fund the NHS properly?’), rhetorical questions (‘How would you feel?’, ‘What is happening to the NHS?’, ‘How many NHS staff does it take to send a fax?’), compliments (‘could you pass on my gratitude?’), non-safety related questions (‘Why couldn’t I have been connected via the switchboard?’, ‘Why does making an appointment have to be such a trying and exhausting process?, ‘Why is there no WiFi?’, ‘Why hasn’t the ATM been repaired?’), inconsequential delays (‘Can someone advise how long it takes to get an appointment?), and indirect or inconsequential issues (‘Why can’t someone keep the hand sanitizers full?’).

References

1 NHS Improvement. NRLS official statistics publications: guidance notes. London, UK: NHS Improvement, 2018.

2 Cooper J, Williams H, Hibbert P, *et al.* Classification of patient-safety incidents in primary care. *Bull World Health Organ* 2018; **96**: 498–505.