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Complaints and patient satisfaction: a comprehensive review of the literature



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Complaints and patient satisfaction:
a comprehensive review of the literature

Duration of project
February to April 2009

Search period
1950 to April 2009

Key words searched

- Customer satisfaction
- Consumer satisfaction
- Client satisfaction
- Patient satisfaction
- Customer complaint
- Patient complaint
- Client complaint
- Patient grievance
- Client grievance
- Consumer grievance
- Customer grievance
- Consumer satisfaction
- Patient satisfaction
- Quality of health care
- Total quality management
- Management quality circles
- Quality control
- Quality assurance (health care)
- Quality indicators (health care)

Databases searched

- The Cochrane Collaboration Cochrane Reviews
- Embase from1980
- CINAHL from 1982
- Medline
- MEDLINE In-Process and Non Indexed Citations

Criteria applied

- Patient satisfaction pertaining to quality of care or patient experience
- Patient complaints pertaining to quality of care or patient experience
- Patient grievances pertaining to quality of care or patient experience

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1. INTRODUCTION

The Centre for Clinical Governance Research (CCGR) was asked by Statewide Quality Branch in March 2009 to identify, review and synthesise evidence on a range of topics intended to support the *Understanding clinical practice toolkit*. This review analyses the literature on *complaints* and *patient satisfactio*n in relation to the assessment and improvement of clinical governance and clinical practice.

The review uses the protocol for the rapid assessment, conceptualization, and timely concise analysis of the literature [PRACTICAL], Jeffrey Braithwaite had the idea of labelling the Centre's mode for reviewing literature 'PRACTICAL'. This monograph was written by Joanne Travaglia, Jeffrey Braithwaite and Deborah Debono developed by the CCGR. PRACTICAL emerged from CCGR's research in the fields of clinical governance, patient safety, interprofessionalism and accreditation amongst other areas.

In this review we present the results of a comprehensive review of the literature on *complaints* and *patient satisfaction*. The literature was identified using a combination of academic literature database searching and snowball technique. At the end of the review we provide abstracts and citations, arranged alphabetically by author, for the articles identified using the outlined search strategy.

2. BACKGROUND

The need for continuous improvement of quality and safety in the provision of patient care has become axiomatic. The resultant paradigm shift from an acceptance of the status quo to a drive for constant improvement in clinical practice has required the engagement of multiple monitoring and improvement strategies. Patients and their relatives are the only source of data for information on the dignity and respect with which they are treated[1] and the best source of information on patient education and pain-management[1]. Assessment, monitoring and exploration of patient complaints and patient satisfaction data provide one indicator of quality of care,[2] can contribute to clinical care improvement strategies[3] and provide health care consumers input into improvement of health care services and delivery.[4] *The purpose of this report is to identify and review the literature that examines patient complaints and patient satisfaction in the context of clinical practice improvement.*

2.1 Definitions of patient satisfaction and patient complaint

Patient complaint and satisfaction data is used for two purposes. Firstly to evaluate patient care and secondly to predict patient 'consumer' behaviour (ie will they recommend a health care service or return for care in the future)[5]. As this review is concerned with implications of patient complaints and patient satisfaction on clinical care, the use of this data to predict consumer behaviour

is not addressed in the current report.

For the purposes of this report, patient complaints have only included complaints about quality of care rather than complaints about symptoms or side effects of drugs, treatment or illness. The current review did not locate an agreed definition of patient satisfaction. It has been suggested that the definition continues to evolve.[6] Ware et al proposed characteristics of the health care providers and services that influence patient satisfaction[5]. The dimensions of patient satisfaction include: art of care (caring attitude); technical quality of care; accessibility and convenience; finances (ability to pay for services); physical environment; availability; continuity of care; efficacy and outcome of care.[5] A working definition is the degree to which the patient's desired expectations, goals and or preferences are met by the health care provider and or service.

3. METHOD

3.1 Overview of method and research question

We undertook a search of terms associated with patient satisfaction and patient complaints using several academic literature databases and using the snowball method. In an initial scope of the literature, we found that the literature identified using the search terms “patient complaint*” and “patient satisfaction” included a large number of irrelevant references that related to symptoms or side effects of medical conditions and medication related complaints/satisfaction. Through a collaborative process, the search terms, limiters and academic databases to be searched were identified using a combination of brainstorming technique and preliminary scoping of the literature. The search terms used in the review are listed in Table 1.

Combinations of these search terms utilised in the literature search are included in Table 3. To focus the literature search, MeSH terms were used when available.

Table 1: Search Terms used in the academic database search

Search Terms
1. “customer satisfaction”
2. consumer satisfaction
3. “client satisfaction”
4. patient satisfaction
5. “customer complaint$”
6. “patient complaint$”
7. “consumer complaint$”
8. “client complaint$”
9. “patient grievance$”
10. “client grievance$”
11. “consumer grievance$”
12. “customer grievance$”
13. consumer satisfaction
14. patient satisfaction
15. *“quality of health care”/ or *total quality management/ or *management quality circles/ or *quality control/ or *quality assurance, health care/ or *quality indicators, health care/

3.2 The search process

3.2.1 Search of electronic academic literature databases

In the first instance, The Cochrane Collaboration Cochrane Reviews electronic database was searched for reviews on patient/client/consumer complaints. A category labelled *Presence and functioning of adequate mechanisms for dealing with client suggestions and complaints* has been identified within the topic *Effective Practice and Organisation of Care Group*. However, there is no literature listed in this category. The Cochrane Collaboration Cochrane Reviews electronic database was also searched for reviews on patient satisfaction in relation to quality of care. There were no reviews identified. The electronic academic health literature databases, Medline and Medline In-Process and Non Indexed Citations (Medicine literature, EMBASE (1980+) (Biomedical and Pharmaceutical Literature) and CINAHL (Cumulative Index to Nursing and Allied Health Literature), (Table2), were systematically searched in April 2009 using the search terms presented in Table 1. The identified references were downloaded into Endnote X2, a reference management software package.

Table 2: Academic literature databases searched

Databases	Purpose
CINAHL (Cumuliative Index to Nursing and Allied Health Literature)	The most comprehensive resource for nursing and allied health literature
MEDLINE (Medicine)	A literature database of life sciences and biomedical information. It includes medicine, nursing, pharmacy, dentistry, veterinary medicine and health care
MEDLINE In-Process and Non Indexed Citations	In-process database for MEDLINE. Basic information and abstracts prior to indexing with MeSH heading(s) and addition to MEDLINE.
EMBASE (1980+)	A major pharmaceutical and biomedical literature database

Truncation of the search terms allowed for the search of plurals and other suffixes, for example, “complaint$” captured “complaint” and “complaints”. The Boolean terms “AND” and “OR” were used to identify references in which defined combinations of search terms occurred, for example, “patient” and “complaints”. When possible, the limiter “human” was applied to the academic literature database searches. Utilisation of the “FOCUS” and “EXPLODE” tools in Medline and Embase, enabled a targeted and comprehensive literature search in these databases.

3.2.2 Snowball technique and citation tracking

Additional references were identified using the “snowball” technique and citation tracking. This process involved searching for appropriate references identified through other literature but not by the systemic search of academic literature databases. These references were also downloaded into Endnote X2 for later analysis.

3.2.3 Search Findings

The number of references found in each data base by each search term is shown in Table 3. In addition, 11 relevant references were identified via the "snowball" technique.

Table 3: Search results for selected databases

SEARCH TERMS	MEDLINE	MEDLINE IN-PROCESS AND NON INDEXED CITATIONS	CINAHL	EMBASE	TOTAL
1. "customer complaint$"	19	1	8	7	35
2. "patient complaint$"	493	37	150	333	1013
3. "client complaint$"	5	0	3	1	9
4. "consumer complaint$"	32	4	9	13	58
5. "patient grievance$"	11	0	5	2	18
6. "client grievance$"	1	0	0	0	1
7. "consumer grievance$"	7	0	0	1	8
8. customer grievance$"	0	0	0	0	0
9. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8	634	95	174	443	1346
10.consumer satisfaction	4995	0	4484	539	10018
11.patient satisfaction	13031	2	16572	3119	32724
12. 10 or 11	17987	2	173	3636	21798
13."quality of health care"/ or total quality management/ or management quality circles/ or quality control/ or quality assurance, health care/ or quality indicators, health care/	40722	4	31865	13074	452165
14. 12 and 13	2165	0	2415	252	4832
15. 9 or 14	2768	42	2567	695	6072
Total after duplicates removed	5327				

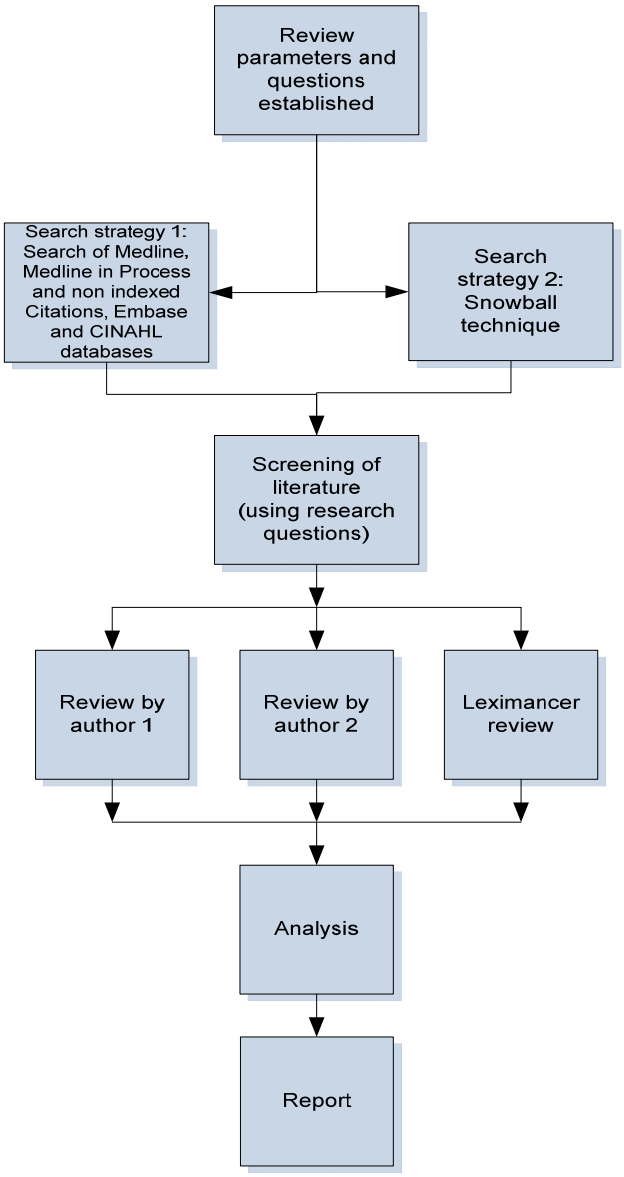
3.3 The review process

This review was conducted in five phases (see Figure 1). In the initial phase, the review parameters were identified. These parameters were in accordance with the requirements of the Statewide Quality Branch. In phase two the search for literature on patient complaints and patient satisfaction measures was conducted. Searches of academic literature databases, snowball technique and citation tracking were undertaken. In phase three, the literature was screened for relevant references. References concerned solely with complaints in relation to litigation, patient satisfaction in relation to specific treatments and irrelevant references that were not pertinent to this review were excluded. Inclusion criteria applied were designed to exclude irrelevant references and are listed in Table 4. In phase four, the literature was reviewed. Literature on the role and measurement of patient satisfaction and patient complaints in relation to quality improvement were selected. The selected abstracts were subjected to data-mining and reviewed by two of the authors. The findings were analysed in phase five and the report written in phase six.

Table 4: Inclusion criteria applied to identified references

Selection criteria	
Patient Satisfaction	Pertaining to clinical practice improvement
Patient complaints/grievances	Pertaining to clinical practice improvement

Figure 1: Review process



3.4 Analysis

The literature search employed the following strategies: a systematic search of selected academic literature databases and "snowball" technique. The first strategy identified 5327 references that met the search criteria. Following the application of the selection criteria (see Table 4) to these references, 544 references remained. The "snowball" technique and citation tracking identified 11 relevant references. Scoping and formal content analysis of the selected literature was conducted.

3.4.1 Content analysis of the selected literature

Using the software program Leximancer 3.0, selected abstracts that met the inclusion criteria (N=555) were subjected to content analysis. The Leximancer software program identifies key themes and concepts in text, the relationship between them and the strength of those relationships. This data is presented as a visual map and as a ranked list of concepts and themes. In the visual map, the concepts are represented by dots. The distance between dots indicates the strength the relationship between the concepts.

4. FINDINGS AND DISCUSSION

4.1 Overview of concepts emerging from the patient satisfaction and complaints literature

The concept map of patient satisfaction and patient complaints is presented in Figure 2. It provides a visual image of the themes and concepts that emerge in the literature, their salience and relationships to each other. It is possible to identify at a glance the concepts that tend to co-occur in the literature, for example, *care* and *satisfaction* and those that are not as strongly related. For example, *customer* and *validity.*

The themes in the reviewed literature overlap. The most salient theme in the literature on patient satisfaction and patient complaints is that of *care*. The four most salient concepts are *care, satisfaction, patient* and *quality***.** The concept of *quality* is linked to *health,* and concepts associated with the measurement of quality such as *research, measure and surveys.* The theme *care* is linked with that of *improvement* through concepts such as *service* and *use*. Some of the discussion in the literature around the concept of *satisfaction* is related to concepts of *experience, expectations* and *nursing***.** The related theme of *patient* contains concepts such as *information, results*, and *data* all of which are related to the concept *patient***.** Interestingly, the theme *patients* does not overlap with that of *patient* but also contains concepts related to *data* such as *study, questionnaire*. It is linked with the theme *survey* through the concept

*developed***.** The theme *patient* is linked with that of *management* through the concept *process* and includes the concepts of *problems, system, customer* and *issues.* The theme *medical* is linked to both the themes *patient* and *patients.* In this theme, concepts including *staff, time, significant* and *treatment* emerge. An outlying theme and concept in this literature is that of *validity.*

Figure 2: Concept map of key concepts relating to patient satisfaction and patient complaints

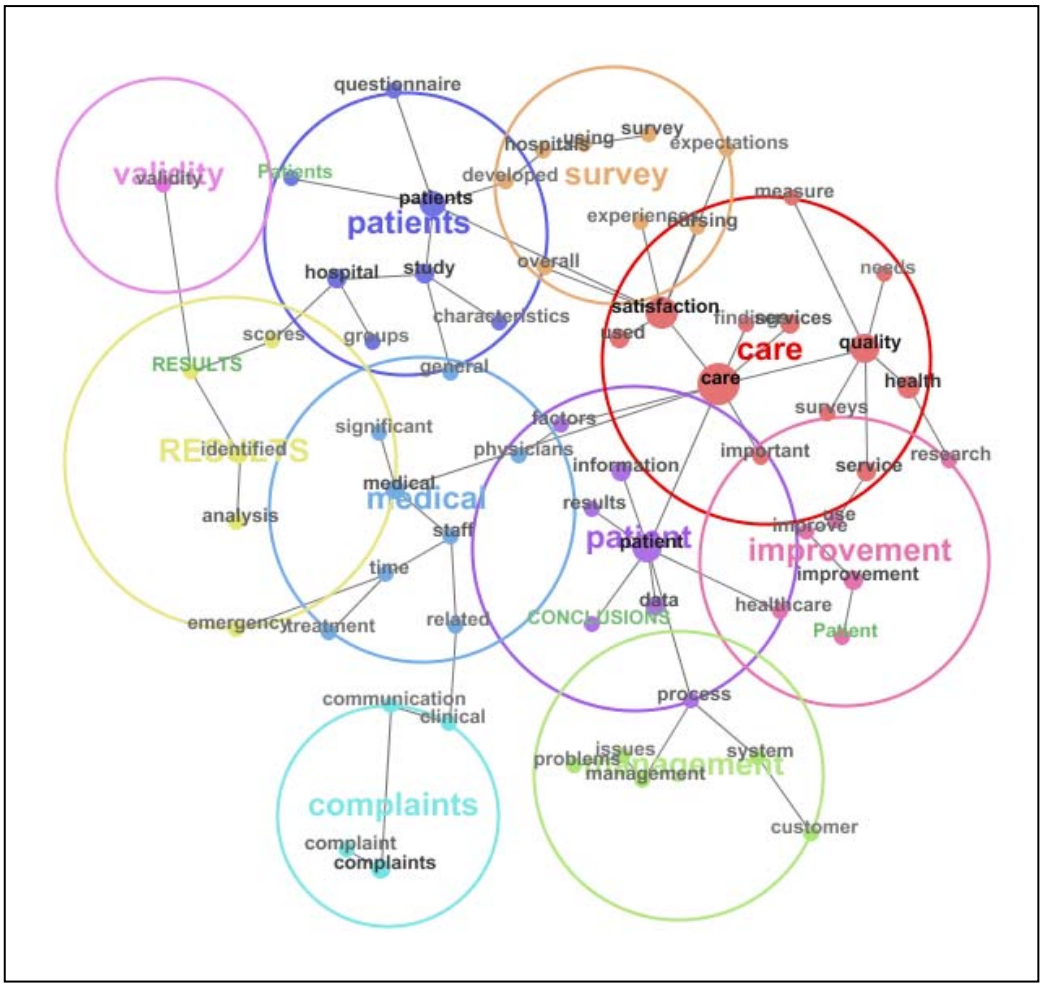


Table 5 below provides a ranked list of word-like concepts. This provides an insight into the salience of the concept in relation to the literature and other concepts. Concepts around patient satisfaction, care, quality, health and complaints are among the nine concepts with the highest relevance. Concepts related to data collection and service *improvement (data, study, information, survey* and *service)* fall within the 35 most highly correlated concepts. The concept of *validity* has a relevance of 6% in the reviewed literature. The citations and abstracts that were interrogated for this analysis are provided (see Appendix C).

Table 5: Ranked map of key concepts (Word-Like) relating to patient satisfaction and patient complaints

Concepts	Count	Relevance

Concepts	Count	Relevance
care	1767	100%
satisfaction	1138	64%
patient	1000	57%
quality	961	54%
patients	791	45%
health	526	30%
complaints	388	22%
study	359	20%
hospital	345	20%
service	265	15%
improvement	253	14%
medical	236	13%
services	230	13%
data	209	12%
used	196	11%
information	195	11%
survey	185	10%
nursing	178	10%
questionnaire	169	10%
using	161	09%
results	159	09%
analysis	155	09%
hospitals	152	09%
staff	150	08%
important	147	08%
use	141	08%
process	131	07%
healthcare	126	07%
improve	123	07%
overall	122	07%
factors	121	07%
complaint	121	07%
research	119	07%
surveys	116	07%
measure	115	07%
management	114	06%
system	110	06%
emergency	106	06%
time	103	06%
validity	98	06%
physicians	97	05%
general	96	05%
problems	94	05%
characteristics	92	05%
experiences	91	05%
clinical	91	05%
expectations	89	05%
groups	86	05%
identified	86	05%
developed	85	05%
related	85	05%
significant	84	05%
findings	84	05%
treatment	84	05%
communication	83	05%
scores	83	05%

Concepts	Count	Relevance
issues	75	04%
customer	75	04%
needs	67	04%

4.2 Discussion

The findings from the data mining described above and an initial preview of the citations informed the selection of three key themes with which to organise and report the identified literature. These broad themes were: confounding factors in the measurement of patient satisfaction, methods for measuring patient satisfaction, effects of patient satisfaction measures, and implications for patient complaint data collection.

