

Audit and patient satisfaction surveys have long been regarded as vital tools for a multitude of reasons benefitting the employer, employee and patient

In the veins

Claire Judge shares the results of a 20-year audit of her microsclerotherapy practice

Audit and patient satisfaction surveys have long been regarded as vital tools for a multitude of reasons, benefitting the employer, employee and patient. These surveys have been shown to affect clinical outcomes, patient retention, and medical malpractice claims.¹ A clinical audit can be used as a continuous quality improvement process, and it can focus on specific issues or aspects of healthcare and clinical practice.² However, at the onset of this audit journey, the researcher was blissfully unaware of these benefits; they were merely seeking to find out how patients were faring after their treatment and how the service could be improved.

For the past 23 years the practitioner has been a microsclerotherapy specialist nurse, initially under the supervision of vascular surgeons and then independently, having qualified as a nurse prescriber. These clinics involve assessing and treating patients with unsightly, predominantly asymptomatic, thread veins on the legs.

Following treatment, patients were advised to reflect on their procedure. After a two to three-month period, if they were not satisfied or still had concerns with the appearance of their veins, they were advised to return to the treating practitioner for further review and assessment. As a result of this process, the practitioner was unable to discern





whether they do not return because they are satisfied with the outcome and do not need further treatment, or they are unhappy and felt it was a waste of their time and money. This created a level of dissatisfaction in the practitioner and they decided to send out a questionnaire, leading to the initial audit 20 years ago.

This proved to be invaluable and, as a result, the audits have been repeated at five-yearly intervals and there is now a series of four audits. These have been used to reflect on the sclerotherapy clinic and how it has improved the practice and outcomes for the patients.

This article aims to show how the audits were conducted, why they have been so useful, what has been learned about this process and what both patient and researcher have gained.

METHODS

The initial audit in 2002 was devised to ask 10 basic questions, which covered the patient's perception of how their veins looked before and after treatment, the side effects encountered, and whether they would return or recommend friends to the service. This was a subjective, anonymous questionnaire, scoring outcomes using a numerical analogue scale.

TABLE 1

1. How would you consider the unsightliness of your legs before treatment?
0-3: appalling, 4-6: significant, 7-10: perfect
2. How would you consider your veins after treatment?
3. How satisfied are you with your treatment?
Disappointed, quite pleased or thrilled?
4. Have you suffered any side effects (staining, blisters)?
5. Were you given enough information before undergoing treatment?
6. Would you return for further treatment?
7. Would you recommend this treatment to your friends?
8. How many treatments did you require?
9. How many days did you need to wear your stockings for (ranging 1-7)?
10. Any further comments regarding your treatment?

As the technique and drugs used have remained unchanged, there was no need to adapt the survey since its concept. Initially, the task was arduous, hand writing and sending paper questionnaires with self-addressed envelopes. However, by 2018, a SurveyMonkey questionnaire was sent either to mobile phones or emails and could be completed in less than three minutes. Disappointingly, the response rate remained approximately one third despite the technology change and ease of use. On each occasion, an average of 147 surveys were dispatched to patients from a single London clinic, which resulted in 60 to 80 replies.

RESULTS

The first three questions were designed to ask patients to score the appearance of their veins before and after the treatment, and then their level of satisfaction.

Table 2: Patients' score of appearance of veins before and after treatment

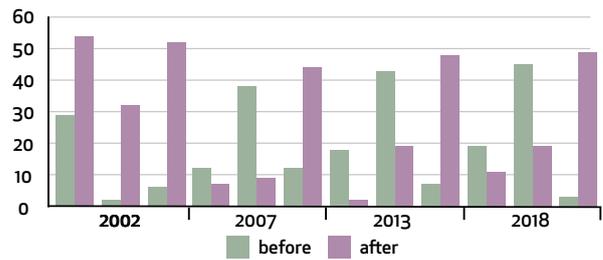


Table 3: Percentage of patient satisfaction

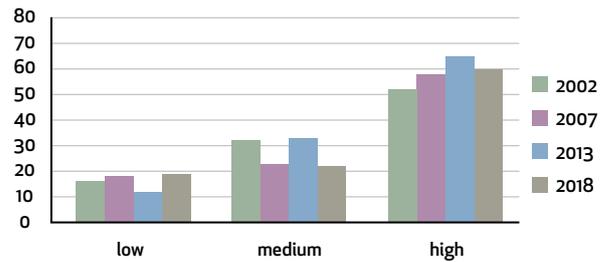


Table 2 indicates patients' perceptions of their veins before and after treatment. Patients were asked to assess their veins from 0 to 10, with appalling to significant scored from 0 to 6, and perfect scored from 7 to 10.

From the results seen in tables 2 and 3, there is a pleasingly steep incline in the veins appearing towards the perfect end of the spectrum following microsclerotherapy and a corresponding high level of patient satisfaction. This has been consistent over the entire 20-year period.

