Patients For Patient Safety Foundation

Real CAPTURING THE VOICE OF PATIENTS

A Handbook for Hospitals on Listening, Learning, and Improving Care

Patients for Patient Safety Foundation

July 2026

FOREWORD

Healthcare has made remarkable progress in diagnostics, treatment, technology, and standardization. Yet preventable harm continues to occur in hospitals and outpatient settings across the world. This reminds us that clinical expertise alone is not enough to ensure safe, respectful, and effective care. One of the most important, and often most underused, sources of learning is the **voice of the patient**.

Patients and caregivers experience care in real time. They notice confusion, delays, discomfort, lack of clarity, near misses, and moments when they felt unsafe or unheard. Often, these observations never reach the right people in a structured way. Conventional satisfaction surveys and complaint systems have value, but they do not fully capture the lived experience of care, nor do they reliably surface the early signals that can prevent avoidable harm.

This handbook is intended to help hospitals capture patient voice in a practical, respectful, and non-punitive manner. It is not about fault-finding. It is about building better systems by listening more carefully to those who receive care and those who accompany them. Patient voice is not an add-on. It is a core part of patient safety, quality improvement, and patient-centred care.

The approach outlined here is simple. Listen at key moments of the patient journey. Ask open questions. Capture what was unclear, what almost went wrong, and what would have helped. Analyse patterns. Act on the learning. Close the loop with patients and families. In doing so, hospitals can move from isolated feedback to a disciplined culture of improvement.

We hope this handbook will serve as a practical companion for hospital leaders, clinicians, quality teams, patient relations staff, and Patient Advisory Councils who wish to make care safer and more humane through the informed participation of patients and families.

ACKNOWLEDGEMENTS

This handbook has been developed through the experience and insights of patients, caregivers, clinicians, hospital administrators, quality professionals, and patient advocates who have contributed to the growing movement for safer, more patient-centred care. Their collective wisdom has shaped the ideas in this guide.

We are especially grateful to those who shared stories, reflections, presentations, and practical examples that helped demonstrate how patient voice can be captured across the journey of care and translated into safer systems.

TABLE OF CONTENTS

HOW TO USE THE HANDBOOK

This handbook is designed for hospitals, healthcare organizations, quality teams, patient relations departments, and Patient Advisory Councils. It can be used to build a new patient voice programme or to strengthen an existing one.

The handbook is organised in a logical sequence:

- Why patient voice matters.
- What real patient voice means.
- Why current feedback methods are not enough.
- What to capture, where, and how.
- How to capture voice without adding to workload.
- How to analyse and act on what patients say.
- How to integrate patient voice into governance and PAC processes.
- How to start small and scale sustainably.

This process of capturing patients voice and structuring it can use simple technologies. We could do this with existing resources. This integrates very well with the current feedback and suggestions processes that hospitals already have.

1. INTRODUCTION: WHY PATIENT VOICE MATTERS

Patient safety begins where care is actually experienced: at the bedside, in the consultation room, at registration, in the waiting area, during procedures, and after discharge at home. Hospitals often depend on audits, indicators, compliance checks, and service feedback to understand performance. These are useful, but they do not tell the whole story.

The patient's perspective often reveals what formal systems miss. A patient may notice a missed identity check, a confusing explanation, a delayed response to pain, a rushed consent process, or uncertainty about what to do after going home. These are not minor issues. They are signals of system performance and potential harm.

Patient voice is important because it helps hospitals:

- Detect safety risks earlier.
- Understand the experience behind the data.
- Improve communication and trust.
- Strengthen patient-centred care.
- Convert recurring problems into systemic improvements.

When hospitals treat patient voice as a safety input rather than only a service input, they unlock a powerful source of learning and improvement.

2. WHAT REAL PATIENT VOICE MEANS

Real patient voice is the patient's and caregiver's own account of what they experienced, understood, felt, feared, noticed, or nearly experienced during care. It includes positive experiences, but is particularly valuable when it reveals confusion, distress, hesitation, or a near miss.