4.2.1 Patient satisfaction: confounding variables

A major theme in the reviewed literature is the complexity of capturing a measurement of patient satisfaction that will accurately inform quality care improvement measures. That is, individual patient satisfaction reports may be mediated by other variables. For example, age[7-10], reported health status,[7 10-12] ethnicity,[13 14] gender,[10] engagement with the system, faith and gratitude,[15] perceptions of what constitutes "good" physicians[16] or care[17 18] and time elapsed since reception of care[19-21] have been demonstrated to predict patient satisfaction scores. Adjustment for variables that predict patient satisfaction scores is vital in gaining an accurate measure of patient satisfaction. It is also important to account for the effect of non participation by those with negative views[22] and patient groups such as the elderly, confused and very ill from whom satisfaction data is difficult to obtain[23] in collective patient satisfaction measures. Research suggests that there are core issues such as compassion and care delivery,[24] problems with information and education, coordination of care, respect for patients' preferences, emotional support, involvement of family and friends, continuity and transition,[25] physical comfort,[25 26] empathy, and personalised therapy[21] that affect patient satisfaction across all clinical settings.

4.2.2 The role of patient satisfaction data in quality improvement

The evidence for the role of patient satisfaction data in quality improvement is mixed. While some research reports no effect of feedback based on patient evaluations on behaviour change,[27-29] other studies report the opposite.[30 31] There is evidence that patient satisfaction survey data is under utilised by staff[32] which may contribute to the reported lack of change. Measures relying on complaints have been shown to be more responsive to change than those relying on satisfaction measures.[33]

Measures of patient satisfaction with different components of care may or may not be correlated with each other and with the overall measure of patient satisfaction.[8 34] For example, in the reviewed literature, a correlation between quality care measures (accreditation and patient satisfaction) was not

demonstrated[35] nor a correlation between lower patient satisfaction and poorer ratings of technical process of care.[36]

4.2.3 Methods for measuring patient satisfaction

Most studies rely on multiple criteria of patient satisfaction for quality measurements. To date there is no single universal method for measuring patient satisfaction.[37]The utilisation of both qualitative and quantitative methods to assess patient satisfaction is recommended. A myriad of tools to measure patient satisfaction have been developed. The tools most frequently cited in the literature to measure patient satisfaction are surveys,[7 8 38-43] critical incident technique[44] and questionnaires.[23 45-55] Case studies, interviews[28 56 57] and observation[56] are also used to gather data. A recent review of the literature identified a lack of standardisation in delivery method, of instruments designed to measure patients' assessment of individual physicians and limited construct validity or correlation with other attributes.[58] On the one hand there is a call for standardisation of tools,[59 60] on the other a recognition that different consumer groups, organisational settings and goals (for example benchmarking versus internal quality improvement) call for different techniques.[61 62] As technical quality of care and satisfaction are associated but not the same, both measures of technical quality of care and patient satisfaction are necessary for assessing quality of care.[63]

4.2.4 Patient complaint data

Patient complaint data has been utilised in the quality improvement process[64-67] and has resulted in changes to policy and procedure[68]. However, detrimental effects of patient complaints on doctors and the relationship with their patients[69] and on fragile local health systems[70] and perceptions that complaint data have no effect on quality improvement[71] suggest that the role of complaints in the improvement of delivery of care is complicated. Complaints by health care providers are also an important source of information.[72] Methodological issues associated with the evaluation and processing of complaints,[73] the interpretation of complaint data[74] and the process by which complaint data can best influence decisions about quality improvement[75] have examined. The importance of classifying complaints, calculating the rate of complaints per clinical activity, the mean response time in affecting improvement has been explored[76-78] and a taxonomy to standardise the coding of complaints developed.[79]

5. CONCLUSION

There is an enormous quantity of literature on the measurement of patient complaints and patient satisfaction. While there is support for the role of complaint data in quality improvement measures,[64-67] detrimental effects of complaints and a lack of evidence of their role in supporting quality improvement have also been noted.[69] Consistent coding and analysis of patient complaints is vital if this data is to accurately inform quality improvement measures.

The literature on patient satisfaction examines determinants of patient satisfaction and methods and tools for measuring it in a variety of clinical settings. While patient satisfaction is a concept that is difficult to measure[80] it can provide a method by which problem areas can be identified and improved, and patient safety calculated[81 82] The literature identifies the effects of extraneous variables and discusses the importance of factoring in the impact of these effects when designing the tools,[83] analysing and reporting patient satisfaction data. The values and beliefs of the researcher about what constitutes satisfactory care are also instrumental in the collection of accurate data.[84] The validity and reliability of measures of patient satisfaction have been explored[38] and confounding variables including sampling and methodological issues[23 25] identified. The need for standardised tools and methodology for measuring patient satisfaction is a recurrent theme in the literature.[59 60 85] While the correlation between patient satisfaction measures and quality of care, as assessed retrospectively from patients' notes, and the technical competence of patients to assess quality of care has been questioned,[34 86 87] the importance offrequent patient feedback as a stimulus to quality improvement[31] and policy change[88] has also been documented. Frequent patient satisfaction survey reports were found to be important in changing practices.[31]

Research has highlighted the importance of linking patient reports to each step of the process in the patient journey in the improvement of quality of care[89]. Currently measures of patient satisfaction may not reflect the whole patient journey but rather just the stages at which it is being measured. Further research is needed.

Given the claim that patient complaint and satisfaction data is useful for quality improvement in care, the research literature demonstrating the link between quality improvement measures and changes in patient satisfaction is sparse. So too is the literature examining the effect of changes in care, made in response to patient satisfaction feedback, on repeated patient satisfaction measures. While there is some evidence indication that patient satisfaction scores improve following quality improvement interventions,[29 90 91] other studies are not supportive.[27 92] There is little literature identifying research that examines the quality improvement measures implemented in response to patient satisfaction reports and the impact of those measures on subsequent patient satisfaction measures. Results of such research would be very useful in the identification of the impact of patient satisfaction and complaint data on

quality improvement strategies that incorporate those findings in their design and implementation.

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Appendix A: Evidence sheet

Topic area	Patient satisfaction and patient complaints
Definition:	While there is no agreed upon definition of patient satisfaction or patient complaints identified in the literature. A working definition is the degree to which the patient's desired expectations, goals and or preferences are met by the health care provider and or service.
Origin:	Patient complaints have a long history of use in the health system as a measure of dissatisfaction, but it is only in recent decades that formal patient satisfaction surveys have been used as a measure of the quality of care, and a link between this measure, and patient safety, has been made.
Description:	The measure of patient satisfaction and complaints is an attempt to capture elements of the quality care against patient expectations. These elements include: the art of care (caring attitude); technical quality of care; accessibility and convenience; finances (ability to pay for services); physical environment; availability; continuity of care; efficacy and outcome of care.
Evidence base:	The evidence for the role of patient satisfaction data in quality improvement is mixed. While some research reports no effect of feedback based on patient evaluations on behaviour change, other studies report the opposite. There is evidence that patient satisfaction survey data is under utilised by staff, which may help explain the reported lack of change. Measures relying on complaints have been shown to be more responsive to change than those relying on satisfaction measures.
Current use:	Patient satisfaction surveys and patient complaint letters are widely used in health systems across the world. The tools themselves vary both in type (survey, questionnaire, critical incident technique) and focus. There has been both a call for standardisation of tools and a recognition that different consumer groups, organisational settings and goals call for different techniques.
Applications for clinical practice improvement:	Patient satisfaction surveys and patient complaint data can be easily integrated elements of clinical practice improvement programs. Their effectiveness depends on their construction, their applicability to the service context, and their use as drivers of change.

Appendix B: Examples of studies of patient satisfaction and patient complaints

Table 6: A selection of validation studies of patient satisfaction measurement tools

Author	Country	Purpose	Participants	Design and method	Outcome measures and results	Conclusion
Davis et al (2008)[45]	Australia	A more appropriate tool to measure the client experience of person-centred care is required to complement other existing measures of quality. A tool developed in the United Kingdom was trialled to determine its utility with a frail older Australian population.	Clients recently discharged from a subacute setting	A random sample of clients recently discharged from a sub-acute setting over a 6-month period in 2005 were sent a questionnaire and invited to respond, a reply-paid envelope being provided for the return of the questionnaire. The questionnaire comprised the 20-item tool and space to provide additional qualitative comments.	20-item Patient-Centred Inpatient Scale (P-CIS) developed by Coyle and Williams (2001). Overall, there was a fundamental core of person-centredness as demonstrated by a ratio score of 0.68. Personalisation and respect dimensions are the main strengths of person-centred care in the health care setting in which the P-CIS was trialled, with personalisation scoring 0.75 and respect scoring 0.77. The miscellaneous components scored 0.69. The findings show that areas of the client experience warranting priority quality improvement effort are specific to the dimensions of empowerment (0.58), information (0.58) and approachability/availability (0.43).	The P-CIS demonstrates the potential to be a contributing component that informs the monitoring and improvement of quality person-centred care in Australian inpatient health care settings.
Davies et al (2008)[31]	USA	To evaluate the use of a modified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to support quality	The CAHPS team from Harvard Medical School and the Institute for Clinical Systems Improvement organized a learning collaborative including eight	Process evaluation of a quality improvement collaborative. Samples of patients recently visiting each group completed a modified CAHPS survey before, after and continuously over a 12-month project.	Changes in patient experiences. Interviews with team leaders assessed the usefulness of the collaborative resources, lessons and barriers to using data. Seven teams set goals and six made interventions. Small improvements in patient experience were observed in some groups, but in others	Small measurable improvements in patient experience may be achieved over short projects. Sustaining more substantial change is likely to require organizational strategies, engaged leadership, cultural change, regular measurement and performance feedback and

Author	Country	Purpose	Participants	Design and method	Outcome measures and results	Conclusion
		improvement in a collaborative focused on patient-centred care, assess subsequent changes in patient experiences, and identify factors that promoted or impeded data use.	medical groups in Minnesota.	Teams were encouraged to set goals for improvement using baseline data and supported as they made interventions with bi-monthly collaborative meetings, an online tool reporting the monthly data, a resource manual called The CAHPS Improvement Guide, and conference calls.	changes were mixed and not consistently related to the team actions. Two successful groups appeared to have strong quality improvement structures and had focussed on relatively simple interventions. Team leaders reported that frequent survey reports were a powerful stimulus to improvement, but that they needed more time and support to engage staff and clinicians in changing their behaviour.	experience of interpreting and using survey data.
Proot et al (2007)[93]	Netherlands	This study deals with the development of a short measurement instrument (MITTZ), aimed at the evaluation of patient and family satisfaction with the care delivered in the terminal phase of illness	43 terminally ill persons and 39 informal caregivers.		The content validity, internal consistency, clinical utility and feasibility of the MITTZ appeared to be good. Explorative factor analysis resulted in seven to eight factors respectively explaining 81% (patients) and 83% (informal caregivers) of the total variance However, underlying constructs have not been identified. Cronbach's alpha was evaluated to be 0.87 and 0.84 respectively.	This first step in the validation of the MITTZ should be interpreted with caution, because the sample size limits the possibilities for analysis. Further validation of the MITTZ with a larger sample is recommended. The MITTZ provides valuable information to improve daily care for terminally ill people, and may be used as an outcome measure in studies in the field of palliative terminal care as soon as more relevant information is available about its validity.
Rao et al	India	To develop a reliable and	Health facilities and patients at	Cross-sectional survey of health	A 16-item scale having good reliability and validity is	The scale developed can be used to measure perceived

Author	Country	Purpose	Participants	Design and method	Outcome measures and results	Conclusion
(2006)[94]		valid scale to measure in-patient and outpatient perceptions of quality in India and (ii) to identify aspects of perceived quality which have large effects on patient satisfaction	clinics	facilities and patients at clinics. SETTING: Primary health centers, community health centers, district hospitals, and female district hospitals in the state of Uttar Pradesh in north India. MAIN OUTCOME MEASURES: Internal consistency, validity, and factor structure of the scale are evaluated. The association between patient satisfaction and perceived quality dimensions is examined.	developed. Five dimensions of perceived quality are identified-medicine availability, medical information, staff behavior, doctor behavior, and hospital infrastructure. Patient perceptions of quality at public health facilities are slightly better than neutral. Multivariate regression analysis results indicate that for outpatients, doctor behavior has the largest effect on general patient satisfaction followed by medicine availability, hospital infrastructure, staff behavior, and medical information. For in-patients, staff behavior has the largest effect followed by doctor behavior, medicine availability, medical information, and hospital infrastructure.	quality at a range of facility types for outpatients and in-patients. Perceived quality at public facilities is only marginally favorable, leaving much scope for improvement. Better staff and physician interpersonal skills, facility infrastructure, and availability of drugs have the largest effect in improving patient satisfaction at public health facilities.
Raftopoulos, V (2005)[18]	Greece	Patient satisfaction with quality of care is a dominant concept in quality assurance and quality improvement programs. Elderly patients are the central users of health care services	There were 24 elderly patients, with a mean age of 70Â±6.02 years old	The study was carried out at two hospitals, a capital hospital and an urban one in Greece. The methodology for the data analysis was similar to the one described by Corbin and Strauss for grounded theory analysis. In order to assure the quality of our qualitative	After open coding of the data obtained from the interviews, we identified five categories: food, nursing care, medical care, room characteristics, and treatment/diagnosis. These five categories are common whether we measure elderly perceived quality of hospital care or patient satisfaction. Second-level categorization (axial coding) included patients' feelings regarding each of the five care	The findings support the need to develop a conceptual framework for patients' satisfaction interpretation, based on their own quality of care assumptions. This is the first step for the development of a valid and reliable scale for measuring quality of care.

Author	Country	Purpose	Participants	Design and method	Outcome measures and results	Conclusion
		and therefore the development of a grounded theory that explains how they perceive quality of care is important for strategy planning and health services evaluation.		research we used triangulation (in-depth interviews, focus group and direct observation). Content analysis of the interviews was primarily based on conceptual analysis of the two main concepts: patients' perceived quality of care and patients' satisfaction with care.	dimensions that are the subcategories of the previous categories. These feelings could be positive, negative, neutral or they may feel indifferent. The final stage of data analysis was selective coding categorization containing direct comments for each category. This third-level categorization contains specific dimensions of nursing and medical care such as: patients' respect as a human being, staff technical skills, staff effective communication, therapeutic touch and empathy.	
Raftopoulos, V (2005)[95]	Greece	To develop and test the psychometric properties of a scale assessing elderly patients' satisfaction with quality of pain management and to explore whether elderly patients' depression (by using Geriatric Depression Scale) correlates with patients' perceived	380 elderly hospitalized patients participated to the study (209 male, 171 female). The mean age of the sample was 73.07 +/- 6.04 years	We developed a scale of elderly patients' satisfaction with quality of pain management based on the existing literature evidence, on the results of a qualitative research and on a previous developed conceptual framework that described how elderly patients perceive quality of hospital care and defined the determinants of	76.6% elderly patients answered they experienced pain during their hospitalization. Pain influenced elderly patients' daily activities, emotional situation, sleep, their relations with the significant others and their walking ability. Elderly patients who have undergone a surgical procedure were 3.9 times more likely to feel pain. Women were half times more likely to feel pain during their hospital stay. The vast majority of elderly patients were totally satisfied with their pain management (92.8%), with the way doctors managed their pain (96.3%) and the way nurses	Pain and satisfaction with pain management are two multidimensional issues that must be explored in accordance with psychological, regional and other factors. Health care professionals should consider routinely screening of elderly hospitalized patients for depression as a method for exploring pain and its characteristics.

Author	Country	Purpose	Participants	Design and method	Outcome measures and results	Conclusion
		quality of pain management.		elderly patients' satisfaction. We evaluated the taxonomy and the feasibility of the scales using reliability analyses and a combination of qualitative and quantitative research methods. Patients:	managed their pain (92.1%). Elderly patients' global satisfaction with pain management correlated with: the pain intensity, the region of the hospital with those patients who were hospitalised in the capital being more satisfied (7.38 +/- 1.19) than those in urban hospitals (6.74 +/- 1.41), the global satisfaction of elderly patients with nursing assistance they received, elderly patients? intention to recommend the hospital to a friend of them or to a relative. T-test indicated that mean satisfaction with pain management, with nursing pain management and with medical pain management did not differ among depressed and non-depressed elderly patients. Global satisfaction with nursing pain management was a major predictor of global satisfaction with pain management. Subscales had a very good internal consistency ranging from 0.78 to 0.95 and good criterion validity.	
Gasquet, I et al. (2004)[47]	France	Few questionnaires on outpatients' satisfaction with hospital exist. All have been constructed	Outpatients	First, a qualitative phase was conducted to generate items and identify domains using critical analysis incident technique and literature review. A list	A 27-item questionnaire comprising 4 subscales (appointment making, reception facilities, waiting time and consultation with the doctor). The factorial structure was satisfactory (loading >0.50	Good estimation of patient opinion on hospital consultation performance was obtained with these questionnaires. When comparing performances between departments or the

Author	Country	Purpose	Participants	Design and method	Outcome measures and results	Conclusion
		without giving enough room for the patient's point of view in the validation procedure. The main objective was to develop, according to psychometric standards, a self-administered generic outpatient questionnaire exploring opinion on quality of hospital care.		of easily comprehensible non-redundant items was defined using Delphi technique and a pilot study on outpatients. This phase involved outpatients, patient association representatives and experts. The second step was a quantitative validation phase comprised a multicenter study in 3 hospitals, 10 departments and 1007 outpatients. It was designed to select items, identify dimensions, measure reliability, internal and concurrent validity. Patients were randomized according to the place of questionnaire completion (hospital v. home) (participation rate = 65%). Third, a mail-back study on 2 departments and 248 outpatients was conducted to replicate the validation (participation rate = 57%).	on each subscale for all items, except one item). Interscale correlations ranged from 0.42 to 0.59, Cronbach alpha coefficients ranged from 0.79 to 0.94. All Item-scale correlations were higher than 0.40. Test-retest intraclass coefficients ranged from 0.69 to 0.85. A unidimensional 9-item version was produced by selection of one third of the items within each subscale with the strongest loading on the principal component and the best item-scale correlation corrected for overlap. Factors related to satisfaction level independent from departments were age, previous consultations in the department and satisfaction with life. Completion at hospital immediately after consultation led to an overestimation of satisfaction. No satisfaction score differences existed between spontaneous respondents and patients responding after reminder(s).	same department over time scores need to be adjusted on 3 variables that influence satisfaction independently from department. Completion of the questionnaire at home is preferable to completion in the consultation facility and reminders are not necessary to produce non-biased data.

Author	Country	Purpose	Participants	Design and method	Outcome measures and results	Conclusion
Greco et al (2001)[40]	Australia	The Practice Accreditation and Improvement Survey (PAIS) is an endorsed instrument by the Australian General Practice Accreditation Limited (AGPAL) for seeking patient views as part of the accreditation of Australian general practices. The current study aimed to assess the validity and reliability of the PAIS.	Patients visiting general practices	From September 1998 to August 2000, a total of 53,055 patients completed the PAIS within 449 general practices across Australia, which is about 8% of all Australian general practices. The validity and reliability of the PAIS instrument was assessed during the study. Patient views were also analysed via 27 items relating to doctors' interpersonal skills, access, availability and patient information.	PAIS was found to have sound validity and reliability measures. Patient evaluations showed a range of scores for the 27 items (69-91%). Lower scoring areas were issues about access, availability and availability of information for patients.	Users of general practice rate the doctors' interpersonal skills (capability) more highly than other practice service issues (capacity). There is, in patients' views, much more room for improving these capacity aspects of general practice. Future research should explore how practices act on the results of patient feedback, and which practice based strategies are more effective in raising standards of care from a patient's perspective.
Gremigni et al (2008)[96]		All healthcare workers' communication skills are recognised as valuable indicators of quality of care from the patient's perspective. Most of the studies measure	Outpatients and hospital staff	Small groups of outpatients and hospital staffs were involved in identifying the domains and generating the items. A quantitative validation phase involving 401 outpatients followed in order to verify the hypothesised dimensionality of	A 13-item questionnaire emerged, comprising four components of outpatients' experience in the healthcare communication domain: problem solving, respect, lack of hostility, and nonverbal immediacy. Psychometric tests were promising as regards factorial validity, evaluated with confirmatory factor analysis, and scales reliability. Factor scores were independent of	The developed Health Care Communication Questionnaire (HCCQ) is a self-administered brief measure with good psychometric properties. The HCCQ gives information that could be taken as an indirect and subjective indicator of the quality of hospital services as provided by non-medical staff. This aspect may have

Author	Country	Purpose	Participants	Design and method	Outcome measures and results	Conclusion
		doctor-patient communication, giving scarce attention to other professionals. This study is aimed at developing and providing preliminary validation of a questionnaire to measure outpatients' experience of communication with hospital personnel other than doctors.		selected items and to measure reliability.	patients' gender, age, and education.	a role in local quality improvement initiatives.
Hendriks et al (2002)[55]	Netherlands	To establish the psychometric properties of the Satisfaction with Hospital Care Questionnaire (SHCQ) for measuring patient satisfaction and evaluations of hospital care quality	Patients and staff in hospital wards	Patients (n = 275) and staff members (n = 83) of four hospital wards completed the 57-item SHCQ addressing 13 aspects of care. Staff members completed the SHCQ from the patient's perspective. The data were analyzed within the framework of generalizability theory.	Generalizability coefficients (GCs) and standard errors of measurement (SEs). GCs indicating differentiation among patients with different overall levels of satisfaction (SHCQ mean scores) were high (> 0.90). GCs indicating differentiation among patients as to satisfaction with aspects of care (SHCQ scale scores) were generally satisfactory (> 0.75) to high. Patients agreed well on overall level of hospital care quality (GCs > 0.90) and differentiated reliably (GCs > 0.80) among aspects of care.	The SHCQ reliably establishes both patient satisfaction and overall quality of hospital care. Whereas patients' ratings may be too lenient, their ranking of the items on care quality appears to be valid, and is therefore suitable for monitoring and improving hospital care. Within scales, however, results should be interpreted more cautiously: for some items, patients cannot really tell the difference in quality of care.

Author	Country	Purpose	Participants	Design and method	Outcome measures and results	Conclusion
					No differentiation among wards was found with respect to quality of care. Patients and staff agreed to a considerable extent (0.78) on ranking the SHCQ items on care quality, but staff ratings were lower. Reliability and validity of patients' evaluations of quality of hospital care varied according to aspect of care.	
Hendriks et al (2001)[54]	Netherlands	To improve the assessment of patients' satisfaction with care in hospital. To investigate alternative item-response formats.	Consecutively discharged patients (n=784) were sampled, of which a representative (sex, age, length of hospital stay) subsample of 514 (65%) responded.	A self-report questionnaire is the most widely used method to assess (in)patients' satisfaction with (hospital) care. However, problems like nonresponse, missing values, and skewed score distributions may threaten the representativeness, validity, and reliability of results. We investigated which of alternative item-response formats maximizes desired outcomes.	Five formats were compared on the basis of sample characteristics, psychometric properties at the scale and item levels, and patients' opinions of the questionnaire. MEASURES: A 54-item satisfaction questionnaire addressing 12 aspects of care was used. Patients responded using either a 10-step evaluation scale ranging from "very poor" to "excellent" (E10), a 5-step evaluation scale ranging from "poor" to "excellent" (E5), or a 5-step satisfaction scale ranging from "dissatisfied" to "very satisfied" (S5). The 5-step scales were administered with response options presented as either boxed scale steps to be marked or words to be circled.: E5 scales yielded lower means than S5 scales. However, at the item level, the S5 scale	No large differences among were found. However, if in items are important carri information, a (5-step) sati response scale, with response presented in words next to eac appears to be the optimal forma

Author	Country	Purpose	Participants	Design and method	Outcome measures and results	Conclusion
					showed better construct validity, more variability, and less peaked score distributions. Circling words yielded fewer missing item scores than marking boxes. The E5 scale showed more desirable score distributions than the E10 scale, but construct validity and reliability were lower.	

Table 7: A taxonomy for inpatient complaints

Author	Country	Purpose	Participants	Design and method	Outcome measures and results	Conclusion
Montini et al et al (2008)[79]	USA	To develop a standard taxonomy for inpatient complaints that could be adopted in a wide array of health service institutions.	Patients in 2 Boston Hospitals	A taxonomy was developed by merging the coding schemes from eight prior studies of patient complaints, and then by revising the received coding scheme in light of the codes and clarifications that emerged from a content analysis of patient complaints. Stratified random sample of 1216 complaints from patients in 2004. Main outcome	A taxonomy comprising 22 patient complaint codes and five provider codes was developed. Inter-rater agreement for complaint codes was good (median Kappa statistic 0.66, interquartile range 0.55-0.80). Four codes were each used in more than 10% of the patient complaints filed: unprofessional conduct (19%); poor provider-patient communication (17%); treatment and care of patient (16%); and, having to wait for care (11%). Of the coding for the profession of the person complained about, 47% of the patient complaints were about staff in general or did not specify	Standardized coding of patient complaint data may provide an opportunity for quality improvement, patient satisfaction and changes in patient care.

Author	Country	Purpose	Participants	Design and method	Outcome measures and results	Conclusion
				measure(s) Patient complaints codes, provider codes and inter-rater reliability.	a particular profession; 22% identified a physician or dentist; 12% nursing staff; 11% administrative or support staff and 8% allied clinical health professionals.	

Appendix C: Bibliography and abstracts

Anderson, E. A. and Zwelling, L. A. (1996). "Strategic Service Quality Management for Health Care." American Journal of Medical Quality 11(1): 3-10.

Quality management has become one of the most important and most debated topics within the service sector. This is especially true for health care, as the controversy rages on how the existing American system should be restructured. Health care reform aimed at reducing costs and ensuring access to all Americans can not be allowed to jeopardize the quality of care. As such, total quality management (TQM) has become a vital ingredient to strategic planning within the health care domain. At the heart of any such quality improvement effort is the issue of measurement. TQM cannot be ef fectively utilized as a competitive weapon unless quality can be accurately defined, measured, evaluated, and monitored over time. Through such analysis a hospital can elect how to expend its limited resources toward those quality improvement projects which will impact customer perceptions of service quality the most. Thus, the purpose of this report is to establish a framework by which to approach the issue of quality measurement, delineate the various components of quality that exist in health care, and explore how these elements affect one another. We propose that the issue of quality mea surement in health care be approached as an integration of service quality attributes common to other service organizations and technical quality attributes unique to health care. We hope that this research will serve as a first step toward the synthesis of the various quality attributes inherent in the health care domain and en courage other researchers to address the interactions of the various quality attributes.

Brand, C., Tropea, J., Ibrahim, J., Elkadi, S., Bain, C., Ben-Tovim, D., Bucknall, T., Greenberg, P. and AD, S. (2008). "Measurement for improvement: a survey of current practice in Australian public hospitals." Medical Journal of Australia 189: 35-40.

OBJECTIVE: To identify patient safety measurement tools in use in Australian public hospitals and to determine barriers to their use. DESIGN: Structured survey, conducted between 4 March and 19 May 2005, designed to identify tools, and to assess current use of, levels of satisfaction with, and barriers to use of tools for measuring the domains and subdomains of: organisational capacity to provide safe health care; patient safety incidents; and clinical performance. PARTICIPANTS AND SETTING: Hospital executives, managers and clinicians from a nationwide random sample of Australian public hospitals stratified by state and hospital peer grouping. MAIN OUTCOME MEASURES: Tools used by hospitals within the three domains and their subdomains; patient safety tools and processes identified by individuals at these hospitals; satisfaction with the tools; and barriers to their use. RESULTS: Eighty-two of 167 invited hospitals (49%) responded. The survey ascertained a comprehensive list of patient safety measurement tools that are in current use for measuring all patient safety domains. Overall, there was a focus on use of processes rather than quantitative measurement tools. Approximately half the 182 individual respondents from participating hospitals reported satisfaction with existing tools. The main reported barriers were lack of integrated supportive systems, resource constraints and inadequate access to robust measurement tools validated in the Australian context. Measurement of organisational capacity was reported by 50 (61%), of patient safety incidents by 81 (99%) and of clinical performance by 81 (99%). CONCLUSION: Australian public hospitals are measuring the safety of their health care, with some variation in measurement of patient safety domains and their subdomains. Improved access to robust tools may support future standardisation of measurement for improvement.

Carr-Hill, R. (1992). "The measurement of patient satisfaction." Journal of Public Health 14(3): 236-249.

Many applied health service researchers launch into patient satisfaction surveys without realizing the complexity of the task. This paper identifies the difficulties involved in executing patient satisfaction surveys. The recent revival of interest in ‘satisfaction’ and disagreements over the meaningfulness of a unitary concept itself are outlined, and the various perspectives and definitions of the components of satisfaction are explored. The difficulties of developing a comprehensive conceptual model are considered, and the issues involved in designing patient satisfaction surveys – and the disasters that occur when these issues are ignored – are then set out. The potential cost–effectiveness of qualitative techniques is discussed, and the paper concludes by discussing how health care management systems could more effectively absorb the findings of patient satisfaction surveys

Jackson, J., Chamberlin, J. and Kroenke, K. (2001). "Predictors of patient satisfaction." Social Science & Medicine 52(4): 609-620.

Correlates of patient satisfaction at varying points in time were assessed using a survey with 2-week and 3-month follow-up in a general medicine walk-in clinic, in USA. Five hundred adults presenting with a physical symptom, seen by one of 38 participating clinicians were surveyed and the following measurements were taken into account: patient symptom characteristics, symptom-related expectations, functional status (Medical Outcomes Study Short-Form Health Survey [SF-6]), mental disorders (PRIME-MD), symptom resolution, unmet expectations, satisfaction (RAND 9-item survey), visit costs and health utilization. Physician perception of difficulty (Difficult Doctor–Patient Relationship Questionnaire), and Physician Belief Scale. Immediately after the visit, 260 (52%) patients were fully satisfied with their care, increasing to 59% at 2 weeks and 63% by 3 months. Patients older than 65 and those with better functional status were more likely to be satisfied. At all time points, the presence of unmet expectations markedly decreased satisfaction: immediately post-visit (OR: 0.14, 95% CI: 0.07–0.30), 2-week (OR: 0.07, 95% CI: 0.04–0.13) and 3-month (OR: 0.05, 95% CI: 0.03–0.09). Other independent variables predicting immediate after visit satisfaction included receiving an explanation of the likely cause as well as expected duration of the presenting symptom. At 2 weeks and 3 months, experiencing symptomatic improvement increased satisfaction while additional visits (actual or anticipated) for the same symptom decreased satisfaction. A lack of unmet

expectations was a powerful predictor of satisfaction at all time-points. Immediately post-visit, other predictors of satisfaction reflected aspects of patient–doctor communication (receiving an explanation of the symptom cause, likely duration, lack of unmet expectations), while 2-week and 3-month satisfaction reflected aspects of symptom outcome (symptom resolution, need for repeat visits, functional status). Patient satisfaction surveys need to carefully consider the sampling time frame as well as adjust for pertinent patient characteristics.

Solberg, L., Asche, S., Averbeck, B., Hayek, A., Schmitt, K., Lindquist, T. and Carlson, R. (2008). "Can patient safety be measured by surveys of patient experiences?" The Joint Commission Journal on Quality and Patient Safety 34: 266-274.

BACKGROUND: A study was conducted to test whether patient reports of medical errors via surveys could produce sufficiently accurate information to be used as a measure of patient safety. METHODS: A survey mailed regularly by a large multispecialty medical group to recent patients to assess their satisfaction and error experiences was expanded to collect more details about the patient-perceived errors. Following an initial mailing to 3,109 patients and parents of child patients soon after they had office visits in June 2005, usable mailed or phone follow-up responses were obtained from 1,998 respondents (65.1% adjusted). Responses were reviewed through a two-stage process that included chart audits and implicit physician reviewer judgments. The analysis categorized the review results and compared patient-reported errors with satisfaction. RESULTS: Of the 1,998 respondents, 219 (11.0%) reported 247 separate incidents, for a rate of 12.4 errors per 100 patients. After complete review, only 5 (2.0%) of these incidents were judged to be real clinician errors. Most appeared to represent misunderstandings or behavior/communication problems, but 15.4% lacked sufficient information to categorize. Women, Hispanics, and those aged 41-60 years were most likely to report errors. Those respondents making error reports were much more likely to report visit dissatisfaction than those not reporting them (odds ratio [OR] = 13.8, p < .001). DISCUSSION: Although patient reports of perceived errors might be useful to improve the patient experience of care, they cannot be used to measure technical medical errors and patient safety reliably without added evaluation. This study's findings need to be replicated elsewhere before generalizing from one metropolitan region and a patient population that is about two-thirds members of one health plan.

Ware, J., Davies-Avery, A. and Stewart, A. (1977). The Measurement and Management of Patient Satisfaction: A Review of the Literature.

Ware, J., Snyder, M., Wright, R. and Davies, A. (1983). "Defining and measuring patient satisfaction with medical care." Evaluation and Program Planning 6(3-4 January): 247-263.

This paper describes the development of Form II of the Patient Satisfaction Questionnaire (PSQ), a self-administered survey instrument designed for use in general population studies. The PSQ contains 55 Likert-type items that measure attitudes toward the more salient characteristics of doctors and medical care services (technical and interpersonal skills of providers, waiting time for appointments, office waits, emergency care, costs of care, insurance coverage, availability of hospitals, and other resources) and satisfaction with care in general. Scales are balanced to control for acquiescent response set. Scoring rules for 18 multi-item subscales and eight global scales were standardized following replication of item analyses in four field tests. Internal-consistency and test-retest estimates indicate satisfactory reliability for studies involving group comparisons. The PSQ well represents the content of characteristics of providers and services described most often in the literature and in response to openended questions. Empirical tests of validity have also produced generally favorable results.

Weissman, J. S., Schneider, E. C., Weingart, S. N., Epstein, A. M., David-Kasdan, J., Feibelmann, S., Annas, C. L., Ridley, N., Kirle, L. and Gatsonis, C. (2008). "Comparing Patient-Reported Hospital Adverse Events with Medical Record Review: Do Patients Know Something That Hospitals Do Not?" Annals of Internal Medicine 149(2): 100-108.

Background: Hospitals routinely survey patients about the quality of care they receive, but little is known about whether patient interviews can detect adverse events that medical record reviews do not. Objective: To compare adverse events reported in postdischarge patient interviews with adverse events detected by medical record review. Design: Random sample survey. Setting: Massachusetts, 2003. Patients: Recently hospitalized adults. Measurements: By using parallel methods, physicians reviewed postdischarge interviews and medical records to classify hospital adverse events. Results: Among 998 study patients, 23% had at least 1 adverse event detected by an interview and 11% had at least 1 adverse event identified by record review. The {kappa} statistic showed relatively poor agreement between interviews and medical records for occurrence of any type of adverse event ({kappa} = 0.20 [95% CI, 0.03 to 0.27]) and somewhat better agreement between interviews and medical records for life-threatening or serious events ({kappa} = 0.33 [CI, 0.20 to 0.45]). Record review identified 11 serious, preventable events (1.1% of patients). Interviews identified an additional 21 serious and preventable events that were not documented in the medical record, including 12 predischarge events and 9 postdischarge events, in which symptoms occurred after the patient left the hospital. Limitations: Patients had to be healthy enough to be interviewed. Delay in reaching patients (6 to 12 months after discharge) may have resulted in poor recall of events during the hospital stay. Conclusion: Patients report many events that are not documented in the medical record; some are serious and preventable. Hospitals should consider monitoring patient safety by adding questions about adverse events to postdischarge interviews.

Williams, B., Coyle, J. and Healy, D. (1998). "The meaning of patient satisfaction: An explanation of high reported levels " Social Science & Medicine 47(9): 1351-1359.

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The social policy background to the proliferation of patient satisfaction surveys is a desire for increased patient representation and participation. Within this context, it is assumed that satisfaction surveys embody patients' evaluations of services. However, as most surveys report high satisfaction levels, the interpretation of satisfaction as the outcome of an active evaluation has been called into question. The aim of this study is to identify whether and how service users evaluate services. This was made possible through unstructured in-depth interviews with users of mental health services and through more structured discussion around their responses on a patient satisfaction questionnaire (CSQ 18B) whose psychometric properties has been well documented. Twenty-nine people with current or recent contact with mental health services within the British National Health Service were interviewed. The data revealed that service users frequently described their experiences in positive or negative terms. However, the process by which these experiences were transformed into “evaluations” of the service was complex. Consequently, many expressions of “satisfaction” on the CSQ 18B hid a variety of reported negative experiences. An explanation for this lack of correspondence is outlined.

Wolosin, R. (2008). Safety and satisfaction: where are the connections? . Patient Safety Quality Healthcare. 5: 28-32,34-36.

"How to address patient complaints." Ed Management 13(9): 103-5.

All patient complaints should be addressed appropriately, with the goal of improving care and boosting patient satisfaction. Address complaints immediately, while the patient is still in the ED. If a complaint is about quality of care, have the patient speak to an individual who can address both medical and risk management issues. Have a policy to address complaints. Make verbal contact with every patient who complains.

(1992). "Patient complaints: guidance for nurses." Nursing Standard 7(7): 29-30.

In response to the debate at RCN Congress in 1990, the College has produced the following guidelines for good practice on handling complaints about care, treatment and services. These guidelines have been written to help nurses, midwives and health visitors to handle complaints in ways which are fair to patients and in which they feel confident. The principles are readily applicable to other disciplines and an effective complaints procedure can only be established on a multidisciplinary basis. They may be used and adapted to form local policies and should be considered in conjunction with the recommendations of the Association of Community Health Councils and government recommendations and proposals to improve patients' satisfaction and confidence in health care services.

(1995). "Using patient input in a cycle for performance improvement." Joint Commission Journal on Quality Improvement 21(2): 87-96.

BACKGROUND: To effectively use patient input to improve performance, an organization needs a systematic method for gathering, assessing, and using those data to improve old processes and design new ones. This method should include the stages in the Joint Commission on Accreditation of Healthcare Organization's cycle for improving performance. It is important to remember that using patient input to improve performance is not an isolated activity but should be linked, in the organization's strategic plan as well as in its practice, to organizationwide efforts to improve performance. DESIGN: Designing a process to use patient input in performance improvement requires reviewing the patient groups served by the organization, the important clinical and organizational functions that affect patients, the dimensions of performance that affect patients in each function, and the possible methods for gathering and using patient input. MEASURE: The measurement method varies depending on the process, patient group, diagnosis, or other subject being measured. Any plan for measurement, including one for gathering patient input, should address the following questions: What data will be collected? Who will be involved in the collection? When, where, and how will the data be collected? ASSESS: Raw data cannot be the basis for improving performance but must be carefully assessed to provide information about current performance, identify opportunities for improvement, help set priorities, and help identify root causes of problems that can lead to improvement. IMPROVE: Whether using patient input to design a new process or to redesign an existing process, the goal is to translate patient input into specific characteristics (key quality characteristics) that can be addressed by the improvement plan. Once a new or redesigned process has been implemented, teams must measure its effect. This measurement often involves going back to patients and collecting feedback to see if the process is meeting their needs and expectations, usually through a written or telephone survey. To develop an instrument to measure satisfaction, staff can return to the specifications and indicators they developed based on patients needs and expectations.

(1997). "An exploratory investigation of the sources of patient satisfaction in ambulatory care." Social Sciences in Health 3(4): 222-231.

An exploratory analysis was carried out to describe patient satisfaction with ambulatory care. The analysis aimed at gaining an understanding of satisfaction with the care received from the patient's perspective; it was guided by the principles of qualitative analysis. Findings from the present study show clearly the central role that relationships and patients' expectations play in satisfaction and relate to (1) knowledge about own illness, (2) a sense of being known and treated in a personal manner, and (3) alertness on the part of the doctor. Expectations are met when patients perceive a congruency with the medical care they receive and when they feel there are positive outcomes. Trust in the doctor and the treatment was found to mediate patient satisfaction.

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(1998). "Patient-driven indicators for quality." Quality Letter for Healthcare Leaders 10(8): 11-2.

Measuring quality encompasses many factors, including patients' perceptions of providers' performance. The Joint Commission on Accreditation of Healthcare Organizations now includes questions developed by The Picker Institute in its ORYX initiative as a way of gauging how well providers meet patients' needs for education, self-care and expectations for treatment.

(2001). "Quality of care: giving consumers a say." States of Health 11(1): 1-8.

In this era of market-driven health care, there's a lot of talk about quality, but low-income consumers and their advocates have not always been part of that discussion. In recent years, many have focused more attention on expanding coverage and promoting enrollment. Now that's shifting, and those who've long advocated consumer involvement as a way to improve health care for all are focusing more on the quality issue. They're discovering that what health plans mean by quality often overlooks just those quality-of-care areas that most concern consumers. This issue of States of Health looks at quality, and shows how an initiative funded by the Nathan B. Cummings Foundation could contribute to a health care system in which a fuller, more consumer-oriented definition of quality actually counts.

(2001). "Satisfaction guaranteed... patient complaints." Nursing Times 97(26): 10-10.

In spite of clinical governance and evidence-based practice, things still go wrong in the NHS. Helene Mulholland talks to one nurse whose job is to deal with patient complaints.

(2004). "Daily satisfaction surveys yield weekly improvements: real-time data address staff, patient concerns." Ed Management 16(10): 117-118.

(2004). "Effective patient grievance policy can be vital tool for improvement: every facility is different; make sure policy fits your organization." Healthcare Benchmarks & Quality Improvement 11(4): 37-41.

(2005). "Nursing home complaints, taken together with other measures, can be used to assess nursing home quality of care." AHRQ Research Activities(298): 16-16.

(2005). "Paperless system solves problem of lost chart costs: patient complaints now are handled in minutes." Ed Management 17(2): 20-21.

Before going paperless, know what you're looking for and what the expected benefits are.

The most technologically advanced system in the world is worthless if your doctors can't use it.

The system will have greater value if your nurses can chart on it as well.

A careful cost-benefit analysis should tell you ahead of time whether the system will pay for itself.

(2007). "Shared governance keeps ED nurses, patients happy: ranking in 95th percentile or higher for 10 years." Ed Management 19(2): 21-23.

Empowering frontline staff to share new ideas for improving processes and to participate in departmental decision making can lead not only to valuable new ideas, but will boost staff morale and lead to consistently high patient satisfaction levels.

Have nurses sit in on all interviews for potential new employees, as well as on policy and procedures committee.

Satisfied nurses with positive attitudes lead to a greater focus on the patient.

When you receive complaints about a specific nurse, ask the nurse what could/should have been done differently.

(2008). "Patient complaints about poor coordination of care or other services may help identify patient safety hazards." AHRQ Research Activities(335): 5-5.

(2008). "Press Ganey: public reporting gives huge boost to patient satisfaction." Healthcare Benchmarks & Quality Improvement 15(12): 121-3.

Hospitals focus on improving satisfaction in preparation for HCAHPS. One-on-one transparency with patients offers best opportunity to satisfy. Quality managers must foster satisfaction improvements the same way they foster clinical improvement.

(2009). "Staff involvement key to satisfaction gains." Ed Management 21(2): 22-3.

One of the keys to achieving and maintaining high levels of patient satisfaction is to actively communicate with and involve your staff in patient safety initiatives, says the ED leadership at Boone County (IA) Hospital. Here are some of the strategies they use: The ED manager share Press Ganey results and comments regularly with the staff, Based on results and patient complaints, the staff determine what safety areas should be addressed for improvement, ED staff nurse will ask every discharged patient if they were pleased with their care, and will immediately address any complaints they raise.

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Aasvang, E. K., Thorsen, D., Petersen, B. L. and Mogensen, T. (2005). "Unexpected events in patient complaints and insurance cases at Hvidovre Hospital, Denmark, 2002-2003. [Danish]." Ugeskrift for Laeger 167(49): 4659-4663.

Introduction: The aim of this study was to do a systematic evaluation patients' complaints and insurance cases, to produce knowledge that will allow the prevention of future similar events. Materials and methods: 143 cases filed as patients' complaints or insurance cases during the period 1 January 2002-30 June 2003 were evaluated for the occurrence of adverse events. In the case of an adverse event, a classification score, ranging from mild to serious, was allotted based on the SAC matrix score. An audit of the case, involving the specialist who had treated the patient, was performed in all cases of serious adverse events. Results: In 61% of the reviewed cases, an adverse event had occurred. It was estimated that in approximately 90% of the cases, the adverse events would not have been reported by the hospital staff, since they did not fit into the categories for mandatory reporting. In 38% of the cases where an audit was carried out, the event was found to have been preventable, Discussion: The study shows that systematic evaluation of patients' complaints and insurance cases, plus audit, is potentially an effective method of preventing future adverse events.

Abashin, N. N. (1998). "[Patient satisfaction as an index of the quality of medical care (according to data of a sociologic survey)]." Problemy Sotsialnoi Gigieny i Istoriia Meditsiny(5): 31-3.

Sociological survey has been carried out in 2 hospitals of Irkutsk. 600 respondents were asked to express their opinion on the quality of medical care and offer proposals on improvement of hospital care.

Abeln, S. (1994). "Risk management. Documenting patient satisfaction." Rehab Management: The Interdisciplinary Journal of Rehabilitation 7(6): 102-103.

Providers can minimize the risk of malpractice suits by focusing on patient satisfaction outcomes.

Abeln, S. H. (1994). "Quality as a risk management tool." Rehab Management: The Interdisciplinary Journal of Rehabilitation 7(2): 105-106.

Ensuring patient satisfaction can provide therapists with an edge in managing the risk of medical negligence claims.

Adair, L. (1994). "The patient's agenda... what do patients really think about the care they receive in hospital?" Nursing Standard 9(9): 20-23.

What do patients really think about the care they receive in hospital? Aware of the shortcomings of satisfaction surveys, Liz Adair set up a project in which former patients told their own stories. The wealth of detail provided the team with enormous insight into where things went well -- and where there was scope for improvement. Liz's work won her the Nurse 94 Innovation in Nursing Management award, sponsored by Ashridge Management College.

Ainsworth, D. (2003). "How to ... handle patient complaints." Nursing Times 99(31): 66-7.

Ainsworth, S. (2007). "It's all change for complaints again." British Journal of Healthcare Management 13(8): 291-293.

Akid, M. (2002). "Would you care to complain?" Nursing Times 98(27): 12-3.

Akinci, F. and Sinay, T. (2003). "Perceived access in a managed care environment: determinants of satisfaction." Health Services Management Research 16(2): 85-95.

With increasing competition in the local and regional healthcare markets, and growing interest in assessing the effectiveness of services and patient outcomes, satisfaction measures are becoming prominent in evaluating the performance of the healthcare system. This study examines the independent effect of predisposing, enabling and medical need factors on perceived access to care with particular focus on insurance plans. A survey questionnaire is developed to investigate access limitations at three levels: (1) the health plan, (2) the individual provider(s) and (3) the healthcare organization. In addition, shortage of providers, residents' perceptions of their health status, satisfaction with access to care and socio-demographic indicators are incorporated into the analysis. Multivariate logistic regression is used to assess the independent effects of the above factors on a dichotomous dependent variable--residents' overall satisfaction with access to healthcare services. The most salient determinants of overall satisfaction with access to care were the type of health insurance plan, cost of insurance premiums, co-payments, difficulty with obtaining referrals, self-rated general health, the opportunity cost of taking time to see a provider (measured by the loss of hourly wages), marital status and the age factor over 80 years.

Alemi, F. and Hurd, P. (2009). "Rethinking satisfaction surveys: time to next complaint." Joint Commission Journal on Quality & Patient Safety 35(3): 156-61.

BACKGROUND: Patient satisfaction surveys require considerable time and resources. Instead of only systematically seeking patient's input through standardized satisfaction surveys, it is proposed that insights into the performance of the organization should also be based on patient complaints. Complaint data are available at a fraction of the cost of conducting satisfaction surveys, and even though complaints may be

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rare, new analytical tools (for example, time-between control charts) enable the analysis of these data in ways that are helpful to improvement teams. CASE STUDY: MEDICAL/SURGICAL UNIT: The choice of whether the analysis should be done per day, per visit, or per discharge depends on the availability of data and the frequency of complaints. A case study shows that an analysis of the last 100 complaints (collected in a 50-day period) was sufficient to detect statistically significant change in the process of care. In the medica/surgical unit, although a complaint occasionally occurred, a series of complaints for the 22nd through the 24th day was unusual. These days of back-to-back complaints marked a departure from the general pattern of no complaints, for which improvement teams could determine the special cause. DISCUSSION: Whereas complaint data represent only the very dissatisfied patients, satisfaction surveys report the average of satisfied and dissatisfied patients. As a consequence, complaint data allow health care managers to hear the voice of their customers without the distortions caused by including other, more satisfied patients. The cost advantage of time to complaint is obvious. The most expensive component of conducting satisfaction surveys is the data collection. In contrast, most hospitals and many other organizations maintain a system for collecting patient complaints for legal and risk management reasons. Much more can be revealed about a unit's operations when both the complaint and the satisfaction rates are calculated.

Allen, L. and Creer, E. (1998). "Increasing patient feedback in ambulatory settings." Journal for Healthcare Quality 20(6): 33-7.

Patient satisfaction survey data provide valuable information about how well healthcare organizations and their individual departments are meeting the needs and expectations of their patients. Lack of sufficient data can severely inhibit an organization's ability to understand its strengths and to target areas in which performance can be improved. This article describes a performance improvement project that a hospital used to increase response rates to its patient satisfaction surveys in its ambulatory care settings. The results were significant: five times more surveys were returned 6 months after implementation of the project than had been returned at baseline. Managers and staff now have the information they need to understand how well they are meeting their patients' needs and to make sound decisions related to performance improvement efforts.

Allen, L. W., Creer, E. and Leggitt, M. (2000). "Developing a patient complaint tracking system to improve performance." Joint Commission Journal on Quality Improvement 26(4): 217-26.

BACKGROUND: Assessing patient satisfaction exclusively through close-ended scaled survey questions may not provide a complete picture of patients' concerns. Only recently has the role of complaint data as a management tool received attention. FORMATION OF THE TEAM AND THE DATABASE: The Complaint Management Team was created in January 1997 at Hartford Hospital (Conn) to develop a coding and reporting mechanism for complaints (negative comments) gathered from patient surveys. Developing the codebook was an evolutionary process. A database was designed to collect three separate complaints and the verbatim text associated with the code. REPORTING: Department-specific, location-specific, and organization wide reports are generated. Quarterly department-specific reports are used to trend the incidence of complaint themes, identify specific locations with problems, and initiate improvement efforts. OVERALL FINDINGS: Since March 1997, most complaints have fallen into five major categories--accommodations (environment), quality of care (care and treatment), respect and caring (humaneness or attitudes and behaviors), timeliness, and communication. The hospital's real estate department has completed a project focused on increasing patient satisfaction with parking. Two projects are still in progress; one is focused on increasing patient satisfaction with respect and staff caring attitude/behaviors, and one on improving satisfaction with the level of noise on the units. DISCUSSION: Approximately 4,000 survey complaints are coded every year. One limitation of the database is that all sources of complaints received throughout the organization are not yet captured. Another limitation is that the outcomes measurement section has exclusive access to the database. CONCLUSIONS: The patient complaint tracking system enables staff, managers, teams, and departments to develop improvement efforts based on quantitative and qualitative data.

Allen, P. D., Klein, W. C. and Gruman, C. (2003). "Correlates of complaints made to the Connecticut Long-Term Care Ombudsman Program: the role of organizational and structural factors." Research on Aging 25(6): 631-654.

Using Long-Term Care Ombudsman Program complaint data (N = 3,360) from all of Connecticut's 261 nursing facilities, this study investigated facility characteristics that may be correlated with resident complaints. Complaints per 100 beds and four subcategories of complaints established by the Administration on Aging (AoA) were the dependent variables. The presence of volunteers trained by the Ombudsman Pro-gram significantly predicted total complaints. At the bivariate level, profit status, size, location, citations, and the presence of a volunteer resident advocate were associated with the rate of complaints. However, multivariate analysis exposed a more complex pattern of relationships. The strongest model explained slightly more than 9% of the variance using the nine predictors. This indicates that other factors such as psychosocial characteristics of complainants may influence complaint reporting, rather than structural/organizational components of the facility.

Allen, P. D., Nelson, H. W., Gruman, C. and Cherry, K. E. (2006). "Nursing home complaints: who's complaining and what's gender got to do with it?" Journal of Gerontological Social Work 47(1-2): 89-106.

Long Term Care Ombudsman Complaint data from one state's 261 nursing homes are examined in the study. We assessed differences between male and female groups, including chiefly residents, but also ombudsmen, the residents' relatives or friends, administrators, legal representatives, and others regarding

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types and rates of complaints as reported in the Administration on Aging (AoA) major categories of: Resident Care, Resident Rights, Administration, Quality of Life, and Complaints Not Against Facility. Proportionately, male residents lodged more complaints than females. Further, males complained more than females about Resident Rights violations and filed more Complaints Not Against Facility. Females lodged significantly more complaints about Care, Quality of Life and Administration.Thus, males were more likely to report technical, impersonal, and legalistic issues, than females, who were more likely to express concerns about personal care and socioemotional-environmental issues. Results yielded further evidence of gender differences in the patterns of resident complaints. Nursing home social workers are highlighted as agents in changing embedded stereotypes about residents and complaints.

Al-Mailam, F. F. (2005). "The effect of nursing care on overall patient satisfaction and its predictive value on return-to-provider behavior: a survey study." Quality Management in Health Care 14(2): 116-20.

OBJECTIVES: To determine the extent of patient satisfaction with care provided at the hospital at all levels and to correlate patients' satisfaction with nursing care, in particular, with their overall satisfaction. Also, to assess the predictive value of patient satisfaction on subsequent return to the hospital. DESIGN: A survey study of a random sample of 420 inpatients to determine the extent of their satisfaction with the overall care provided at the hospital. SETTING: A 110-bed private hospital in Kuwait, January 1-March 31, 2004. RESULTS: The extent of overall patient satisfaction with the quality of care provided at the hospital was found to be quite high (Excellent, 74.7%; Very good, 23.7%). Individually, nursing care received the maximum patient satisfaction ratings (Excellent, 91.9%; Very good, 3.9%). A positive correlation (r = 0.31, P = .01) was noted between patients' perception of nursing care and their overall satisfaction with the health care provided at the hospital. Significant positive correlation (r = 0.36, P = .01) was also found between overall patient satisfaction and their reported intentions of returning and recommending the hospital to others. CONCLUSIONS: Patient satisfaction surveys can be of great value to health care providers not only in recognizing and improving the quality of care, but also as predictors of return-to-provider behavior of the patients. Overall patient satisfaction is linked with quality nursing care, which, in turn, depends on the quality of leadership practiced at the institution. Transformational leadership behavior promotes nurse satisfaction, which adds to their work effectiveness and motivates them to provide quality patient care.

Altschul, A. T. (1983). "The consumer's voice: nursing implications." Journal of Advanced Nursing 8(3): 175-83.

Winifred Raphael pioneered survey research into nursing problems. In particular she was interested in what patients thought about their care. Her sympathetic approach and her trust in the motivation of nurses resulted in ready acceptance of her findings and an eagerness of nurses to use these findings as a basis for improving their performance. This article discusses the paradox of patients wanting to talk, but staff being reluctant to listen, especially where emotionally charged topics are concerned. Recognition that it may be therapeutic for patients to discuss painful experiences and an increasing willingness by nurses to listen to patients may call for a system of providing support for the nurses themselves. Unaided, nurses may find the strain excessive and therefore, in spite of the best intention, may feel obliged to cut the patient off. There is evidence that a change has occurred in recent years in nurses' attitudes to researchers. Whereas early reports reveal a defensiveness and a rejection of critical comments by researchers, recent studies show that patients are less critical of nursing care than the nurses are themselves, and that nurses welcome investigations into their work. Lack of communication with patients is most frequently criticized by patients and by nurses. Because of this nurses increasingly believe that patients may need help to make their views known and increasingly incorporate patient-advocacy in their role.

Al-Windi, A. (2005). "Predictors of satisfaction with health care: A primary healthcare-based study." Quality in Primary Care 13(2): 67-74.

Objective: The main aim of this study was to examine the overall satisfaction with health care among a multi-ethnic primary healthcare practice population. The second aim was to explore the relations between satisfaction/dissatisfaction and socio-demographic characteristics, health status, healthcare utilisation and medicine use in Jordbro, Haninge, Sweden. Method: The study included 1055 out of 1442 consecutive adult patients visiting a Swedish healthcare centre. The relationship between satisfaction and socio-demographic characteristics, perceived health, chronic disease, complaint symptom, consultations with the general practitioner (GP) and healthcare need was assessed using final logistic regression analysis. Results: Age, perceived health and complaint symptoms were related to patient satisfaction with health care in the univariate analysis. However, only age and healthcare need remained significantly and independently related to patient satisfaction in the logistic regression analyses when the impact of all confounders was taken into account. Age under 65 years and healthcare need were the strongest predictors of dissatisfaction with health care. Poor perceived health and low numbers of consultations with the GP were related to reporting that healthcare need was not met. Conclusion: Age and healthcare need were significantly and independently related to patient satisfaction in the logistic regression analysis adjusted for all confounders. Poor perceived health was related to dissatisfaction and unmet healthcare need in the univariate analyses. Maintaining a continuous relationship with patients with poor perceived health is essential, and efforts should be made to improve the quality of care for these patients. copyright 2005 Radcliffe Publishing.

Ammentorp, J., Rasmussen, A. M., Norgaard, B., Kirketerp, E. and Kofoed, P.-E. (2007). "Electronic questionnaires for measuring parent satisfaction and as a basis for quality improvement." International Journal for Quality in Health Care 19(2): 120-4.

BACKGROUND: Using paper questionnaires to measure quality of care from the perspective of the patient is a time consuming procedure resulting in very slow feedback. Response rates are low and patients who

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cannot read the local language are usually excluded. OBJECTIVE: To investigate the applicability of an electronic questionnaire by evaluating the response rate. To study whether computer-based continuous monitoring could elucidate reasons for parents being less satisfied with care and treatment and to compare parent satisfaction with the results of a study performed in 2003. METHODS: Parents were asked to assess the quality of care and treatment by answering questions on a touch-screen computer. The questions, which were translated into seven languages, corresponded to the indicators selected by the department for monitoring parents' satisfaction. The system was developed in cooperation with a software company. RESULTS: A total of 780 parents answered (69%). Of these, 2% parents answered in a foreign language. The main reasons for being less satisfied were perceived difficulties in getting in contact with the staff, having experienced unnecessary long waiting time and having the impression that the nurses did not have enough time. Significant improvements in satisfaction had occurred as compared to a study from 2003. CONCLUSION: By using electronic questionnaires, it was possible to focus on the small percentage of parents not satisfied, to identify reasons for being less satisfied and to respond immediately to the feedback from the parents. Electronic surveys produce a satisfactory response rates.

Anderson, K., Allan, D. and Finucane, P. (2000). "Complaints concerning the hospital care of elderly patients: a 12-month study of one hospital's experience.[see comment]." Age & Ageing 29(5): 409-12.

OBJECTIVE: to determine the number, instigators, nature and outcome of complaints concerning elderly patients treated at a single hospital over 1 year. DESIGN: descriptive analysis of computerized data gathered prospectively; follow-up of complaints until resolution. SETTING: large, urban, university teaching hospital in Australia. SUBJECTS: all patients aged 65 years and above whose hospital care was the subject of complaint. METHODS: analysis of computerized database of all complaints made in a single year. RESULTS: 1.44 complaints were made per 1000 occasions of service to elderly people (95% confidence intervals, 1.19 - 1.69). This was similar to the overall complaint rate of 1.32 per 1000 occasions of service for patients of all age groups (95% confidence intervals, 1.19- 1.45). However, 73% of complaints were made by advocates rather than by elderly patients themselves and 96% related to communication or treatment issues. Many complaints resulted in an explanation and/or an apology and, to date, none has resulted in litigation. CONCLUSIONS: complaints concerning older hospitalized people are as common as those concerning younger patients. Analysis of complaints provides pointers for improvements in quality of care.

Anderson, K., Allan, D. and Finucane, P. (2001). "A 30-month study of patient complaints at a major Australian hospital." Journal of Quality in Clinical Practice 21(4): 109-11.

Health practitioners often regard complaints about the quality of patient care in a negative light. However, complaints can indicate strategies to improve care. Therefore, an audit was undertaken of all formal complaints about patient care at a major Australian hospital over a 30-month period. The profile of complainants, the reasons for complaints, and the outcome were analysed. A total of 1308 complaints, concerning the care of 1267 patients, were received. The complaint rate was 1.12 per 1000 occasions of service. In all, 57% of complaints were lodged by advocates and 71% of complaints related to poor communication or to the treatment provided. In 97% of occasions, an explanation and/or an apology resulted. To date, no complaint has proceeded to litigation. Complaints are potentially useful quality assurance tools and can identify remediable system flaws. Health professionals and employers should understand why patients complain and be able to respond appropriately.

Anderson, R., Barbara, A. and Feldman, S. (2007). "What patients want: A content analysis of key qualities that influence patient satisfaction." Journal of Medical Practice Management 22(5): 255-61.

We sought to identify key qualities of healthcare that influence patient appraisal of satisfaction with primary care. An Internet survey of patients was used to collect anonymous ratings of physicians on several dimensions of healthcare experiences, as well as comments about aspects of care that were excellent and those that could be improved. Qualitative data analysis was used to discern content clusters and relate them to high and low ratings of patient satisfaction. Content analysis revealed that patients perceive and value at least seven domains of healthcare in defining outstanding quality (access, communication, personality and demeanor of provider, quality of medical care processes, care continuity, quality of the healthcare facilities, and office staff. All seven were cited as reasons for rating physicians as excellent, while four domains (communication, care coordination, interpersonal skills, and barriers to access) drove negative ratings. We conclude that patient satisfaction ratings are highly influenced by a core of communication and follow-up care. Physicians who do not possess these traits will not likely attain high ratings, while having these core traits does not necessarily ensure high patient satisfaction.

Andrzejewski, N. and Lagua, R. T. (1997). "Use of a customer satisfaction survey by health care regulators: a tool for total quality management." Public Health Reports 112(3): 206-10; discussion 211.

OBJECTIVES: To conduct a survey of health care providers to determine the quality of service provided by the staff of a regulatory agency; to collect information on provider needs and expectations; to identify perceived and potential problems that need improvement; and to make changes to improve regulatory services. METHODS: The authors surveyed health care providers using a customer satisfaction questionnaire developed in collaboration with a group of providers and a research consultant. The questionnaire contained 20 declarative statements that fell into six quality domains: proficiency, judgment, responsiveness, communication, accommodation, and relevance. A 10% level of dissatisfaction was used as the acceptable performance standard. RESULTS: The survey was mailed to 324 hospitals, nursing homes, home care agencies, hospices, ambulatory care centers, and health maintenance organizations. Fifty-six percent of provider agencies responded; more than half had written comments. The three highest

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levels of customer satisfaction were in courtesy of regulatory staff (90%), efficient use of onsite time (84%), and respect for provider employees (83%). The three lowest levels of satisfaction were in the judgment domain; only 44% felt that there was consistency among regulatory staff in the interpretation of regulations, only 45% felt that interpretations of regulations were flexible and reasonable, and only 49% felt that regulations were applied objectively. Nine of 20 quality indicators had dissatisfaction ratings of more than 10%; these were considered priorities for improvement. CONCLUSIONS: Responses to the survey identified a number of specific areas of concern; these findings are being incorporated into the continuous quality improvement program of the office.

Aragon, S. J. and Gesell, S. B. (2003). "A patient satisfaction theory and its robustness across gender in emergency departments: a multigroup structural equation modeling investigation." American Journal of Medical Quality 18(6): 229-41.

This investigation tested the patient-centered Primary Provider Theory of Patient Satisfaction across gender in national random samples of emergency patients. Using multigroup structural equation modeling, the results supported the model's robustness. Physician service, waiting time, and nursing satisfaction explained 48%, 41%, and 11% of overall satisfaction plus 92% and 93% of female and male satisfaction, respectively. Unit increases in physician service satisfaction increased waiting time, nursing, and overall satisfaction by 0.991, 0.844, and 1.031 units, respectively. Unit increases in waiting time satisfaction increased nursing and overall satisfaction by 0.417 and 0.685 units, respectively. A unit increase in nursing satisfaction increased overall service satisfaction by 0.221 units. The investigation offers an alternative paradigm for measuring and achieving emergency department satisfaction, hierarchically related to patient expectations, where the primary provider has the greatest clinical utility to patients, followed by waiting for the primary provider, and then by nursing service.

Arnetz, J. E. and Arnetz, B. B. (1996). "The development and application of a patient satisfaction measurement system for hospital-wide quality improvement." International Journal for Quality in Health Care 8(6): 555-66.

A regional Swedish hospital has been the site of a quality improvement program that focuses on patient satisfaction, staff work environment and quality of hospital services. This article describes the study component that measures patients' views of the quality of care. The purpose of this study was to develop a reliable and valid instrument, to determine the predictors of patients' ratings of quality and to measure patient satisfaction at two points in time to determine whether patient ratings change following a quality improvement initiative. The instrument developed in this study was designed to assess patients' perceptions of the quality of hospital services, staff work environment and overall satisfaction for the purpose of providing feedback to hospital staff. This information would be used for quality improvement efforts within the hospital. Unique to this instrument are questions regarding patients' perceptions of the hospital staff work environment. The results revealed that the questionnaire demonstrated valid and reliable properties. The significant predictors of quality ratings were information concerning one's illness, and perceptions of the staff work environment. Patient satisfaction was measured and then reassessed following the implementation of various department-based improvement programs. The reassessment revealed significantly higher patient ratings in most areas. An intrinsic aspect of this quality program was the engagement of, and feedback process to, hospital personnel. Questionnaire results were reported graphically to hospital management and staff, thus serving as a catalyst for improvement.

Aspinal, F., Addington-Hall, J., Hughes, R. and Higginson, I. J. (2003). "Using satisfaction to measure the quality of palliative care: a review of the literature.[see comment]." Journal of Advanced Nursing 42(4): 324-39.

BACKGROUND: The advent of clinical governance in British health policy has placed increased demands on health care providers and practitioners to ascertain the quality of their services. Traditional indicators of quality of health care, such as death or recovery rates, are not appropriate in palliative care. Thus, it is important to establish alternative approaches to measuring the quality of palliative care services and interventions. AIMS: Satisfaction levels have been used widely in palliative care to assess quality. A literature review was conducted which aimed to explore the strengths and weaknesses of using satisfaction as an indicator of the quality of palliative care services. It also aimed to provide a solid basis upon which further work could be built. METHODS: Five electronic databases were searched using key words and phrases and key authors. Hand searches were conducted of four journals that contributed significantly to the concept of satisfaction, and reference lists of reviewed papers were scrutinized. Relevant papers were reviewed, data were extracted and these data were thematically analysed. FINDINGS: There are a number of important unresolved issues in the literature with regard to using satisfaction as an indicator of the quality of palliative care services. First, few alternatives to satisfaction are available. Secondly, satisfaction is under-theorized and no widely accepted definition exists. Thirdly, there are methodological inconsistencies across studies. It is important to take into account these findings when planning and implementing change following service evaluation using satisfaction as a measure. CONCLUSIONS: Relying on findings of satisfaction surveys to determine clinical and policy amendments in palliative care may not result in improvements in overall quality of care. Using satisfaction as a method of assessing the quality of health care services is particularly problematic and requires further investigation in both practical and conceptual terms. [References: 59]

Atwal, A. and Caldwell, K. (2005). "Older people: the enigma of satisfaction surveys." Australian Occupational Therapy Journal 52(1): 10-16.

Background and Aims: Health and social care reforms have emphasised the need for health and social care

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professionals to monitor user satisfaction. Obtaining the opinions of clients is an important mechanism for improving quality in health and social care. This paper discusses methodological issues in measuring satisfaction among older service clients.

Methods and Results: Examples will be used from the authors' own experiences of conducting research with older people to ascertain opinions and levels of satisfaction. The strengths and weakness of methods used to collect the opinions of older clients using interview and non-standardised questionnaires are critically considered. The authors suggest that occupational therapists need to understand the methodological issues that can impact upon older clients' responses to satisfaction questions.

Conclusion: If occupational therapists are committed to the ethos of client-centred practice, then clients must not only be consulted and involved in service delivery, but also in the design and implementation of satisfaction surveys.

Avis, M. (1997). "Incorporating patients' voices in the audit process." Quality in Health Care 6(2): 86-91.

Obtaining patients' views about their experiences of care should be an integral part of clinical audit. The importance of listening to patients as an aspect of quality can be attributed, in part, to the growth of consumerism in health care, and this in turn has led to the widespread use of satisfaction surveys to obtain patients' views. This paper raises some doubts about current methods for assessing patient satisfaction, and recommends the use of qualitative methods to capture patients' voices in audit.

Avis, M., Bond, M. and Arthur, A. (1995). "Satisfying solutions? A review of some unresolved issues in the measurement of patient satisfaction." Journal of Advanced Nursing 22(2): 316-22.

The measurement of patient satisfaction has been encouraged by a growing consumer orientation in health care, especially since it yields information about consumers' views in a form which can be used for comparison and monitoring. However, drawing on literature from a variety of sources, this paper suggests that there remain several unresolved issues relating to the measurement of satisfaction, and some serious questions about the validity of the concept. It is argued that current approaches to measuring satisfaction may not be grounded in the values and experiences of patients; therefore satisfaction surveys could be denying patients the opportunity to have their opinions included in the planning and evaluation of health care services. [References: 60]

Awara, M. and Fasey, C. (2008). "Patients' satisfaction and quality of care in psychiatric out-patient settings." Journal of Mental Health 17(3): 327-335.

Background: Patients' satisfaction with the provided care reflects the success of a given service and improves compliance to treatment regimes as well as promptness in seeking help for further episodes. Aims: To find out whether we meet our service users' expectations, to spotlight any areas of deficiency, and to explore patients' characteristics predicting and correlating with their satisfaction. Method: All patients (103) attending psychiatric out-patient service for 3 consecutive months at Victoria Centre, North East London Mental Health Trust, were approached. The Psychiatric Care Satisfaction Questionnaire (PCSQ) was employed and multiple regression analysis was used to identify predictors of satisfaction. Results: Fifty nine percent of patients approached, consented to the study. Overall, 85% of the participants were satisfied with the service. A sizable proportion expressed dissatisfaction with their type of therapy, feasibility of obtaining appointments, degree of therapists' omnipotence, need for counselling, availability of information and medication side effects. Services unrelated to the therapist also needed improvement. Women, those who are unemployed and those expressing a need for counselling were found to be less satisfied than their counterparts. Age was found to be directly related to satisfaction. Conclusions: Service planners need to focus on areas of weakness highlighted, employing basic measures such as enhancement of communication skills. Availability of alternative therapies should be considered. Predictors of lower satisfaction should be targeted. Declaration of interest: None. copyright Shadowfax Publishing and Informa UK Ltd.

Badri, M. A., Attia, S. T. and Ustadi, A. M. (2008). "Testing not-so-obvious models of healthcare quality." International Journal of Health Care Quality Assurance 21(2): 159-74.

PURPOSE: The purpose of this paper is to show that, although there has been some research to identify the dimensions on which healthcare quality and in-patient satisfaction should be measured, the confirmation of constructs and indicators that constitute an overall care quality and satisfaction remains unclear. The objective is to present several models of service quality and satisfaction in healthcare for discharged patients; and to test those models in a sample of discharged patients in public hospitals in the United Arab Emirates. DESIGN/METHODOLOGY/APPROACH: A detailed in-patient survey (using interviews) was used. Data were collected with questionnaires from adult discharges (n = 244) in public hospitals in the UAE. Several structures are proposed and tested. Confirmatory Factor Analysis (CFA) and LISREL SIMPLIS using maximum likelihood estimation were used to estimate and test the parameters of the hypothesized models derived deductively from the previous literature. FINDINGS: Several models (with one, two, three and four constructs) with different structures were tested using CFA. The final recommended model is based on three constructs--quality of care, process and administration, and information. The goodness-of-fit statistics supported the basic solution of the healthcare quality-satisfaction model. ORIGINALITY/VALUE: The model has been found to capture attributes that characterize healthcare quality in a developing country such as the UAE and could represent other modern healthcare systems. It can be used as a basis for evaluation in healthcare practices from discharges (in-patients) point of view. The study highlights the importance of patients' satisfaction with care as predictors of quality of care. The results also confirm the construct validity of the previously discussed healthcare quality scales.

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Bailey, J., McVey, L. and Pevreal, A. (2005). "Surveying patients as a start to quality improvement in the surgical suites holding area." Journal of Nursing Care Quality 20(4): 319-26.

The holding area, as the patient's first introduction to the surgical suites, has the potential to set the tone for the entire surgical experience. To identify targets for improvement efforts in the holding area, a convenience sample of 51 surgical patients completed a 12-item patient satisfaction survey developed using Androfact before discharge from hospital. Results reveal 5 aspects that fall below the desired benchmark satisfaction rate of 80%: staff holding personal conversations in the patients' presence, being offered distraction materials while waiting, pleasantness of the physical environment, reassurance that family members would be kept up-to-date during the surgical procedure, and comfort to provide personal information without worrying that others were listening. Discussion of findings indicates priorities for improvement efforts in the holding area.

Bakst, S. (1962). "What we did about patient complaints." Modern Hospital 98: 110-4.

Bark, P., Vincent, C., Jones, A. and Savory, J. (1994). "Clinical complaints: a means of improving quality of care." Quality in Health Care 3(3): 123-32.

OBJECTIVES--To establish the reasons for clinical complaints, complainants' feelings about the original incident, and their motivation in complaining. DESIGN--Postal questionnaire survey. SETTING--24 hospitals in North West Thames region. SUBJECTS--1007 complainants who had written to 20 hospitals between 1 January 1992 and 30 June 1993 about a complaint involving a clinical incident. MAIN MEASURES--Personal details, the nature of the complaint, the complainant's reaction to the original incident, the quality of the explanation at the time of the incident, the reasons for making a complaint, and what would have prevented the incident. RESULTS--491 completed questionnaires were received (response rate 49%). Complaints arose from serious incidents, generally a clinical problem combined with staff insensitivity and poor communication. Clinical complaints were seldom about a clinical incident alone (54; 11%); most (353; 72%) included a clinical component and dissatisfaction with personal treatment of the patient or care. In all, 242(49%) complainants reported a need for additional medical treatment, 206(42%) reported that the patient's condition had worsened as a result of treatment, and 175(36%) that side effects had been experienced. In 26(5%) cases the patient had died. Complainants' primary motive was to prevent recurrence of a similar incident. Lack of detailed information and staff attitude were identified as important criticisms. CONCLUSIONS--The emphasis must be on obtaining a better response to complaints at the clinical level by the staff involved in the original incident, not simply on adjusting the complaints procedure. Staff training in responding to distressed and dissatisfied patients is essential, and monitoring complaints must form part of a more general risk management programme.

Barkley, W. M. and Furse, D. H. (1996). "Changing priorities for improvement: the impact of low response rates in patient satisfaction." Joint Commission Journal on Quality Improvement 22(6): 427-33.

BACKGROUND: A disturbing trend in patient satisfaction research has been a willingness to accept low response rates as inevitable. However, it may not be appropriate to generalize data based on low responses to the full population of patients, since to do so may threaten the validity of the findings. METHOD: Satisfaction data were collected from 19,556 inpatients discharged in 1994 from 76 hospitals using the 69-item NCG Patient Viewpoint Survey, an instrument that primarily uses a set of five response options, which are transformed to a 0- to 100-point scale. Surveys were sent to random samples of 100 to 1,400 patients, and were followed by postcard reminders. For each hospital sample, results for the "First 30%" were compared with those for "All Respondents," or the total number of respondents, for which the average response rate was 58%. FINDINGS: Results on individual scale scores and the subsequent improvement priorities for individual hospitals had a 50-50 chance of being different when the First 30% responses were compared with the All Respondents responses. For 9 out of 13 survey scales, the scores were significantly different between the First 30% and All Respondents when data were aggregated across all hospitals. For 42% of the 76 hospitals, a different set of scales would be identified as those most in need of improvement. DISCUSSION: The capriciousness of within-hospital differences based on the First 30% versus All Respondents brings into question the utility of patient satisfaction data based on low response rates even with a reliable instrument and with controlled, consistent data collection methods across hospitals. Target response rates should be set at 50% or higher. Additional research on the effects of response rates on patient satisfaction data are recommended.

Barlesi, F., Boyer, L., Doddoli, C., Antoniotti, S., Thomas, P. and Auquier, P. (2005). "The place of patient satisfaction in quality assessment of lung cancer thoracic surgery." Chest 128(5): 3475-81.

STUDY OBJECTIVES: To compare the quality of non-small cell lung cancer (NSCLC) surgical care with patient satisfaction. DESIGN: Prospective study. SETTING: Academic hospital departments of thoracic oncology and surgery. PATIENTS AND METHODS: Patients presenting with recently diagnosed NSCLC and eligible for front-line thoracic surgery were eligible. Patient satisfaction was assessed using the Questionnaire of Satisfaction of Hospitalized Patients. Quality of surgical care was evaluated using an original score built accordingly to British Thoracic Society guidelines. Univariate analysis used parametric (Pearson correlation, t test) and nonparametric tests (Mann-Whitney U test) according to test conditions. Probability of survival was estimated using the Kaplan-Meier method. RESULTS: Seventy patients (mean age, 63.7 years) were included. Lobectomy was performed in 62 cases, and pneumonectomy was performed in 8 cases. In all, 28 patients had a postoperative complication. One-year survival rates for patients with stage I-II and stage IIIA NSCLC were 84% and 58%, respectively. Mean patient satisfaction was 78 +/- 13/100 and 69 +/- 13/100 for global staff and structure index, respectively (+/- SD). Mean score

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for quality of surgical care was 88.7/100 (range, 51 to 100). The absence of postoperative complication was significantly related to a high level of satisfaction regarding the structure ($r = 0.30$, $p < 0.05$). Other features of patient satisfaction did not show a significant correlation with the quality of the preoperative selection process or the surgical procedure itself ($r < 0.20$). CONCLUSIONS: Considering the lack of significant correlation, the present study does not support a shortcut between quality of care and patient satisfaction. Nonetheless, patient satisfaction should be integrated into rather than substituted for the quality of health-care assessment, which also needs further development.

Barr, D. A. (2004). "Race/ethnicity and patient satisfaction. Using the appropriate method to test for perceived differences in care." Journal of General Internal Medicine 19(9): 937-43.

OBJECTIVE: To determine whether an established patient satisfaction scale commonly used in the primary care setting is sufficiently sensitive to identify racial/ethnic differences in satisfaction that may exist; to compare a composite indicator of overall patient satisfaction with a 4-item satisfaction scale that measures only the quality of the direct physician-patient interaction. DESIGN: Real-time survey of patients during a primary care office visit. SETTING: Private medical offices in a generally affluent area of northern California. PARTICIPANTS: Five hundred thirty-seven primary care patients selected at random from those entering a medical office. MAIN OUTCOME MEASURES: Patient satisfaction using 1) a composite, 9-item satisfaction scale (VSQ-9); and 2) a 4-item subset of that scale that measures only satisfaction with direct physician care. RESULTS: The 9-item, composite scale identified no significant difference in patient satisfaction between white and nonwhite patients, after controlling for patient demographics and other aspects of the visit. The 4-item, physician-specific scale indicated that nonwhite patients were less satisfied than white patients with their direct interaction with the physicians included in the study (P </=.01). CONCLUSIONS: Measurements of patient satisfaction that use multi-item, composite indicators should also include focused comparisons of satisfaction directly with the care provided by the physician. In measurements of patient satisfaction, patient race/ethnicity should be included as an explanatory variable. The results also confirm earlier findings that factors external to the direct physician-patient interaction can have substantial effects on patients' perceptions of that interaction.

Barr, D. A. and Vergun, P. (2000). "Using a new method of gathering patient satisfaction data to assess the effects of organizational factors on primary care quality." Joint Commission Journal on Quality Improvement 26(12): 713-23.

BACKGROUND: As health care in the United States evolves increasingly toward managed care, there are continuing concerns about maintaining the quality of the physician-patient interaction, of which patient satisfaction is one measure. A quality assessment tool that measures both patient satisfaction with care and the ways organizational factors affect satisfaction will enable clinicians and administrators to redesign the care process accordingly. SURVEY METHODOLOGY: The measure of the quality of a physician office visit includes both the administration of a standardized satisfaction instrument and direct observation of the patient throughout the care process. This methodology was tested in 1997-1998 on an initial sample of 291 patients at a large multispecialty medical group in northern California. The surveyor recorded objective characteristics of the visit, surveyed patients about their impression of certain aspects of the visit related to satisfaction, and administered a standardized visit satisfaction survey. A second set of control patients who visited the same physician on the same day was contacted by phone and given the satisfaction survey two to four weeks later. PRINCIPAL FINDINGS: Patients readily accepted the presence of a surveyor during their visit, with an overall response rate of 78%. While patients contacted retrospectively gave lower satisfaction ratings, the presence of a surveyor did not affect patients' satisfaction responses. Data obtained by using the concurrent methodology provides significant information about organizational factors influencing patient satisfaction. CONCLUSIONS: Measuring patient satisfaction concurrently during a physician office visit offers an attractive alternative to other methods of measuring this key aspect of quality.

Barr, J. K., Banks, S., Waters, W. J. and Petrillo, M. (2004). "Methodological issues in public reporting of patient perspectives on hospital quality." Joint Commission Journal on Quality & Safety 30(10): 567-78.

BACKGROUND: Increasing attention is being focused on public reporting of patient satisfaction and experience with hospital care, both nationally and at the state level. Comparative reports on hospital patient satisfaction use a standard survey, but little is known about underlying methodological approaches for reporting these quality measures. METHODS: Literature, Web sites, and key informants were used to identify nine public reports. In-depth reviews were conducted to determine approaches to collecting, analyzing, and publicly reporting comparative data. Data were grouped into four analytic categories: survey, sampling, computation of scores, and reporting of scores. RESULTS: The reports were similar in response rates and sampling procedures but differed in the number of hospitals included, the survey instrument, and survey procedure. The reports varied considerably in the techniques for computing hospital scores and decisions about reporting scores. CONCLUSIONS: Reports from nine locales illustrate the decision making necessary to produce comparative reports on hospital patient satisfaction. Differences stem from decisions about the survey instrument and statistical decisions about how to interpret and report data. These issues should be clearly delineated as part of any public reporting process.

Barr, J. K., Giannotti, T. E., Sofaer, S., Duquette, C. E., Waters, W. J. and Petrillo, M. K. (2006). "Using public reports of patient satisfaction for hospital quality improvement." Health Services Research 41(3 Pt 1): 663-82.

OBJECTIVE: To explore the impact of statewide public reporting of hospital patient satisfaction on hospital quality improvement (QI), using Rhode Island (RI) as a case example. DATA SOURCE: Primary data collected through semi-structured interviews between September 2002 and January 2003. STUDY

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DESIGN: The design is a retrospective study of hospital executives at all 11 general and two specialty hospitals in RI. Respondents were asked about hospital QI activities at several points throughout the public reporting process, as well as about hospital structure and processes to accomplish QI. Qualitative analysis of the interview data proceeded through an iterative process to identify themes and categories in the data. PRINCIPAL FINDINGS: Data from the standardized statewide patient satisfaction survey process were used by hospitals to identify and target new QI initiatives, evaluate performance, and monitor progress. While all hospitals fully participated in the public reporting process, they varied in the stage of development of their QI activities and adoption of the statewide standardized survey for ongoing monitoring of their QI programs. Most hospitals placed responsibility for QI within each department, with results reported to top management, who were perceived as giving strong support for QI. The external environment facilitated QI efforts. CONCLUSION: Public reporting of comparative data on patient views can enhance and reinforce QI efforts in hospitals. The participation of key stakeholders facilitated successful implementation of statewide public reporting. This experience in RI offers lessons for other states or regions as they move to public reporting of hospital quality data.

Bauld, L., Chesterman, J. and Judge, K. (2000). "Measuring satisfaction with social care amongst older service users: issues from the literature." Health & Social Care in the Community 8(5): 316-324.

Issues of quality and accountability in social care for older people are of increasing importance. A key factor in determining quality is the extent to which older people themselves are satisfied with both the assessment of their needs and the services provided. The 1997 White Paper, Modernising Social Services, stated that local authorities will need to establish authority-wide objectives and performance measures to improve the quality and efficiency of services. In measuring quality, the White Paper stipulated that social service departments would need to design and administer satisfaction surveys as one means of capturing user and carer perceptions and experiences of services. This paper attempts to highlight some of the main issues to be considered when designing and conducting such surveys with older users of community care services. Through a review of the British and North American literature on older people's satisfaction with services, current approaches to measuring satisfaction are outlined and the relationship between the characteristics and circumstances of older people and their responses to satisfaction questions is examined. The paper concludes by offering some solutions to overcoming current problems by drawing conclusions about quality from survey findings, so that older people's opinions about the services they receive can begin to be assessed in a more meaningful way.

Bendall-Lyon, D. and Powers, T. L. (2001). "The role of complaint management in the service recovery process." Joint Commission Journal on Quality Improvement 27(5): 278-86.

BACKGROUND: Patient satisfaction and retention can be influenced by the development of an effective service recovery program that can identify complaints and remedy failure points in the service system. Patient complaints provide organizations with an opportunity to resolve unsatisfactory situations and to track complaint data for quality improvement purposes. SERVICE RECOVERY: Service recovery is an important and effective customer retention tool. One way an organization can ensure repeat business is by developing a strong customer service program that includes service recovery as an essential component. The concept of service recovery involves the service provider taking responsive action to "recover" lost or dissatisfied customers and convert them into satisfied customers. Service recovery has proven to be cost-effective in other service industries. THE COMPLAINT MANAGEMENT PROCESS: The complaint management process involves six steps that organizations can use to influence effective service recovery: (1) encourage complaints as a quality improvement tool; (2) establish a team of representatives to handle complaints; (3) resolve customer problems quickly and effectively; (4) develop a complaint database; (5) commit to identifying failure points in the service system; and (6) track trends and use information to improve service processes. SUMMARY AND CONCLUSIONS: Customer retention is enhanced when an organization can reclaim disgruntled patients through the development of effective service recovery programs. Health care organizations can become more customer oriented by taking advantage of the information provided by patient complaints, increasing patient satisfaction and retention in the process. [References: 43]

Benneyan, J. C., Lloyd, R. C. and Plsek, P. E. (2003). "Statistical process control as a tool for research and healthcare improvement." Quality & Safety in Health Care 12(6): 458-464.

Improvement of health care requires making changes in processes of care and service delivery. Although process performance is measured to determine if these changes are having the desired beneficial effects, this analysis is complicated by the existence of natural variation-that is, repeated measurements naturally yield different values and, even if nothing was done, a subsequent measurement might seem to indicate a better or worse performance. Traditional statistical analysis methods account for natural variation but require aggregation of measurements over time, which can delay decision making. Statistical process control (SPC) is a branch of statistics that combines rigorous time series analysis methods with graphical presentation of data, often yielding insights into the data more quickly and in a way more understandable to lay decision makers. SPC and its primary tool-the control chart-provide researchers and practitioners with a method of better understanding and communicating data from healthcare improvement efforts. This paper provides an overview of SPC and several practical examples of the healthcare applications of control charts.

Bialor, B. D., Musial, J. L., Rojas, G. E. and Fagan, M. J. (1999). "Use of an open-ended question to supplement a patient satisfaction questionnaire in a medical residents' clinic." American Journal of Managed Care 5(12): 1542-1549.

Objectives: To determine (1) the proportion of responses to an open-ended question related to patient satisfaction that could be categorized into 1 or more of 9 previously developed domains of outpatient care

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and (2) whether any other important aspects of care could be identified by adding the open-ended question to a satisfaction questionnaire. Study Design: A 3-month observational study was done at the internal medicine clinic of an urban teaching hospital. Patients and Methods: As part of a patient satisfaction study, 511 visitors were asked after their visit, "What are the 1 or 2 things that are most important to you when you see a doctor?" The responses were categorized independently by 2 raters into 1 or more of the 9 domains. When these 2 raters disagreed, the responses were read to a third rater. When either all 3 raters disagreed, or at least 1 rater thought a new domain was mentioned, those responses were categorized by consensus. Interobserver reliability between raters 1 and 2 was calculated by using Cohen's K statistic. Results: The 355 responses were categorized as follows: 303 (85.4%) identified one or more domains that were part of the previously developed taxonomy, 9 (2.5%) identified a new domain, 11 (3.1%) identified both old and new domains, and 32 (9.0%) could not be categorized. Cohen's x was 0.57 (P<.001). Cultural sensitivity and physician honesty were the additional domains identified, by 1.1% and 4.5% of respondents, respectively. Conclusions: The previously developed taxonomy of domains can be used in this setting to categorize the large majority of open-ended responses. Such responses can identify important aspects of care that were either previously unidentified or were already identified but given low ratings. This information then can help improve quality of care.

Bird, S. (2002). "The art of dealing with complaints." Australian Family Physician 31(12): 1101-2.

Complaints against medical practitioners are relatively frequent. Appropriate management of complaints is an important part of good practice management. This article provides some guidelines for general practitioners on how to respond to patient complaints.

Bismark, M. M., Brennan, T. A., Paterson, R. J., Davis, P. B. and Studdert, D. M. (2006). "Relationship between complaints and quality of care in New Zealand: a descriptive analysis of complainants and non-complainants following adverse events." Quality & Safety in Health Care 15(1): 17-22.

OBJECTIVES: To estimate the proportion and characteristics of patients injured by medical care in New Zealand public hospitals who complain to an independent health ombudsman, the Health and Disability Commissioner ("the Commissioner"). DESIGN: The percentage of injured patients who lodge complaints was estimated by linking the Commissioner's complaints database to records reviewed in the New Zealand Quality of Healthcare Study (NZQHS). Bivariate and multivariate analyses investigated sociodemographic and socioeconomic differences between complainants and non-complainants. SETTING: New Zealand public hospitals and the Office of the Commissioner in 1998. POPULATION: Patients who lodged claims with the Commissioner (n = 398) and patients identified by the NZQHS as having suffered an adverse event who did not lodge a complaint with the Commissioner (n = 847). MAIN OUTCOME MEASURES: Adverse events, preventable adverse events, and complaints lodged with the Commissioner. RESULTS: Among adverse events identified by the NZQHS, 0.4% (3/850) resulted in complaints; among serious, preventable adverse events 4% (2/48) resulted in complaints. The propensity of injured patients to complain increased steeply with the severity of the injury: odds of complaint were 11 times greater after serious permanent injuries than after temporary injuries, and 18 times greater after deaths. Odds of complaining were significantly lower for patients who were elderly (odds ratio (OR) 0.2, 95% confidence interval (CI) 0.1 to 0.4), of Pacific ethnicity (OR 0.3, 95% CI 0.1 to 0.9), or lived in the most deprived areas (OR 0.3, 95% CI 0.2 to 0.6). CONCLUSION: Most medical injuries never trigger a complaint to the Commissioner. Among complaints that are brought, severe and preventable injuries are common, offering a potentially valuable "window" on serious threats to patient safety. The relatively low propensity to complain among patients who are elderly, socioeconomically deprived, or of Pacific ethnicity suggests troubling disparities in access to and utilisation of complaints processes.

Boerstler, H., Foster, R. W., O'Connor, E. J., O'Brien, J. L., Shortell, S. M., Carman, J. M. and Hughes, E. F. X. (1996). "Implementation of total quality management: conventional wisdom versus reality." Hospital & Health Services Administration 41(2): 143-159.

Hospitals nationwide are beginning to implement continuous quality improvement (CQI) (Barsness et al. 1993; Kosta 1992). In large part this is due to the belief that the implementation of CQI will lead to higher quality patient care, improved patient satisfaction, better employee morale, and lower cost service delivery. However, to date there have been few empirical studies of CQI implementation efforts in healthcare (Shortell et al. 1994).

Boettcher, R. E. (1998). "A study of quality-managed human service organizations." Administration in Social Work 22(2): 41-56.

The author reports on a study of 41 HSOs which are consciously attempting to implement a total quality management approach to agency administration. After a brief introduction to the principles of TQM, an estimate of the extent of utilization of this approach, inferred from the sample, is made. The agencies in the study sample are described in terms of characteristics which typify the quality-management organization, with attention given to differences in degree of implementation. The impact of TQM on such variables as client satisfaction, customer complaints, and employee morale is reported. Several bi-variate relationships are presented as possible directions for future research.

Bogart, G. (1992). "The United States does a poor job of evaluating medicare." Hospital Topics 70(4): 11-11.

The United States spends more money per person on healthcare than does any other country in the world, and this rate of spending is increasing. Healthcare expenses currently absorb more than 12 percent of the

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American gross national product, and recent projections indicate that such expenses will exceed 16 percent by the year 2000. By the year 2005, the U.S. Medicare program is expected to absorb more of the national budget than either Social Security or defense. One justification for the high rate of spending has been that, for those who receive it, U.S. healthcare is the best in the world. There is, however, no way to validate this view because no national or international agreed-upon set of criteria for measuring quality of care exists. Proponents of the American system seem to assume that if it costs more, it must be better. If this is true, it is certainly not reflected in American consumer satisfaction: a recent poll of citizens of ten developed countries indicated that Americans were by far the least satisfied with their healthcare system. This article focuses on the American oversight of Medicare hospitals to determine it, in this narrow area, dissatisfied American consumers are justified.

Boscarino, J. A. and Adams, R. E. (2004). "Public perceptions of quality care and provider profiling in New York: implications for improving quality care and public health." Journal of Public Health Management & Practice 10(3): 241-50.

Despite a growing emphasis on providing health care consumers with more information about quality care, useful and valid provider-specific information often has not been available to the public or has been underutilized. To assess this issue in New York State, random telephone surveys were conducted in September 2002 and March 2003, respectively, of 1,001 and 500 English- or Spanish-speaking persons, 18 years or older. Results indicated that 33% of New Yorkers were very concerned about the quality of care, with African Americans being particularly concerned. Less than half of the respondents recalled hearing or seeing information about health care quality in the past year and less than 20% actually used this information in medical decision making. African Americans were the least likely to recall receiving or being exposed to quality-related information, whereas women and more educated adults were the most likely to report being exposed. Furthermore, New Yorkers received quality information from multiple sources, with about 20% saying that they obtained information about physician and hospital quality from media (eg, newspaper) and nonmedia (eg, recommendation by family member) sources. Evaluations of different kinds of information suggested that some types (eg, whether or not a doctor is board certified) carried more weight in health care decision making than other types (eg, government ratings). Unexpectedly, those who used information to make health care decisions were more likely to have reported experiencing a medical error in the household. Finally, in the 6-month follow-up survey, concerns about the quality of care in the state remained about the same, while fears of terrorism decreased and preparations for future terrorist attacks increased. In the survey, few major differences were found in results based on payer status (eg, private insurance versus Medicaid/no insurance). These findings have implications for both the private and public health care sectors. Specifically, they suggest that greater access to and use of provider-specific health care information by the public is a viable way to improve quality, particularly if health care professionals support the public use of these data.

Bostan, S., Acuner, T. and Yilmaz, G. (2007). "Patient (customer) expectations in hospitals." Health Policy 82(1): 62-70.

The expectations of patient are one of the determining factors of healthcare service. The purpose of this study is to measure the Patients' Expectations, based on Patient's Rights. This study was done with Likert-Survey in Trabzon population. The analyses showed that the level of the expectations of the patient was high on the factor of receiving information and at an acceptable level on the other factors. Statistical meaningfulness was determined between age, sex, education, health insurance, and the income of the family and the expectations of the patients ($p<0.05$). According to this study, the current legal regulations have higher standards than the expectations of the patients. The reason that the satisfaction of the patients high level is interpreted due to the fact that the level of the expectation is low. It is suggested that the educational and public awareness studies on the patients' rights must be done in order to increase the expectations of the patients.

Boudreaux, E. D., Mandry, C. V. and Wood, K. (2003). "Patient satisfaction data as a quality indicator: a tale of two emergency departments." Academic Emergency Medicine 10(3): 261-8.

OBJECTIVE: Patient satisfaction is a commonly measured indicator of quality emergency care. However, the existing empirical literature on emergency department (ED) patient satisfaction provides little guidance on how to analyze, interpret, and use data obtained in the clinical setting. Using two EDs as examples, the authors describe practical strategies designed to identify priority areas for potential improvement. METHODS: The authors used a cross-sectional, observational design. All patients who presented for emergency care during the designated time periods were eligible. Patients were randomly selected, contacted by telephone, and surveyed using three measures of global satisfaction, 23 perceived quality-of-care indicators, and six perceived wait times. Descriptive statistics were calculated. Comparisons were made of each of the perceived care and wait time indicators against explicitly defined acceptability criteria to determine satisfiers/dissatisfiers. Each indicator was correlated with the three global satisfaction indices. The authors integrated results obtained from applying the acceptability criteria with those obtained from the correlations to yield priority indicators for remediation and maintenance strategies. RESULTS: For hospitals A and B, respectively, 15 (52%) and 16 (55%) of perceived care and wait time indicators failed to meet acceptability criteria. Using the correlations with overall satisfaction, the authors further narrowed the priority areas for remediation to six indicators for hospital A and three indicators for hospital B. One maintenance indicator was revealed for hospital A and four for hospital B. CONCLUSIONS: A combination of applying explicit acceptability criteria to descriptive statistics and using correlation coefficients with overall satisfaction can help to maximize the usefulness of patient satisfaction data by uncovering priority areas. These priority areas were broken down into maintenance and remediation indicators and were found to vary considerably depending on the hospital in question. Such strategies can help to refine performance improvement efforts

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by targeting those domains with the greatest impact on overall satisfaction.

Bowers, M. R. and Kiefe, C. I. (2002). "Measuring health care quality: comparing and contrasting the medical and the marketing approaches." American Journal of Medical Quality 17(4): 136-44.

Health care quality, a key concept for medical practice and research, is also a widely used construct in health care administration and marketing research. We explored discipline-specific differences in the definition of quality, with the intent of finding a more unified approach. We summarized definitions and basic conceptual approaches to quality in both disciplines and then compared them on several attributes: basic goals, sources of measurement, role of patient perceptions, role of health care personnel, and need for risk adjustment. We developed a conceptual model combining the 2 approaches. Both disciplines could benefit from broadening their outcome measures. Patient satisfaction deserves more attention from medical researchers, whereas marketing approaches should go beyond using patient satisfaction as the only outcome of interest. It is conceptually feasible to integrate medical and marketing approaches to quality, with important insights resulting from this integration. [References: 49]

Bowers, M. R., Swan, J. E. and Koehler, W. F. (1994). "What attributes determine quality and satisfaction with health care delivery?" Health Care Management Review 19(4): 49-55.

Patient-based determinants of quality and satisfaction play an important role in choosing a health care provider. This study identifies five attributes of health care delivery that define patients' perceptions of quality and satisfaction. Managerial implications for diagnosing quality concerns of patients are discussed.

Boyer, L., Antoniotti, S., Sapin, C., Doddoli, C., Thomas, P. A., Raccah, D. and Auquier, P. (2003). "The Link between Satisfaction and Quality of Care for Inpatients. [French]." Journal d'Economie Medicale 21(7-8): 407-418.

Objective: To look for the relations between the patient's satisfaction (evaluated by the French validated Questionnaire of Satisfaction of Hospitalised patients, QSH) and the quality of care, according to two diseases (diabetes, lung cancer). Quality of care is measured by some objective indicators, in accordance with the recognised guidelines. Methods: The scientific committee has chosen in cooperation with the medical staff the items for the evaluation of quality of care. Our instrument is divided into two parts: a common part to both pathologies based on criteria resulting from the accreditation handbook; and a specific part for each pathology according to the literature review. The patients' satisfaction is evaluated by the QSH. The quality of care is assessed retrospectively from the patients' files. Results: No simple relation between satisfaction and quality of care is highlighted in this pilot study including 119 subjects. The least satisfied patients are not those who have the worst quality of care. Satisfaction related to the hospital staff is negatively correlated with the quality of care " accreditation" ($r = -0.23$; $p < 0.05$). This result is also found with the logistic regression (OR = 0.57; 95% IC [0.39; 0.83]. A link has been highlighted between the "specific" quality of care and the satisfaction with nurses (OR = 1.16; 95% IC [1.01; 1.32]) but not with the doctors ($p > 0.05$). Conclusion: In spite of the current tendency to assimilate satisfaction and quality of care, it doesn't seem relevant to evaluate a quality whose only reference is the patients' opinion.

Boyer, L., Francois, P., Doutre, E., Weil, G. and Labarere, J. (2006). "Perception and use of the results of patient satisfaction surveys by care providers in a French teaching hospital." International Journal for Quality in Health Care 18(5): 359-364.

Objectives. The aim of this study was to assess clinical staff's opinions on the results of in-patient satisfaction surveys and their use within the quality improvement process. Setting. The institution is a 2200-bed teaching hospital of tertiary health care employing 8000 professionals. Patient satisfaction surveys are carried out each year using a validated questionnaire mailed to a random sample of patients. The specific results of each department are sent to the medical and paramedical managers. Methods. We conducted a questionnaire survey on 500 care providers randomly selected in every medical and surgical department. Results. A total of 261 questionnaires were returned and analysed. Overall, 94% of responders had a favourable opinion of the patient satisfaction surveys. They considered that the patient was able to judge hospital service quality, especially in its relational, organizational, and environmental dimensions. The specific results for the department were less well known than the overall hospital results (60 versus 76%). These results were formally discussed in the department according to 40% of responders; 40% declared that these data resulted in improvement actions and considered that they led to modifications in their behaviour with patients. Conclusions. Despite a declared interest in satisfaction surveys, the results remain underused by hospital staff and insufficiently discussed within teams. copyright 2006 Oxford University Press.

Braun, B. L., Kind, E. A., Fowles, J. B. and Suarez, W. G. (2002). "Consumer response to a report card comparing healthcare systems." American Journal of Managed Care 8(6): 522-8.

OBJECTIVE: Report cards to date have focused on quality of care in health plans rather than within healthcare delivery systems. The purpose of this study was to evaluate consumer response to the first healthcare system-level report card. STUDY DESIGN: Qualitative assessment of consumer response. METHODS: We conducted 5 focus groups of community members to evaluate consumer response to the report card; 2 included community club members, 3 included community-dwelling retired persons. Discussions were audiotaped and transcribed; comments were categorized by topic area from the script, and common themes identified. RESULTS: Focus group participants, in general, were unaware of the current emphasis on medical quality improvement initiatives. However, they believed that the opinion that the descriptive clinic information and patient survey data contained in the report card would be most useful

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mainly for choosing a healthcare system if they were dissatisfied with current medical care, if their healthcare options changed, or if they were in poor health. Personal experience was considered a more trustworthy measure of healthcare quality than were patient survey results. Trustworthiness was perceived to be higher if the report card sponsor was not affiliated with the healthcare systems being evaluated. Participants also believed care system administrators should use the data to enact positive clinic-level and physician-level changes. CONCLUSIONS: Healthcare consumers appreciated the attention to patient experiences and supported healthcare quality improvement initiatives. Report cards were considered important for choosing a healthcare system in certain circumstances and for guiding quality improvement efforts at all levels.

Brown, A. D., Sandoval, G. A., Levinton, C. and Blackstien-Hirsch, P. (2005). "Developing an efficient model to select emergency department patient satisfaction improvement strategies.[see comment]." Annals of Emergency Medicine 46(1): 3-10.

STUDY OBJECTIVE: Patient satisfaction is an important performance measure for emergency departments (EDs), but the most efficient ways of improving satisfaction are unclear. This study uses optimization techniques to identify the best possible combination of predictors of overall patient satisfaction to help guide improvement efforts. METHODS: The results of a satisfaction survey from 20,500 patients who visited 123 EDs were used to develop ordinal logistic regression models for overall quality of care, overall medical treatment, willingness to recommend the ED to others, and willingness to return to the same ED. Originally, 68,981 surveys were mailed, and 20,916 were returned, representing an overall response rate of 30.3%. We then incorporated these regressions into an optimization model to select the most efficient combination of predictors necessary to increase the 4 overall satisfaction measures by 5%. A sensitivity analysis was also conducted to explore differences across hospital peer groups and regions. RESULTS: Results differ slightly for each of the 4 overall satisfaction measures. However, 4 predictors were common to all of these measures: "perceived waiting time to receive treatment," "courtesy of the nursing staff," "courtesy of the physicians," and "thoroughness of the physicians." The selected predictors were not necessarily the strongest predictors identified through regression models. The optimization model suggests that most of these predictors must be improved by 15% to increase the overall satisfaction measures by 5%. CONCLUSION: This study introduces the use of optimization techniques to study ED patient satisfaction and highlights an opportunity to apply this technique to widely collected data to help inform hospitals' improvement strategies. The results suggest that hospitals should focus most of their improvement efforts on the 4 predictors mentioned above.

Brown, R. B. and Bell, L. (2005). "Patient-centred quality improvement audit." International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services 18(2-3): 92-102.

PURPOSE: This article aims to describe the research process, and the development of the instrument now employed in auditing patients' perceptions of quality improvement in a community health care trust in a coastal town in Essex, England. DESIGN/METHODOLOGY/APPROACH: The new instrument is currently being implemented and the findings thus far are described. FINDINGS: The instrument has measured health outcomes in terms of quality improvement from the users' perspective, and has also highlighted gaps between what the service offers in terms of quality and users' perceptions of what is delivered. The study demonstrates the importance of the professional role in quality improvement. ORIGINALITY/VALUE: Patient-centred quality improvement audit should be undertaken regularly so that both non-clinical managers and health care professionals can establish whether or not they are providing services that are patient-friendly and effective from the user's viewpoint. In the course of their work, professionals and managers discuss patients and speak on their behalf in various forums, and knowing what patients actually expect and perceive before speaking on their behalf may be of great benefit in such instances.

Burroughs, T. E., Cira, J. C., Chartock, P., Davies, A. R. and Dunagan, W. C. (2000). "Using root cause analysis to address patient satisfaction and other improvement opportunities." Joint Commission Journal on Quality Improvement 26(8): 439-49.

BACKGROUND: Despite the considerable attention that health care organizations are devoting to the measurement of patient satisfaction, there is often confusion about how to systematically use these data to improve an organization's performance. A model to use in applying traditional quality improvement methods and tools to patient satisfaction problems includes five primary steps: (1) identifying opportunities, (2) prioritizing opportunities, (3) conducting root cause analysis, (4) designing and testing potential solutions, and (5) implementing the proposed solution. PATIENT SATISFACTION SURVEYS: A satisfaction survey serves best as a high-level screening device, not as a tool to provide highly detailed information about the root causes of patient dissatisfaction. The primary purpose of the survey in the model is to identify improvement opportunities and areas of significant improvement or deterioration. Secondary tools such as brief patient interviews or focus groups may better serve to probe intensively into the problem areas identified by the survey. These tools allow for a direct dialog with the patient to uncover root causes of dissatisfaction and establish potential solutions. DISCUSSION: Although the primary focus of this model has been patient satisfaction issues, the basic steps could easily be applied to virtually any improvement opportunity. Improvement teams should commit to a schedule of 90-minute weekly meetings for 7 weeks. The model, a simple translation of traditional improvement methods and tools to address the unique issues facing patient satisfaction improvement teams, can save improvement teams considerable time, resources, and frustration as they design and launch initiatives to improve patient satisfaction. [References: 26]

Burroughs, T. E., Davies, A. R., Cira, J. C. and Dunagan, W. C. (1999). "Understanding patient willingness to recommend and return: a strategy for prioritizing improvement opportunities." Joint Commission Journal on Quality Improvement 25(6): 271-87.

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BACKGROUND: Beginning in April 1995, an ongoing, comprehensive measurement system has been developed and refined at BJC Health System, a regional integrated delivery and financing system serving the St Louis metropolitan area, mid-Missouri, and Southern Illinois, to assess patient satisfaction with inpatient treatment, outpatient treatment, outpatient surgery, and emergency care. This system has provided the mechanism for identifying opportunities, setting priorities, and monitoring the impact of improvement initiatives. METHODS: Satisfaction with key components of the care process among 23,361 patients (7,083 inpatients, 8,885 patients undergoing outpatient tests/procedures, 5,356 patients undergoing outpatient surgery, and 2,037 patients receiving emergency care) at 15 BJC Health System facilities was assessed through weekly surveys administered in April 1995 through December 1996. RESULTS: Structural equation models were developed to identify the key predictors of patient advocation-willingness to return for or recommend care. Across all venues of care the compassion provided to patients had the strongest relationship to patient advocation. Within each venue of care, however, a slightly different set of secondary factors emerged. The resulting models provided important information to help prioritize competing improvement opportunities in BJC Health System. In one hospital, a general medicine unit working for several years with little success to improve its patient satisfaction decided to focus on two primary factors predicting patient advocation: nursing care delivery and compassionate care. Root cause analysis was used to determine why two items-staff willingness to help with questions/concerns and clear explanation about tests and procedures-were rated low. On the basis of feedback from phone interviews with discharged patients, the care delivery process was changed to encourage patients to ask questions. Across the next two quarters, this unit experienced significant improvements in both targeted items. DISCUSSION: The significance of compassionate care and care delivery again speaks not only to the importance of the technical quality of clinical care but also to the customer-focused way in which this care was provided. After the primary predictors of patient advocation were identified, management was able to strategically focus improvement initiatives to maximize their impact. Across the organization, improvement teams scanned their data to find key factors where performance was lacking. Once these key opportunities were identified, the teams developed potential solutions and launched initiatives to improve their performance. SUMMARY AND CONCLUSIONS: Results suggest that some core issues are of extreme importance to patients regardless of whether they are receiving care in an inpatient, outpatient, or emergency setting. The compassion with which care is provided appears to be the most important factor in influencing patient intentions to recommend/return, regardless of the setting in which care is provided.

Burstein, J. and Fleisher, G. R. (1991). "Complaints and compliments in the pediatric emergency department." Pediatric Emergency Care 7(3): 138-40.

We conducted an analysis of all communications received from patients or their families by the director of a pediatric emergency department over a three-year period, during which approximately 150,000 visits occurred. Communications were characterized as complaint or compliment and subclassified by type: waiting time, staff attitude, quality of medical care, and billing. Chi 2 analysis was used to identify factors that predisposed to complaint or compliment and to identify the subtype. After quality-of-care issues, complaints stemmed most often from billing issues or waiting time for care for nonurgent disorders (especially medical problems), while complimentary letters most frequently addressed staff attitude and quality of care. The problems that we identified might be addressed by providing families improved access to non-emergency department care sources, education regarding the role of an emergency department, and better explanation of billing procedures during the registration process. Additionally, our findings serve as a reminder that many parents appreciate the care given to their children, particularly for life-threatening emergencies.

Burstin, H. R., Conn, A., Setnik, G., Rucker, D. W., Cleary, P. D., O'Neil, A. C., Orav, E. J., Sox, C. M. and Brennan, T. A. (1999). "Benchmarking and quality improvement: the Harvard Emergency Department Quality Study." American Journal of Medicine 107(5): 437-49.

PURPOSE: To determine whether feedback of comparative information was associated with improvement in medical record and patient-based measures of quality in emergency departments. SUBJECTS AND METHODS: During 1-month study periods in 1993 and 1995, all medical records for patients who presented to five Harvard teaching hospital emergency departments with one of six selected chief complaints (abdominal pain, shortness of breath, chest pain, hand laceration, head trauma, or vaginal bleeding) were reviewed for the percent compliance with process-of-care guidelines. Patient-reported problems and patient ratings of satisfaction with emergency department care were collected from eligible patients using patient questionnaires. After reviewing benchmark information, emergency department directors designed quality improvement interventions to improve compliance with the process-of-care guidelines and improve patient-reported quality measures. RESULTS: In the preintervention period, 4,876 medical records were reviewed (99% of those eligible), 2,327 patients completed on-site questionnaires (84% of those eligible), and 1,386 patients completed 10-day follow-up questionnaires (80% of a random sample of eligible participants). In the postintervention period, 6,005 medical records were reviewed (99% of those eligible), 2,899 patients completed on-site questionnaires (84% of those eligible), and 2,326 patients completed 10-day follow-up questionnaires (80% of all baseline participants). In multivariate analyses, adjusting for age, urgency, chief complaint, and site, compliance with process-of-care guidelines increased from 55.9% (preintervention) to 60.4% (postintervention, P = 0.0001). We also found a 4% decrease (from 24% to 20%) in the rate of patient-reported problems with emergency department care (P = 0.0001). There were no significant improvements in patient ratings of satisfaction. CONCLUSION: Feedback of benchmark information and subsequent quality improvement efforts led to small, although significant, improvement in compliance with process-of-care guidelines and patient-reported measures of quality. The measures that relied on patient reports of problems with care, rather than patient ratings of satisfaction with care, seemed to be more responsive to change. These results support the value of benchmarking and collaboration.

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Calnan, M. (1988). "Towards a conceptual framework of lay evaluation of health care." Social Science & Medicine 27(9): 927-33.

It is argued in this paper that much of the empirical research into the public's and patients' perceptions of the adequacy of health care has suffered from conceptual weaknesses. In addition, and maybe as a result of these weaknesses, a contradictory pattern of findings has emerged from this research. To overcome some of these problems it is suggested that an investigation of lay evaluation of health care should be carried out within a conceptual framework which incorporates the following elements. (i) The goals of those seeking health care in each specific instance. (ii) The level of experience of use of health care. (iii) The socio-political values upon which the particular health care system is based. (iv) The images of health held by the lay population. Each of these elements interrelates with the others and their influence will be mediated through socio-demographic characteristics of the service users.

Cangialose, C. B., Cary, S. J., Hoffman, L. H. and Ballard, D. J. (1997). "Healthcare policy development. Impact of managed care on quality of healthcare: theory and evidence." American Journal of Managed Care 3(8): 1153-1170.

Each strategy for managing healthcare risk has important and unique implications for the patient-provider relationship and for quality of care. Not only are different incentive structures created by different risk-sharing arrangements, but these incentives differ from those in a fee-for-service environment. With fee-for-service and traditional indemnity insurance, physicians have incentives to provide healthcare services of marginal value to the patient; under managed care, physicians have fewer incentives to provide marginally beneficial services. However, the impact of financial arrangements on quality of care remains ambiguous, because it depends on the strategic behavior of physicians with regard to their informational advantage over their patients. Using the framework of an agency theory model, we surveyed the current scientific literature to assess the impact of managed care on quality of care. We considered three different dimensions of quality of care: patient satisfaction, clinical process and outcomes of care measures, and resource utilization. Although we found no systematic differences in patient satisfaction and clinical process and outcomes between managed care and fee-for-service plans, resource utilization appears to be decreased under managed care arrangements. Given the strengths and weaknesses of fee-for-service and managed care, it is unlikely that either will displace the other as the exclusive mechanism for arranging health insurance contracts. Policy makers may be able to take advantage of the strengths of both fee-for-service and managed care financial arrangements.

Carey, R. G. and Seibert, J. H. (1993). "A patient survey system to measure quality improvement: questionnaire reliability and validity." Medical Care 31(9): 834-45.

This study describes the results of a four-year research effort to develop inpatient and outpatient questionnaires that have sufficient validity and reliability to be used to measure patient perceptions of quality. As part of this effort, over 50,000 inpatients, emergency room patients, and ambulatory surgery patients from over 300 hospitals representing every US census region were surveyed. Separate questionnaires, called Quality of Care Monitors, were developed for inpatients and outpatients. The inpatient questionnaire consisted of 8 scales: Physician Care, Nursing Care, Medical Outcome, Courtesy, Food Service, Comfort and Cleanliness, Admissions/Billing, and Religious Care. The outpatient questionnaire had 7 scales: Physician Care, Nursing Care, Medical Outcome, Facility Characteristics, Waiting Time, Testing Services and Registration Process. The study found strong evidence of construct validity, predictive validity, and internal consistency for both questionnaires. Each questionnaire is capable of measuring separate dimensions of patient experience. A data bank developed from these questionnaires is currently accessed regularly by participating hospitals to assess quality improvement and to make benchmark comparisons with similar hospitals.

Carmel, S. (1990). "Patient complaint strategies in a general hospital." Hospital & Health Services Administration 35(2): 277-88.

This study aimed to understand specific complaint behaviors of inpatients regarding perceived problems in the receipt of hospital services and to study the effect of provider responses to the different complaint strategies on patients' overall satisfaction with hospital services. The analysis was performed on 155 patients who had reported a problem in the receipt of services and had acted to elicit a change. Three complaint strategies were studied--formal, informal, and a combination of both. The use of these strategies was studied in relation to type of hospital service and the type of ward where the problem emerged. Two questions were investigated--what strategy leads to the best outcome for the patients? and how does each outcome affect overall satisfaction with hospital services?

Carruthers, A. E. and Jeacocke, D. A. (2000). "Adjusting the balance in health-care quality." Journal of Quality in Clinical Practice 20(4): 158-60.

In an increasingly informed society there has been a growing interest by consumers in evaluating the quality-of-care provided by their practitioners. This task is complicated by an asymmetry in the technical knowledge required to assess health-care quality between consumers and health providers. Recently attempts have been made to incorporate patient views into the assessment of quality to try and address this asymmetry. A number of quality initiatives have been developed to help provide consumers with markers of practitioner competency including professional training programmes and examinations, quality standards and quality assurance activities. International trends include federal funding for quality improvement activities within practices, and greater use of information technology to provide error warning systems for practitioners, to monitor practice patterns, and to promote better communication of information between health services. It is important in developing these new initiatives that 'symmetrical' approaches which

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capture consumers' views on quality are employed.

Carson, P. P., Carson, K. D. and Roe, C. W. (1998). "Toward understanding the patient's perception of quality." Health Care Supervisor 16(3): 36-42.

Patients often don't have the technical competence to judge the quality of medical care. Therefore, they rely on different criteria than do professionals in assessing quality. They perceive quality as a gestalt of experiences influenced by such issues as empathy, integrity, and appearance of competency. Patients do not complain about service quality when it is appropriately provided. But to satisfy the consumer, providers must go beyond being reliable, polite, and honest. They must provide prompt services, be approachable, and provide individualized attention. To ultimately delight consumers, however, providers must meet the unarticulated needs of the patient.

Casebolt, K. (1990). "How to better handle patient complaints: seven simple rules of the road." Patient Accounts 13(10): 2-4.

Castle, N. G., Brown, J., Hepner, K. A. and Hays, R. D. (2005). "Review of the literature on survey instruments used to collect data on hospital patients' perceptions of care." Health Services Research 40(6 Pt 2): 1996-2017.

OBJECTIVE: To review the existing literature (1980-2003) on survey instruments used to collect data on patients' perceptions of hospital care. STUDY DESIGN: Eight literature databases were searched (PubMED, MEDLINE Pro, MEDSCAPE, MEDLINEplus, MDX Health, CINAHL, ERIC, and JSTOR). We undertook 51 searches with each of the eight databases, for a total of 408 searches. The abstracts for each of the identified publications were examined to determine their applicability for review. METHODS OF ANALYSIS: For each instrument used to collect information on patient perceptions of hospital care we provide descriptive information, instrument content, implementation characteristics, and psychometric performance characteristics. PRINCIPAL FINDINGS: The number of institutional settings and patients used in evaluating patient perceptions of hospital care varied greatly. The majority of survey instruments were administered by mail. Response rates varied widely from very low to relatively high. Most studies provided limited information on the psychometric properties of the instruments. CONCLUSIONS: Our review reveals a diversity of survey instruments used in assessing patient perceptions of hospital care. We conclude that it would be beneficial to use a standardized survey instrument, along with standardization of the sampling, administration protocol, and mode of administration. [References: 102]

Chahal, H., Sharma, R. D. and Gupta, M. (2004). "Patient satisfaction in public outpatient health care services." Journal of Health Management 6(1): 23-45.

This paper is part of earlier research work conducted in the health care services sector. The customer relationship management concept has encouraged the adoption of a marketing culture not only in the private sector, but in public health care sector as well. In this paper the authors have analysed the factors affecting patient satisfaction in public health care outpatient services. Patient satisfaction is measured with respect to technical and non-technical characteristics of health care service encounters, categorised into four basic components: attitude towards doctors, attitude towards medical assistants, quality of administration and quality of atmospherics. The authors hypothesise that all four factors are closely related to consumer satisfaction. The paper measures the degree of consumer satisfaction experienced by patients through the tested self-developed five point Likert scale and has highlighted the problem faced by them. The impact of age, education level and gender of the decision maker on satisfaction/dissatisfaction is analysed using relevant statistical tools. The responses have been integrated into important factors on the basis of factor analysis after verifying the validity and reliability of the schedule. The paper concludes with the strategic actions necessary for meeting the needs of patients of the government health care sector in developing countries.

Charters, M. A. (1993). "The patient representative role and sources of power." Hospital & Health Services Administration 38(3): 429-42.

Because the 1990 accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations call for the establishment of patient grievance procedures, this study examines the possibility of patient representatives serving in that capacity. Members of the National Society of Patient Representation and Consumer Affairs were surveyed to examine current roles of patient representatives--in particular, their handling of complaints, the types and sources of their power, the potential for conflict of interest as an institutionally employed advocate, and requirements for and barriers to successful job performance. The study reveals a great variation in the activity profiles of patient representatives. Additionally, it shows that the staff in place is professionally capable of moving in many directions and that departments have become the patient grievance mechanisms called for by the Joint Commission, depending on the hospital's management philosophy as reflected in allocation of authority and resources.

Chaska, B. W. (2006). "Growing loyal patients." Physician Executive 32(3): 42-6.

Chaston, I. (1994). "Internal customer management and service gaps within the National Health Service." International Journal of Nursing Studies 31(4): 380-90.

One implication of being required to respond to the Patients' Charter without access to more resources, is that managers in the U.K. health care sector will have to ensure integration of multiple functions across their

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units in order to achieve the objective of creating a quality conscious workforce. This situation will probably demand adoption of an internal marketing philosophy within the NHS; thereby ensuring implementation of TQM and/or Customer Care schemes in which departments work together to create effective internal customer chains. To determine the degree to which the NHS have effectively adopted an internal customer orientation, a survey was undertaken using a modified version of the Parasuraman SERVQUAL model. The majority of respondents indicated the existence of Type 1, 2, 3 and 4 Gaps in the internal customer management process within their unit. Major influencers of these service gaps include departments placing internal efficiency ahead of internal customer needs elsewhere in the organization, limited effort to gain further understanding of internal customer needs and an inadequate level formal quality standards for managing internal customer relations. Respondents consider their departments are able and willing to enhance the quality of provision if the issue was given higher priority by senior management. Identified obstacles to increased future emphasis behind an internal customer philosophy include insufficient resources to service internal customer needs, lack of trust between departments and limited confidence about abilities to manage the process. Unless senior managers in the NHS can be persuaded to allocate the resources needed to create effective internal customer chains, then concern must exist about the capability of operating units to fulfil the health care standards specified in the Patients Charter.

Chavan, R., Porter, C. and Sandramouli, S. (2007). "Formal complaints at an eye hospital: A three-year analysis." Clinical Governance 12(2): 85-92.

Purpose: Complaints can provide the health provider with vital information on its performance and can point towards areas for improvement. The purpose of this study was to undertake a retrospective study of all formal complaints in an eye hospital over a three-year period in order to look at the complaint rate, demographics, their nature, how they were resolved and the lessons learned. Design/methodology/approach: Complaints received were entered onto the complaints module of the DATIX database system. Formal patient complaints between April 2003 and March 2006 available on the DATIX database were analysed retrospectively. Findings: The study found that there were total of 94 formal complaints out of 186,323 attendances at the hospital. The overall complaint rate was 5.09 per 10,000 attendances. 52(55.31 per cent) complaints were about rescheduling or cancellation of appointments. Complaints related to communication failure were 17(18.08 per cent) followed by clinical complaints, which totalled 13 (13.82 per cent). Four (4.25 per cent) complaints each under the category of amenities, administrative and waiting times were also recorded. The complaint rate for Outpatients Department was 1.5 per 10,000 attendances. The in-patient ward had a complaint rate of 0.91 per 1000. The complaint rate for A&E department was 0.88 per 10,000 attendances. The operation theatre plus laser sessions had a complaint rate of 0.95 per 10,000. 79 (84.04 per cent) complaints were resolved at the first stage of local resolution. Complaints during the study period brought about two clinical changes in practice. Originality/value: The use of complaints data as an important tool to learn from less satisfied patients is recommended. Comparing and sharing data on complaints between hospitals can help to highlight common deficient areas and can also be used to plan strategies.

Chiou, W.-B. (2007). "Customers' attributional judgments towards complaint handling in airline service: a confirmatory study based on attribution theory." Psychological Reports 100(3 Pt 2): 1141-50.

Besides flight safety, complaint handling plays a crucial role in airline service. Based upon Kelley's attribution theory, in the present study customers' attributions were examined under different conditions of complaint handling by the airlines. There were 531 passengers (216 women; ages 21 to 63 years, M = 41.5, SD = 11.1) with experiences of customer complaints who were recruited while awaiting boarding. Participants received one hypothetical scenario of three attributional conditions about complaint handling and then reported their attributional judgments. The findings indicated that the passengers were most likely to attribute the company's complaint handling to unconditional compliance when the airline company reacted to customer complaints under low distinctiveness, high consistency, and when consensus among the airlines was low. On the other hand, most passengers attributed the company's complaint handling to conditional compliance under the conditions in which distinctiveness, consistency, and consensus were all high. The results provide further insights into how different policies of complaint management affect customers' attributions. Future directions and managerial implications are also discussed.

Cho, S.-H. and Kim, C.-y. (2007). "Trends in patient satisfaction from 1989-2003: adjusted for patient characteristics." Daehan Ganho Haghoeji 37(2): 171-8.

PURPOSE: To identify trends in patient satisfaction adjusted for sociodemographic factors and health status from 1989-2003. METHODS: Five repeated cross-sectional surveys were used. The study sample included 290,534 household members 20 years of age and over from the five survey periods of 1989, 1992, 1995, 1999, and 2003. Satisfaction was measured using a five-point scale, ranging from "very satisfied" to "very dissatisfied." Crude satisfaction rates, representing the proportion of patients satisfied (very satisfied or satisfied), were calculated for each survey period. Satisfaction rates adjusted for age, sex, marital status, education, and self-rated health status were calculated for each of the five years. RESULTS: Crude satisfaction rates increased from 15.4% in 1989 to 40.5% in 2003. The proportions of satisfaction and dissatisfaction were reversed after 15 years had passed. However, the satisfaction trend was not linear throughout the different years, with 1992 being the year with the lowest satisfaction rate (9.7%). These trends in crude rates did not change even after adjusting for patient characteristics. The odds of satisfaction in 1992 were 38% lower (odds ratio 0.62, 95% CI 0.60 to 0.64) than the odds in 1989. In 2003, the odds of satisfaction were 4.01 times (95% CI 3.89 to 4.13) the odds for 1989. Older, female, married, and less-educated people were more likely to be satisfied. Patients who rated their health as "very good" had the highest satisfaction rate, and those with "neutral" health ratings had the lowest. General hospitals achieved substantial improvement whereas pharmacies became the lowest-rated of all institutions. CONCLUSIONS:

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The Korean health system has achieved better patient satisfaction rates over the past 15 years. Increased health expenditure, resources, and quality improvement efforts may have contributed to this progress.

Clark, P. A., Wolosin, R. J. and Gavran, G. (2006). "Customer convergence: patients, physicians, and employees share in the experience and evaluation of healthcare quality." Health Marketing Quarterly 23(3): 79-99.

This article explores the interrelationships between three categories of service quality in healthcare delivery organizations: patient, employee, and physician satisfaction. Using the largest and most representative national databases available, the study compares the evaluations of hospital care by more than 2 million patients, 150,000 employees, and 40,000 physicians. The results confirm the relationship connecting employees' satisfaction and loyalty to their patients' satisfaction and loyalty. Patients' satisfaction and loyalty were also strongly associated with medical staff physicians' evaluations of overall satisfaction and loyalty to the hospital. Similarly, hospital employees' satisfaction and loyalty were related to the medical staff physicians' satisfaction with and loyalty to the hospital. Based upon the strength of the interrelationships, individual measures and subscales can serve as leverage points for improving linked outcomes. Patients, physicians, and employees, the three co-creators of health, agree on the evaluation of the quality of that service experience. The results demonstrate that promoting patient-centeredness, enhancing medical staff relations, and improving the satisfaction and loyalty of employees are not necessarily three separate activities in competition for hospital resources and marketing leadership attention.

Cleary, P. D. (2003). "A hospitalization from hell: a patient's perspective on quality." Annals of Internal Medicine 138(1): 33-9.

Patients usually cannot assess the technical quality of their care; however, examining a hospitalization through the patients' eyes can reveal important information about the quality of care. Patients are the best source of information about a hospital system's communication, education, and pain-management processes, and they are the only source of information about whether they were treated with dignity and respect. Their experiences often reveal how well a hospital system is operating and can stimulate important insights into the kinds of changes that are needed to close the chasm between the care provided and the care that should be provided. This article examines the case of a patient admitted for ankle arthrodesis due to severe hemophilia-related arthritis. The surgery was successful, but the hospital stay was marked by inefficiency and inconveniences, as well as events that reveal fundamental problems with the hospital's organization and teamwork. These problems could seriously compromise the quality of clinical care. Unfortunately, most of these events occur regularly in U.S. hospitals. Relatively easy and inexpensive ways to avoid many of these problems are discussed, such as reducing variability in non-urgent procedures and routinely asking patients about their experiences and suggestions for improvement.

Cleary, P. D., Edgman-Levitan, S., McMullen, W. and Delbanco, T. L. (1992). "The relationship between reported problems and patient summary evaluations of hospital care." Qrb Quality Review Bulletin. 18(2): 53-9.

A nationwide telephone survey of 6,455 adult medical and surgical patients discharged from 62 general hospitals focused on aspects of hospitalization that affected patients' overall evaluation of their care. Eighty percent reported the care they received was excellent or very good. The strongest predictors of patients' evaluations were reported health status and the number of problems reported. Most of the associations between patient characteristics and summary evaluations were explained by differences in the number of problems reported. However, controlling for number of reported problems, the associations between evaluations and age, health status, and preferences were still statistically significant.

Cleary, P. D. and McNeil, B. J. (1988). "Patient satisfaction as an indicator of quality care." Inquiry 25(1): 25-36.

In this review of the theoretical and empirical work on patient satisfaction with care, the most consistent finding is that the characteristics of providers or organizations that result in more "personal" care are associated with higher levels of satisfaction. Some studies suggest that more personal care will result in better communication and more patient involvement, and hence better quality of care, but the data on these issues are weak and inconsistent. Further research is needed to measure specific aspects of medical care and the ways in which patient reports can complement other sources of information about quality. In addition, more research on the determinants of satisfaction and the relationship between quality and satisfaction among hospitalized patients is recommended. [References: 102]

Clement, M. and Gagnon, E. (2006). "The Quebec complaint examination system: stakeholder perspectives on the purpose and intake of complaints." Health Care Analysis 14(1): 51-63.

Quebec's complaint examination system has devoted considerable effort to supporting dissatisfied users who may wish to register complaints. It is open to question, however, whether this level of effort has, in fact, aided users in filing their complaints, and whether, once filed, the intake and processing of complaints has been rigorous and fair. Has the intake and handling of complaints at least improved? This is the question we shall attempt to answer here by presenting the results of our study concerning the impact of the Complaint Assistance and Support Centers (CAAPs) on the intake of complaints. The results show that the Quebec complaint examination system and its Complaint Assistance and Support Centers help make complaints more admissible and ensure that each complaint is examined. However, the system is also hindered by differences and conflicting interpretations among the various stakeholders regarding the legitimacy of complaints, respect for users' rights, and the mission of the system. Although complaint examination

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systems seek to encourage users to express their points of view, users' voices are still only partly audible.

Clemes, M. D., Ozanne, L. K. and Laurensen, W. L. (2001). "Patients' perceptions of service quality dimensions: an empirical examination of health care in New Zealand." Health Marketing Quarterly 19(1): 3-22.

The 1984 liberalization of the New Zealand economy has resulted in a health care sector that has become very competitive (Zwier and Clarke, 1999). The private sector is now able to supply health care services and, as a result, a greater value is being placed on patient satisfaction (Zwier and Clarke, 1999). However, despite the increasing focus on customer satisfaction, research into health care patients' perceptions of the dimensions of service quality is scarce. This can be problematic, as quality of care is an essential issue in the strategic marketing of health care services (Turner and Pol, 1995). This study takes a step towards addressing this deficiency by identifying patients' perceptions of the dimensions of service quality in health care. The findings of this study are based on the empirical analysis of a sample of 389 respondents interviewed by telephone. The findings indicate that the service quality dimensions identified in this health care specific study differ in number and dimensional structure from the widely adopted service quality dimensions first identified by Parasuraman, Berry and Zeithaml (1988): reliability, responsiveness, assurance, empathy and tangibles. The service quality dimensions identified in this study were: reliability, tangibles, assurance, empathy, food, access, outcome, admission, discharge and responsiveness. In addition, health care patients perceive the service quality dimensions relating to the core product in health care delivery (for example, outcome and reliability) as more important than the service quality dimensions relating to the peripheral product in health care delivery (for example, food, access and tangibles). Finally, the results of this study suggest that patients with different geographic, demographic, and behavioristic characteristics have different needs and wants during health care delivery and therefore perceive different service quality dimensions as important.

Cohen, G., Forbes, J. and Garraway, M. (1996). "Can different patient satisfaction survey methods yield consistent results? Comparison of three surveys." British Medical Journal 313(7061): 841-844.

Objective - To examine the consistency of survey estimates of patient satisfaction with interpersonal aspects of hospital experience. Design - Interview and postal surveys, evidence from three independent population surveys being compared. Setting - Scotland and Lothian. Subjects - Randomly selected members of the general adult population who had received hospital care in the past 12 months. Main outcome measures - Percentages of respondents dissatisfied with aspects of patient care. Results - For items covering respect for privacy, treatment with dignity, sensitivity to feelings, treatment as an individual, and clear explanation of care there was good agreement among the surveys despite differences in wording. But for items to do with being encouraged and given time to ask questions and being listened to by doctors there was substantial disagreement. Conclusions - Evidence regarding levels of patient dissatisfaction from national or local surveys should be calibrated against evidence from other surveys to improve reliability. Some important aspects of patient satisfaction seem to have been reliably estimated by surveys of all Scottish NHS users commissioned by the management executive, but certain questions may have underestimated the extent of dissatisfaction, possibly as a result of choice of wording.

Cohen, L., Delaney, P. and Boston, P. (1994). "Listening to the customer: implementing a patient satisfaction measurement system." Gastroenterology Nursing 17(3): 110-115.

Patient satisfaction is an important issue in positioning ambulatory medical services. An effective patient satisfaction measurement program not only helps the hospital managers improve the quality of clinical and administrative activities, but also helps the hospital remain viable in increasingly competitive markets. A method for the design and measurement of patient satisfaction with outpatient Endoscopy Lab services is described in this article. The survey focuses on the sequence of events experienced by the patient. Outcome measures of primary interest include global patient satisfaction and the likelihood of using the service again if given the choice. Analysis of patient responses shows that global satisfaction with the outpatient experience is positively associated with service return intention. Additional analysis shows that facility cleanliness, privacy, and nurse attention are most strongly associated with global patient satisfaction. Results underscore the importance of various service attributes on patient satisfaction and return intention and of the need to further expand the use of patient satisfaction measurement in the outpatient Endoscopy Lab.

Conesa, A., Bayas, J. M., Asenjo, M. A., