

The Measurement of Patient Satisfaction with Acute Services in Ireland

*Irish Patient Satisfaction Literature
Review and Scoping Exercise*

**Fearghal Grimes
April, 2003**

CONTENTS	PAGE
Background	2
Chapter 1	
Literature Review	3
Chapter 2	
Method	12
Chapter 3	
Results	14
Chapter 4	
Discussion	21
References	22
Appendix	24

If you have an apple and I have an apple and we exchange these apples, then you and I will still each have one apple. But if you have an idea and I have an idea and we exchange these ideas, then each of us will have two ideas.

George Bernard Shaw

On behalf of the Irish Society for Quality & Safety in Healthcare, I welcome and commend the vision of the Health Services Partnership Forum in examining the area of patient satisfaction. As this report describes, it is an area about which much has been identified, but little has been standardised. Though much work of the highest quality is delivered within Irish healthcare, we still need a comprehensive and consistent approach to measuring the satisfaction of the patient who is after all, the most important person in this process

This report may provide the impetus and direction for addressing the need to gather patients views. Armed with the correct data, we can further progress the spirit of partnership between caregivers and care recipients.

I congratulate Fearghal Grimes for his clear and thorough research. I also thank Hilary Coates, our past president of the Society for her insightful comments on the work and Denise O'Shea and Mary O'Connell in the executive of the Society for their unflinching energy in finalising the report. Lastly I want to extend special thanks to Seosamh O'Maolalai for working with us to bring this project to life and to the special project group of the National Partnership Forum for the investment in time, money and resources that such work entails.



Ian Callanan

President ISQSH

“Measurement of patient satisfaction with acute services”

Background

The 1994 health strategy, *Shaping a Healthier Future* (Department of Health, 1994), challenged those providing health services to ensure that the views of patients/clients and of the wider public are taken into account in service planning and provision in Ireland. The 1994 strategy acknowledged that much work was required to achieve change in this area. Since then there has been significant growth in the use of patient indicators of service quality, particularly the use of patient satisfaction surveys.

The new National Health Strategy *Quality and Fairness: A Health System for You* (Department of Health 2001) sets out a vision for how the health system should develop over the next decade in order to deliver high quality care for all users. One of the key principles in it is the provision of a people-centred health service that identifies and responds to the needs of individuals.

The National Health Strategy 2001 has set out a series of actions for achieving this goal. One such action is:

The National Health Strategy national goal No.3: Responsive and appropriate care delivery.

Objective 1. The patient is at the centre in the delivery of care.

Action; *A national approach to the measurement of patient satisfaction will be introduced.*

The Health Services National Partnership Forum (HSNPF) is the joint management / trade union body which leads and facilitates workplace partnership in the Irish health service. In order to address the “Key Elements of a Change Programme for the Health Sector” as outlined in the Programme for Prosperity and Fairness (Page 30), the HSNPF has designed and implemented a range of projects across the health sector. One of these projects is entitled “Survey of Patient Satisfaction With Acute Services”. It is being implemented in the context of the National Health Strategy National Goal No.3 as outlined above. In October 2002, the HSNPF commissioned the Irish Society for Quality and Safety in Healthcare to carry out research as part of this project. This research has two components: firstly, an in-depth literature review of the theory and practice of the measurement of patient satisfaction/perception and secondly, a scoping exercise to provide a comprehensive review of the current practice of patient satisfaction across acute care health facilities in Ireland.

“The theory and practice of the measurement of patient satisfaction / perception”

Historical Context

Studies of patient satisfaction with healthcare originated in the USA in the 1950s where survey research was the method of choice and throughout the 1960s, several such studies were carried out in the United Kingdom (Bowling, 1992; McIvor and Carr-Hill, 1989). Throughout the 1970s and 1980s, the number of patient satisfaction studies began to grow as the emphasis on quality assurance in healthcare increased. The NHS reforms, including the Patients' Charter fuelled the momentum of research and by 1991, approx. £5 million was invested in such surveys in the NHS (Batchelor et al, 1994). Between 1995 and 2000 there were 4,056 entries to Medline alone on the subject of patient satisfaction (Bisset and Chesson, 2000). Patient satisfaction studies can thus be perceived as a product of the orientation to consumerism and recognition of the need for dialogue between service users, providers and purchasers. Indeed, this concept of consumer and customers continues to sit uneasily with health care today, where many clinicians and professionals still feel it inappropriate to treat patients as consumers.

Difficulties in defining Patient Satisfaction

Despite its centrality, there is no agreed definition of the concept of patient satisfaction.

Patient satisfaction is a multidimensional concept, i.e. patients will be satisfied or dissatisfied about different aspects or dimensions of their healthcare and the ways in which it is provided. Consequently, there is a plethora of definitions:

- An evaluation by the patient of a received service where the evaluation contains both cognitive and emotional reactions. (Fitzpatrick, 1997)
- Reactions to salient aspects of the context and process and results of their experience (Hardy et al, 1996).
- Reactions to the context, process and results of their experiences (Pascoe, 1983; McGee, 1998).
- An individuals positive evaluations of distinct dimensions of healthcare (McCartan et al, 1996).

“Satisfaction” is not a straightforward concept. It would seem “satisfaction” is not something pre-existing in the patient waiting to be measured, but a judgement people form over time as they reflect on their experience. This judgement can be influenced by both internal and external factors and by the additional information and experience they may gain during their hospital stay. Patient satisfaction is an attitude – a person's general orientation towards a total experience of healthcare. Satisfaction comprises both cognitive and emotional facets and relates to previous experiences, expectations and social networks (Keegan et al, 2002). Meredith and Wood (1995) have described patient satisfaction as ‘emergent and fluid’. It also has been described as a particularly passive form of establishing consumers views (McIvor, 1992).

Satisfaction is rarely defined in surveys and there is evidence that patients do not judge health services in that way (Williams, 1994). For some, satisfaction means a minimum state of acceptability of services, for others, near perfection. Without a clear definition, patients are unlikely to make reliable distinctions between ‘satisfied’, ‘very satisfied’, and ‘not satisfied’ – let alone rate their ‘satisfaction’ on a scale of one to ten. Regarding the various dimensions of patient satisfaction within healthcare there is much disagreement over the actual number of dimensions ranging from six to twelve. Moreover, some literature argues that patient satisfaction studies are unsuitable for addressing questions of equity and fail to focus on issues of choice, safety, redress, psychological problems or outcomes (Scott and Smith, 1994).

Why are we now measuring patient satisfaction/perception?

There is an increasing emphasis on consulting patients in the planning of healthcare delivery (Department of Health, 2001) and on an organisational environment which focuses on audit and accountability. As techniques to measure the quality of healthcare proliferate and improve, health professionals are beginning to understand that patients and their families hold unique vantage points as expert witnesses of care (Delbanco, 1996) and that they should plan their services to reflect the needs of patients. Patient satisfaction is now a critical variable in any calculation of quality or value and therefore in the assessment of corporate/individual accountability, it is a legitimate and important measure of quality of care. Patients are rightly becoming more involved in their own healthcare and are being encouraged to do so. The movement to include patient evaluations of care is growing as more providers/organisations realize that patient satisfaction measurement is a cost effective, non-invasive indicator of quality of care. The Joint Commission of Accreditation of Healthcare Organisations (JACHO, 1994) has embraced patient satisfaction as a valid indicator and mandated in its 1994 standards for accreditation that “the organisation gathers, assesses, and takes appropriate action on information that relates to patient’s satisfaction with service provided”.