Patient voice is different from satisfaction scoring. A patient may report that care was "good" or "satisfactory" and still have experienced a medication concern, a near miss, a confusing discharge summary, or a sense that nobody was listening. Satisfaction measures often capture sentiment; patient voice captures meaning, context, and risk.

Real patient voice should include:

- What was clear and reassuring.
- What was unclear or confusing.
- What almost went wrong.
- What made the patient feel safe and respected.
- What made the patient hesitate to speak up.
- What the patient or caregiver should change if they could.

The aim is to understand care through the patient's eyes, across the entire journey, not only at one point.

3. WHY CURRENT FEEDBACK SYSTEMS ARE NOT ENOUGH

Most existing feedback systems are complaint-based or end-of-stay based. This means they often capture only the most dissatisfied patients, long after the event has passed. They also tend to focus on service issues (cleanliness, waiting time, billing) rather than safety issues (near misses, communication gaps, discharge confusion).

Common limitations include:

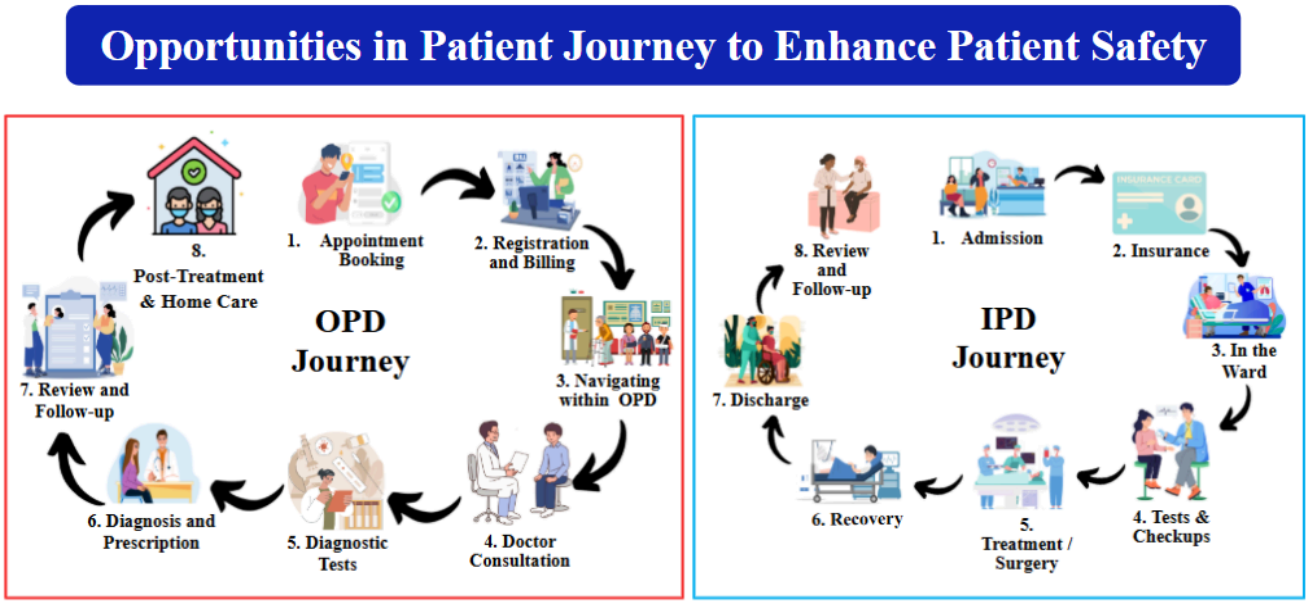
- Feedback comes too late to prevent harm.
- Many patients never complain, even when something goes wrong.
- Questions are often general and do not pinpoint touchpoints.
- Systems do not capture the moment where the issue occurred.
- Results are not always translated into specific, actionable changes.
- Participation is low, especially among vulnerable or busy patients.

Hospitals need a more sensitive and proactive approach. A short question like "Was anything unclear?" asked at the right time can reveal more than a long satisfaction survey completed much later.

4. WHAT TO CAPTURE, WHERE, AND HOW

Patient voice should be captured across the entire patient journey. Each stage presents opportunities to hear safety signals, confusion points, and improvement ideas.

