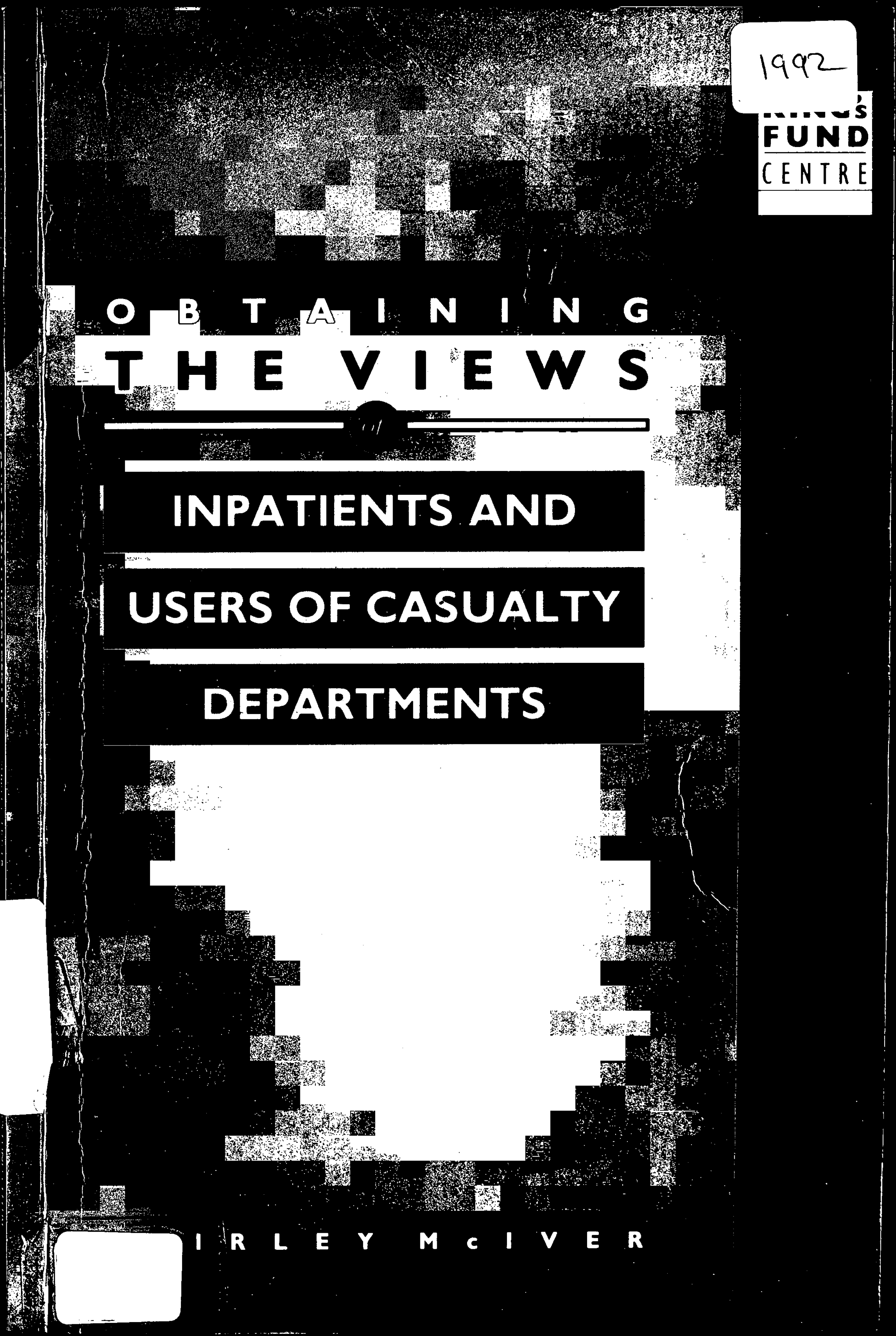

OBTAINING THE VIEWS

of

INPATIENTS AND USERS OF CASUALTY DEPARTMENTS

IRLEY McIVER

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The King's Fund Centre is a service development agency which promotes improvements in health and social care. We do this by working with people in health and social services, in voluntary agencies, and with the users of these services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences, information services and publications. Our aim is to ensure that good developments in health and social care are widely taken up. The King's Fund Centre is part of the King's Fund.

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PREFACE

This publication is the fourth in a series aimed at helping health service staff to obtain the views of service users, and it is written for anyone who has been given this responsibility, whether nursing, medical, paramedical, or managerial. The series presumes no social science background and offers a flexible approach which is very amenable to local adaptation and interpretation.

The example questions and response formats given here are for guidance only and can be altered for individual use. Details about questionnaire construction and testing are given, as well as where to turn for further help in this area. Information about non-survey methods is provided and the reader is encouraged to combine a number of methods to achieve useful information in different circumstances and with different types of service user.

The book is produced by the Consumer Feedback Resource, an information and advice service aimed at improving feedback techniques, disseminating information about current projects and examples of good practice and networking.

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1 INTRODUCTION

A recognition that user views of health care services are an important part of quality improvement systems continues to grow more widely. Even professional organisations, such as the royal colleges, have begun to take an interest. For example, the Royal College of Surgeons now sees patient satisfaction as an essential part of clinical audit and in 1990 set up a project to investigate the extent to which surgical treatment and services meet patients' needs and expectations. (Meredith, 1991A).

This interest is very welcome and hopefully will result in well validated and good quality instruments for obtaining patients' views about their care. In the meantime, health care professionals are faced with the task of developing their own instruments or choosing to employ someone from among the burgeoning number of consultants specialising in the area of 'patient satisfaction' research.

One of the problems facing those wishing to use a structured approach to obtaining user views, such as questionnaires or interviews, is knowing what questions to ask. These should be based on issues important to users but relevant to managers who want to use the information to improve service quality. This book aims to provide guidance on this issue.

Some service areas have a history of research on patients' views and experiences while other areas have virtually ignored this activity. The two service areas covered in this booklet provide examples of the two extremes. The inpatient service has a long history of research going back to the 1960s, much of it published work of academic origin. In contrast there are very few published or unpublished accounts of attempts to obtain user views in casualty departments.

These two extremes pose contrasting problems to the researcher looking for information upon which to base the development of relevant questions. The inpatient area has a wealth of questionnaires to examine, a few of which are well-used standardised questionnaires, and the difficulty lies in choosing the 'right' one. This choice is facilitated by an examination of the strengths and weaknesses of each of the four main standardised questionnaires. It is not too demanding to develop a list of questions for the use of those who choose to devise their own instrument, once the difficult job of sorting out which questions are essential has been tackled.

The casualty area has only a few studies to guide the researcher, but these are enough to provide a good foundation. Those which explore the patients' views in a detailed way are drawn upon as a preferred source of material. This is because studies which collect qualitative data from patients are a more valid source of patients' views than those which use questionnaires based upon the service providers' idea of what concerns patients. The number of patients surveyed is not necessarily the most important consideration. Within the casualty setting there is also the difficulty of the environment and the condition of the patients to take into consideration. The methodological implications of these factors are discussed and an approach which copes with 'emergency' as well as 'non-emergency' patients is suggested.

Despite the differences there are methodological problems which are common to both settings, and these are covered first in a separate chapter which will be useful to anyone who wants basic guidance on getting user views.

It is also worth reminding those involved in this activity that methodology is not the only important aspect of the process of getting user views. At least two others are vital. The first is the provision of good quality information to patients so that they know what to expect and how to judge the service they receive. The second is the development of a patient-oriented culture so that all staff are willing to listen to the views of patients and their relatives and make changes in their attitudes and working practices.

One of the most difficult tasks eventually may be to co-ordinate the process of collecting user views, as the day when patients and relatives are bombarded with questionnaires from different agencies seems to be getting closer. If individual hospital specialties, department managers, different community health services, FHSAs or GPs and local authorities are all distributing questionnaires at the same time, patients could become weary and irritated.

The first way out of this dilemma is for the different organisations concerned to communicate with one another, particularly if large-scale surveys are planned. Jointly developed questionnaires are difficult to achieve but overlaps in information collection can be avoided and it may be fairly easy to co-ordinate publicity in order to present a unified picture to local people.

A second solution is to vary the methods used to collect views, so that patients' interest is maintained. There is a methodological advantage here as well because it will be easier for all types of people to respond, not just those who can read and write English. Interviews, discussion groups and patients' forums are more rewarding to the patient than the questionnaire survey because they bring personal contact and the chance to share views with others. Suggestion boxes and telephone helplines provide a less pressurised format catering to individual impulse and need, and offering an easy option for those who prefer not to become too involved.

All methods have weaknesses and no one method is recommended as the best in all circumstances. The following chapters consider the best mix of methods for the casualty and inpatient settings and provide relevant questions to ask users.

2 METHODOLOGICAL OVERVIEW

Anyone who wishes to obtain user views is faced with a number of methodological problems. Four of the most important are:

- ★ which method to use
- ★ who to ask (sampling, etc)
- ★ when to ask
- ★ how to ensure a questionnaire is valid and reliable.

Issues around each of these problems will be discussed in this chapter.

Which Method to Use

The issue of which methods are appropriate to obtaining user views in a health service setting has been explored in depth in McIver (1991A). Briefly, there are two main types:

Quantitative methods which collect numerical information and answer *how many?* questions.

Qualitative methods which collect narrative information and answer *Why?* and *How?* questions.

Quantitative methods translate information into numbers – the analysis of records, the coding of details, the collection of times, dates, ages, etc. The most common quantitative method used in the process of collecting user views is the self-completion questionnaire survey.

The structured self-completion questionnaire is a valuable tool for discovering *how many* users have a particular view. As with every method, it also has a number of limitations. The four main limitations concern agenda setting, sensitivity, selectivity and lack of user participation.

1 Agenda Setting

The structure of a coded response questionnaire limits the topic area and the responses for the user. This can be a serious weakness if it does not cover the issues considered important by service users,

In order to overcome this weakness it is important to include questions about factors which are relevant to the user. These factors can be discovered by exploring users' experience of service delivery with a qualitative method, such as interviews or focus group discussions.

In some service areas, qualitative methods have already been used a number of times and so factors important to users have been discovered. There have been a few such studies of users of casualty departments and many of inpatients and so it is possible to construct a questionnaire based upon factors important to users. This process will be explained in chapters 3 and 4.

2 Sensitivity

Many self-completion questionnaires try to cover too many topics using too few questions, so they suffer from superficiality. They are not sensitive enough to collect information which can distinguish between areas of good quality and poor quality from the user perspective. For example, here is a typical question used in a survey of A&E in 1987:

> What did you think of the decor/facilities in the waiting area? Poor, Satisfactory, Good, Very Good.

This will not distinguish between what is good and what is not in the environment. How is a person to make a judgement given a general question like this? Firstly, what should s/he compare the decor/facilities *to* (McDonald's, the Ritz, an individual's home?) and secondly, what in the decor/facilities is s/he looking *at* (wallcovering, chairs, cleanliness, lighting, refreshment facilities?).

There are two main ways to overcome the limitation of insensitive, too general questionnaires: ask the right *type* of questions, and ask the right *number* of questions.

Type of question means the way the question is constructed. The aim is to elicit specific information which can be acted upon. Asking patients to make judgements about service quality ('satisfaction') assumes that patients possess sufficient knowledge of services to compare them with an expected standard, yet most users are unlikely to have been given enough information about service standards to know what to expect from the service.

Until standards are made public, in patients' charters and similar well-publicised documents, it is wise to keep this type of question to a minimum because it is likely to elicit a vague response (the patient wants to please because s/he is grateful and so, in the absence of knowledge about what it is s/he is comparing to what, s/he will tick the satisfied box). At the very least, care should be taken to single out items as clearly as possible, so the user knows what s/he is being asked to comment about.

It is better on the whole to ask the user questions which elicit information about what happened to them, so that staff, who know what the expected standards are, can judge whether or not the quality is satisfactory.

An example question referring to the A&E environment might be:

Did you have any problems locating the reception desk on first entering the department?

YES

NO

COMMENTS

This format asks a specific question enabling a simple codable answer, yet allows space for comments which may help interpretation (such as 'I had no problems this time because I knew where to go but I did when I first came a month ago').

A number of other response formats are possible, but little research has been carried out to discover which type of format users prefer. Some researchers consider that alternatives suggested by interviews with patients are best. For example, an inpatient questionnaire called 'What the patient thinks' uses formats such as:

What were your feelings about going into hospital this time?

I was expecting the worst

I was very worried about what might happen

I was nervous but not too anxious

I wasn't particularly bothered

I wasn't at all worried

Others use scales such as 'very satisfied' to 'very dissatisfied' or 'excellent' to 'poor'. A study comparing these two response formats found that the five scale 'excellent' to 'poor' format (excellent, very good, good, fair, poor) termed the E5 by the researchers performed better than the 'very satisfied' to 'very dissatisfied' (S6). This led them to state:

> *'...we recommend the E5 over the S6 response format in studies of patient satisfaction with specific medical encounters'.*
> (Ware and Hays, 1988)

As there appears to be little firm evidence to enable a selection between the other formats, a combination to suit the type of question seems to be the best way forward. A mixture of Yes/No/Comments, user-based alternatives, and the 'excellent' to 'poor' scale are used in the example questions given later.

The **number** of questions asked will also enable the information to be specific. Usually the more questions about a particular topic, the more detail can be collected. Unfortunately long questionnaires are time consuming both to complete and to analyse. There is no evidence that patients prefer shorter questionnaires but it will certainly take them less time to complete a short one and that could be a motivating factor if they are about to go home.

A way around the problem is to divide up the topics covered into a number of short questionnaires. Instead of dealing with everything – access, environment, staff attitude, treatment, discharge – in one questionnaire, split the topics into a number of separate questionnaires. These short questionnaires can be used in a number of different ways and so can provide a flexible, useful tool. They can be used:

- ★ **simultaneously** – (with different people if desired) to provide a 'snapshot' of user views on different aspects of the service
- ★ **alone** – to monitor a particular aspect of service delivery which is causing concern
- ★ **consecutively** – as part of a rolling programme of service monitoring
- ★ **together with other methods** – to explore a particular aspect of service delivery from a number of different angles.

3 Selectivity

As not everyone can fill in a self-completion questionnaire, it is selective for certain types of people. Those who cannot complete it tend to be certain categories of patient who may have consistently different views, and so a sampling bias may be created: those who cannot read very well and so refuse the questionnaire (or even worse, fill it in without properly understanding what is being asked in order to avoid embarrassment); those of other cultures who do not read English, those with impaired eyesight, and those who cannot use their hands, are all unable to complete questionnaires.

In order to elicit the views of these categories of service user, other methods are necessary. A simple way to overcome the limitation when distributing questionnaires within the department is to have someone distribute the questionnaires and stay around to help those unable to complete one themselves. The person should be an experienced interviewer able to treat the questionnaire as an interview schedule without causing interviewer bias.

4 Lack of User Participation

The survey method, like most social research methods, is a one-way process in which information is collected from people but the results of the survey are rarely fed back to them. This is not likely to encourage people to take part again because we like to know that the information we supply has been useful.

One way to overcome this limitation is to inform service users (and staff) about results, recommendations and possible future action. This can be accomplished in many ways,from short easy to read and interestingly presented details about the survey displayed on notice boards in areas where service users wait, through press and radio reports, to public meetings and displays at local fairs and similar events.

A second way is also to use methods which encourage more participation, such as advisory forums, and patients councils. Apart from the value to the service user, these can help service providers think through issues and develop solutions to problems.

Qualitative methods collect explanations and reasons and so help in the understanding of issues. The most common methods used are interviews, including critical incident technique (a form of interview where the interviewer categorises what an individual describes as having happened to them into good and bad incidents), and focus group discussions (where a facilitator with a checklist of topics encourages seven or eight people to discuss their views or experiences).