Both outcomes reflect how effective the treatment is, which is reassuring for practitioner, patients and employers. >

Table 4: Would patients recommend treatment or return themselves

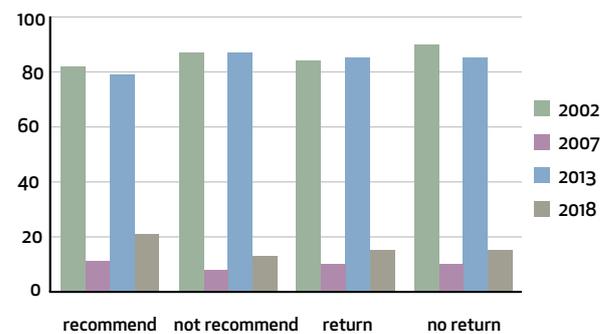
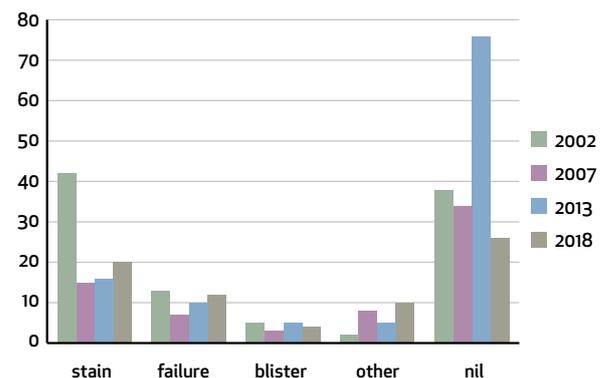


Table 5: Side effects



SCLEROTHERAPY



In table 4, questions 6 and 7 are amalgamated and it is evident that patients would both return and recommend the treatment to their friends and/or family. Figures have been consistent since the outset. These positive results helped reinforce knowledge that patients were happy with the outcome of their treatment, and the latter questions enabled further interrogation of the clinical practice.

This anonymous questionnaire enabled patients to be honest without the risk of feeling awkward particularly when asked directly by the practitioner. The side effect options could prompt the patients' memories and encourage them to reflect on any problems they may have forgotten. Finding out more about the side effects enabled valuable information to be captured and to compare this with other existing published data and enable a positive change. In 2002, it was very clear that there was a high level of staining. As a result of this practice was reviewed and the strength of the solution was decreased. By 2007 it was obvious that this had made a 50% improvement in the staining outcome. Failure rate had also improved, but this may have been as a result of the practitioner's increased experience and better technique.

When the clinic was initially set up in 1997, patients were expected to return for a follow up after a two to three month interval; this was reassuring for both the patients, practitioner and assessor. It enabled progress to be observed and further treatments offered if required (this is reflected in the 2002 data). Subsequently, in 2007, patients were asked to self-assess and would come back if they felt it was necessary. Judging by the satisfaction results, this did not affect their satisfaction or the outcome, but it did

Table 6: Number of treatments required

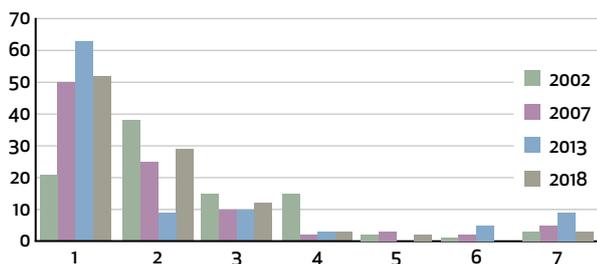
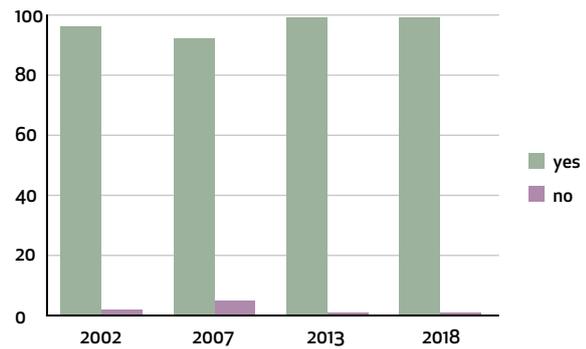


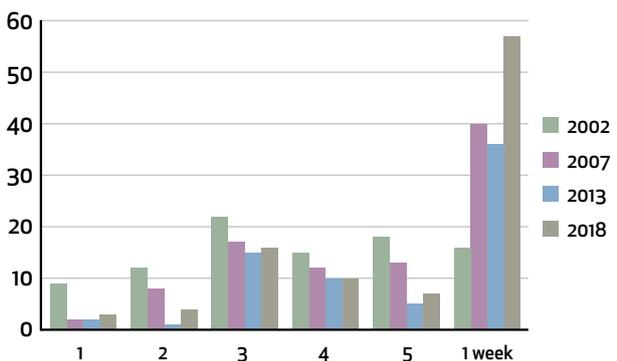
Table 7: Was enough information provided?



affect the number of revisits. It would have been more lucrative to continue to ask patients to return for a follow up, but it is questionable whether this would have been ethical when the outcome of satisfaction is unaffected.