4.1 Key touchpoints



4.2 What to ask

At each touchpoint, questions should be open, short, and respectful. Examples:

- Was anything unclear for you today?
- Did anything almost go wrong, or feel like it might?
- Did you feel comfortable asking questions or sharing concerns?
- What would have helped you feel safer or more confident?
- If you could change one thing about this part of your care, what would it be?

Questions are adapted in detail in the Annexures, per OPD, IPD, procedure, and discharge stage.

4.3 What to capture

Hospitals should record:

- The exact words of the patient or caregiver, as far as possible.
- The touchpoint where the comment was made.
- The safety or experience theme involved.
- Whether immediate action is needed.
- Whether similar issues have been raised before.

The focus is on capturing meaningful signals, not long narratives for every patient.

5. CAPTURING PATIENT VOICE WITHOUT ADDING WORKLOAD

It is essential that capturing patient voice does not feel like an additional burden to staff. The process should be embedded into existing interactions, kept short, and supported by simple tools.

5.1 Core principle: Ask at the point of care

Whenever possible, the staff member who is already interacting with the patient or caregiver should ask the questions. This could be:

- Reception staff at registration or exit.
- Nurse during routine rounds or at handover.
- Doctor at the end of consultation.
- Discharge nurse or coordinator during discharge.
- Technician or radiographer after a diagnostic procedure.

This way, no separate visit or additional person is required.

5.2 Random sampling model

If frontline staff are unable to capture feedback consistently, hospitals can use a “random sampling” approach. Trained staff or volunteers briefly meet patients at the point of contact (for example, OPD exit, discharge lounge, waiting area) and ask 3–5 focused questions.

Key features:

- Short, respectful conversation (1–2 minutes).
- No duplication of work.
- Sampling a variety of patients each day.
- Entry directly into a simple digital or paper tool.

5.3 Keeping the interaction light

To avoid burden:

- Limit questions to a maximum of 3–5 per interaction.
- Ask only what is relevant to that touchpoint.
- Use simple language.
- Make it clear that honest feedback is welcome and will not affect care.
- Avoid long, formal surveys unless required for special purposes.

5.4 Staff guidance

Staff should be guided to:

- Listen without defensiveness.
- Avoid explaining away or justifying issues on the spot.
- Thank the patient or caregiver.
- Capture the feedback accurately.
- Escalate urgent safety concerns immediately through existing channels.

The aim is to make patient voice part of everyday care conversations.

6. SIMPLE TECHNOLOGY AND TOOLS

Technology should support the process, not complicate it. The best solutions are those that are simple, familiar, mobile-friendly, and able to consolidate data automatically.

6.1 Recommended options

- Voice notes: Patients or caregivers can dictate feedback to a staff member's device, or to a dedicated number, especially where literacy or language is a barrier.
- Staff-assisted entry: Staff enter responses on behalf of the patient, using a simple app or form, during the interaction.
- Mobile-friendly forms: Google Forms, Microsoft Forms, or similar tools accessed via link or QR code.
- Tablets or kiosks: Placed at OPD exits, waiting areas, and discharge counters for quick entry.
- QR codes: Printed on discharge summaries, OPD slips, wristbands, or posters. Scanning opens a short form with 3–5 questions.

6.2 How technology can help consolidate & analyse

Beyond capturing responses, the system should:

- Consolidate responses from multiple touchpoints and devices.

- Group feedback by department, date, and stage of care.
- Allow tagging with themes (near miss, communication gap, etc.).
- Display trends and top concerns in simple dashboards.
- Flag urgent or serious safety concerns for rapid review.
- Provide weekly or monthly summary reports for quality teams and leadership.

The goal is automatic consolidation and simple analysis, not complex data science.

6.3 Choosing the right level of technology
Hospitals can start with basic tools and upgrade over time:

- Small hospitals : Paper forms with weekly manual consolidation into a spreadsheet.
- Medium hospitals: Google/Microsoft Forms, QR codes, simple dashboards from spreadsheets.
- Large hospitals: Custom or commercial patient experience platforms that integrate with hospital information systems.