How do patient’s views relate to health?

Patient satisfaction is a desired outcome that matches clinical outcomes and influences other outcomes. Studies have shown that it is much more than a ‘happiness index’ (Weiss, 1990; Fitzpatrick, 1983). Evidence has begun to emerge that satisfaction is an important outcome measure and is related to improvements in health status (Fitzpatrick, 1991). Patient satisfaction is an increasingly useful measure in assessing consultations and patterns of communication (patient satisfaction is associated with longer and more informative medical consultations, McGee, 1998). Patient feedback can be used systematically to choose between alternative methods of organising or providing healthcare (such as length of consultation or arrangements for out of hour’s care) (Fitzpatrick, 1991). McGee (1998), also associates it with valued outcomes such as higher patient adherence to health recommendations, to continued use of appropriate health services and to higher levels of general health/well-being. Research has shown that patient perception of the quality of care closely matches judgements by peers of their care-givers. Moreover, satisfied patients respond more positively to medical management and experience better clinical and functional outcomes (Press and Malone, 2003).

What factors influence satisfaction?

Surveys overwhelmingly show that the majority of consumers, usually 80% or more, express overall satisfaction with their care, with few respondents responding negatively to any given item. Satisfaction is however, a relative measure, which research literature shows, may be influenced by many factors. For analytical purposes, two groups of factors affecting satisfaction were identified: those relating to the characteristics of the respondent, and those relating to health service delivery factors (Bruster et al, 1994).

• Patient expectation

The meeting of patient expectations is assumed to play a role in the process by which an outcome can be said to be satisfactory or unsatisfactory. Expectations are an important influence on the patient’s overall measurement of satisfaction with a healthcare experience. Patient satisfaction is influenced by the degree to which care fulfils expectation (Mahon, 1996). Some literature however suggests that a link between satisfaction and fulfilment of patient expectations is not necessarily the case, since it is possible that the patient’s evaluation of a service may be largely independent of actual care received (Williams, 1994).

• Age

Older respondents generally record higher satisfaction (Pope and Mays, 1993; Williams and Calnan, 1991; Owens and Batchelor, 1996) – possible explanations include lower expectations of healthcare and reluctance to articulate their dissatisfaction.

- **Illness**

While some studies have found that sicker patients and those experiencing psychological stress are less satisfied, (with the possible exception of some chronically ill groups) distinguishing between the experience of sickness or experience of health service treatment or other factors as causes of dissatisfaction has proven difficult (Hall and Milburn, 1998; Cleary et al, 1992).

- **Prior satisfaction**

Crow et al, (2003) in their review of literature identified that satisfaction was linked to prior satisfaction with healthcare and granting patient's desires (e.g. for tests).

- **Patient – professional relationship**

There is consistent evidence across settings that the most important health service factor affecting satisfaction is the patient-practitioner relationship, including information and technical competence (Crow et al, 2003).

- **Choice of service provider**

Choice of service provider is associated with higher satisfaction (Crow et al, 2003). Care provided under fee-for-service arrangements generates greater satisfaction than that delivered with prepaid schemes. Gatekeeping organisations where patients have little or no choice in their treatment, or are assigned treatment, score relatively poorly on satisfaction.

- **Gender, ethnicity, and socio-economic status**

Evidence about the effects of gender, ethnicity, and socio-economic status is equivocal due to the small amount of literature available on each (McGee, 1998; Crow et al, 2003)

Choice of survey instrument

There are a wide variety of patient satisfaction questionnaires of varying sizes, detail and focus. Some are detailed, multi-dimensional scales designed to assess the overall concept of satisfaction and have been tested for reliability and validity, while others are simpler one-off questionnaires designed for specific settings, which do not aspire to such sophistication. There are several reviews of the measures of patient satisfaction currently available discussing their individual, theoretical and empirical properties (McGee, 1998; OHM, 2002). The following are important criteria for choosing a patient satisfaction instrument – generic or specific measures, question focus and psychometric properties (Bisset and Chesson, 2000; McColl et al, 2001).

Generic or specific measures

Satisfaction or dissatisfaction can be expressed around a number of aspects of healthcare (specific) and also in a global sense. However, if generic measures of satisfaction are to be useful, there needs to be a clear understanding of which specific aspects of a service influence that rating. An overall satisfaction score supplemented by information on the more specific aspects of the service provides respondents with the opportunity to assess all aspects of the service. Whereas, it is of no help to know that the majority of patients are satisfied in an overall sense with their experience – maintaining a status quo (Williams and Calnan, 1991).

Question focus

It has long been acknowledged that the wording and presentation of questions influences responses (Cohen et al, 1996). Questions may focus on patient's actual experience or on their evaluation of results. Short, clear questions are best. Over reliance on negative statements to elicit information about patient's perceptions and views may provide a misleading picture. Moreover, asking patients if they agree with a negative description of their hospital experience tends to produce greater apparent satisfaction than asking if they agree with a positive description (Cohen et al, 1996).

Psychometric properties

Structured measures of patient satisfaction should adhere to the principles of psychometric measurement. However, reviews of studies have shown that authors demonstrated a poor understanding of the importance of core measurement properties if a measure is to measure satisfaction with confidence (Sitzia, 1999; Roberts, 1999). Questionnaire reliability and validity become increasingly important as survey results are more frequently used as measurement data in assessing quality improvement interventions.

Validity: the measure should be a 'true' measure of patient satisfaction and not, for example, be a measure of general life satisfaction. Qualitative methods are needed to ensure that those aspects of health services most salient to the patients are included in the survey. Another concern about the validity of survey results relates to the willingness of patients to make negative evaluations of the health service they largely depend on for their care. Consequently, every effort should be made to ensure views remain anonymous or confidential.

Reliability: It should be consistent, such that, given similar experiences, patients would return similar ratings on the scales (test-retest reliability).

Choice of method of administration of survey

A review of the most recent literature regarding the choice of method of administration of survey finds much commonality. Tables 1. & 2. give comprehensive overviews of choice of instrument. Other findings include:

- Differences between mail and telephone response rates can be significantly reduced by telephone follow-up of mail non-respondents, though this adds to the costs.
- Impersonal and mail methods result in more criticism/less reported satisfaction because respondents' anonymity is not compromised and there is no pressure for socially acceptable responding (Crow et al, 2003)
- Mail methods give more variability in responses (people feeling strongly either way respond), but there may be concealed proxies.
- Mailing questionnaires 1-2 day's post-discharge yields higher return rates than handout at discharge (Press and Malone, 2003).
- On-site surveys under-represent low users in ambulatory populations.
- Qualitative approaches are more resource intensive but generate a different sort of information than structured questionnaires.

Table 1: Summary of advantages and disadvantages of various modes of survey administration (McColl, et al 2001).

	Face-to-face Interviews	Telephone Interviews	Postal Questionnaires
Response rates: General populations Special populations	Usually best Usually good	Usually lower than face-to-face Satisfactory to best	Poor to good Satisfactory to good
Representative samples Avoidance of refusal bias Control over who completes questionnaire Gaining access to a named selected person	Requires good interview technique Good Good	Requires good interview technique Moderate Good for those with telephone	Poor Poor to good Poor to good
Ability to handle: Long questionnaires Complex questions Boring questions Item non-response Filter questions Question sequence control Open-ended questions	Good Good Good Good Good Good Good	Moderate Moderate Moderate Good Good Good Good	Satisfactory to poor Moderate to poor Poor Moderate Moderate to poor Poor Poor
Quality of answers: Minimise social desirability responses	Poor	Moderate	Satisfactory
Avoid distortion due to: Interviewer characteristics Interviewer opinions Influence of other people Allows opportunity to consult	Poor Moderate Moderate Moderate	Moderate Moderate Good Poor	Good Good Poor Good
Implementing the survey: Ease of finding suitable staff Speed Cost	Poor Poor Poor	Moderate Good Moderate	Good Poor Good

Table 2: What survey methods should be used to gather information? (OHM 2002)

Survey Method	Brief Description	Key Advantages	Key Disadvantages
Questionnaires	A structured document that can be self-administered or interviewer administered Mode of collection determined by resources, length, sensitivity, complexity, respondents, etc. Suited to situations where high response rate required	<ul style="list-style-type: none"> • Allows for collation of both qualitative and quantitative data • Relatively inexpensive 	<ul style="list-style-type: none"> • Questions must be carefully designed so that they are clear concise and relevant • The choice of response options can affect how people think & respond to questions • Generally require software support to record results
Postal surveys- Questionnaires		<ul style="list-style-type: none"> • Cost effective • Specific segments can be easily targeted • Wider sample distribution possible • Visuals may be used • No interviewer bias 	<ul style="list-style-type: none"> • Difficulties associated with procuring an accurate list of people/their details • No opportunity for explanation or follow-up questions • Capacity of people to respond – reading/writing skills
Email/computerised surveys		<ul style="list-style-type: none"> • Cost & time effective • Visuals may be used • Increased control to monitor and ensure completed questionnaires • Ease of data collection 	<ul style="list-style-type: none"> • Access to computer may be limited • Does not allow for the probing of data
Focus groups	Qualitative interviews with a small number of carefully chosen people (6-12) brought together to discuss a range of topics. To be at their most effective they should be conducted by trained moderators	<ul style="list-style-type: none"> • Allows for the exchange & probing of ideas • Facilitates high level of flexibility in terms of the discussion held • Speedy results • Relatively low cost 	<ul style="list-style-type: none"> • Statistical representation is not a necessity • Quality of data is influenced by skills of moderator • Data is more difficult to analyse in a strict quantitative sense • Affords less control than individual interviews • Groups can be difficult to assemble • Must be conducted in a conducive environment
Personal interviews	Personal interviews may be structured or unstructured. Both methods require trained interviewers. Not suited to surveying large groups of people	<ul style="list-style-type: none"> • Direct source of data • Provides for a wide variety of views and high levels of flexibility • Interactive, e.g. visual questions can be used 	<ul style="list-style-type: none"> • Time-consuming for both parties involved • Costly • Scheduling may be difficult • Interviewer bias can influence results • Must be conducted in a conducive environment
Telephone Interviews	Generally administered using a structured questionnaire. Requires trained surveyors	<ul style="list-style-type: none"> • Direct source of data • Interactive • Generally less costly than personal interviews 	<ul style="list-style-type: none"> • Time restraints on the part of participants • Low co-operation rates • Interviewer bias can influence results • Precludes those that do not have a telephone

There are a wide variety of 'off-the-shelf', valid and reliable survey instruments currently available. In Switzerland, the National Co-ordination and Information Office of Quality Improvement has recommended Picker survey instruments assessing patients experiences of healthcare to be administered in 300 hospitals on an annual basis (Jenkinson et al, 2002).

Planning / Sampling Strategy

One of the main concerns about satisfaction surveys is that they are conducted with inadequate planning. Review articles stress the importance of identifying clear objectives and marrying them with the appropriate method – a contingency approach is the most important aspect of survey design in the health services.

Critical Decisions in the Survey Process - (OHM, 2002)

1. What is the objective of the patient satisfaction survey/how will the data be used?
2. What aspects of service quality need to be measured?
3. What kind of questions should be asked in order to elicit the required information?
4. Who should be surveyed/how many respondents are required?
5. What survey methods should be used to gather the information?
6. Who should administer the survey (including data analysis and reporting)?
7. When should the survey be completed?
8. Where should the survey be completed?
9. How frequently should the survey be undertaken?
10. How will quality assurance be managed?

Population

The choice of a target population for sampling depends on the survey being conducted. Under most situations, the target population will be all enrolees and a random sample of them may be studied. Other analysis will limit the target population to a subgroup with a particular medical condition (such as diabetes) or characteristic (such as children under age three). Identifying these populations or sub-populations may present a challenge of the moving target due to ongoing enrolment and disenrolment. Moreover, difficulties of collecting sufficiently large samples for auditing the care of specific patient groups have been found with even common surgical procedures such as appendectomy (Black and Moore, 1993).

Timing of survey and completion of interview or questionnaire

The reliability of every survey is dependent upon the timing of the survey and completion of interview or questionnaire, as has already been identified. Surveys carried out whilst respondents are still inpatients mean they are unable to comment on the whole process and may feel their confidentiality is compromised (McGee, 1998; Batchelor et al, 1994; Delbaco, 1996; OHM, 2002). Additionally, not too much time should be allowed to elapse between experience of service and collection of sampling, lest patients experience difficulty with recall or have new healthcare experiences within the elapsed time (Sherman, 1999).

Potentials for bias or misinterpretation of survey results.

Several areas of potential bias are routinely documented in the literature:

Poor response rate: Respondents should reflect the overall patient profile in terms of sex, age and service used. Some empirical work has shown that the conclusions drawn from low response rates are qualitatively different than those of the larger group of patients – low response rates yielding higher satisfaction scores (Barkley and Furse, 1996; Lasek, 1999). Given that one of the serious limitations to patient satisfaction studies is the skewed pattern of data and inflated satisfaction scores, methods for boosting response rates may be particularly important. Resources and effort are required to expand follow-up from non-responders. In Ireland, McCarthy et al, (1998) increased response rates by 18% through a three phase follow-up procedure (reminder letters and telephone call), however the demographic profiles and overall satisfaction scores were similar for initial responders and late responders.

Instruments used – wording of questions and response scales: As already discussed the wording of questions affects the response given. Questions about specific aspects of care should be included as they are less ambiguous and more sensitive than general questions and secondly, open-ended questions should be included in questionnaires to aid interpretation of the responses to precoded questions (Sitzia and Wood, 1997).

Response scales play a key function in the measurement of patient satisfaction. A major disadvantage of using standard rating scales is that only the researcher's previously defined responses are permitted. Further, closed questions may result in over-estimates of satisfaction (Fitzpatrick, 1991). Studies also note that lower satisfaction scores are returned for scales requesting judgements of aspects of care as 'excellent, very good, fair or poor' compared to alternative rating scales e.g numerical scales. Similarly, some authors note that the objective rating of experience i.e. "were you encouraged to talk? did you have to wait?" yields more reliable, informative and actionable results than surveys, which ask for satisfaction ratings on aspects of care (Ware and Hayes, 1988; Cleary et al, 1992; Coulter and Fitzpatrick, 2000).

Representativeness of survey

High quality evaluation consists of surveying both representative individuals within a particular system, representative aspects of care and representative groups within the health system as a whole. McGee, (1998) outlines three areas of concern pertaining to representativeness. The surveying of representative individuals within a particular system may exclude many patients for pragmatic reasons. Many surveys relate to hospital care only, with pre-admission and discharge information lost. Sampling of in-patients often excludes seriously ill patients or patients absent during the sampling period due to tests or procedures. Using this procedure only 38% of 'bed occupants' in a UK general hospital were asked to participate in a recent study (Hardy, 1996).

Representativeness also relates to the type of setting evaluated in satisfaction surveys. The majority of surveys look at general adult in-patients, maternity services and outpatient clinics, few look at those in long term care (psychiatric/geriatric) or institutional settings for learning disability. Whilst acknowledging the challenges of consultation in these settings, there is a particular irony in giving less attention to the views of these groups whose ongoing living environment is the health setting (McGee, 1998).

Uses of patient satisfaction/perception surveys

Patient satisfaction surveys should be seen as part of a quality improvement process, which includes evaluation and dissemination of results to key players, consultation and development of plans for improvement, implementation of plans, and re-evaluation to measure gains and identify new priorities for improvement. However, all too often this does not occur as surveys are carried out in isolation and consequently they are frequently seen as irrelevant.

Critical questions in the survey process

Difficulties of reporting and interpretation are related to the nature of patient satisfaction surveys. While satisfaction with delivered services is important, focusing on it alone fails to address customer needs. Understanding the difference between customer needs and customer satisfaction is crucial to the hospitals' success in quality management. Hospitals are no longer asking "How do you like our doctors?" but "How well did we help you understand what it would be like when you woke up from surgery?" (Gustafson, 2000)

Summary

This literature review has demonstrated that the measurement of patient satisfaction is complex and evolving. A wide variety of factors have been shown to impact on patient satisfaction with the healthcare they receive. Consequently, the tools to measure these impacts have had to become more complex and refined. This in turn has increased the likelihood of bias throughout the process. The 'explosion' of research into patient satisfaction has further demonstrated that a stand alone patient satisfaction survey, although a legitimate assessment of a service, is far from a complete assessment of a service. The accurate measurement of patient satisfaction now requires careful planning, possibly several tools and increasingly sizeable resources. This evolution of the measurement of patient satisfaction means that is now an established and essential element of the healthcare process.

Areas identified for further research / Recommendations

Crow et al, (2003) in their review of satisfaction studies identified the following areas where further research may be warranted:

- With respect to methodological issues, research is needed on:
 - The effect of timing of surveys on reported satisfaction
 - The extent of bias introduced by interviewers
 - Cross-cultural issues
 - How consumer feedback can be incorporated into healthcare decision making

- With respect to the role of expectations, research is needed on:
 - Classifying different types of expectations and exploring how consumers operationalise these in evaluations
 - Identifying influences on expectations
 - Examining the relationship between socio-demographic factors and expectations
 - Exploring how different types of illnesses and health outcomes affect evaluations.

This project consisted of a quantitative survey using a telephone questionnaire.

Project Aims / Rational

The aim of this project was to provide a comprehensive review of the current practice of the measurement of patient satisfaction across acute healthcare facilities in the Republic of Ireland.

It was agreed, in consultation with the Health Services National Partnership Forum (HSNPF) and the Irish Society for Quality and Safety in Healthcare (ISQSH) that a twin-pronged approach be taken in assessing the acute care health facilities, namely that:

- All hospitals throughout the country, providing acute care, be approached and asked to participate in the scoping exercise.
- Healthcare bodies involved directly/indirectly in acute patient care be approached and asked to participate in the scoping exercise*

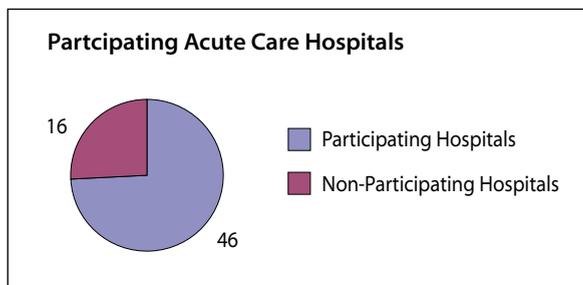
**(Consultation between the HSNPF and the ISQSH identified the second group of healthcare bodies as a group comprising: the Health Boards, the health insurance companies and the ISQSH).*

Project population

The Department of Health and Children website www.doh.ie has identified 62 hospitals that provide acute care. A researcher from the ISQSH contacted all 62 hospitals and 46 agreed to participate in the scoping exercise (Figure 1). The interviews were carried out in a two-week period in February 2003.

Figure 1. Hospitals who participated in the scoping exercise

Sampling



The scoping exercise involved conducting a ten minute telephone survey (Appendix 2) with an appropriate individual, within each hospital/healthcare related body. The ISQSH researcher contacted each hospital/healthcare related body directly and asked to speak to a senior member of staff, familiar with the operation of the hospital and knowledgeable about the measurement of patient satisfaction in that organisation.

Obtaining consent

The researcher established organisational consent by asking the interviewee for permission to conduct the interview. The researcher gave an overview of the project, explained about confidentiality and explained the focus of the interview. If consent from someone more superior was required, the interview was suspended until this consent had been received.

Ethical considerations

In order to protect the hospital's and healthcare related bodies confidentiality, the following procedures were implemented.

- All hospital/healthcare related body information was kept anonymous.
- The hospitals/ healthcare related bodies data was destroyed on completion of the project

Questionnaire Design

An 18-question, telephone survey document was developed by the researcher, in conjunction with the Irish Society for Quality and Safety in Healthcare (Appendix 2). The survey was designed to collect information on the following areas:

- Organisational information
- The systems in place for measuring patient satisfaction/perception within Irish healthcare
- Details/Contents of the Survey
- Survey Follow-up

Piloting

Before commencement of the main survey a pilot survey of five hospitals was carried out. The purpose of the pilot survey was to test the content, structure, comprehensibility and acceptability of the questionnaire. The researcher noted no negative reaction from respondents; therefore the survey instrument remained unchanged.

Data Analysis

Data was collated and analysed by the ISQSH researcher. Microsoft Word and Excel were used to analyse the data.

The results section is divided into five parts corresponding to the relevant section of the survey instrument (Appendix 2).

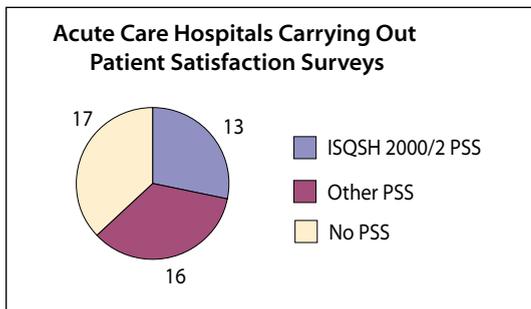
Satisfaction /Perception Measurement

Hospitals reported a variety of systems / approaches used in measuring patient satisfaction/perception..

Figure 2. demonstrates that of the 46 hospitals, 13 had participated in the *National Patient Perception of the Quality of Healthcare Survey 2000* conducted by the ISQH*. Other patient satisfaction surveys were conducted in thirteen out of forty-six hospitals.

In 17 hospitals, patient satisfaction was not currently being assessed, nor had it been assessed in the past.

Figure 2. Acute Care Hospitals that carried out Patient Satisfaction Surveys



**In 2002 the Irish Society for Quality in Healthcare changed its name to the Irish Society for Quality and Safety in Healthcare.*

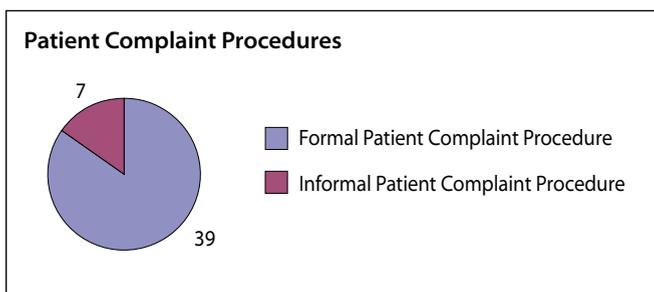
Fifteen hospitals surveyed had a patient **Comment Card System** in place (i.e. A system whereby a “comment” card was freely available to patients where they could record positive or negative statements about their care, anonymously). Ten of these hospitals did not carry out any other measurement/assessment of patient satisfaction.

Four hospitals had set up patient **Focus Groups** (i.e. qualitative interviews with a small number of selected people), where satisfaction with the various services was sometimes discussed. In each of these hospitals, other forms of assessing patient satisfaction such as an organisational patient satisfaction survey or comment card system were also employed. Likewise, three hospitals had **Consumer Panels** set up (i.e. similar to, but larger than focus groups), again as part of a co-ordinated approach to measure/assess patient satisfaction.

Two hospitals reported having a **Patient Advocacy** department through which satisfaction with services provided could be channelled.

Figure 3. shows that thirty-nine out of forty-six hospitals reported that they had a formal **Patient Complaint** procedure in operation (patient leaflets, reporting structure, etc.) while the remaining seven, stated that they had an informal process in operation (complaints were dealt with by the hospital manager or director of nursing, as they arose).

Figure 3. Patient Complaint Procedures in Hospitals



Organisation wide or service/departmental approach

Of the 29 hospitals that carried out patient satisfaction surveys (17 hospitals out of 46 had not carried out patient satisfaction surveys in the past), 10 carried out the surveys across the organisation, 8 carried out service or departmental satisfaction surveys and 11 of the hospitals carried out both.

All surveys had been carried out since 1999.

All of the service/departmental satisfaction surveys had been undertaken by hospital staff and in a very few cases, by the audit or quality department within the hospital.

Regarding the organisational wide surveys, 13 hospitals had used the ISQH/ISQSH as an external agent to carry out the survey on their behalf. Ernst & Young had been employed by one hospital to carry out a satisfaction survey, whilst the remainder of hospitals had undertaken the organisational survey by themselves.

Details of the Survey

In all cases except where the survey was carried out by an external agent (17), hospitals developed their own assessment tool or amended an existing tool. No hospital reported using a validated, existing tool for an organisational or service/departmental survey.

A variety of instruments were used to carry out the various surveys. Telephone interviews were only used in the ISQH 2000 survey, where they interviewed 150 patients from each of the thirteen participating hospitals. The 2002 organisational wide survey carried out by the ISQSH was a postal questionnaire, where 500 patients from each of the ten participating hospitals involved were surveyed. The majority of the remaining surveys were postal, with a few hospitals opting for face to face interviews, particularly for the service/departmental surveys.

A majority of satisfaction surveys focussed on in-patients. (It is impossible to give exact figures due to the fact that hospitals were frequently unaware of all the surveys that were undertaken there and could not give exact figures regarding numbers, patient type, age, etc. The measurement of outpatient satisfaction particularly, although small, invariably was conducted at service/departmental level.)

All surveys reported were carried out on adults, there was no recorded survey conducted on children.

In relation to the numbers taking part in the various surveys, it is difficult to be exact due to the nature of hospital's replies. The organisational surveys reported surveying between 150 and 500 patients per hospital. Again data regarding the multitude of service/departmental surveys was unreliable due to lack of knowledge of the individual hospitals.

Contents of Survey

All hospital surveys assessed various dimensions of care. The quality of the hotel aspects of the services was included in every survey, whilst there was some variation in the measurement of other dimensions of care. **See Table 3.**

Table 3. The number of hospitals who measured the various dimensions of care during their organisational wide satisfaction survey (n=21)

Waiting Times	13	Hotel aspects	21	Bed management	15
Admission Procedure	3	Complaints	19	Medication	17
A/E	16	Dignity/Privacy	13	Pain Relief	18
Communication	3	Staff Assistance	18	Discharge procedures	16
Information	13	Procedures/Operations	13		

Survey Follow-up

A wide variety of direct benefits to patients occurring as a result of feedback from patients were recorded.

- Hospital Information Booklet created/updated - 18 hospitals
- Improved Patient information Leaflets -10 hospitals
- Improvements in A/E departments (e.g. televised waiting times, drink machines) - 6 hospitals
- Improved waiting list management (e.g. regular review of waiting lists) - 4 hospitals
- Improved physical environment (e.g. improved seating in out-patients) - 4 hospitals
- Segregation of catering and housekeeping duties - 3 hospitals
- Improved patient facilities (e.g. televisions in patient rooms) - 5 hospitals
- Communication skills for frontline staff - 3 hospitals
- Improved TV access for patients - 2 hospitals
- Improved hospital signage - 2 hospitals

In all cases where surveys were carried out, the Chief Executive Officer or General Manager of the hospital was identified as the person responsible for acting on the results of the survey. Additionally, where a "Patient Services Manager" or a "Quality Manager" was in place, they too were accountable for acting on the results. This was the case only for organisational wide surveys, hospitals reporting that where individual or service or departmental surveys were carried out, they themselves were responsible for action.

Thirty-three out of forty-six hospitals surveyed stated that the existing management structure within the hospital would implement any recommended changes. The remaining 13 hospitals identified the quality / accreditation structure within their hospital as the system to implement any recommended changes.

All hospitals that carried out patient satisfaction surveys reported that they disseminated the results of the survey back to staff through a variety of mediums (staff presentations, staff leaflets/handbooks, hospital newsletter and hospital intranet). No hospital reported that they disseminated results back to patients, however hospitals that took part in the ISQH/ISQSH patient satisfaction surveys explained that the results of these national surveys were available as an aggregate report, through the ISQSH office.

Finally, in relation to the systems that were in place for carrying out the surveys on a regular basis, 22 out of 46 hospitals stated an on-going commitment from hospital management would ensure this. 13 of 46 hospitals with quality/accreditation structures in place stated that this structure would ensure ongoing commitment and 11 hospitals could identify no system in place in their organisation that would ensure commitment to a satisfaction survey on a regular basis.

Figure 4. What System is in Place to Ensure Regular Patient Satisfaction Surveys?

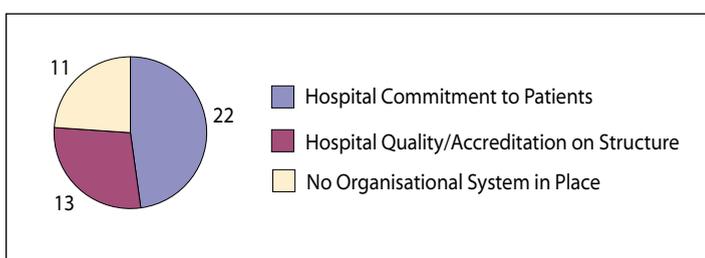


Table 4. Hospital Feedback Summary

	ISQI Patient Satisfaction Survey 2000	ISQSI Patient Satisfaction Survey 2002	Other Patient Satisfaction Survey	Comment Card System	Focus Group	Consumer Panels	Patient Advocacy	Organisation Wide Survey	Departmental Survey	Survey Carried out By External Agent	Results Disseminated To Staff	Results Disseminated To Patients
Hospital 1			X					X			X	
Hospital 2			X					X	X		X	
Hospital 3				X								
Hospital 4				X								
Hospital 5	X	X				X		X	X	X	X	
Hospital 6												
Hospital 7			X						X		X	
Hospital 8	X			X	X			X	X	X		
Hospital 9			X					X			X	
Hospital 10				X								
Hospital 11			X						X		X	
Hospital 12												
Hospital 13												
Hospital 14	X	X					X	X	X	X	X	
Hospital 15			X	X					X		X	
Hospital 16	X	X			X	X		X		X	X	
Hospital 17	X	X						X	X	X	X	
Hospital 18	X	X						X	X	X	X	
Hospital 19				X								
Hospital 20			X					X	X		X	
Hospital 21			X						X	X	X	
Hospital 22				X								
Hospital 23			X					X	X		X	
Hospital 24												
Hospital 25	X	X			X			X	X	X	X	
Hospital 26												
Hospital 27			X					X	X		X	
Hospital 28			X					X			X	
Hospital 29				X								
Hospital 30	X							X	X	X	X	
Hospital 31												
Hospital 32	X	X		X			X		X	X	X	
Hospital 33				X				X				
Hospital 34				X								
Hospital 35			X					X			X	
Hospital 36												
Hospital 37	X	X		X				X	X	X	X	
Hospital 38	X	X						X	X	X	X	
Hospital 39	X							X		X	X	
Hospital 40				X								
Hospital 41												
Hospital 42												
Hospital 43			X	X	X	X			X		X	
Hospital 44												
Hospital 45				X								
Hospital 46	X	X						X		X	X	
	13	10	13	15	4	3	2	21	18	14	25	0

This section contains feedback from the health boards and the private medical insurance companies and the ISQSH. Feedback from each group shall be discussed separately.

Health Boards

The researcher contacted an appropriate spokesperson(s) in each of the country's ten health boards. The following is the feedback from each of the health boards

Health Boards A, B & C

Collectively these three health boards had participated in a study designed to provide baseline information on both experiences and expectations of people in the region of health services. The survey focused on a wide variety of health service issues including patient's experiences of acute healthcare. Telephone interviews were conducted with 1500 residents from the three health boards. The computer aided telephone interview instrument was developed in consultation between the health boards and the company appointed to carry out the research. Individuals were selected for interview on the basis of tightly controlled quotas for age and sex. The survey was carried out in August 2002. Dimensions of care assessed in the acute care section of the interview included: experience of admission, communication by staff, aspects of patient care, hotel aspects and discharge procedures.

The report was published in December 2002 and it is envisaged that all three health boards will use the study findings to improve the quality of services they provide to their patients/clients

Health Board D

This health board has not conducted any formal measurement of patient satisfaction of acute services at board level. It is aware that several of the hospitals within its remit have undertaken such surveys. The board is cognisant of the Goal No. 3, - Objective 1. in the new National Health strategy "Quality and Fairness - A Health System For You", and hopes to incorporate it into a new board initiative of setting up "patient partnership groups" in each of its hospitals. It is envisaged that these frameworks will provide a mechanism to measure patient satisfaction on a regular basis.

Health Board E

Again this health board has not undertaken a patient satisfaction survey of its acute care services in the past. It too, is aware of individual hospitals within its remit undertaking patient satisfaction surveys, but has had no input to them. The board has identified the national health strategy goal as a priority for the year and provision has been made in the 2003 service/provider plan for its implementation.

Health Board F

Although this health board has not undertaken a formal patient satisfaction survey of acute services, it has introduced a system of focus groups and consumer panels across its acute services, designed, amongst others to gauge satisfaction with services. The process commenced in 2001 and feedback from these groups has already resulted in improved services to patients.

Health Board G

Measurement of patient satisfaction of acute services only takes place on an ad hoc basis in this health board, i.e. hospitals undertake it themselves. Although when approached the public health department has assisted numerous small service/departmental satisfaction surveys.

Health Board H

No formal measurement of patient satisfaction with acute services occurs in this health board. Hospitals have undertaken this themselves.

Health Board I

No formal measurement of patient satisfaction with acute services occurs in this health board. Hospitals have undertaken this themselves.

Health Board J

No formal measurement of patient satisfaction with acute services occurs in this health board. Hospitals have undertaken this themselves. A health board audit department provides support for individuals for such studies.

Health Insurance Companies

The two main health insurance companies agreed to participate in the study.

Company A:

This company carries out a biannual patient satisfaction survey. It was last carried out in November/December 2002 by their marketing division. They developed the survey instrument themselves. It is a postal survey distributed to patients recently discharged from hospital and those post day surgery. There were 7,829 participants in the last survey. Dimensions of care that were assessed included: waiting times, hotel aspects, dignity/privacy, information and billing integrity. Direct benefits to patients that have occurred as a result of patient feedback include a recently established waiting lists initiative to counter emerging waits. The survey also informs discussions with providers. The Claims and Hospital Relations Department is responsible for acting on the results of the survey. Results have been distributed to staff.

Company B:

This company reported that it carries out patient satisfaction surveys on an ad hoc basis. The surveys have been service or issue specific, with the company developing its own questionnaire and carrying out the survey itself. These surveys have all been postal and the population size variable dependent upon the issue/service targeted. Past surveys have looked at some dimensions of care including hotel aspects and waiting times. The ability to go back to the participating organisation with patients concerns was identified as being beneficial to patients and this was the responsibility of the Provider Affairs Department. Staff within the organisation were made aware of the results of the surveys and the Customer Care Department was currently examining the possibility of formalising the patient satisfaction survey process.

Irish Society for Quality and Safety in Healthcare

The Irish Society for Quality and Safety in Healthcare is a non-profit, non-governmental organisation. It is dedicated to improving the quality and safety of healthcare, to supporting the development of professionals in healthcare quality through education and to providing a network for those working in or interested in healthcare quality.

The society has conducted two national patient satisfaction surveys in 2000 and 2002. Both have had slightly different formats. The National Patient Perception of the Quality of Healthcare Survey 2000, was conducted by means of a computer aided telephone interview system. One hundred and fifty in-patients from each of the 13 participating hospitals were interviewed, post-discharge, on various aspects of their care. The society developed a widely used and validated survey instrument in partnership with the Royal College of Surgeons, Ireland. The instrument assessed eight dimensions of satisfaction with healthcare: overall impression, admission procedure, information given, care and assistance, tests and operations, pain management, hotel aspects and discharge procedures. The survey findings were based on the response of 1950 patients. Paediatric, psychiatric, de-toxication and patients with severe cognitive impairments were excluded from the study. Participating hospitals were responsible for acting on the results of the survey and as evidenced in the replies listed earlier in this chapter, there were direct benefits of this feedback to patients. The results of the survey containing the aggregate findings were published nationally. To preserve confidentiality, participating hospitals were anonymised.

The society's 2002 national patient satisfaction survey, which was launched in March 2003, was carried out by means of a postal questionnaire. The survey instrument was essentially the same, with some changes and additions based on feedback from

patients and participating hospitals. Notwithstanding these changes, the 2002 questionnaire examined similar topics to the 2000 version. Ten hospitals took part in this survey. Similar exclusions applied to participants. Five hundred patients were randomly selected from participating hospitals discharge lists and sent copies of the questionnaire. A total of 2085 questionnaires were returned, a response rate of 44%. A similar publication and feedback mechanism is to be employed with the 2002 survey as was used with the 2000 survey.

The following table shows a summary of health board and health insurance company feedback

Table 5. Feedback from Health Boards and Health Insurance Companies

	Patient Satisfaction Survey	Comment Card System	Focus Groups	Consumer panels	Patient Advocacy	Organisational Wide Survey	Departmental Survey	Survey Carried Out By External Agent	Results Disseminated To Staff	Results disseminated to Patients
Health Board A	X					X		X	X	
Health Board B	X					X		X	X	
Health Board C	X					X		X	X	
Health Board D										
Health Board E										
Health Board F			X	X	X					
Health Board G										
Health Board H										
Health Board I										
Health Board J										
Health Insurance A	X					X	X		X	
Health Insurance B							X		X	

Conclusions

The results of this scoping exercise demonstrate that much work needs to be done on the measurement of patient satisfaction across the Irish healthcare system if the goal of “*A national approach to the measurement of patient satisfaction*” is to be achieved.

With the exception of the hospitals that have partaken in the ISQSH surveys, where patient satisfaction surveys were carried out in other hospitals they frequently seem to be poorly planned, lacking validity and reliability and prone to bias.

There is a high degree of uniformity in survey content. Survey follow up is less uniform with the implementation of survey recommendations reliant upon the management/quality structures in the individual organisations.

Positively, all hospitals that undertook patient satisfaction studies attributed direct benefits to patients. However, despite these benefits, most organisations did not demonstrate a commitment to carry out this measurement on a regular basis.

It is very clear that the ISQSH have and continue to play a very significant role in the measurement of patient satisfaction in the Irish healthcare system. Their two national surveys have provided national benchmarks against which all hospitals can assess themselves. The surveys are validated and reliable and every effort is taken to reduce bias. Indeed these surveys have probably been the stimulus for many surveys. However, despite their apparent success the numbers of hospitals that participate in the ISQSH's national surveys remains low (13 and 10).

Limitations of Project

Due to the size and complexity of many of their organisations surveyed, all hospital / healthcare related bodies spokespersons stated that it was impossible to give exact information on individual organisations e.g. sample population numbers and patient type, and that they could not be certain that they had included everything that they had done concerning patient satisfaction. Another limitation of this project is the fact that all participating hospitals and health boards are anonymised.

Future Recommendations

The results of this project demonstrate the need for several initiatives in the Irish healthcare system, which should include the following:

- The establishment of a National Database of all patient satisfaction surveys that is continually updated and available to all users.
- Increased hospital participation in national patient satisfaction surveys.
- The electronic availability to all healthcare professionals of best practice guidelines concerning the measurement of patient satisfaction.
- Development of mechanisms for ensuring that research findings are implemented and that follow up action occurs e.g. use of performance indicators within the service planning process.
- Survey results should be fed back to service users.
- Methods to ensure key stakeholder buy in should be developed.

- Barkely, W.M. and Furse, D.H. Changing Priorities for Improvements. The impact of low response rate in patient satisfaction. *The Joint Commission Journal on Quality Improvement* 168:641-646, 1996.
- Batchelor, C., Ownes, D., Read, M., and Bloor, M. Patient Satisfaction Studies: Methodology, Management and Consumer Evaluation. *International Journal Healthcare Quality Assurance* 7(7):22-30, 1994.
- Bisset, A.F. and Chesson, R. Is this Satisfaction Survey Satisfactory? Some points to consider in their planning and assessment. *Health Bulletin* 58(1):45-52, 2000.
- Black, N. and Moore, L. Comparative audit between hospitals; the example of appencectiomy. *International Journal of Quality assurance in Healthcare* , 1993.
- Bowling, A. Assessing health needs and measuring patient satisfaction. *Nursing Times* 88(31):31-34, 1992.
- Bruster, S., Jarman, B., and Bosanquet, N. National Survey of Hospital Patients. *British Medical Journal* 309:1542-1549, 1994.
- Cleary, P.D., Edgeman-Levitan, S., and McMullen, W. The relationship between reported problems and patient summary evaluations of care. *QRB* 2:53-59, 1992.
- Cohen, G., Forbes, J., and Garraway, M. Can Different patient satisfaction survey methods yield consistent results? Comparison of three surveys. *British Medical Journal* 313:841-844, 1996.
- Coulter, A. and Fitzpatrick, R. The Patients Perspective Regarding Appropriate Healthcare. In: *Handbook of Social Studies in Health and Medicine*, Anonymous London:Sage, 2000,p. 454-464.
- Crow, R., Storey, L., and Page, H. The measurement of patient satisfaction: Implications for health service delivery through a systematic review of the conceptual, methodological and empirical literature. 2003.
- Delbanco, T. Quality of care through the patient's eyes. Satisfaction surveys are just the start of an emerging science. *British Medical Journal* 313:832-833, 1996.
- Department of Health and Children (2001) Quality and Fairness: A Health System for You. Dublin: Stationary Office
- Department of Health and Children (1994). Shaping a Healthier Future. Dublin: Stationary Office
- Draper, M., Cohen, P., and Buchan, H. Seeking consumer views: what use are results of hospital satisfaction surveys? *International Journal for Quality in Healthcare* 13(6):463-468, 2001.
- Fitzpatrick, R. Survey of Patient Satisfaction: I - Important general considerations. *British Medical Journal* 302:887-891, 1991.
- Fitzpatrick, R. Surveys of Patient Satisfaction: II - Designing a Questionnaire and Conducting a Survey. *British Medical Journal* 302:1129-1132, 1991.
- Fitzpatrick, R., Hopkin, A., and Havard-Watts, O. Social dimensions of healing. *Soc. Sci. Med.* 17:501-510, 1983.
- Hall, J.A. and Milburn, M.A. Why are sicker patients less satisfied with their medical care? Tests for two explanatory models. *Health Psychology* 17(1):70-75, 1998.
- Hardy, G.E., West, M.A., and Hill, F. Components and Predictors of Patient Satisfaction. *British Journal Of Health Psychology* 1:65-85, 1996.
- JCAHO *Joint Commission on the Accreditation of Healthcare Organisations, 1994 Manual for the Accreditation of Hospitals*, Illinois:Oak Brooks, 1993.
- Jenkinson, C., Coulter, A., and Bruster, S. The Sicker Patient Experience Questionnaire: development and validation using data from in-patient surveys in five countries. *International Journal, for Quality in Healthcare* 14(5):353-358, 2002.
- Keegan, O., McDarby, V, Tansey, A., and McGee, H. Community involvement in A/E satisfaction survey. *Submitted for publication* , 2003.

Lasek, R.J., Barkely, W.M., and Harper, D. An evaluation of the impact of non-response bias on patient satisfaction surveys. *Medical Care* 35(6):646-652, 1997.

Lin, B. and Kelly, E. Methodological issues in patient satisfaction surveys. *International Journal of Healthcare Quality Assurance* 8(6):32-37, 1995.

McCartan, D., McAleer, E., and Naqvi, I. Service Quality: a satisfaction survey of the elderly. *International Journal of Healthcare Quality Assurance* 9(3):4-10, 1996.

McColl, E., Jacoby, A., Thomas, L., Soutter, J., and Bamford, C. Design and use of questionnaires: a review of best practice applicable to surveys of health service staff and patients. *Health Technology Assessment* 5(31), 2001.

McGee, H., McCarthy, K., O'Boyle, C., and Willow, D. Tallaght Hospital group patient satisfaction survey; response rates across adult, child and psychiatric groups. Anonymous 4th Annual Conference of the Irish Society of Quality in Healthcare: 1998.

McGee, H. Patient Satisfaction Surveys: Are they useful as indicators of quality of care? *Journal of Health Gain* June: 5-7, 1998.

McIvor, S. and Carr-Hill, R. *The NHS and its Customers - A survey of the current practices of customer relations*, University of York: Centre of health Economics, 1989.

Meredith J and Wood, N. The development of the Royal College of Surgeons of England's patient satisfaction audit service. *Journal Quality in Clinical Practice* 15:67-74, 1995.

Ownes, D. and Batchelor, C. Patient Satisfaction and the Elderly. *Soc. Sci. Med.* 42(11):1483-1491, 1996.

Pascoe, G.C. Patient satisfaction in primary health care. *Evaluation and Programme Planning* 6:185-203, 1983.

Press, I. and Malone, M. Patient Satisfaction and the Cost/Quality Equation. *Press Ganey*, 2003.

Roberts, P. Testing user satisfaction tools. *Nurse Researcher* 6(3):67-75, 1999.

Scott, A. and Smith, R.D. Keeping the customer satisfied. *International Journal for Quality Assurance in Healthcare* 6(4):353-359, 1994.

Sherman, S. 18 Commandments of Customer Satisfaction Management. Anonymous Press, Ganey 10th Annual Client Conference, Nashville, Tennessee: 1999.

Sitzia, J. How valid and reliable are patient satisfaction data? An analysis of 195 studies. *International Journal for Quality in Healthcare* 11(4):319-328, 1999.

Sitzia, J. and Wood, N. Patient satisfaction: a review of issues and concepts. *Soc. Sci. Med.* 45(12):1829-1843, 1997.

Ware, J.E. and Hays, R.D. Methods for measuring patient satisfaction with specific medical encounters. *Medical Care* 26(4):393-402, 1988.

Weiss, B. and Serf, J. Patient satisfaction survey instrument for use in healthcare organisations. *Medical Care* 28:434-445, 1990.

Williams, B. Patient satisfaction: a valid concept? *Soc Sci Med* 38(4):509-516, 1994.

Williams, S.J. and Calnan, M. Convergence and divergence: assessing criteria of consumer satisfaction across general practice, dental and hospital care settings. *Soc. Sci. Med.* 33(6):707-716, 1991.

Young-Mahon, P. An analysis of the concept 'patient satisfaction' as it relates to contemporary nursing care. *Journal of Advanced Nursing* 24:1241-1248, 1996.

Patient Satisfaction Surveys - Issues to Consider. Office of Health Management.: 1-10, 2002.

The following papers / studies / reports are the main, recently published material, relating to the measurement of patient satisfaction relating to acute care.

The National Patient Perception of the Quality of Healthcare 2000, published by the Irish Society for Quality in Healthcare.

This study is discussed in detail in Chapter 3.

ENT Outpatients Clinics in the Eastern Regional Health Authority – A review of patient satisfaction across hospitals. The Health Services Research Centre, Department of Psychology, Royal College of Surgeons Ireland on behalf of the Eastern Regional Health Authority, September 2002.

The aim of this study was to consult outpatients provided with ENT appointments and assess their satisfaction with services made available. Two distinct groups were assessed – attenders and non-attenders. The results of the 129 respondents were analysed in detail providing insightful information into satisfaction levels of attenders and non-attenders.

A Report on the Experiences & Expectations of People of the Health Services, published by the Eastern Regional Health Authority, December 2002.

This extensive report was commissioned to provide baseline information on the experiences and expectations of the people in the region of health services, so as to support the improvement in the planning and delivery of quality services for people throughout the region. The survey focuses on a wide variety of health services issues including user experience of: - General Practice, Inpatient Hospital Services, Outpatient Hospital Services, Accident and Emergency, Residential Care, Community Health Services, Complaints Procedures and General Attitudes to the Health Service. The survey findings of the 1500 respondents are discussed in detail and many issues to be addressed are identified.

Patient Satisfaction Surveys – Issues to Consider, published by the Office of Health Management, December 2002.

This work commissioned by the Office of Health Management outlines practical information for those considering measuring patient satisfaction with services.

Outpatient clinic waiting times and non-attendance as indicators of quality. K McCarthy, H McGee, C O'Boyle, published in *Psychology, Health and Medicine* 2000.

A Profile of Attenders to a South Dublin City Accident and Emergency Department. M Laffoy, B O'Herlihy, G Keye, published in the *Irish Journal of Medical Science* 1996.

Organisation Information

Name _____

Type of Organisation _____

Contact Person _____

Satisfaction/Perception Measurement

1. What system / approach does your hospital/s use in assessing patient satisfaction/perception?

2. Does it use an organisational wide or a service departmental approach?

Organisation wide Service/Departmental

3. When was it last carried out?

4. Was it carried out internally?

Yes No By who? _____

5. Did an external agent carry it out?

Name _____

Details of survey

6. Did the organisation develop its own measurement tool/questionnaire?

Yes No

7. Did it amend an existing measurement tool/questionnaire?

Yes No

8. Did it use an existing, validated tool? (If so which one?)

Yes No (If so which one?) _____

9. Was the survey carried out by

Telephone Post Other

10. What type of patients were measured?

- In-patients Out-patients Other

11. Was there an age limit?

- Yes (What?) _____ No

12. How many patients were surveyed?

Content of Survey

13. What dimensions of care were assessed?

- | | | |
|--|--|--|
| <input type="checkbox"/> Waiting times | <input type="checkbox"/> Hotel aspects | <input type="checkbox"/> Bed management |
| <input type="checkbox"/> Admission Procedure | <input type="checkbox"/> Complaints | <input type="checkbox"/> Medical Students |
| <input type="checkbox"/> A/E | <input type="checkbox"/> Dignity/privacy | <input type="checkbox"/> Pain Relief |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Staff Assistance | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Information | <input type="checkbox"/> Procedures/Operations | <input type="checkbox"/> Discharge Procedure |
| <input type="checkbox"/> Other | | |

Survey Follow-up.

14. What direct benefit to patients has occurred as a result of feedback from patients?

15. Who is responsible for acting on the results of the survey?

16. What systems are in place to implement any recommended changes?

17. Have the results of the survey been disseminated to?

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| <input type="checkbox"/> Staff | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Patients | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

18. What systems are in place for carrying out the survey on a regular basis?