There is also observation, which can collect useful additional information about events which are below the conscious level of those taking part in a situation, for example, working practices or interaction between staff and patients. An extension of this method is participant observation, which is similar to 'shadowing', where the aim is to obtain some experience of what it feels like to be involved in a particular activity.

Other, less formal qualitative methods are public meetings, and the various forms of groups such as advisory groups, patients, councils, and patients' forums.

There are also various ways of making it easier for patients to express their views, such as suggestion boxes, improved complaints procedures and telephone help lines.

Who to Ask

The related questions of who to ask for their views and how many people to include in a survey or project, are ones which seem to worry a number of people. This is not surprising because the answer is not simple but will depend upon the aim of the project and the method used.

Sample size has been examined elsewhere (McIver, 1991A), but as a brief general guide it is better to go for a small sample and get a high response rate than to go for a large sample but get few people responding. The typicality of the people included, as measured by the percentage who respond, is the crucial factor.

A reasonable figure to aim for during a regular self-completion questionnaire survey in either an inpatient or casualty setting in a medium-sized hospital is about 500, collected to cover a representative time period (for example, at different times over a week or fortnight, not concentrated on two days or every Wednesday afternoon). Aim to get a least 75 per cent returned. This will probably mean that two reminders will be necessary.

If the aim is to gather the views of those within a particular ward or speciality where turnover is lower, a smaller number will be sufficient. This will also be the case if the aim is to explore in greater depth issues of concern to patients, through interviews or discussion in groups. In these qualitative or exploratory projects any number between 15 and 75 respondents is acceptable.

In order to get a sample of *typical* people who use the service, it is important to avoid pre-selection. Researchers are often selective when approaching people on wards or in casualty departments. For example, Sullivan (1989) reported that for their study of users of an A&E department:

> *'A decision was taken to interview only the walking wounded and to approach them at random, with the exception of parents with young children.'*

Gibson and Walsh (1990), on the other hand, interviewed relatives and both emergency and non-emergency patients. They categorised patients in the following way:

> *'Patients (along with their relatives and friends) who came into Accident and Emergency themselves were defined as non-emergency; those patients who were brought in by the emergency ambulance service (plus their friends and relatives who may have used alternative transport) were defined as emergency.'*

Those working in Accident and Emergency departments will know that there are a number of other ways in which patients can be defined. For example, Mitchell (1987) divides patients into three categories:

1. Routine accident and emergency patients (walking wounded) who form the bulk of the department's workload.
2. A&E referral patients who are generally more serious accident or emergency cases. They are brought into A&E (often by ambulance) and are examined by an A&E doctor who decides if a consultation with a specialist is required.
3. GP referral patients who have been referred by a GP directly to a consultant on the grounds that they are emergency cases requiring immediate hospital care. They are brought back to A&E to be examined by a member of the relevant team before a decision is taken about their admission to a ward.

Some research questions may make it necessary to divide patients up into categories such as these, perhaps to concentrate on one category only. For example, an in-depth qualitative study carried out by the Royal College of Surgeons on patient satisfaction with surgical care (Meredith, 1991B) found that there were important differences between the responses of those who had received 'potentially life saving' and those who had received 'repair' surgery. Patient satisfaction tended to be higher among those in the latter category because the patient was given more control. Also the object of 'repair' surgery is to improve what the patient immediately feels or sees, whereas in most 'potentially life saving' cases (such as operations for cancer), patients find themselves having to submit to serious, disruptive, and perhaps painful surgery because they are told that their minor symptoms may become serious problems if not dealt with.

A medical condition may be as important as age, gender, ethnic group and class in affecting a person's expectations and so their responses to questions about their views on the care they have received. Their condition may also affect the way they are treated and this may have an impact on their views. Researchers involved in a qualitative study for Eastbourne, Brighton and Hastings health authority found that there was a belief among some patients that non-emergency patients received less attention and less consideration than those who were emergencies or were officially ill (BMRB, 1991).

The presence of different categories of patient is an important factor to consider if managers or researchers want to find out in detail whether some patients are more happy with their care than others and the reasons for this. However, as far as regular *monitoring* of service quality from the user viewpoint is concerned, this amount of detail is probably unnecessary.

Instead it is important to collect views from all categories involved, emergency and non-emergency, however defined. The responses of relatives and friends should be distinguishable from those of patients, and consideration should be given to the possibility of asking older children (10 plus) for their own views as described in McIver (1991A).

When to Ask

There are two principal occasions when service users can be asked for their views: at the time they use the service, or at home after they have received care. There are also a number of variations within these two divisions, for example, users of casualty departments can be asked during the time they are in the department, or, if they are admitted, while they are on the ward. Inpatients can be asked at the beginning, middle or end of their stay, before discharge. At home, patients can be surveyed within a week of discharge or after several weeks.

The choice will depend upon the aim of the project because some questions, such as those about discharge, outcome and post-discharge care, cannot be answered during the middle of a patient's stay.

The availability of resources is also an important factor. Ward-based surveys are cheaper and less time consuming than home-based ones because distribution is easy and initial response rate is high. It is a fairly simple procedure to include an interviewer to help patients having difficulty filling in the questionnaire and to help in the collection of those completed. The interviewer should have some experience and should not be someone employed on the ward or directly involved in the care of those on the wards being surveyed. Interviews are also cheaper on the ward because travel costs and the chasing up of patients who are unavailable are avoided.

Home-based postal questionnaires are cheaper than home-based interviews because travel and interviewer costs are excluded, but as the initial response rate is likely to be lower (possibly only 30-40 per cent) it is necessary to allow for at least one and probably two reminders. There is some evidence to suggest that response rate can be affected by certain variables, such as who is seen as responsible for sending out the questionnaire, but not by others such as length of questionnaire and type of questions included.

For example, Jacoby (1990) found that questionnaires sent out by the family practitioner committee achieved a higher response rate than those sent out by the Institute for Social Studies in Medical Care (66 per cent ISSMC and 84 per cent FPC) but there were no differences in the nature of replies given. A review by French (1981) found evidence that personal contact before a survey increased the response rate.

The key seems to be to make the survey as relevant and personal as possible, perhaps by informing patients early on during their inpatient or casualty visit that they may receive a questionnaire after they have left. Clearly laid out, easy to read, questionnaires are essential, as is the provision of pre-paid reply envelopes.

Telephone interviews are a good alternative to postal questionnaires, falling somewhere between face-to-face interviews and postal questionnaires in terms of cost. The main drawbacks are that not everyone has a telephone and some very elderly and infirm people or those with hearing difficulties may be unwilling to use one.

There is some confusion over whether patients' views are affected by the location. The gut feeling is that respondents may be afraid to be completely honest while still in the department or on the ward, but research does not conclusively support this feeling. French (1981) examined research on the issue in detail and concluded:

> *'There is not yet sufficient evidence of good quality to establish whether patients tend to be more honest while they are still in hospital or after discharge, but the balance of evidence suggests*

> *that patients are more ready to voice criticism while they are still in hospital.'* (p.29)

Recent research does not clarify the picture to any great extent. For example, Morgan-Cooke (1991) distributed 500 questionnaires to inpatients during their stay and posted a further 500 to a separate set of patients within three weeks of their discharge. The response rate was predictably lower for the postal questionnaires but not much lower: 208 were received back by post compared with 244 from patients on the wards (41.6 per cent and 48.8 per cent).

When the two data sets were compared and subjected to statistical tests, there were nine questions where the responses of patients at home differed from those on the ward in a significant way. Five of these indicated that patients were more likely to be be critical at home and four the reverse.

Those areas where *discharged* patients were *more satisfied* than those on the ward were:

Do you feel you were told enough about how to look after yourself at home? (57 per cent agreed on ward; 70 per cent at home).

Listen to radio whenever wanted (47 per cent agreed on ward; 58 per cent at home).

Satisfied with access to telephone (72 per cent on ward; 84 per cent at home).

Discharged patients were *less satisfied* than those on the wards in questions about the bed being at the right level, being quiet enough to sleep at night, the way the food was presented, enjoyment of supper, and sufficient choice of meals.

Apart from the first question about information on looking after yourself at home, which may have been given after the questionnaire was completed, it is difficult to see why discharged patients should be more satisfied than current inpatients in the areas mentioned. Perhaps access to radio, telephone and visitors is of more critical importance to those in hospital than sleep and food, which grow in importance with the comparison of home comforts. It is probably unwise to speculate from this one study, particularly as the total response rate was less than 50 per cent.

A more reliable study is reported by Beeton (1991). This was conducted during work for a certificate in research methodology and was specifically designed to find out whether patients' perceptions of physiotherapy changed after discharge.

Eighty-four consecutive outpatients completed a questionnaire in the physiotherapy department at their last attendance. A postal questionnaire was then sent out either two weeks after the discharge date (group A) or four weeks after the discharge date (group B).

The response rate, achieved by *one* reminder following the initial mailing, was 81 per cent for group A (two weeks) and 73.4 per cent for group B (four weeks). This shows that good response rates are possible from postal surveys with just one reminder at two weeks after discharge, although well-designed questionnaires and letters are vital. In this study the letters were signed by the acute unit general manager — a senior person but one not immediately responsible for the service.

The results showed that there were three statistically significant differences in the answers given by group A and five statistically significant differences in the answers given by group B, when compared with responses at discharge.

Looking at the two questions that both groups of patients changed their responses to:

Question 7 asked: How much information did your physiotherapist give you about your condition? A lot, some, a little, no information. Seven patients in group A and six in group B changed their category from 'a lot' to 'some' suggesting that they perceived they had been given less information when followed up than at discharge.

Question 9 asked: Was the physiotherapy treatment you received what you expected? Better than expected, disappointing, didn't know what to expect. Three patients in group A and 7 in group B changed their answers from 'better than expected' at discharge to 'as expected' at follow up, suggesting that these patients did not rate the treatment as highly at follow up. As Beeton suggests, this may be because patients felt more optimistic about their treatment in the department but perhaps on living with their residual condition did not feel that their original perception was as good in hindsight. Beeton concludes that:

> *'The study shows that different results are obtained if satisfaction is evaluated at the place of delivery or at a later date, and if patient satisfaction surveys are completed in the department higher ratings may be obtained which may not be reproduced if patients are then followed up at a later date.'*

Beeton's conclusion contradicts that of French (1981) but this may be because different questions are involved. In any case it would be unwise to generalise from one study. It would be best to vary the location depending upon the type of information required. However, where surveys are done within a department or with inpatients on the ward, every effort should be made to convince patients the views they give will be confidential.

How to Ensure a Questionnaire is Valid and Reliable

There are a number of ways to try and ensure that a questionnaire is collecting the information it is meant to collect in a reliable manner. Some of these ways are highly technical and involve various kinds of statistical tests but it is possible to achieve a high standard by piloting and checking the questionnaire as follows:

Piloting

Always pilot a new questionnaire at least twice. The *first* time, take about 20 different kinds of user typical of those who will be expected to fill in the questionnaire during the main survey and go through the questionnaire in detail with them. After each question has been answered ask the respondent how they interpreted it in order to check whether they are reading it in the way it is meant to be read. Also ask about relevance to the user and friendliness of design. Make alterations to the wording of the questions and the design and layout, as necessary.

The *second* time, take about 50 users and administer the questionnaire as it is intended to be done in the main survey (for example, by post or at the ward or department). Then take approximately 10 of these respondents at random and interview them using the same questions. Explain that the questionnaire is being checked for future use. Match the results of the interview to those of the relevant questionnaire. There should be very few differences. At the same time, collate the results of the pilot of 50 users and check that the information is *useful*. Does it provide information which makes it possible to improve services from the user perspective?

Checking

Firstly, by doing a survey using the same questionnaire at two different time periods (for example, six months apart) it will be possible to check for reliability. If nothing has changed, the results should be similar. If improvements have been made in a particular area then these should show up in the survey results.

Secondly, if surveys are carried out in two or three different hospitals, the results *within* each hospital should be more similar than the results *between* hospitals.

Lastly, results using an alternative method, such as interviews, discussion groups or observation, should be essentially similar to the survey. For example, if the survey shows that a number of people feel they do not get enough privacy during examination in the casualty department, an observer or interviewer who has not read these results should pick up on the same point.

By following these general guidelines, questionnaires of good standard can be constructed for the regular monitoring of patient views on service quality. Further advice can be found in Carr-Hill, McIver, Dixon (1989); Fitzpatrick (1991); Cartwright, (1983); Luck, Lawrence, Pocock, Reilly (1988). Companies which may be able to help in supplying computer software for use in the analysis of survey data can be found in the useful addresses section. The frequent use of qualitative methods will ensure that details of how patients would like services to be improved will also be gathered . Further advice can be found in Winn (1990); Walker (1985); National Consumer Council (1990). Details of the way in which these general guidelines can be adapted for use in the casualty and inpatient services are given in the next two chapters.

3 CASUALTY DEPARTMENTS

Background

A literature review of consumer feedback in the NHS published in 1987 found it 'difficult to understand' why there had been so few studies of the views of users of casualty departments (Jones, Leneman, Maclean, 1987). Perhaps the scarcity of studies is partly explained by the methodological difficulties encountered. As Dixon and Carr-Hill comment in their review of customer feedback surveys:

> *'If anything, A&E studies are more difficult costly and time consuming than out-patient research.'* (Dixon, Carr-Hill, 1989, p30).

These difficulties are not insurmountable, however, and with enough time and care spent at the planning stage, they should not prove to be any more difficult or costly.

The key is to spend time working out *who* to ask, *when* to ask them, what *methods* to use, and what *questions* to ask. The first three issues have been covered in detail in the previous chapter but it may help to cover them briefly again with specific reference to the casualty department. This will be followed by consideration of the issues which are important to users in order that a list of relevant questions can be compiled.

Methods

There is no single method recommended for obtaining user views, and it is best to use a combination of methods to suit the circumstances and the type of information required. A combination suitable for monitoring user views on quality of care in casualty departments might be as follows:

- ★ A suggestion box prominently displayed in the department together with the results of any surveys and changes made as a consequence.
- ★ Regular surveys by postal or telephone questionnaire.
- ★ Regular end-of-visit interviews, paying particular attention to those unlikely to respond in the survey.
- ★ Observation by the interviewer while waiting for respondents.
- ★ Regular multidisciplinary staff discussion groups about customer relations.

The type of questions to ask during questionnaire surveys and interviews is dependent upon the factors which are important to users. These may change, hence the necessity of including regular interviews to explore issues with patients. A start can be made by examining previous studies, particularly these using qualitative methods.

Factors Important to Users

There appear to be very few published accounts of attempts to obtain user views in casualty departments, although a number of unpublished reports exist. One good published example of research using a qualitative method is that carried out for North West Thames Regional Health Authority (Caple, Deighan, 1986). This used an indepth interviewing method called critical incident technique (CIT) to collect data from 572 patients in A&E and outpatient departments. The researchers were able to identify six aspects of service delivery which are important to users:

- ★ understanding the system
- ★ access to information
- ★ continuity in the pace of events
- ★ personalised attention
- ★ friendliness and efficiency
- ★ consistency.

An adaptation of the CIT method, combined with observation was used by staff at a hospital in South Wales (Sullivan, 1989). Fifty users of the emergency department were interviewed at the end of the clinical process by staff from departments other than A&E. During the interviews, which lasted 20 minutes on average, patients were first asked to give an account of each stage of the process they had just been through. This was to elicit spontaneous comments about the service. Then they were asked questions about those areas which they had not mentioned.

When the answers were analysed, care was taken to separate spontaneous from probed responses so that incidents critical to patients could be separated from those directed by service providers.

A large number of respondents spontaneously mentioned signposting, waiting time, information and privacy. These included favourable and unfavourable comments. Sixty per cent of patients made comments about information when talking about what happened in the initial consultation and there were 29 spontaneous comments about information provision during the time after the initial consultation (visiting the x-ray department, seeing the consultant again, etc).