Regardless of technology level, the principles of short interaction and structured analysis remain the same.

7. ANALYSING PATIENT VOICE AND IDENTIFYING PATTERNS

Collecting patient voice is only the first step. Hospitals must analyse it and convert it into meaningful action.

7.1 Tagging framework
Each response should be assigned one or two tags. Suggested themes include:

- Near miss (something almost went wrong).
- Communication gap (unclear explanation, conflicting information).
- Identity/allergy miss (concern about correct patient or allergies).
- Environment risk (falls, cleanliness, noise, privacy).
- Hesitation to speak (patient felt unable to raise concerns).
- Handover failure (information lost or changed between teams).
- Discharge confusion (unclear medicines, follow-up, warning signs).
- Post-discharge issue (difficulty at home, access concerns).
- Positive catch (staff or patient prevented harm by speaking up).

7.2 Weekly or monthly review
Quality teams should review tagged feedback regularly:

- Count how many times each theme appears.
- Identify departments or touchpoints with repeated issues.
- Check for clusters around specific times, processes, or teams.
- Highlight any urgent safety concerns for immediate escalation.
- Note improvements after interventions.

7.3 From Stories to System learning

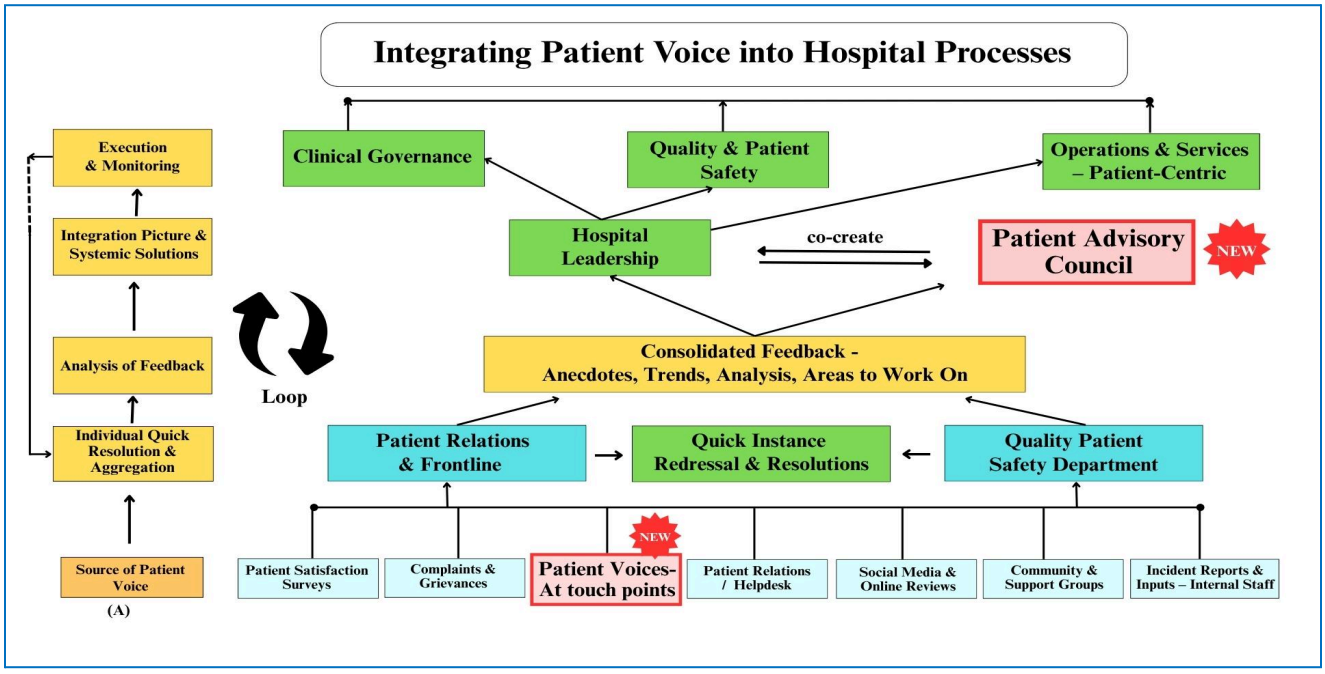
Examples:

- Repeated comments about unclear discharge medicines should trigger a review of discharge counselling, printed instructions, and medication reconciliation.
- Multiple concerns about fall risk should lead to environmental checks, staff training, and reinforcement of fall prevention protocols.
- Frequent hesitation to speak up may indicate culture issues; hospitals may need to improve psychological safety, signage inviting questions, and staff communication style.

Analysis should result in specific actions with timelines and owners, not general observations.

8. INTEGRATING PATIENT VOICE INTO HOSPITAL SYSTEMS

Patient voice can be easily integrated into existing hospital governance & feedback system.



8.1 Suggested flow

- Frontline capture: Staff or random interceptors collect patient voice at touchpoints.
- Patient relations: Service issues are resolved promptly.
- Quality and patient safety: Analyse patterns across departments and themes.
- Clinical and operations teams: Act on recurring issues with process changes.
- Leadership: Receive regular summaries and oversee priority actions.
- Patient Advisory Council (PAC): Review themes and advise on patient-centred solutions.

8.2 Interfaces with existing mechanisms

Patient voice can complement:

- Patient satisfaction surveys.
- Complaints and grievances.
- Patient relations desk records.
- Social media and online reviews.
- Incident reports from staff.
- Accreditation and quality indicators.

By integrating these inputs, hospitals get a richer picture of performance and realtime patient experience.

8.3 Governance and accountability

For effectiveness:

- Each major theme should have a designated owner (department head, quality leader, etc.).
- Action plans should be documented with timeframes.
- Leadership should receive a concise dashboard of trends and actions.
- "You Said, We Did" communication should be shared with patients and staff to demonstrate action & impact.

This builds trust and encourages more honest patient participation.

9. ROLE OF PATIENT ADVISORY COUNCILS

Patient Advisory Councils (PACs) give hospitals a structured mechanism to bring patient and caregiver perspectives into governance and design.
PACs are advisory rather than operational. They do not manage daily feedback. Instead, they provide, patient-centred interpretation of patterns and perspective from different patient groups (chronic, elderly, paediatric, etc.).

PACs can:

- Review aggregated patient voice themes, not individual cases.
- Identify blind spots where hospital perception differs from patient experience.
- Help prioritise which issues matter most to patients and caregivers.
- Co-design or advise on solutions (communications, signage, processes, environment).
- Provide feedback on whether implemented changes are clear and helpful.

Integrating PAC insights with quality and leadership decisions can significantly strengthen patient-centred care.

10. IMPLEMENTATION ROADMAP FOR HOSPITALS

Hospitals should start small, learn, and then scale. A phased approach builds ownership and sustainability.

10.1 Phase 1 – Pilot

- Select one high-impact touchpoint (for example, discharge in one department).
- Use a short, standard set of 3–5 questions.
- Choose simple technology (QR code, WhatsApp, or tablet).
- Train staff or interceptors to ask questions and capture responses.
- Tag responses using the themes in this handbook.
- Review feedback weekly for one to three months.

10.2 Phase 2 – Learn and act

- Identify the top three recurring themes from the pilot.
- Assign owners and action plans for each theme.
- Implement one or two visible changes that patients would notice.
- Communicate "You said, we did" messages in posters, WhatsApp broadcasts, or newsletters.
- Share learning with staff to reinforce the value of patient voice.

10.3 Phase 3 – Scale and integrate

- Extend patient voice capture to more departments and touchpoints (OPD, diagnostics, ICU).
- Strengthen technology as needed (better dashboards, integration with HIS).
- Embed patient voice review into routine quality and safety meetings.
- Involve PAC in reviewing trends and co-designing solutions.
- Continually refine questions and methods based on local experience.

Over time, patient voice becomes a natural part of hospital culture and self-improvement.

11. CONCLUSION AND NEXT STEPS

Patient voice is not a courtesy mechanism. It is a safety mechanism. Hospitals that rely only on complaints will often hear too late and from too few people. Hospitals that listen at the right moments across the patient journey will hear earlier, learn faster, and improve more deeply.

This Handbook proposes a practical approach that is simple enough to start and an effective tool. The test of success is not the number of responses collected, but the number of meaningful changes made because patients and caregivers were heard.

ANNEXURES
CAPTURING PATIENT VOICE ACROSS THE PATIENT JOURNEY

Sample Questions

Potential questions that should be asked & various touch points that patients & healthcare providers have. These are not as surveys but as prompts and suggestions. You can add questions relevant to your context. These could be to patient (preferred) or caregiver. These questions are categorised under "Moments of Truth" that patients have interacted with health care providers.

1. First contact (phone, website, WhatsApp)

- Did you clearly understand what you needed to bring with you (old reports, medicines, insurance papers, ID)? What was missing or unclear?
- When you called or booked online, did someone explain what to expect in your visit? What could have been explained better?
- Did you face any difficulty finding the hospital, the correct building, floor, or department? What sign or information would have made it easier for you?

2. Registration / Reception

- Was the registration process easy to follow? What step or took too much time?
- Did staff check your name, age and correct contact details carefully? Did you notice any mistake that you had to correct?
- Was the bill clear to you?

3. OPD Waiting area diagnostics / procedures

- Were you told how long you may have to wait/ reason for any delays? What would have helped reduce your stress/ anxiety while waiting?
- Was the waiting area comfortable (chairs, lighting, cleanliness, toilets, drinking water)? What felt wrong?
- Did you know clearly when it was your turn and where to go next?
- Did you see or experience any situation in the waiting area that felt like a near-miss (for example, almost falling, children/elders at risk, confusion about who is called next)?
- Did anyone ask about your past illnesses, allergies, or regular medicines at registration? Did they write it correctly? If no, what should have been asked?

4. OPD Consultation with Doctor

- During your consultation, did you feel the doctor or team listened to you without rushing? What important concern of yours was not heard or noted?
- Did you clearly understand your diagnosis and the next steps? If not, what part was confusing?
- Did the doctor or staff ask about your allergies, current medicines, and past medical history in enough detail? What was missed?

- Were you physically examined; did you feel uncomfortable & embarrassed (Specially Female Patients).

5. Investigations (Lab tests, Imaging, ECG, etc.)

- Before your test (blood test, X-ray, MRI, CT, etc.), did someone explain what will happen, how long it will take, and what you might feel? What was not explained that should have been?
- Did staff check your identity (name, age, hospital number) before the test? Was there a mistake
- For imaging tests like MRI/CT, did you feel prepared (noise, lying still, emergency button, what to do if uncomfortable)? What information would have reduced your fear or prevented repeating the test?
- Did you notice any mix-up or risk (for example, almost taking someone else's test, wrong label, wrong patient being called)? Please describe.
- Was the test area clean, respectful of privacy, and safe to move around? What felt unsafe?
- Were you provided hospital gown? Did the Change room have privacy.

6. Admission and Transfer to Ward

- Did someone explain clearly the need for admission and the plan for your stay? What remained unclear for you?
- Did staff confirm your identity and key details (name, diagnosis, allergies, other illnesses) when you were shifted to the ward? What should they have checked but did not?
- Did you receive information on basic safety in the ward (how to call for help, side rails, using the washroom safely, fall risks)? What safety advice was missing?
- While being moved (from OPD to ward, or ward to OT/ICU), did you feel safe and handled with care? Any moment where you felt at risk (e.g., trolley movement, lifts, corridors)?

7. Inpatient ward care (Nurses, Junior doctors, Housekeeping)

- Did the staff introduced themselves and explain how they will help & how to call?
- Did staff wash or sanitize their hands before touching you or your equipment? Did you notice any instance where this did not happen?
- Were your regular medicines and injections given on time and explained to you? Any time you felt a medicine was wrong, missed, or almost repeated?
- Did you ever feel at risk of falling or slipping (getting up from bed, going to toilet, using stairs)? How could they prevent that risk?
- Did you feel comfortable asking questions or raising doubts with nurses or junior doctors? If not, what made it difficult to speak up?

8. Pain Management and Comfort

- When you were in pain, did staff respond quickly and take your pain seriously?
- Did you feel your room/ward was comfortable enough (noise, lights at night, temperature, privacy)? What disturbed your rest?

- Was your dignity respected during examinations and procedures (proper draping, gender sensitivity, avoiding unnecessary exposure)? Any moment you felt embarrassed or disrespected?

9. Consent and Pre-Procedure / Surgery

- Before your procedure/surgery, did someone explain in simple language what will be done, why it is needed, and what the risks and benefits are? What remained unclear?
- Did you or your family feel you had enough time and space to read and understand the consent form before signing? If not, what rushed or confused you?
- Were your allergies, past illnesses, and current medicines checked and confirmed again just before the procedure? Was anything important not asked?
- Did you feel any pressure to sign without asking questions or getting another opinion? What could have helped your decision-making?
- Is there anything in the consent process that made you nervous/unsure?

10. Operation Theatre / Procedure room

- As a patient or caregiver, did you feel the team in OT/procedure room checked identity, procedure, and side of the body carefully? Any step you did not see being checked?
- Before you were taken in, did someone tell your family where they can wait and how they will be informed about progress? What was missing?
- Did you notice any situation that felt like a near-miss (almost wrong procedure, wrong side, confusion about patient)? Please describe in your own words.

11. ICU / High-Dependency care

- If you or your family member were in ICU, did the team explain daily what is happening and how the patient is doing, in understandable language?
- Did you ever feel something was wrong (breathing, tubes, monitors) but hesitated to call staff? Why did you not raise concern?
- Is there one change in ICU communication or access that would have reduced your fear or confusion?

12. Communication between Teams (handover, shift change)

- When staff changed shifts, did you feel the new team knew your case well? What important detail got missed?
- Did you ever notice two team members saying different things about your diagnosis, plan, or medicines?
- Is there an example where clear communication between staff prevented a mistake for you?

13. Discharge Planning and Education

- On the day of discharge, did someone sit with you and explain your discharge summary, medicines, and follow-up in simple language? What was confusing or unclear?

- Did you understand, what you need to do at home (medicines, wound care, warning signs, diet, activity)? If not, what is still unclear?
- Did you understand how to monitor health at home & how & when to report & call.
- Were all your regular medicines and new medicines checked together to avoid duplication or dangerous combinations?
- Did you feel rushed to leave without clarifying doubts?
- What change in discharge process that would prevent mistakes for the next patient?

14. After Discharge / at Home

- After going home, did you know whom to call or message if you had a problem or new symptom? What was missing in this information?
- Did you face any difficulty getting prescribed medicines, using devices, or following instructions at home? Describe any mistake or near-miss that happened at home.
- Did anyone from the hospital follow up to check on your recovery and clarify doubts? How could this follow-up be made more useful?
- Is there any moment in your entire journey where you felt unsafe, confused, or ignored, which you have not yet mentioned?

15. Overall safety and voice

- During your entire journey, was there any time you felt “something is not right” but did not feel safe to speak up? What would have helped you voice it?
- If you could change just one thing in this hospital to make care safer for patients like you, what would it be?
- Did any staff member do something that prevented a mistake or made you feel especially safe? Please share, so we can learn from it.

We can also have a fixed set of open questions at any touchpoint to capture safety signals and near misses. We can encourage the staff to ask these even if the formal process is not in place yet.

- “Is there anything that almost went wrong for you today, even if it was corrected in time?”
- Was there any step where you felt, “If I had not noticed, this could have harmed me or my family member”?

Patients For Patient Safety Foundation

My Health, My Responsibility

Scan the QR codes to access Patient Engagement Tools

Safe Health Library

Patient Engagement Toolkit for Patients & Healthcare Providers

Patient Advisory Councils (PACs)

Patient-Friendly Hospital (PFH) Standards

D10 Ground Floor, Nizamuddin East, New Delhi, India, 110013

+91 92896 96709 info@patientsforpatientsafety.in

www.patientsforpatientsafety.in