The data from 2007 indicated that patients felt that they were not getting enough information. This prompted the development of a website, which ensured that when patients booked an appointment they were directed to the information prior to their consultation; this information was reinforced during their consultation. It was vital that this was improved as informed consent is an essential part of the consent process.³

Table 8: Time wearing stockings



The use of stockings is a contentious topic, as is evident in table 8 regarding the use of stockings. It is clear that the researcher fully endorses their use and has, over the years, increased the length of time that the patients are asked to wear them. Patients are requested to wear them for 72 hours day and night, and then for a further week in the daytime only (this is negotiable and will vary according to the vein type). There is little scientific evidence to uphold this, however over the years it has been observed that patients with the most impressive results have worn them for longer. Reflecting on these results, can this be justified? Certainly the results from 2002 show increased side effects, and the stockings are only worn for a short period of time, but is this due to practitioner's lack of experience or the stockings? In 2013, patients had fewer side effects and similar satisfaction levels, and wore the stockings for less time. This is something for further review.

Finally, the opportunity for patients to write comments after completing the survey allowed them to make further suggestions regarding the service. If they were unhappy, they could air their views anonymously. If they chose to sign it, this allowed the practitioner to contact them to offer help and reassurance, and to rebuild trust.



DISCUSSION

Audit is now a fact of professional life. We are accountable to our nursing body as part of nursing revalidation (which is essential to remain on the NMC register) and, as evidence of good nursing practice, we are told to gather and reflect on feedback from a variety of sources, using it to improve your practice and performance (the code NMC 9.2). But we are also accountable to our patients and employers.

The audit in 2002 was a personal exercise, a survey to assess skills and outcomes of the treatment. Twenty years later, it has become a vital tool in all aspects of the sclerotherapy clinics.

According to NHS England 2018, clinical audit is a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well, and where there could be improvements.⁴ As service providers, we have a duty to be open and honest with our patients, and accountable for the treatments we offer.

This practice is a useful way of assessing and growing all aspects of the clinic

are excellent ways to promote the service free of charge.

CONCLUSION

As has been shown, patient satisfaction affects clinical outcomes, patient retention, and medical malpractice claims. It affects the timely, efficient, and patient-centred delivery of quality health care.¹ The surveys that have been undertaken are clearly a very effective indicator in measuring the success of the sclerotherapy service.

Most importantly, this practice is a useful way of assessing and growing all aspects of the clinic. If the audit takes place over the summer, when there is usually less demand for sclerotherapy treatment, there is time to carry out the survey and it can prompt patients to reassess their legs, tell their friends and rebook for follow up. The data gleaned can be disseminated on social media to promote the service throughout the year.

The results of these audits have consistently shown that patients have been given enough information and would both return and recommend the treatment. These pleasing results can, to a large extent, be attributed to the rapport and relationship that the practitioner endeavours to establish during the consultation. The thoroughness of the consultation, discussing all the potential side effects, as well as the limitations of the treatment, will ensure the patient has realistic expectations and will significantly influence the patient's ultimate acceptance of the result. This transparency is key to patient's trust and to delivering ultimate satisfaction. **AM**



Before

After

This patient satisfaction data enables the practitioner to give patients factual and accurate statistics which help with their decision making and form an essential part of the consent process. These statistics can be part of the consultation, and can help build trust and rapport with the patient. Studies have shown that the rapport built at this stage of the patient journey helps reduce the risk of legal action due to a dissatisfied patient after treatment⁵, and it also improves patient compliance. Satisfied patients demonstrate greater compliance with their medical care⁶, which may also explain why patients are happy to wear their stockings for long periods of time.

According to research, patient satisfaction also leads to patient loyalty and improved patient retention. If we satisfy one customer, the information reaches four others. If we alienate one customer, it spreads to 10, or even more if the problem is serious.¹ There is sufficient evidence to prove that organisations with high customer loyalty can command a higher price without losing their profit or market share.¹ According to healthcare consulting firm Press Ganey, patients are five times more likely to select a practice because they had a positive experience there. Armed with positive patient satisfaction levels, this is reassuring for both myself and my employers.

Finally, in this current climate of social media, the use of these statistics and patient quotes regarding the service

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Claire Judge is a vascular/sclerotherapy nurse specialist and independent nurse prescriber with over 23 years' experience in sclerotherapy; she has clinics at the Royal Free Hospital London, East Grinstead and Woking. She is one of the founding members and is also on the board of the British Association of Sclerotherapists (BAS) and she teaches other practitioners. She has published articles and chapters on microsclerotherapy. She also speaks and demonstrates on this speciality at vascular conferences.