Privacy, or rather the lack of it, was mentioned spontaneously by 12 patients during their description of the initial consultation and seven when talking about the period after the initial consultation.

The observation reports provided by the interviewers formed a very useful supplement to the information gathered during the interviews. The report states:

> *'The(se) observations ... serve both to reinforce many of the points made by patients during the interview and to provide additional insights into the workings of the department.'* (p.22)

This was particularly true of the comments patients made about privacy. Observing interviewers were able to describe many examples of bad practice which seemed to be accepted as normal by staff but which could be improved very easily and in most cases at no extra cost.

Another study based upon a qualitative method was carried out by Social and Market Survey Research at the casualty department of a hospital in North East England (Gibson, 1991; Gibson, Walsh, 1990). The researchers interviewed 42 non-emergency users (while in the department or at home) and 11 emergency users (at home or on the ward) in order to explore the user's agenda of importance, before constructing a structured interview schedule. The structured schedule was then used to interview 300 non-emergency cases, 150 relatives and friends, and 40 emergency cases. A self-completion version of the questionnaire was also piloted.

In the first phase of the depth interviewing, a number of issues were raised and later included in the survey. These were:

- ★ access to the department, including car parking and transportation to and from the hospital

- signposting to all departments, inside and outside the hospital
- waiting times in the various parts of the department and associated areas
- environmental issues – that is, whether the department was sufficiently clean, warm, well decorated, and so on, and whether telephones, toilets and refreshments were adequate
- attitude and accessibility of staff, principally doctors, nurses and receptionists, measured in terms of courtesy, efficiency, helpfulness, and reassurance
- attitude regarding security.

Similar areas for concern have been noted in other studies eliciting user views of casualty departments. The issue of poor signposting, inadequate parking, and difficult physical access to casualty departments, especially for disabled people, was raised during a study of London's Acute Services by the Greater London Association of Community Health Councils (GLACHC/King's Fund London Acute Services Initiative, 1991). Also considered important by the voluntary groups, CHCs and 'key informants' consulted were spartan waiting areas, including lack of children's toys and facilities for feeding and changing babies, length of waiting time before assessment and poor information.

Long waits in casualty departments without explanation were of great concern to Camden Consortium, a group of service users and others concerned with mental health in Camden (Good Practices in Mental Health, Camden Consortium, 1988). Long unexplained waits only added to the distress and confusion frequently experienced by people suffering from a mental illness. These users and ex-users also mentioned that often few attempts were made to reassure frightened patients by introducing people to them, by not leaving them alone, by letting them know where they were going, or what the ward procedures were like when they were admitted from A&E.

Analysis of complaints received about casualty/A&E departments reveal much the same concerns with the addition of 'missed diagnosis'. For example Hunt and Glucksman (1991) uncovered the following categories during an analysis of the 122 complaints made about an A&E department over a seven year period:

	%
★ attitude problems	(37.7)
★ missed diagnosis	(36.1)
★ waiting time	(32.8)
★ cursory examination	(14.7)
★ poor communication	(11.5)
★ triage related	(8.2)
★ RTA fees (pre 1985)	(6.5)
★ no transport home	(6.5)
★ physical environment	(6.5)
★ lack of privacy	(3.3)
★ miscellaneous	(3.3)
★ no follow-up arranged	(2.5)

Note: the percentages do not add up because many people mentioned more than one complaint.

By 'attitude problems',the authors mean complaints about the attitude of medical staff. Rudeness and an apparent lack of sympathy for ill patients together with an 'off hand', 'flippant', 'arrogant' and 'dismissive manner' were the main complaints levelled at medical staff by the patients and relatives. Missed diagnosis, poor communication between staff and patient, 'staff attitudes' and waiting times also featured in an analysis of complaints carried out by Richmond and Evans (1989).

Surveys using structured questionnaires (that is, limited response) seem to have concentrated on only a few issues raised in the qualitative research. They have tackled inappropriate use (North Western Regional Health Authority); waiting time, reason attending, access and a question about understanding what the hospital doctor said (Macclesfield Health Authority); reason attending, waiting time, whether explanations were clear, decor, general satisfaction with waiting, treatment, and courtesy of staff (Swindon Health Authority).

The exception is the Social and Market Survey Research (SMSR) study mentioned already where the questionnaire included 22 questions covering whether or not the GP was seen, access and signposting, waiting time and whether reasons given, environment, privacy, security, staff attitude, information provision and general rating of medical treatment, doctors, nurses, other staff and environment.

The construction of a questionnaire aimed at collecting quantitative information poses a dilemma, in that the more detailed it is, the more likely it is to collect accurate and useful information about user views but the longer it is and so the more difficult for the user to complete and for managers to analyse, understand and act on the results. The SMSR questionnaire seems to have struck a reasonable balance between detail and length and was found useful by the hospital involved.

An alternative approach is to separate the issues important to users into a number of headings and to monitor them in different ways, or using short and specific questionnaires. The following section attempts to examine ways of monitoring the issues important to users under four headings: (1) Waiting time; (2) access and environment; (3) information provision; (4) treatment and care.

Questions to Ask Users

1 Waiting time

The length of time users have to wait in the emergency department is a source of discontent for many. There are exceptions, such as the South Wales study (Sullivan, 1989) which showed that most respondents were pleased with the short time they had to wait but this was thought by the researchers to be a 'relatively quiet' period (60 per cent of the respondents were seen within 30 minutes) and is not typical. Concern over waiting times has been mentioned in numerous publications (for example, Mitchell, 1987; IHSM/ACHEW,1988).

A survey into the waiting times in the A&E department at Southmead HA (1988) showed that the average waiting time to see a nurse was 48 minutes, but this depended upon the time of day, varying between 73 minutes (11-13 hours) and 11 minutes (1-8 hours). This study was solely concerned with waiting time and did not include the views of patients about waiting time, a sensible approach given that it is likely that more patients will be dissatisfied with waiting time during busy periods than during slack ones. Any study wishing to elicit views about waiting time will have to take this into account.

Other factors to take into consideration are a possible wait to see a doctor after initially seeing a nurse, waiting to receive a specific test such as an x-ray, and waiting to see the doctor again before discharge or hospital admission. The *total* waiting time can vary considerably depending upon the presenting problem, as can the subjective experience of waiting. A person in pain, confusion or distress, or worried about a child's condition, may experience a relatively short wait as excessive.

Given this highly variable 'subjective' dimension to waiting time, plus the variable 'objective' factors such as time of day, and unpredictable emergencies such as road traffic accidents, waiting time is not an easy subject to monitor.

It makes sense to try to measure 'objective' waiting times through a recording system rather than 'subjective' times by asking patients how long they have had to wait. This is because users will have to be asked a battery of questions — the time they arrived, the time they were first seen, the time they waited to see a doctor, and so on — in order to find out their total waiting time, and unless they are keeping a 'time diary' during their wait, it will be difficult for them to remember accurately.

One example of waiting times collected 'objectively' is given in Mitchell (1987). Times were recorded on an activity schedule with blanks for manual entry of times, which were filled in by the receptionist and various medical and nursing staff who come into contact with the patient. A schedule was attached to every fifth casualty card which accompanied each patient throughout their stay in the department. Patients were divided into two groups: 'routine' and 'referral' (either A&E referral or GP referral — those needing a consultation with a specialist).

A total of 220 cases from a total of 1,100 *routine* casualties during an 11-day period was monitored. The average wait to be seen by a doctor for examination was found to be 24 minutes and the average total visit time was 70 minutes. However, these averages concealed variation during busy and quiet periods, leading the researchers to comment that:

> '*...the data suggest that the number of patients entering the department during periods of the day is at least partly the determinant of long visit times.*' (p.128)

Where the 644 referral patients were concerned, the picture was different. For these, the mean visit time lasted 143 minutes. There was considerable variation between specialties (ranging from 102 minutes for paediatrics to 178 minutes for trauma and orthopaedics) and also between different consultants in the same specialty. Unlike routine patients, the referral patient visit time was found to bear little relation to patient numbers. In most cases long waits were recorded as due to the doctor being busy. Very long waits seemed to be due to multiple factors.

A detailed study of waiting times, such as that reported by Mitchell, is useful because it can provide information about the reason for long waits and so enable corrective action to be taken. Asking patients whether or not they are 'satisfied' with the length of the time they waited, will not do this.

Recommendations made following Mitchell's report were:

★ **Staffing issues**

Appoint an additional senior house officer to increase medical cover at peak times.

Adjust staffing patterns to meet fluctuations in patient numbers more effectively.

Review availability of doctors from specialty firms.

★ **Medical practice**

House officers should be given authority to admit patients.

If the house officer is busy and unable to examine a patient, then the registrar should be called immediately.

★ **Role of nursing staff**

Consider feasibility of introducing a system where experienced nursing staff can 'discharge' patients without them being seen by a doctor.

The patient with a minor injury should have the opportunity to consult a nurse rather than a doctor.

An experienced nurse should be able to send a patient direct to x-ray on arrival.

★ **Communication with patients and the public**

A designated member of staff should regularly inform patients about likely waiting times.

An information sheet explaining the work and role of the A&E department should be issued to all new patients.

Long-term plans should be aimed at reducing inappropriate attendances through public education.

★ **General practitioners**

Inform GPs about the function of the A&E department. Hold regular meetings to discuss the service provided.

★ **Other services**

Representatives of other departments (x-ray, laboratory, portering, etc) should be invited to regular meetings to discuss their interaction with the A&E treatment process and to resolve problems that may develop in these areas.

★ **Setting and monitoring standards**

The A&E department and specialty firms should set themselves explicit patient working time standards.

Introduce a monitoring system to keep a check on waiting times.

Consultants should issue clear guidelines to their team for responding to referral patients in the A&E department.

★ **Further research**

Review availability and usage of x-ray and laboratory facilities.

Investigate the feasibility of admitting GP referral patients straight to the appropriate ward.

Investigate the possibility of utilising the short-stay ward as an admissions ward.

The Mitchell study provides a good illustration of the kinds of detailed practical suggestions to improve quality of care that can be gained from an 'objective' study of waiting times.

Some of the recommendations made in the study concern inappropriate attendance and this is an issue which has received considerable attention. When the NHS was set up in 1948, it was thought that general practitioners would be the first point of contact for people with non-urgent, minor illnesses, leaving the emergency department to cope with sudden illnesses and accidents only.

Many studies have shown that on average about three-quarters of patients attending A&E departments have not contacted the family doctor first. For example, a study conducted at a hospital in the North of England found that only 19 per cent of respondents had contacted their GP first (Gibson and Walsh, 1990); a study in Swindon found that only 22 per cent had contacted their GP and over a quarter of patients indicated there had been a delay of more than two days between the onset of the illness or accident and their visit to A&E. The same pattern can be seen in many other studies.

As the volume of patients can be connected to delays in treatment, there is an incentive to management to deter 'inappropriate attendance' or to stop patients 'misusing' the A&E department. So why do patients use the casualty department for 'minor' or 'non-urgent' conditions rather than their general practitioner?

There have been a number of studies aimed at answering this question: most seem to show that patients choose to attend the emergency department rather than their GP because they consider their injury or illness more appropriate to this setting. The factors associated with this appear to be:

- ★ the degree of unexpectedness of the illness/injury and the way it interfered with their normal activities, caused them to define it as an 'accident' and follow the lay assumption that 'illness is for the doctor and accidents are for the hospital'. (Holohan, 1976)
- ★ the advice of family and friends (Holohan, 1976)
- ★ treatment for specific injuries such as stitching for a cut, or x-ray for a broken bone (Calnan, 1988; Singh, 1988)
- ★ need for speed and desire to avoid a GP appointment system (Singh, 1988; Wood and Cliff, 1986; Davies, 1986) or to avoid contacting GP out of hours (Holohan, Newall, Walker, 1975)
- ★ perception that GP could not help in this situation (Wood and Cliff, 1986; Davies, 1986)
- ★ not registered with GP (Davison, 1983; Walsh, 1990).

There appear to be two main ways to cope with people attending with minor illnesses and injuries which could be treated by their GP.

The first is to provide better information about the role of the A&E department. This includes information to local people (particularly those living nearby who may be more likely to attend), to new patients attending the department, and to GPs who should also be encouraged to provide information to their patients about the services they offer. It is likely that few patients are aware that their GP will stitch small cuts, treat bites, etc. Also how to contact their GP out of hours for an emergency. Obviously this kind of information will have to be provided in all languages spoken locally.

The second is to use a triage system where patients are assessed by a nurse when they first attend. This system has been operated successfully at the Royal Preston Hospital since 1988 and has been gradually extended (Carew-McColl and Buckles, 1990; Buckles and Carew-McColl, 1991). The system now operates largely through the telephone which has several lines at the triage desk. This allows GPs and other primary health care workers to telephone and discuss their patients with the A&E triage nurse, and also gives prospective patients the opportunity to telephone the triage nurse before they attend. The nurse can refer the patient elsewhere or give some indication of current waiting time in the department.

When the change first occurred, local GPs and health workers were informed and invited to a meeting where possible problems were discussed. Also the system received plenty of publicity in the local press which publishes the triage number. Eventually a poster advertising the extended triage service was produced and distributed to schools, factories, libraries and other public places.

At first the triage nurses were very apprehensive about their new role, but initially a senior doctor was immediately available to the nurse in case she had a query or ran into difficulties. Regular lunchtime meetings were held at which a number of topics were discussed. But clinical examination techniques and a weekly digest of problems arising proved to be the most useful and supportive.

Assessment after a years' operation (Buckles and Carew-McColl, 1991) showed that about 20 telephone calls a day are received and about two-thirds of these patients are invited for treatment – many at a time convenient to patients and staff. New attendances are down by 2 per cent for the first time and 5 per cent are being redirected elsewhere. The writers comment:

> *'extended triage can be hard work but, after examining the advantages and disadvantages, we believe our campaign is paying dividends.'*

It is worth noting that the patient receives some of the advantages – a phone call begins personal care, and often means less waiting.

Another development of the triage system is to use nurse practitioners in A&E. A study discussing differences in treatment by nurse practitioners and doctors found that in most cases the doctors' and nurses' diagnoses were the same and came to the conclusion that nurse practitioners could be useful in the A&E department (James and Pyrgos, 1989; see also Head, 1988). The usefulness of community psychiatric nurses in A&E departments has been examined by Salkowkis, Atha, Storer, 1989; and Atha, 1990. Minor injuries sections have also been suggested (Macclesfield, 1986). Also the use of GPs in A&E (Green, 1991).

To sum up, the issue of waiting times in A&E is a complex one which cannot be tackled by just 'measuring' patient satisfaction. The length of time different types of patients have to wait at different times of the day and night should certainly be monitored periodically to assess the situation and to discover why long waits are occurring, with a view to minimising them.

Various ways of tackling waiting time have been suggested, including better information to patients and GPs about the role of the A&E department, and the use of extended triage and nurse practitioners.

Some long waits are inevitable and there is evidence to show that patients do not mind waiting if they are kept informed of how long they will have to wait and the reason for the delay. This practice can be monitored using a questionnaire and will be discussed shortly. A comfortable waiting environment also helps to overcome some of the distress of a long wait and this will be tackled in the next section.

2 Access and environment

The physical environment was shown to be an irritant rather than a determinant of dissatisfaction for users by the study carried out for North West Thames RHA (Caple and Deighan, 1986). Nevertheless, the quality of facilities can be important because anxiety can be increased by confusing signs and by not being able to find somewhere to park. Long waits are made more distressing by uncomfortable chairs and lack of drinks. These features can be monitored by an independent outsider using a checklist who preferably does not know the department. A questionnaire survey of patients is also a possibility.

Many studies show that poor signposting is a frequent complaint made by those attending casualty departments. It was mentioned by 16 of the 57 people who did not know where to go in the Macclesfield study, while 6 per cent of respondents in the Humberside study had difficulty finding the department. Fourteen of the 50 patients interviewed in the Welsh study complained about the inadequacy of signposting.

Those who have been before and know where to go will not have the same problem as first-timers, but it is preferable to have signposting clear enough so that those who have not been before are able to find their way easily.

Other factors mentioned by users are parking, friendliness of access to disabled people, and travelling home. Some questions relevant to this area might be :

Questions about access and environment

1 Did you easily find your way to the hospital today?

☐ Yes

☐ No

If yes, was this because:

☐ The signposting was clear

☐ I had been before

☐ The person I was with knew the way

☐ Other (please describe)

If no, why was it difficult to find your way? Please explain.

2 Once you were at the hospital, was it easy to find the emergency department?

☐ Yes

☐ No

If yes, was this because :

☐ The signposting was clear

☐ I had been before

☐ The person I was with knew the way

☐ Other (please describe)

If no, what difficulty did you have?

3 How did you travel here today?

☐ By ambulance

☐ car

☐ taxi

☐ public transport

☐ motor cycle

☐ foot

Other (please describe)

4 If you travelled by car, did you find it easy to park?

☐ Yes
☐ No
☐ Not relevant

If no, please describe the difficulty

5 On first entering the department did you have any problems locating the reception desk?

☐ Yes
☐ No

Comments . . . .

6 Did you have any difficulty speaking to the receptionists through the glass petition?

☐ Yes
☐ No
☐ Didn't speak to them

Comments . . . .

7 On a scale of 1 to 5, where 1 equals excellent and 5 equals poor, how good do you think the following facilities provided in this department are?

	1	2	3	4	5
Public telephone	☐	☐	☐	☐	☐
Toilets	☐	☐	☐	☐	☐
Refreshments	☐	☐	☐	☐	☐
Reading material	☐	☐	☐	☐	☐
Children's entertainment	☐	☐	☐	☐	☐
Seating	☐	☐	☐	☐	☐
Signposting	☐	☐	☐	☐	☐

If you wish to make comments about any of these facilities, please do so here. Comments . . . .

8 On a scale of 1 to 5, where 1 equals excellent and 5 equals poor, how would you rate the following items in the department today?

	1	2	3	4	5
Lighting	☐	☐	☐	☐	☐
Decor	☐	☐	☐	☐	☐
Temperature	☐	☐	☐	☐	☐
Noise level	☐	☐	☐	☐	☐
Cleanliness	☐	☐	☐	☐	☐

If you wish to make comments about any of these items, please do so here.

Comments . . . .

9 Do you think you will have any difficulties going home today?

☐ Yes
☐ No
☐ Not relevant

If Yes, why is this? . . . .

10 Do you have any suggestions for improving the facilities in the casualty department? . . . .

3 Information provision

Nearly all studies of patients and carers show a desire for better information. For example: about where places are; what is happening and what will happen next; about the reason for diagnostic tests; about treatment, the side effects of drugs, and self care.

One study (Heffring et al, 1986) found that quality and timeliness of information was critical to patient satisfaction, with the majority of patients defining these dimensions as more important than 'getting well'.

Users of casualty departments are no exception. Access to information was one of the six aspects of service delivery identified by users as important in the Caple and Deighan study. A large number of respondents in the study reported by Sullivan spontaneously mentioned information with both favourable and unfavourable comments, showing how important it was to them. Information flow for patients and relatives was also on the list of subjects that occurred during the explorative interviews reported by Gibson and Walsh.

Questions about information provision

1 When you were first seen at the reception desk, was it made clear to you approximately how long you would have to wait?

☐ Yes

☐ No

☐ Did not apply

Comments ....

2 During your wait, were you kept informed of the reason for delays?

☐ Yes

☐ No

☐ No delays

Comments ....

3 Did you feel confused about what was happening at any time during your visit to the department?

☐ Yes

☐ No

If Yes, when was this? ....

4 If you were sent to another part of the department for tests or treatment, was it clear where you had to go?

☐ Yes

☐ No

☐ Did not apply

Comments ....

5 Do you feel that the doctor and/or nurse you saw gave you enough information about what was wrong with you (or the patient)?

☐ Yes

☐ No

Comments ....

6 Do you feel that the doctor and/or nurse that you saw gave you enough information about the treatment you received?

☐ Yes

☐ No

Comments ....

7 Did you *understand* the information that was given to you by the nurses and/or doctors who spoke to you?

☐ Yes

☐ No

If No, please describe ....

8 Has it been made clear to you what you (or the patient) needs to do to help improve your condition (or that of the patient)?

☐ Yes
☐ No
☐ Does not apply

Comments . . . .

9 If you (or the patient) needs further treatment, are you clear about the arrangements for this?

☐ Yes
☐ No
☐ Does not apply

Comments . . . .

10 If you need extra advice about your (or the patient's) condition over the next few days, do you know who you can contact for help?

☐ Yes
☐ No
☐ Does not apply

Comments . . . .

11 Have you received a leaflet explaining the service provided by the casualty department?

☐ Yes
☐ No
☐ Does not apply

12 Do you have any suggestions about ways we can improve the quality of information we give to you?

4 Treatment and care

A number of surveys of patients conducted during the 1970s and 1980s in Britain asked one or two questions about whether staff were helpful or courteous enough (for example, Swindon, 1987, for A&E). But few included detailed questions about the different dimensions of treatment and care. During the same period in the USA, these dimensions were being explored quite thoroughly and reports of this work have begun to filter across the Atlantic (for example, Medical Care, September 1990 supplement)

It is worth making clear that treatment and care is here intended to include both domains mentioned by Donabedian (1980): the technical (the application of the science and technology of medicine and of the other health sciences, to the management of a personal health problem) and the interpersonal (the social-psychological aspects of the physician-patient interaction).

Patients can comment on the technical aspect in two main ways. The first is by expressing their perceptions about the competence of staff involved in their care. The second is by giving their views on the outcome of care. Questions about satisfaction with the outcome of treatment are beginning to occur in survey questionnaires in Britain (for example, Burbach and Quarry 1991; Hill, 1986) This is not to be confused with asking patients about their health status as an outcome measure.

There are a number of elements to the interpersonal aspect of care. Broadly they can be drawn together under the general topic of the effect of communication on the outcome of care. Good communication, which includes features such as being talked to and treated like a human being with rights of privacy, dignity and respect and perhaps of even more importance, being *listened* to as if one had a valid point of view (person-centred care) has been found to have a positive effect on compliance and health outcome. Evidence of this kind has been growing in studies of doctor-patient interaction (for example, Horder and Moore, 1990; Levenstein et al, 1986).

Questions about treatment and care

1 Do you feel you were treated like a person or like a number?

☐ Like a person

☐ Just a number

Comments . . . .

2 Did you find all the staff you saw helpful?

☐ Yes

☐ No

If no, please describe the circumstances in which you found staff unhelpful . . . .

3 Did all the staff you see treat you with respect?

☐ Yes

☐ No

If no, please describe circumstances . . . .

4 Did you find all the staff you saw *listened* to what you had to say?

☐ Yes

☐ No

If no, please describe circumstances . . . .

5 Did you find all the staff you saw were reassuring in their manner to you?

☐ Yes

☐ No

If No, please describe circumstances ....

6 Were you confident that all the staff you saw were competent?

☐ Yes

☐ No

Comments ....

7 Did you feel you had enough privacy to talk so that you could not be overheard when :

Yes	No	
☐	☐	Speaking to the receptionist
☐	☐	Being seen for the first time
☐	☐	Being treated
☐	☐	Being treated in other areas of the department

8 Did you feel you had enough privacy when undressed?

☐ Yes

☐ No

☐ Does not apply

9 Any comments about lack of privacy in general?

10 Did the presence of any of the other people waiting cause you any problems?

☐ Yes

☐ No

If Yes, please explain ....

11 Did you feel safe during your time in the department?

☐ Yes

☐ No

If Yes, please explain ....

12 In your view has your health improved as a result of your treatment at the casualty department?

☐ Yes

☐ No

Comments ....

13 Do you have any suggestions about how we can improve the care and treatment we provide in the casualty department?

Summary

An examination of research which aimed to identify the issues important to users of casualty departments showed that improved signposting, and access, waiting time, privacy, information and communication featured highly in their list of desired changes. Surveys show that casualty departments are frequently weak in these areas. These and related issues concerning the casualty environment and treatment and care, have been examined and ways of monitoring user views about them have been suggested. The questions and response formats given are examples which can be adapted to local use as required. Questionnaires using these examples can be constructed and piloted by following the advice given in chapter 2.

4 INPATIENTS

Background

Surveys collecting the views of hospital inpatients started early in the 1960s and there are probably more of them than for any other type of patient. Four major pioneering studies date from the 1960s (Barnes, 1961; McGee, 1961; Cartwright, 1964; Raphael, 1967) and hundreds have been conducted since, although many are unpublished.

When the King's Fund Centre carried out a review of inpatient surveys conducted between 1968 and 1974, 173 surveys were received, excluding surveys in 20 hospitals carried out by King's Fund Centre staff (Raphael, 1974). During a similar review for 1983 onwards, carried out by the Centre for Health Economics in 1988, reports of 35 inpatient surveys were received – the second largest number after maternity studies.

With such a large amount of experience to draw upon, it should be possible to construct a good instrument for collecting the views of inpatients. Unfortunately most of the surveys have been carried out in an ad hoc manner with little attempt to learn from experience and refine the methodology.

There are four exceptions to this statement: the first is the work carried out by Winifred Raphael of the King's Fund Centre in the 1960s and 1970s. The second is the work carried out by UMIST and the Health Policy and Advisory Unit (HPAU), under the direction of Dr Andrew Thompson on the 'what the patient thinks' questionnaire. The third is the CASPE project to develop the PATSAT questionnaire which can be scored by an optical mark reader. Finally, there is the development of a number of questionnaires in the USA, particularly the patient judgements of hospital quality questionnaire (PJHQ) and shorter versions (PJS 10 and PJS 20).

These four systematic attempts to develop a valid and reliable questionnaire which fits into the working practices of hospital managers will be examined in turn before some suggestions are given for a way of building upon the experience of these questionnaires which allows more local flexibility.

Methods

The Raphael questionnaire

The questionnaire was first piloted by Winifred Raphael in ten hospitals, the results of which were published in the first two editions of *Patients and Their Hospitals* (Raphael, 1969 and 1973). A third edition, based on responses from 10,863 patients in 68 general hospitals, was published in 1977, together with a revised questionnaire.

Raphael's aim was to:

> *'...devise a questionnaire that general hospitals could use themselves to find the views of patients about their stay in hospital.'* (p.7)

It was meant to be a tool for hospital management and staff to use in order to bring about improvements in service quality. For that reason it was kept short and easy to analyse. There were 28 questions which covered five areas of life in hospital.

★ **The ward and its equipment:** (four questions covering comfort of bed, noise, temperature, and privacy)

★ **Sanitary accommodation:** (four questions covering whether there were enough bathrooms, washbasins and lavatories, and whether they were clean and private enough)

★ **Meals:** (seven questions covering whether the different meals were satisfactory, choice, temperature and amount of food)

★ **Activities:** (six questions covering arrangements about visiting, waking time, lights out, quiet, and provision of books, radio and other entertainment)

★ **Care:** (three questions about notice of admission, attention of nurses and information)

★ A general question and two open questions about what the patient liked best and least about the hospital.

The response format was straight forward: yes/no/explanations and suggestions. This enabled easy coding and yet allowed the patient to make comments.

All types of wards were included in the surveys except obstetric, paediatric, geriatric and psychiatric. The included wards were selected by chance and each ward sister gave a questionnaire to the first 30 patients leaving the ward over a two-day period. The patient had to be aged 15 or over, to have been in the ward at least four nights and to be able to read and write English.

The questionnaire was piloted in ten general hospitals using an experimental design in which in half the wards the questionnaires were issued shortly before the patients' discharge and in the other half they were sent together with a stamped addressed envelope after the patient had returned home.

A total of 1,348 completed questionnaires were returned (a 62 per cent response rate). The response rate was higher where the questionnaires were distributed prior to discharge (67 per cent) than those sent after discharge (57 per cent) but it is important to note that no follow-up letter was sent to respondents in the postal survey.

The results of the main survey, based upon responses from over 10,000 patients, showed that sanitary accommodation came in for most criticism, although when the results were split into two time periods (1967-70 and 1971-74) there were greater improvements in the level of discontent in this area than any other. Complaints were about lack of privacy as well as shortage of sanitary accommodation.

Other areas of discontent were hot and stuffy wards; noise at night; the discomfort of protective undersheets and plastic mattress covers; boredom; too early waking time; and the difficulty of getting information about their own conditions and about the reason for various tests and treatments.

Those who answered the questionnaires on the ward were more critical about the hospital than those who answered after they returned home, except for the question about information. Raphael comments on this finding that perhaps those on the ward still expected that information would be given to them before they left.

Some findings were predictable – for example, the older the patient, the more likely they were to express contentment. Other results were more unexpected – for example, there was no close relationship between contentment and cost per inpatient week.

Of special interest was the fact that Raphael also asked each hospital to report on action taken as a result of the survey. She found it:

> *'...impossible to describe the variety and the great number of*

changes made as a result of the survey.'

Many of these changes could be categorised into six headings: changes in organisation; minor changes in equipment; changes in meals; changes in facilities; and changes needing capital expenditure. She also mentioned a reported positive effect on staff morale which helped in three ways: by greater awareness of their patients' needs; by appreciation of the beneficial changes (many of which the staff had always wanted to make); and especially by the warm praise almost invariably expressed by patients.

Strengths and weaknesses

The King's Fund Centre still receives requests for the Raphael inpatient questionnaire and there is no doubt that as a survey tool it has many advantages:

- ★ It is well laid out, making it easy for service users to complete.
- ★ Most of the questions have simple yes/no answers, which facilitate analysis.
- ★ There is space for the respondent to add explanations and suggestions. This helps in the identification of specific issues of concern to patients and provides valuable information about the kind of improvements which they want.
- ★ It covers a number of different aspects of the inpatient service, making it possible for managers to obtain views on different aspects in one survey.

An advantage important to Raphael at the time of the third edition was that the results could be collected and analysed centrally so that one hospital could measure its results alongside others. This was one of the reasons that she published the median percentage of critical results for the surveys carried out in 68 general hospitals.

A widely used standard questionnaire certainly has this advantage if it is combined with a central database of results. Unfortunately such a database no longer exists at the King's Fund Centre. When Winifred Raphael died, the library continued to distribute copies of the questionnaire but no attempt was made to elicit and record results. Also many hospitals adapted the Raphael questionnaire to suit their own purpose, resulting in numerous variations on the original questionnaire and so destroying its 'standard' format.

Is it worth reviving the Raphael questionnaire as a standard tool suitable for widespread use today? Excellent as the questionnaire was as a pioneering tool for the 1970s and early 80s, it suffers from a number of weaknesses which tend to limit its usefulness as a tool for the 1990s. These have been described in detail in earlier publications (McIver, 1991B, McIver, 1991C).

For the purpose of this analysis of inpatient questionnaires, the main weakness lies in the questions. In the light of more recent studies, Raphael's questions do not seem to cover the issues that are of most concern to patients. An analysis of the open questions carried at the end of the questionnaire (what the patient liked best and least), tends to support this. A large majority of comments about what they liked best (93 per cent) dealt with human or organisational factors such as staff, atmosphere and relaxation. This shows the importance of such factors to patients. Only seven per cent gave physical matters like food and the ward.

The comments on what they liked *least* were almost equally divided between physical matters (49 per cent) and human and organisational factors (46 per cent). Similar results were obtained in a North West Thames RHA study of users of A&E and outpatient departments which relied completely on an interview technique designed to elicit patients' own areas of concern (Caple and Deighan, 1986). This survey of 572 patients found that physical factors were irritants rather than crucial areas of concern for patients. The issues that mattered most to them were human and organisational factors, such as understanding the system, access to information, continuity in the pace of events, personalised attention, friendliness and efficiency, and consistency.

In Raphael's questionnaire over half the questions are about physical factors – seven dealing with meals. This would not be such a problem if the questionnaire were longer so that more detailed questions about other topics could be included. As it is, the questionnaire just does not cover issues important to patients in enough detail.

The 'what the patient thinks' questionnaire

The origin of the 'what the patient thinks' questionnaire was a doctoral dissertation carried out at the Department of Management Sciences at UMIST in 1975 by Dr Andrew Thompson under Professor Brian Moores. Dr Thompson developed the questionnaire over a number of years and it has continued to receive modification based upon the experience of use in dozens of hospitals.

The questionnaire is now available from the Health Policy and Advisory Unit (HPAU), a national charity established in 1986 with the aim of conducting independent research in the field of health care (see Useful Addresses). Dr Andrew Thompson, the chairman of HPAU, is still involved in developing the questionnaire, although he has moved to Cardiff Business School (UWIST).

Those who wish to use the questionnaire buy a survey package which includes copies of the questionnaire which is intended for postal distribution, a random sampling frame, standard letters, pre-paid reply envelopes, and training for staff. The hospital is responsible for sending out the questionnaire and two reminder letters but the questionnaires return to HPAU and are analysed there. The unit produces reports and the findings are presented at a staff seminar.

Over 100 hospitals have used the survey including 12 hospitals in South Wales, Oxford Region, and London and every acute hospital in greater Glasgow during 1990/91. The whole process takes about six months – three months sampling period, two months for questionnaire returns and about one month for analysis. The package costs approximately #8,500 plus VAT for ten inpatient wards (1990 prices).

The questionnaire is designed to investigate patient opinions about the quality of care received whilst in hospital. It is detailed and comprehensive and therefore very long. The A4 size booklet consists of 45 pages containing about 90 main questions with subquestions and these are split into five main areas: 'arriving at hospital', 'Inside the ward', 'the people in hospital', 'information' and 'leaving hospital'.

Strengths and weaknesses

The 'what the patient thinks' questionnaire has a number of advantages:

- It is very clearly laid out, nicely designed and produced to a high standard. These factors encourage patients to complete it.
- It has been extensively piloted, improved after trial and error over a number of years, and tested for validity and reliability. This ensures that the results are of good quality and can be relied upon.
- It is extremely comprehensive and detailed, enabling specific issues of concern to patients to be addressed.
- Those who use it need only a minimum of research expertise and technology because they buy a package which includes analysis, report presentation and recommendations for action.

★ The questionnaire is linked to a database of results (National DATA Archive) and so it is possible to make comparisons between the results of individual surveys and national results.

The questionnaire also has a number of weaknesses, although attempts have been made to overcome many of them. Criticism has been made about the difficult wording of some of the questions, but the most recent version has simplified the wording or omitted these questions. All the same, the questionnaire demands quite a high level of literacy and is unlikely to be useful with many minority ethnic people (their agenda of importance may be different). Also the confused elderly, people with learning difficulties, and those who have received little education such as travellers, may find it difficult to complete, although anyone experiencing difficulty is encouraged to get help with filling it in if they can and the views remain their own.

The length of the questionnaire does not appear to be a deterrent to those who are able to complete it, although as it requires a fairly high level of concentration and energy, people who are still weak or sick, or on medication which affects concentration, may find it too demanding. This does not mean that the response rate will be poor. The current average is said to be over 70 per cent.

A long questionnaire also produces a large statistical report which can be difficult for managers and professionals to make use of. HPAU produces a 20-side management action report to help combat this problem. Surveys conducted by external researchers tend to be difficult to turn into an effective tool for service change because they lack staff ownership, although this problem can be overcome if staff are involved from the beginning.

Managers who are responsible for wards having a throughput of a majority of reasonably literate patients, or who are prepared to use it in conjunction with a method designed to elicit the views of those who will be overlooked, should give the 'what the patient thinks' questionnaire serious consideration. However, they should be prepared to work very hard at turning statistics into interesting information, raising staff motivation during the survey, using the results as a training aid and helping staff to use the results to improve service quality.

The PATSAT questionnaire

The PATSAT questionnaire has been developed by Clinical Accountability, Service and Planning Evaluation (CASPE) Research, under the auspices of the King's Fund (see useful addresses). It was piloted in Bloomsbury Health Authority during 1988 and extended to another six sites during 1990; in early 1992 28 hospitals were using the system. The questionnaire is part of a system designed to provide a way of routinely monitoring patient satisfaction. Unlike most other surveys which are 'snapshots in time' and run the risk of being 'one offs', the PATSAT system aims to provide continuous monitoring.

Questionnaires have been produced for acute inpatients, and outpatients, antenatal and postnatal, obstetric in and out patients, acute psychiatry, paediatrics, A&E, genito-urinary medicine services and intensive care patients.

The PATSAT questionnaire comprises two types of topics: firstly those described as core, which are common to all broadly similar service users and cover issues that, during research, patients identified as important to them; secondly there are local topics identified as important by local managers or interested groups.

The PATSAT system is linked to the hospital's patient administration system (PAS). The PATSAT software codes patient details onto a questionnaire which is sent to the ward or clinic with a personalised letter asking each patient to complete the questionnaire. There is also a manual (non-PAS) system for use in wards which have a short length of stay or those which do not have a PAS.

Questionnaire responses are scored by an optical mark reader and the collated scores about the services concerned are then analysed by the PATSAT software. Reports can be analysed by ward, clinic, consultant, age groups, specialty and similar variables.

The core topics are very general and the questionnaire is short with a simple format – a topic (for example, doctors, nurses, the clinical treatment you receive) followed by a scale of 'very satisfied' to 'very dissatisfied' headed by schematic faces expressing the corresponding emotion. The aim of the questionnaire is to highlight broad areas of concern and monitor them over time. When dissatisfaction occurs, subsidiary questionnaires are available which provide a more in-depth analysis. These second level questionnaires are intended to be a detailed 'snap shot' focusing on a particular area of service, and they employ an attitude scale that ranges from 'strongly agree' to 'strongly disagree'.

In addition there is a box on the questionnaires for patients to add comments if they wish. The comments are typed by topic onto a software package called ASKSAM which is a text storage and retrieval system. This means that additional reports can be produced from verbatim comments made by patients.

Strengths and weaknesses

The PATSAT questionnaire has a number of advantages:

- ★ It is simple, clear and easy to read. This means that practically everyone should be able to complete it. The question format is so simple that translation into other languages should not be a problem.
- ★ The questionnaire is short, making it easy for managers and staff to digest the results and see where problems are occurring.
- ★ The fact that it is used continuously means that comparisons with earlier time periods can be made, and it may be possible to see if changes made to improve quality have had an impact upon patients.
- ★ CASPE hold a database of results enabling comparison of individual hospitals with national averages.
- ★ Once the initial hardware and software has been bought it is an inexpensive way to monitor patient views.
- ★ The PATSAT survey process is designed to fit into the hospital management system, making it easier for managers to improve service quality as a result of the information.

The PATSAT questionnaire also has a number of weaknesses and these have been described by several researchers (Carr-Hill, Dixon, Thompson, 1989). The main problem lies in the superficiality of the questionnaire. A single question about complex issues such as information provision, nursing care and 'radio, TV, dayroom' is not enough to encourage patients to thing critically about the care they have received.

Also the 'very satisfied – very dissatisfied' response format is unlikely to encourage patients to be discriminating in their responses. For example, they may be generally satisfied with their nursing care 'under the circumstances' (for instance, bearing in mind the fact that they understand nurses to be overworked and underpaid) but unhappy about certain specific elements of that care (such as the fact that many of their requests for assistance went unanswered for a long period of time, or that some nurses seemed too busy to answer questions, or that sometimes they were treated like a child, or handled roughly, and so on).

A short questionnaire covering many issues and using the 'satisfaction' response format is such a crude tool that it is likely to elicit a very undiscriminating response from patients (see also McIver, 1991A, 1991C and Ware and Hays, 1988).

Unfortunately this means that although the PATSAT system provides more detailed questionnaires to investigate areas shown as unsatisfactory by responses to the basic questionnaire, it it likely that these will be underused because many areas of dissatisfaction will be missed at the initial stage.

Another serious problem lies in the fact that the response rate is low. This is common for the first distribution of questionnaires and most surveys overcome this by chasing up non-respondents. The PATSAT system does not allow for this at present and so the responses may not be representative. A similar problem was found when a 'patient comment card' system was tested in the USA (Nelson et al, 1991).

An evaluation of the CASPE system at St George's Hospital, Wandsworth, confirmed these weaknesses (Raftery and Zarb, 1990). By following up respondents to increase the response rate and interviewing a sample of respondents to compare their detailed accounts with their questionnaire responses, the researchers were able to check the validity of the questionnaire. The study also produced results which may well apply to any questionnaire survey of inpatients.

By following up non-respondents on an individual basis, the researchers achieved a 68 per cent response rate, with the majority who did not respond being too ill to participate. Of the 395 who completed the questionnaire, almost a quarter required help filling in the answers. This suggests that even simple questionnaires can prove difficult for a sizable proportion of patients.

When following up a sample of patients to interview them within a month of discharge, the researchers found that 75 out of 237 (23 per cent) could not be contacted even after phone calls and home visits and this 'prompted concern over the accuracy of addresses'.

The follow-up interviews explored patients' hospital experiences and these showed that while many aspects of the CASPE questionnaire worked well, some questions did not adequately cover the patients' experience. This led them to suggest modifications to the original questionnaire.

> *'Greater attention should be paid to the interpersonal aspects of medical care. Different types of nurses should be distinguished, as should cleaners and other domestic staff. Questions on the admission process, transport and the general environment were also useful.'* (Raftery and Zarb, 1990, p. 1693)

The researchers also recommended that there should be personal distribution of questionnaires and follow up of non-respondents to increase response rate and help those having difficulty to complete the questionnaire and that as dissatisfaction tended to emerge from written comments and personal interviews, further investigation may be required.

Managers who already have the necessary technology, or who intend to buy it, might find the PATSAT system a useful tool to help them monitor patient satisfaction at a fairly general level. However, they should be prepared to back up the system with information to patients which enables them to understand the kind of service standards the hospital is aiming to deliver in order that they can make realistic evaluations of service quality. Also the system should be combined with use of more sensitive methods on a regular basis. Semi-structured interviews, discussion groups or patient advocates should pick up details which are masked by the continuously used general questionnaire.

The patient judgements of hospital quality (PJHQ) questionnaire

At first impression, there appears to have been a more concerted attempt in the USA to develop standardised questionnaires to measure patient satisfaction. A second glance reveals that many of these questionnaires are built upon attitude scales and although often subjected to tests for *reliability* it is not clear how *valid* they are – that is, whether the questions asked are relevant to the patient. The emphasis appears to be on measurement itself rather than on what is being measured.

One exception to this is the PJHQ questionnaire which was developed following group discussions with patients and the collection of patients' comments from questionnaires, as well as a comprehensive review of existing instruments. A copy of the questionnaire and an account of its development can be found in a September 1990 supplement of *Medical Care* (vol. 28, No.9).

The questionnaire includes 106 questions but only 46 of these ask for patients' views on quality of care. Some of the questions collect sociodemographic information, details of previous experience, reason admitted, and so on. Also some collect information which would not be relevant to a British context – why the hospital was chosen, efficiency of billing procedures and type of health insurance, for example. The main questions about quality of care are split into seven sections: admission; your care in the hospital; your nurses; your doctor; other hospital staff; living arrangements; discharge.

These questions all follow the same style (a topic with an explanation) and have the same response format (a scale from excellent to poor). For example:

Instructions: How well doctors, nurses and other staff explained how to prepare for tests and operations:

excellent, very good, good, fair, poor, don't know.

There are also two questions relating to expected outcome and perceived outcome, and two open questions asking which particular aspect of the hospital stay helped the patient to improve, and which kept the patient from improving.

Shorter versions of the original questionnaire have also been developed (Hays, Larson, Nelson, Batalden, 1991) and it is clear that those involved see the questionnaires as part of a larger project to develop patient-based measures of hospital quality, which they term the 'patient judgement system'.

Strengths and weaknesses

To someone used to British patient satisfaction questionnaires which tend to be similar in content and format, the different style of the PJHQ is very interesting. Some of the questions are new and the response format is not one currently in regular use in Britain. Also it is easy to be impressed by the amount of resources (time, money, collaborative research expertise, coordination) which have gone into its development and testing for reliability and validity compared to most British questionnaires (apart from those mentioned above).

In many ways the PJHQ seems to have the advantage of combining the simple format of the CASPE questionnaire with the detail of 'what the patient thinks'. At the same time, it also seems to suffer from some of the weaknesses of both. For example, the main version is long, requiring commitment and energy from patients. Also, as it is detailed, it requires quite a high level of literacy.

The brevity and simplicity of the question style means that some of them appear to ask two questions or more at the same time. For example, three questions about housekeeping staff, laboratory workers and x-ray staff ask patients to judge:

> *'how well they did their job and how well they acted towards you.'*

Why are patients being asked to balance out ability to perform a task and caring concern in order to make a judgement about the quality of care these staff provide?

Similarly, question 52 asks about:

condition of your room: cleanliness, comfort, lighting, and temperature.

What if cleanliness was excellent but temperature too hot? How are patients to answer the question under these circumstances?

Questions like these show that the questionnaires' roots lie in tools to obtain ratings of hospital quality so that hospitals can be compared, rather than in ways of finding out patient views so that quality in individual hospitals can be improved from the patients' perspective.

Differences in the British health care system make it difficult to assess the usefulness of the PJHQ questionnaire. At the very least it will require adaptation and piloting in British hospitals by experienced researchers before it can be adopted as a valid and reliable instrument. Until then, its main value lies in suggesting areas for questions and as an example of a particular kind of question and answer format.

Summary

An examination of the four standardised survey questionnaires available shows that none of them is ideal, although the HPAU 'what the patient thinks' and CASPE PATSAT questionnaires could be useful in the right circumstances. It is possible that other questionnaires may become standardised (through repeated use) in the near future. For example, Social and Market Survey Research Ltd (see useful addresses) has developed an inpatient questionnaire which has been used in Humberside. Standard questionnaires covering specific issues may also become available – for example, the Royal College of Surgeons in 1990 employed a sociologist to begin the development of a tool to audit patient satisfaction with surgical care (Meredith, 1991B).

Those who would like to develop their own questionnaires or interview schedules are faced with the daunting task of searching out copies of locally devised questionnaires and then copying any questions that seem relevant. This is a haphazard way to construct a questionnaire because the originals are of varying quality.

A good questionnaire is based upon exploratory interviews which find out what patients consider important issues, and the language they use to describe them. Although it may be necessary to carry out this exploratory work in some service areas, for hospital inpatients it is not really essential because many studies have been already carried out and the issues identified.

The four standardised questionnaires described were all based on interviews and there have been a number of studies of inpatients using qualitative methods. By examining these it will be possible to identify issues important to patients and devise relevant questions.

Factors important to users

When patients are asked to talk about their health care experiences in interviews or group discussions it is possible to find out the issues which are of real concern to them. An example of this approach is the qualitative research carried out in 1990 by the British Market Research Bureau for Eastbourne, Brighton and Hastings health authorities. This research was conducted as the foundation for a questionnaire survey.

A series of nine mini-groups (of three or four patients each) was conducted among people who had recently been discharged from hospital. Groups were structured by age and sex and within each an attempt was made to cover both emergency and planned admissions and to include patients from a wide range of specialties. A total of 37 men and women took part in the discussions which took place in local hotels about a week after discharge.

According to the researchers, the most important issue for all patients was:

> *'...their health and whether or not they felt better for their stay in hospital.'*

Other considerations were either related to, or secondary to this. Important issues were found to be:

- ★ **The outcome:** getting better and feeling better after being in hospital.
- ★ **Confidence in the clinical staff:** staff professionalism in talking to the patient, carrying out treatment and in handling equipment. Also general level (and accuracy) of communication between staff and between staff and patient.

- ★ **Staff kindness, time to listen and explain:** most important of all was the person who first welcomed the patient into hospital.
- ★ **Waiting time and rescheduled appointments:** repeated rescheduling of appointments (either before or during the stay in hospital) eroded confidence in medical efficiency and professionalism. This and long waiting times before treatment communicated a lack of concern with the individual.
- ★ **The ward and life on the ward:** including cleanliness; physical comfort; social factors such as other patients, staff, visitors, TV and radio facilities; sleep; and food.

This study is interesting because of the reported emphasis which those taking part placed on their health and the outcome of treatment. It seems obvious, but satisfaction questionnaires rarely cover this issue.

Other issues, such as confidence in clinical staff, staff kindness, continuity of care and ward environment, frequently occur in both satisfaction questionnaires and interview research. For example, a questionnaire developed by a team of researchers from Social and Market Survey Research for a health authority in Humberside (also based upon qualitative research) asked an open question:

> *'For you what are the priorities that make for a good service?'*

The aim of including this question was to remain sensitive to the patients' agenda during the structured questionnaire phase of the research. On the questionnaire, space was given for the respondents to fill in their first, second and third priorities. Out of a total of 519 respondents, 367 wrote down their first priority, 300 also gave a second priority and 208 also put down a third.

The responses were then categorised and six headings emerged. These were:

★ Friendly staff (37 per cent first priority; 64 per cent first, second and third priority)

Approachable staff, caring doctors and nurses, personal care/treatment.

★ Efficient organisation (13 per cent first priority; 31 per cent first, second and third priority)

Easy access/availability, short waiting lists, convenient appointments.

★ Information/communication (5 per cent; 23 per cent)

Honest information and communication, being listened to and able to ask questions, advice on after care.

★ Quality of medical care (12 per cent; 19 per cent)

Good medical care by professional and experienced staff, local treatment, home visits, good ambulance service.

★ Built environment/facilities (2 per cent; 16 per cent)

Surroundings, facilities, equipment, government,finance, cleanliness.

★ Home comforts (2 per cent; 16 per cent)

Warmth, food, privacy, visitors being made welcome, appropriate facilities for children.

A comparison of the above list with issues identified by the British Market Research Bureau earlier show that there is considerable overlap.

Qualitative data can be analysed in a number of ways. In addition to locating the issues that concern patients, it is also possible to identify the dimensions of those issues which are relevant. For example, qualitative research carried out for Wandsworth health authority in 1990 looked at the main factors influencing satisfaction/dissatisfaction.

Adopting a slightly different approach to the studies mentioned, the researchers carried out interviews with patients after a questionnaire survey using a modification of the CASPE approach had taken place. The aim of the interviews was to test the reliability of the questionnaire and to collect more detailed information about the factors influencing consumer satisfaction.

A total of 132 patients were interviewed out of the 237 eligible. The responses were organised into a series of descriptive categories for each topic covered and the number of times each was mentioned was also recorded, so giving an indication of the weight patients attached to each. Unfortunately this method of assessing importance may not be accurate because the number of times a topic is mentioned may indicate how permissible it is to refer to a topic, not its importance.

The results were a series of dimensions. For example, for doctors, the categories were:

friendliness/unfriendliness, informative/uninformative
helpful/unhelpful

For *treatment and care:*

confidence/anxiety

aftercare/follow-up

discharge arrangements

This is a way of breaking up the information into more detailed categories to aid analysis or questionnaire development. The most complex example of this approach is that carried out by researchers in the USA during the development of the patient judgements of hospital quality questionnaire. Taking patients' written comments and transcripts of focus group discussions they first identified a list of topics covering the subject of patients' comments (for example, care on the ward, admission); they then differentiated between three main areas of concern (procedures; staff; and physical equipment or facilities); and finally they identified the attribute that was salient to the patient. For example, with regard to procedures associated with any phase of hospital stay, patients made frequent comments about the efficiency, ease, promptness, and timeliness of the service. The precise word used differed depending upon the phase or site of the hospital experience.

In other words, an analysis of qualitative data (for example, from interviews and group discussions) can highlight:

1. Aspects of the hospital visit which are of most concern to patients in influencing whether they have a good experience or not (for example, treatment, environment).
2. The criteria (language) they use to describe what they like and dislike about those aspects.

The details will differ for individual hospitals, but the general categories will remain the same – or so the results of qualitative research to date suggest. The main categories seem to be:

- ★ treatment and care (including outcome)
- ★ staff friendliness and competence
- ★ information and communication
- ★ efficiency of procedures (including admission and discharge)
- ★ ward environment and facilities.

The two main problems for those wanting to construct a questionnaire, questionnaires or an interview schedule to cover these issues is first to decide which topics to include in the same questionnaire, and second which (how many) questions to ask within each topic. Just how *detailed* should it be?

It is a good idea to keep questionnaires fairly short to aid analysis and to encourage completion; yet detail helps patients to be specific and aids in the identification of problem areas. To accomplish these aims it seems sensible to divide the topics into a number of questionnaires.

Some subject areas, particularly staff friendliness and competence, may discourage the patient if treated as a separate topic because patients rarely want to criticise staff. If questions of this kind are included as part of a larger questionnaire they may be more acceptable. Others, such as efficiency of procedures may be difficult to tackle as a separate issue divorced from a particular context, such as admission or discharge. Given these reservations, the following topic areas are suggested:

★ admission

★ treatment and care (including staff competence and friendliness)

★ information and communication

★ ward environment and facilities

★ discharge and outcome.

Details of the particular factors which concern patients within each of these areas, plus a list of relevant questions, are given in the next section.

Questions to ask users

Admission

There are advantages in constructing a separate questionnaire for admission: questions about waiting time between referral and admission can be included and it is a topic which can be covered adequately while patients are on the ward.

Experiences which occur during admission can influence the way the patient feels during the whole of their stay in hospital. For example, the qualitative research carried out by the British Market Research Bureau for Eastbourne, Brighton and Hastings Health Authorities found that:

> *'It was clear that the first person who met the patient on arrival at the hospital had a strong influence on the patient's attitude to the whole stay.'*

The most important feature of the initial contact appeared to be reassurance that the member of staff had the time and inclination to attend to each patient's needs individually. The introduction was important and ideally explained:

- ★ the hospital facilities which were available
- ★ all about the treatment to be given so that the patient knew what to expect at each stage
- ★ encouragement to the patient to ask if they had any worries or questions.

The following questions are suggested as relevant to ask those whose admission was planned.

Questions about admission

1 Thinking back to when this stay in hospital was first discussed, how long did you have to wait before you were admitted?

☐ Less than 2 weeks
☐ 2 – 4 weeks
☐ 1 – 3 months
☐ Between 3 and 6 months
☐ Between 6 and 9 months
☐ Between 9 months and 1 year
☐ over 1 year (please specify)......................

2 What are your views on this waiting time?

. . . .

3 Did you manage to get into hospital the first time you were asked to attend or were you turned away because there were not enough beds?

☐ Yes, first time

☐ No, not the first time

4 How much warning did you get of the actual day you were to be admitted to hospital?

☐ A few hours

☐ A day or two

☐ Three days to a week

☐ More than 1 week

Comments . . . .

5 In getting to the hospital, did you have any problems with:

	Yes Problems	No Problems	Not Applicable
Ambulance service	☐	☐	☐
Public transport	☐	☐	☐
Parking	☐	☐	☐
Distance from car park or bus stop	☐	☐	☐
Getting a lift	☐	☐	☐
Cost of transport	☐	☐	☐
Finding your way to the hospital	☐	☐	☐

6 Did you receive any written information about the hospital before you arrived here?

☐ Yes

☐ No

Comments ....

7 Were you clear about why you needed to go into hospital?

☐ Yes

☐ No

Comments ....

8 When you arrived at the hospital, were you made to feel welcome?

☐ Yes

☐ No

Comments ....

9 Were you confused or frightened at any time before you reached the ward?

☐ Yes

☐ No

10 If you were confused or frightened, did anyone reassure you?

☐ Yes

☐ No

☐ Does not apply

11 When you first arrived at the ward, did anyone greet you?

☐ Yes

☐ No

Comments ....

12 Did anyone tell you about ward rules and regulations and where to find things like the toilets and bathroom?

☐ Yes

☐ No

Comments ....

13 Did anyone make sure that you knew what was going to happen to you?

☐ Yes

☐ No

Comments ....

14 Do you have any suggestions about how the care you received on your way to the ward could be improved?

Treatment and care

This is the least explored area of concern to patients, particularly in Britain, and there is still a need for qualitative research to explore which aspects of treatment and care are important to inpatients. The small number of studies which have delved into this subject have discovered that one of the key issues that patients mention when discussing their experience of treatment and care is the extent to which it is 'patient-oriented'. Merteko et al following discussions with patients during the design of the PJHQ questionnaire describe this as the demonstration of an 'accommodation of patient wishes'.

A similar issue was identified by Gibson (1991) who found that friendly, approachable and caring staff were 'the most commonly cited priorities for a good service'.

This does not mean that patients ignore efficiency or competence, however, as these issues were also mentioned as important in both the above studies. Patients have views on the apparent efficiency and skill of those caring for them, whether or not they feel confident enough to give them to a professional, and several studies indicate that satisfaction ratings by patients correlate positively with indices of technical quality developed by experts (Roter, Hall, Katz, 1987; Willson and McNamara, 1982).

Further research in this area should concentrate particularly on what counts as good practice in the 'accommodation of patient wishes' for people of different cultures and religions. Studies of variations in levels of satisfaction between black and other minority patients and white patients are few and far between, but they show that many of their needs are different.

For example Ahmad (1990) found several differences in level of satisfaction when he compared the questionnaire and interview responses of 101 Asian and 159 white inpatients. Asian patients were less likely to receive the book *Coming into Hospital* (60 per cent of Asians did not receive it, compared to 46 per cent whites), Asian patients were less satisfied with radio arrangements, mixed wards, food, nursing staff and information given about their illness and treatment.

Among the recommendations made to improve the service from the point of view of the Asian patient were translation of literature, provision of hospital radio programmes in Asian languages, inservice training about Asian cultural, social and religious norms, provision of good and nutritious Asian food, including information about the availability of Halal meat, and the provision of an adequate interpreter service.

Given the likely differences between the views on treatment and care between people of different religious and cultural backgrounds, it is advisable to identify self-completion questionnaires in a way which enable major cultural groups to be distinguished and the response rates and results compared. Low response rates from patients of a particular cultural group should encourage further research using a qualitative method, such as interviews using a person who speaks the appropriate language and/or who follows the same religion.

Questions about treatment and care

1 During you stay in hospital do you feel that you were treated like a person or like a number?

☐ Like a person

☐ Like a number

Comments . . . .

2 Was there consideration for your individual needs?

☐ Yes

☐ No

Comments . . . .

3 Were you ever made to feel embarrassed?

☐ Yes

☐ No

If yes, please describe the circumstances . . . .

. . . .

4 Did the doctors and nurses always respect your need for privacy?

☐ Yes

☐ No

If no, please describe the circumstances . . . .

. . . .

5 Were the nurses always careful and considerate enough when they tended to you?

☐ Yes

☐ No

Comments ....

6 How long did it usually take staff to respond to your calls for assistance? (Bell, voice, etc)

☐ Very promptly (within a few moments)

☐ Quite fast (10-15 minutes)

☐ Slow (15 minutes or more)

☐ Don't know

Comments ....

7 If you suffered pain, were you given something for it within what you consider to be a reasonable time?

☐ Yes

☐ No

☐ No pain

Comments ....

8 Were you always clear about what was going to happen next as far as your treatment was concerned?

☐ Yes

☐ No

Comments ....

9 Do you feel that your views have been considered as far as the treatment is concerned?

☐ Yes

☐ No

Comments . . . .

10 Are you happy about the treatment you have received?

☐ Yes

☐ No

Comments . . . .

11 Do you think that all the staff who helped in your treatment and care were good at their job?

	Excellent	Very good	Good	Fair	Poor	Don't know
Doctors	☐	☐	☐	☐	☐	☐
Nurses	☐	☐	☐	☐	☐	☐
Paramedics (x-ray staff, etc)	☐	☐	☐	☐	☐	☐
Administration	☐	☐	☐	☐	☐	☐
Porters	☐	☐	☐	☐	☐	☐
Cleaners	☐	☐	☐	☐	☐	☐

12 Did you feel that you and the belongings you had brought with you were safe and secure while you were in hospital?

☐ Yes

☐ No

Comments . . . .

13 Do you have any suggestions about how your treatment and care could have been improved?

☐ Yes

☐ No

Comments . . . .

Information and communication

If there is one area which patients have consistently expressed dissatisfaction about it is this one which must have the dubious honour of being the most researched and least improved area of health care. In research carried out as long ago as 1961, patients were dissatisfied with communication and lack of information (McGhee,1961; Barnes, 1961). Four chapters of Cartwright (1964) dealt with the issue of staff-patient communication and described various reasons for the 'unsatisfactory state of affairs'.

In their literature review of consumer feedback research in the NHS, Jones, Leneman, Maclean (1987) describe numerous studies which find problems in this area and they comment:

> *'We have certainly found no evidence of any real improvement since this problem was articulated more than twenty years ago.'* (p.85).

Sadly, recent studies in all service areas, including inpatients, confirm their finding. For example, after discovering through exploratory group discussions with patients, that 'staff kindness, time to listen and explain' were very important to them, the British Market Research Bureau sent a questionnaire which included questions about information provision, to 6010 patients in Eastbourne, Brighton and Hastings. A total of 4267 were returned (71 per cent) and results showed that around one in four patients, particularly the young, were keen to have more information about their condition, and two in five felt that sometimes things had not been clearly explained by the doctor (British Market Research Bureau, 1991).

Qualitative research carried out by the Royal College of Surgeons on patient satisfaction with general surgery found similar concerns and the results encouraged the researcher to comment:

> *'The communication and information issues addressed in this small study indicate that there exists a great potential for enhancing the average surgical patient's knowledge, communicative competence and sense of personal responsibility through the careful design and timely provision of a range of standardised printed information. So many of the frustrations patients report appear to stem partly from their disposition (helplessness/anxiety) and partly from their inability to grasp or tendency to misinterpret aspects of the system into which they are drawn'.* (Meredith, 1991B)

If hospital managers are looking for a priority area to begin making improvements from the patient's perspective, information and communication probably deserve that honour.

Questions about information and communication

1 Do you feel that the nurses and doctors have told you enough about your treatment?

☐ Yes

☐ No

Comments ....

2 Did they explain things so that you could understand?

☐ Yes

☐ No

Comments ....

3 Did they listen to what *you* had to say?

☐ Yes

☐ No

Comments ....

4 Did they answer your questions fully enough?

☐ Yes

☐ No

Comments ....

5 Were there times when you had difficulty finding out what you wanted to know?

☐ Yes

☐ No

Comments ....

6 Did the information you were given correspond with what actually happened?

☐ Yes

☐ No

Comments ....

7 Do you know what is going to happen to you next?

☐ Yes

☐ No

Comments ....

8 Did the nurses or doctors usually seem too busy to answer your questions

	Doctors	Nurses
Yes	☐	☐
No	☐	☐

Comments . . . .

9 If you saw other staff (for example, physiotherapists, x-ray staff, etc) did they explain what was going to happen to you?

☐ Yes, everyone

☐ No, some did not

☐ Not applicable

If no, please specify . . . .

10 Do you feel that you relatives were kept well informed about your condition?

☐ Yes

☐ No

Comments . . . .

11 Were there times when you had questions but didn't know who to turn to for answers?

☐ Yes

☐ No

Comments . . . .

12 Were there any members of staff who you would have liked to talk to but had difficulty contacting?

☐ Yes

☐ No

If yes, please describe ....

13 Were you confused or frightened at any time?

☐ Yes

☐ No

If yes, did anyone reassure you? ....

14 Did you ever want more written information?

☐ Yes

☐ No

If yes, what information was it?

15 Do you have any suggestions about how we can improve the information we provide you with?

Ward environment and facilities

This is an area which is nearly always included in questionnaires to inpatients, often in a detailed fashion and sometimes to the virtual exclusion of other aspects. The 'hotel services', as they are sometimes called, appear to be an area which everyone agrees patients can make useful comments about.

Often different aspects are examined separately and in detail. For example, catering has been the subject of many studies (for example, Cheltenham and District Health Authority, 1987; Torbay CHC, 1987; Preston Health Authority, 1989; Wakefield CHC, 1990; Milton Keynes CHC, 1990). It has been reported that some health authorities are considering the adoption of a rating system similar to that used in commercial catering (Lewis, 1990) and Wessex Regional Health Authority has produced an Egon Ronay style consumer guide to hospital food in the region.

Such measures are welcome because catering and other facilities are often sources of dissatisfaction to patients, particularly to those of other religions and cultures who require a different diet or particular washing arrangements. Washing, bathing and toilet facilities, noise at night, and amenities to prevent boredom, are all frequent areas of dissatisfaction for patients (Jones, Leneman, MacLean, 1987). Perhaps guides or rating systems can be developed to cover these other 'hotel' facilities.

Questions about ward environment and facilities

1 Was the ward temperature usually right for you?

☐ Yes

☐ No

Comments . . . .

2 Was the bed comfortable?

☐ Yes

☐ No

Comments . . . .

3 What was the standard of cleanliness like? (Think about toilets, bathroom, etc, as well as the ward.)

☐ Everywhere was clean enough

☐ Some places were not clean enough, particularly . . . (please describe)

. . . .

4 What were the meals like? Were they big/small enough, hot enough, tasty enough?

Yes, they were fine

No, they were poor because (please describe)

. . . .

5 Were you often disturbed while sleeping or resting?

☐ Yes

☐ No

Comments . . . .

6 Did any of the ward rules bother you, for example, waking time, lights out, visiting time?

☐ No, the rules were fine

☐ Yes, some of the rules bothered me, particularly

. . . .

7 Could you easily get to the TV and radio when you wanted, and get away from them when you didn't?

☐ Yes

☐ No

Comments . . . .

8 Could you get access to papers, magazines, books and telephones when you wanted them?

☐ Yes

☐ No

Comments . . . .

9 Did you have a place where you could keep your personal belongings safe?

☐ Yes

☐ No

Comments ....

10 Was it easy to find your way around the hospital or was the signposting poor?

☐ It was easy to find my way

☐ The signposting was poor

☐ Don't know

11 Did you find that other patients on the ward caused you distress?

☐ Yes

☐ No

Comments ....

12 Do you have any suggestions about how the ward environment and facilities could be improved?

Discharge and outcome

There is a risk that if surveys are consistently carried out on the ward, patient views about discharge procedure and outcome will be overlooked. Patients, particularly the elderly who are generally only too keen to express gratitude about their health care, consistently find problems with discharge procedure and aftercare co-ordination, and so it is important that this area is not neglected.

For example, qualitative research carried out be the British Market Research Bureau for Eastbourne, Brighton and Hasting's health authorities (British Market Research Bureau, 1991) discovered that from the patient's point of view the discharge procedure has gone smoothly when the following had taken place:

- ★ The appropriate doctor was available, on time, to examine the patient and declare him or her well enough to go home.
- ★ One of the staff had taken the trouble to check in advance that there would be someone to collect the patient and someone to help him or her manage at home.
- ★ Notes and advice were given to the patient to take home to ease any anxiety about being away from immediate medical care.
- ★ Any medicine was ready when the patient left, so that a return visit to collect it was not needed.
- ★ Any further appointment was clearly given, in writing, including the time and date of the appointment, and where to go within the hospital.
- ★ The patient had been given a letter to take to his or her GP. This procedure provided the patient with the welcome reassurance that medical supervision would continue.

Those involved in the study reported many problems, including: the appropriate doctor not being available to discharge the patient; changes in the date of discharge causing anxiety and inconvenience; medicine being supplied without instruction or explanation; medicine not being ready on time; and lack of knowledge about whether their GP had been informed.

When the researchers carried out a large scale (quantitative) survey, they found that although 50 per cent of the total number of respondents had received only a few hours warning, 76 per cent felt the warning was 'perfectly adequate' and only 20 per cent would have liked more. This suggests that for many but not all patients, a few hours is adequate. Other studies have shown that elderly patients in particular are likely to require more warning. A study of discharged patients aged 60 years or over found that a third of a sample of 115 patients were dissatisfied with the notice of discharge given. A third of respondents were informed on the day they went home (Harding and Modell 1989).

Although 86 per cent of respondents in the BMRB study had been given instructions on leaving hospital about what should and should not be done, only 28 per cent of these had received written information. Also, 20 per cent had received no instructions at all. The figures varied widely between specialities and also between the same specialities across districts, showing inconsistency of practice.

There was a fairly even split between those who were given a letter to their own doctor and those who were not (47 per cent yes, 49 per cent no) and again wide differences occurred between specialties within a district and in the same specialty across districts.

Again elderly people have been found to be particularly at risk from lack of written information and poor communication between hospital and those taking on care of the patient after discharge - for example carers, GP, district nurses, home helps or others (Armitage, 1985; Bowling and Betts, 1985; Harding and Modell, 1989; Williamson, 1985). Williams and Fitton 1991 carried out a comparison of 133 randomly selected patients aged 65 years and over who had been readmitted in emergency within 28 days of discharge and a matching control group of 133 patients who were not readmitted. They found that carer problems were important principal and contributing reasons for readmission. Carers of readmitted patients experienced more problems, frustrations and concerns than the carers of control patients, leading them to suggest that communication between professionals and carers should be improved and, in particular, that the needs of carers should be assessed before discharge of patients from hospital.

Uncertainty as to prognosis ranked very highly among the main concerns of carers. The researchers found that many commented that their feelings of helplessness and despair were exacerbated by not knowing how the patient's condition was likely to progress, what would happen and for how long they would have to maintain their role. This led them to conclude:

'It is necessary to communicate information and give the carer an understanding of the patient's medical condition and prognosis. Early support by district nurses, social workers and general practitioners is also necessary.' (Williams, Fitton, 1991, p108.).

It is clear that problems associated with inadequate checking of home circumstances, poor information provision, insufficient notice of discharge, and inconsistent community support appear to be common enough to provide a key to where improvements are likely to be necessary (see also GLACHC, 1991).

Questions about discharge and outcome

1 Do you feel it was the right decision to discharge you on the day it occurred?

☐ Yes

☐ No

Comments ....

2 How much warning that you were to leave hospital did you have?

A few hours

A day

1-2 days

3 or more days

3 Did you feel that the warning was adequate?

☐ Yes

☐ No

Comments ....

4 Did you have to wait to be discharged after the time arranged?

☐ Yes

☐ No

If yes why was this ....

5 Were you happy about the arrangements made for you to get home?

☐ Yes

☐ No

Comments ....

6 Did everything go smoothly?

☐ Yes

☐ No

If no, what went wrong? ....

7 If you were given medicine to take home are you clear about what it is for and when you must take it?

☐ Yes

☐ No

☐ Not applicable

Comments ....

8 Has someone explained to you how you can help yourself to get better now you are at home?

☐ Yes

☐ No

Comments ....

9 Have you been given any written information about what you can do to help yourself?

☐ Yes

☐ No

Comments ....

10 Have you been given the name and address of any self-help organisation which may be able to provide you with further information and support?

☐ Yes

☐ No

☐ Does not apply

If no, would you be interested in receiving details of an organisation?

11 Have you been given written notice of the date, time and place of any follow up appointment?

☐ Yes

☐ No

☐ Not applicable

12 Have arrangements been made for you to receive care or support at home?

☐ Yes

☐ No

☐ Not applicable

Comments ....

13 If arrangements for you to receive care at home have been made are they running smoothly?

☐ Yes

☐ No

☐ Not applicable

Comments ....

14 Do you feel that the treatment you received in hospital has improved your condition?

☐ Yes, I feel much better

☐ I'm not sure yet

☐ No, I feel worse

15 If you feel better, which aspect of your treatment most helped you to improve?

16 If you feel worse, what do you think kept you from improving?

Day cases

A growing number of patients are being treated in hospital on a one day only basis. The fact that they are usually discharged the same day means that many of the details important to patients staying a night or more may not apply to them and other aspects may become significant. Common sense suggests that factors which help them to prepare for the operation or procedure and those which relieve anxieties and help them to recover at home are likely to be particularly important, but there appears to be a lack of qualitative research on patient views in this area.

The surveys that have been reported tend to be of satisfaction with day cases in other countries and/or looking at whether day surgery for a particular condition is acceptable to patients (for example, Davies, Horrocks, 1989; O'Connor, Gibberd, West, 1991; Harju, 1991).

There appears to have been little research to find out what factors are important to patients who are about to have or have had day case treatment. The Audit Commission (see useful addresses) carried out 'a number of' unstructured discussions with patients before piloting the questionnaire included in Measuring Quality: The patient's view of day surgery (1991).

This publication includes clear instructions for use of the questionnaire, details of a separate questionnaire for parents of children undergoing treatment, and a computer disk containing ready formatted files for entering data onto the computer and some basic tabulations of results.

The Audit Commission questionnaire is reasonably detailed although it includes a list of aspects of care to which only a satisfied/dissatisfied/not applicable response is possible. This may not be sensitive enough to pick up problems in those areas mentioned. However, space for comments is provided at the end and this may help to encourage users to think about issues in more detail and report on items not mentioned. Certainly those who want to find out the views of day case patients quickly, easily and in a way which enables comparison with other hospitals using the same questionnaire, should go for the Audit Commission package.

Those who want to carry out a more detailed study of patient's views about day cases would be well advised to start at the beginning and carry out an interview study of patients. Interviews both before and after surgery/investigation will elicit the patient's main pre- and post-procedure worries and expectations which will probably indicate that particular types of information are necessary to prepare the patient and enable him or her to cope after the procedure. An American study comparing two day cases settings where patient teaching styles differed showed that patients were more worried about post-operative discharge instructions at the site that did little formal teaching than at the one which considered teaching to be critical to patient care and allotted it sufficient time (Icenhour, 1988).

A survey of day case treatment at Bedford General Hospital (North Bedfordshire CHC, 1987) found that information, both pre- and post-procedure, was inconsistent and often inadequate. Too much of the information was conveyed in verbal form only. A worrying 66 per cent of patients said they had received no advice or information about what to do at home if after-effects developed or worsened.

The Bedford study, which used a more detailed questionnaire than that designed by the Audit Commission, also highlighted problems with patients having had a general anaesthetic being discharged earlier than they should have been, having problems getting home, having ill-effects and incapacity and not having follow-up contact with GP or community nurse.

In sum, although day case treatment is a growing area it is under-researched as far as the location of issues important to patients is concerned and further research is needed before typical problems, anxieties and dissatisfaction can be identified.

Summary

An examination of regularly used inpatient questionnaires has suggested that the pioneering Raphael questionnaire is now out of date but HPAU's 'what the patient thinks' and CASPE's PATSAT system could be useful in the right circumstances. The PJHQ, developed in the USA, might be useful if subjected to expert adaptation and piloting in Britain.

There has been enough research on the inpatient experience to enable individual hospitals or districts to construct questionnaires from existing information to suit local requirements and example questions and response formats have been given. Day case has been less well researched and so it is probably advisable to use the Audit Commission questionnaire package or conduct interviews with patients to establish their priorities before developing a questionnaire.

Again, it is worth emphasing that self-completion questionnaire surveys should not be the only method used to gain an insight into patients' views about care they receive. Apart from the fact that many people are unable to complete them, questionnaires are an impersonal and formal way to collect views. Research consistently shows that customers of all kinds, including patients, prefer personal care and attention. (Cleary and McNeil, 1988; Heffring, Neilsen, Sklarz, Dobson, 1991; Kalafat, Siman, Walsh, 1991; Calnan, 1991). Surveys do not provide a very good example of a person-centered attitude towards service provision, necessary though they may be to collect information from large numbers of people.

One way to achieve a personal approach to user feedback, while retaining the efficiency of the survey, is to use the survey in combination with one or two other methods. Inpatient care provides opportunities for a wide range of approaches to feedback. For example:

- ★ patient advocates (Holmes, 1991)
- ★ interviews by patient representatives while on the ward (Kalafat, Siman, Walsh, 1991)
- ★ interviews at discharge by staff (Taylor, 1991)
- ★ post-dischage interviews at home by 'patients perception group' of staff and CHC secretary (Harding, 1990)
- ★ display boards with named individuals who can be contacted for help (Palmer Community Hospital in Sunday Times Best of Health, 1989)
- ★ display boards with information on how to make suggestions and complaints (Bolingbrooke Hospital in Sunday Times Best of Health, 1989)

Whichever methods are used, it is essential that they are part of wider strategy to ensure service quality and one in which the views and suggestions of staff are an important component.

5 CONCLUSION

Despite the high profile that 'patient satisfaction' has received in recent years there is still uncertainty about how to obtain the views of service users among health care professionals. This is understandable because although many of the methods available have been tried out and tested in the social sciences, their application to specific health service settings is new. This is particularly the case in some areas, such as the casualty department.

It is not a simple procedure to adapt social science techniques, such as surveys and focus group discussions, in order that they can become a management tool for monitoring service quality from the user viewpoint. In these circumstances, the method used is only one part of a wider system for ensuring service quality, and guidance on the setting up of quality systems or quality management does not always include sufficient detail of how specific user feedback methods and techniques will fit into the system.

One exception is the quality programme described by Kalafat, Siman, and Walsh, 1991, which provides details of a built in 'patient response system'. The system which includes interviews by patient representatives also details where the collected data goes and how it is used.

Another valuable aspect of this programme is that it recognises the importance of personal contact. When complaints are received by the patient representatives they are conveyed by both phone and standard form to a person designated in each department to respond to patient complaints. It is the contact person's responsibility to convey concern to the patient, whether action has been taken or not. The problem and its resolution are then forwarded to a research and evaluation section.

The three top priorities in the reporting system for maintaining service quality described by Kalafat, Siman, and Walsh are:

- ★ The provision of systematic feedback concerning compliments to medical centre staff.
- ★ The provision of a response to every patient who expresses a concern.
- ★ The identification and resolution of systematic problems at the middle-management (department head) level if possible.

This approach, described by the writers as a combination of 'high-tech automation and high-touch personal contact' seems to be exactly what is needed in the adaptation of information – gathering techniques to a system which aims to ensure a patient-oriented quality service.

All customers, whether internal or external: patients, relatives, GPs, or staff in other departments, benefit from personal attention. But this must be set against the necessity of dealing with large numbers of people and collecting masses of information. This is one of the problems that quality improvement systems have to tackle.

One of the solutions is to improve methods of communication. As far as professional/staff and patient communication is concerned this is a major area for improvement and a number of developments are possible. The Patient's Charter is a step in the right direction but more effort needs to be put into helping patients realise what it means to them. Their 'rights' should be spelt out and the implications made clearer.

The 'rights' will mean more to the patients if they are adapted to the local context so that individual patients attending particular hospitals know what to expect. A well-publicised hospital charter which describes service aims such as that published by Pilgrim Hospital in Boston, Lincolnshire (Sykes and Teasdale, 1989) is a good idea because it begins the process of improving dialogue between staff and patients. This will be a long process but a charter is the first step.

Those who want to construct their own charter of patient's rights might find useful the very detailed section on 'patient's rights and special needs' in the consumer checklist published by the King's Fund Organisational Audit Programme.

If this kind of charter is backed up with the development of better information for patients, in written and other formats, then patients will be able to make informed comments about their care when asked.

This is an area ripe for development and it would be a sad state of affairs if a reviewer in ten years time were able, as Jones, Leneman and MacLean were in 1987, to say they found 'no evidence of any real improvement' since the problem of poor staff-patient communication was articulated in the 1960s.

The rights will mean
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Pilgrim Hospital in Boston
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but a charter is the first

Those who want to
rights might find useful
rights and special needs
the King's Fund Organisation

If this kind of charter
better internal
then patients will be
their care which

This is an area
of affairs
Lenorman and
evidence
staff-patient

USEFUL ADDRESSES

Answers Software
Argent Computer Services
191/5 Shenley Road
Borehamwood
Herts WD6 1AW
(081-207 1929)

Association of Community Health Councils for England and Wales (ACHCEW)
30 Drayton Park
London N5 1PB
(071-609 8405)

Audit Commission
1 Vincent Square
London SW1P 2PN
(071-828 1212)

British Market Research Bureau
Saunders House
53 The Mall
Ealing
London W5 3TE
(081-567 3060)

CASPE
14 Palace Court
Bayswater
London W2 4HT
(071-229 8739)

College of Health
St Margaret's House
21 Old Ford Road
London E2 9PL
(081-981 6719)

Health Policy Advisory Unit (HPAU)
14-18 West Bar Green
Sheffield S1 2DA
(0742 729556)

Patients' Association
8 Victoria Park Square
Bethnal Green
London E2 9PF
(081-981 5676)

Pilgrim Design-A-Questionnaire (PDQ)
Medical Physics Department
Pilgrim Hospital
Sibsey Road
Boston Lancs PE21 9QS
(0205 364801)

Q-Aid I
nitiative Software Applications Ltd
10 The Square Market
Harborough
Leicestershire LE16 7PA
(0858 464622)

Social and Market Survey Research Ltd (SMSR)

Victoria House
82 Beverly Road
Hull HU3 1YD
(0482 211200)

REFERENCES

Ahmad M. 'Inpatient satisfaction survey in Birch Hill Hospital, Rochdale', Master of Public Health Thesis, University of Liverpool.

Armitage S. 'Discharge referrals – who's responsible? Nursing Times, 20.2, 1985.

Atha C. 'The role of the CPN with clients who deliberately harm themselves'. In Charles Brooker (Ed). Community psychiatric nursing: A research perspective. Chapman and Hall, 1990.

Audit Commission. Measuring Quality: The patient's view of day surgery. HMSO, 1991.

Barnes E. People in Hospital. London, Macmillan, 1961 (1981).

Beeton K. 'Do patients' perceptions of physiotherapy change after discharge?'. Certificate in research methodology. Polytechnic of East London, 1991. Copy in King's Fund Centre Library.

Bowling A, Betts G. 'Communication on discharge'. Nursing Times, 15.8.1985.

Bradbury Y, Lewis B. 'North Western Regional study of accident and emergency services' 1982. Department of management services UMIST. Copy in North Western RHA Library and King's Fund Centre Library.

British Market Research Bureau. 'Patient satisfaction amongst hospital in-patients: A report on qualitative research'. January 1991. 'Report on a survey of hospital in-patients in three District Health Authorities', November 1991. Copies of these reports can be obtained from Eastbourne Health Authority, 9 Upperton Road, Eastbourne, BN21 2BH. Also copy in King's Fund Centre library.

Buckles E, Carew-McColl M. 'Triage by telephone'. Nursing Times, 6 February, vol 87, no 6, 1991: 26-28.

Burbach F, Quarry A. 'Quality and outcome in a community mental health team'. International Journal of Health Care Quality Assurance, vol 4, no 2, 1991: 18-26.

Callaghan B, Coote A, Hulme G, Stewart J. 'Meeting needs in the 1990s'. Institute for Public Policy Research, 1991: 30-32. Southampton Street, London WC2E 7RA.

Calnan M. 'Towards a conceptual framework of lay evaluation of health care'. Social Science and Medicine, 1988, vol 27, no 9: 927-933.

Calnan M, Williams S. 'Please treat me nicely'. The Health Service Journal, 17 January, 1991: 25.

Caple T, Deighan Y. Managing Customer Relations. North West Thames Regional Health Authority, 1986.

Carew-McColl M, Buckles, E. 'A workload shared'. The Health Service Journal, 4 January, 1990: 27.

Carr-Hill R, Dixon P, Thompson A. 'Too simple for words'. The Health Service Journal, June 15, 1989: 728-729.

Cartwright A. Human Relations and Hospital Care. London, Routledge Kegan Paul, 1964.

Cartwright A. Health Surveys in Practice and in Potential. London, King Edward's Hospital Fund for London, 1983 (Reprint 1988).

Cheltenham and District Health Authority. Delancy Hospital, Hospital Meals, Patient Satisfaction Survey, 1987.

Cleary P, McNeil B. 'Patient satisfaction as an indicator of quality care'. Inquiry, 25, Spring 1988: 25-36.

Davies A, Horrocks M. 'Patient Evaluation and complications of daycase herniorrhaphy under local anaesthetic'. Journal Royal College of Surgeons, vol 34, June 1989: 137-139.

Davies T. 'Accidnent department or general practice?' British Medical Journal, vol 292, 1986: 241-243.

Davison AG et al. 'Use and misuse of an accident and emergency department in the East End of London. Journal of the Royal Society of Medicine, vol 76, 1983: 37-40.

Dixon, P, Carr-Hill R. Customer feedback surveys – a review of current practice. Part III of Carr-Hill, McIver and Dixon. The NHS and its customers. University of York, Centre for Health Economics, 1989.

Donabedian A. 'The definition of quality and approaches to its assessment'. Explorations in quality assessment and monitoring, vol 1. Ann Arbor, Michigan, Health Administration Press, 1980.

French K. 'Methodological considerations in hospital patient opinion surveys'. International Journal of Nursing Studies, vol 18, 1981: 7-32.

Fitzpatrick R. 'Surveys of patient satisfaction: II – Designing a questionnaire and conducting a survey'. British Medical Journal, vol 302, 11 May, 1991: 1129-1132.

Gibson A. 'Assessing user satisfaction: A discussion of methodological issues relating to surveys in accident and emergency departments'. Social and Market Survey Research, 1991.

Gibson A. 'Quality of personal care: A study of patients and their relatives'. Social and Market Survey Research, 1991.

Gibson A, Walsh J. 'Satisfaction with an A&E department'. Social and Market Survey Research, 1990.

Glasser B, Dennis N. 'An appraisal of people centred health care in relation to injuries'. College of Health, July 1991.

Good Practices in Mental Health/Camden Consortium. Treated Well? A code of practice for psychiatric hospitals. London, Good Practices in Mental Health, 1988.

Greater London Association of Community Health Councils, London's Acute Health Services. A user perspective. King's Fund London Acute Services Initiative, 1991.

Green J. 'Half the aggro' Health Service Journal, October 24, 1991.

Hadfield, L. 'In search of excellence in A&E'. Nursing Standard, 25, vol 3, 1989.

Hansagi H, Edhag O, Allebeck P. 'High consumers of health care in emergency units: How to improve their quality of care'. Quality assurance in health care. vol 3, no 1, 1991: 51-62.

Harding H. 'What does the patient think'. Information distributed by Northern RHA at the 1990 quality of care exhibition at Birmingham Exhibition Centre.

Harding J, Modell M. 'Elderly peoples' experiences of discharge from hospital'. Journal of the Royal College of General Practitioners, 39 (January) 1989: 17-20.

Harju E. Patient satisfaction among day surgery patients in a central hospital. Quality Assurance in Healthcare, vol 3, no 2 1991: 85-88.

Hays R, Larson C, Nelson E, Baltalden P. 'Hospital trends: A short-form patient-based measure'. Medical Care, vol 29, no 7, July 1991: 661-668.

Head S. 'Nurse practitioners: The new pioneers'. Nursing Times, vol 84, no 26, 1988: 27-28.

Heffring M, Neilson E J, Sklarz M, Dobson G. 'High tech, high touch: Common denominators in patient satisfaction'. Hospital and health service administration, March/April 1986.

Hill J. 'Patient evaluation of a rheumatology nursing clinic'. Nursing Times, 2 July, 1986: 42-43.

Holohan A M, Newell D J, Walker J H. 'Practitioners, patients and the accident department'. The Hospital and Health Services Review, March 1975: 80-87.

Holohan A. 'Accident and emergency departments: illness and accident behaviour'. Sociological Review Monograph, 22, 1976: 111-119.

Holmes P. 'The patient's friend'. Nursing Times, vol 87, no 19, 8 May, 1991: 16.

Horder J, Moore G. 'The consultation of health outcomes'. November, 1990: 442-443.

Hunt M T, Glucksman M E. 'A review of 7 years of complaints in an inner-city accident and emergency department. Archives of Emergency Medicine, 8, 1991: 17-23.

Icenhour M. Quality interpersonal care: A study of ambulatory surgery patients' perspectives. Aorn Journal, vol 47, part 6, 1988: 1414-1419.

IHSM/ACHEW. Managing A&E: A guide to good practice in management of accident and emergency departments. IHSM, 75 Portland Place, London, WIN 5AN. 1988.

Jacoby A. Possible factors affecting response to postal questionnaires: Findings from a study of general practitioner services. Journal of Public Health Medicine, vol 12, no 2, 1990: 131-135.

James M. Nurse practitioners in accident and emergency. Nursing Times, vol 86, no 49, 1990: 51.

Jones L, Leneman L, Maclean U. Consumer Feedback for the NHS: A literature review. London, King Edward's Hospital Fund for London, 1987.

Kalafat J, Siman M, Walsh L. 'A systemic health care quality service programme'. Hospital and Health Services Administration, 36, 4, Winter 1991: 571-588.

Laurent C. 'Spotting trouble in A&E'. Nursing Times, 8 May, vol 87, no 19, 1991: 56-57.

Levenstein J, McCracken E, McWhinney I, Stewart M, Brown J. 'The patient-centred clinical method. (1) A model for doctor-patient interaction in family medicine'. Family Practice, vol 3, no1, 1986: 24-30.

Lewis R. Hospitals to get star ratings? International Journal of Healthcare Quality Assurance, vol 3, no1, 1990: 31-32.

Luck M, Lawrence B, Pocock B, Reilly K. Consumer and Market Research in Health Care. London, Chapman and Hall, 1988.

McGhee, A. The patient's Attitude to Nursing Care. Edinburgh and London, Livingstone, 1961.

McIver S (A). An Introduction to Obtaining the Views of Users of Health Services. London, King's Fund Centre, 1991.

McIver S (B). Obtaining the Views of Outpatients. London, King's Fund Centre, 1991.

McIver S (C). Obtaining the Views of Users of Mental Health Services. London, King's Fund Centre, 1991.

Macclesfield CHC. A report on a survey of the accident and emergency department, Macclesfield District General Hospital, 1986. Copy held at the King's Fund Centre.

Meredith P (A). Audit and the quality of clinical care: Patient satisfaction. Annals of the Royal College of Surgeons, College and Faculty Bulletin. May 1991, vol. 73, no 3: 51-54.

Meredith P (B). Patients' satisfaction with general surgery. Research in progress, Surgical Audit Unit, Royal College of Surgeons, 1991.

Meterko M, Nelson E, Rubin H (Eds). Patient judgements of hospital quality: Report of a pilot study. Medical Care, 28, 1990 (Supplement).

Milton Keynes CHC. Survey of food at Milton Keynes District Hospital, 1990.

Mitchell F P. Timeliness of care in the accident and emergency department. Hospital and Health Services Review, May 1987: 127-131.

Morgan-Cooke M. Consumer Surveys. Southmead HA, 1991. Copy in King's Fund Centre Library.

Nelson E, Hays R, Larson C, Batalden P. The patient judgement system: Reliability and validity. Quality Review Bulletin, June 1989: 185-191.

Nelson E, et al. The patient comment card: A system to gather customer feedback. Quality Review Bulletin, September 1991: 278-285.

North Bedfordshire CHC. A survey of daycase treatment, 1987. Copy in King's Fund Centre Library.

O'Connor S, Gibberd R, West P. Patient satisfaction with day surgery. Australian Clinical Review, 11, 1991: 143-149.

Peterson M. Measuring patient satisfaction: Collecting useful data. Journal of Nursing Quality Assurance, 2, 3, 1988: 25-35.

Preston Health Authority. Catering services, patient satisfaction survey, 1989.

Raftery J, Zarb G. Satisfaction guaranteed? The Health Service Journal, 15 November, 1990: 1692-1693.

Raphael, W. Survey of patients' opinion surveys in hospital. King's Fund Project Paper no. 9, 1974.

Raphael, W. Patients and their hospitals. London, King Edward's Hospital Fund for London, 1977. (third edition).

Richmond P W, Evans R C. 'Complaints and litigation - three years experience at a busy accident and emergency department, 1983-85'. Health Trends, vol 21, 1989: 42-45.

Roter D, Hall J, Katz N. 'Relations of physicians' behaviours to analogue patients' satisfaction, recall, and impressions'. Medical care, 25, 1987: 437.

Salkovskis P, Storer D, Atha C. 'A&E: Defining the problem'. Nursing Times, 19 April, vol 85, no 16, 1989: 50-52.

Singh S. 'Self referral to accident and emergency department: Patients' perceptions'. British Medical Journal, vol 297, 1988: 1179-1180.

Southmead Health Authority. 'Survey into the waiting times in the accident and emergency department', 1988. Copy in King's Fund Centre library.

Sullivan S. Report of the research into an A&E department. October 1989. Copy in King's Fund Centre library.

Sunday Times Best of Health. 'Winning entries for hospital of the year 1989'. Sunday Times/Anderson Consultant Health Care Practice. Copies from: The Institute of Health Services Management. 75 Portland Place, London WIN 4AN.

Swindon Health Authority. 'A report following investigations into patient satisfaction with the accident and emergency reception area within the Princess Margaret Hospital. 1987. Copy in King's Fund Centre library.

Sykes P, Teasdale K. 'Door to open dialogue'. The Health Journal, 9 November 1989: 1374.

Taylor L. 'The Princess Grace Hospital - assuring quality'. National Association of Quality Assurance in Health Care Journal, Spring, issue 4, 1991: 8-10.

Torbay CHC. Catering survey at the Torbay General Hospital, 1987. Copy in King's Fund Centre library.

Wakefield CHC. Survey of patient catering service, 1990.

Walker R. Applied Qualitative Research. London, Gower, 1985.

Walsh, M. 'Why do people go A&E?'. Nursing Standard. 7 November, vol 5, no 7, 1990: 24-28.

Walsh, M. 'Patient's choice: GP or A&E department'. Nursing Standard. 28 November, vol 5, no. 10, 1990: 28-31.

Ware J, Hays R. 'Methods for measuring patient satisfaction with specific medical encounters'. Medical Care, vol 26, no 4, 1988.

Williams E, Fitton F. 'Survey of carers of elderly patients discharged from hospital'. British Journal of General Practice, 41, March 1991: 105-108.

Williamson V. 'Who really cares? A survey on the aftercare of elderly patients discharged from acute hospital'. Brighton Community Health Council, 1985. Copy in King's Fund Centre library.

Willson P, McNamara J. 'How perceptions of a simulated physician-patient interaction influence intended satisfaction and compliance'. Social Science and Medicine, 16, 1699, 1982.

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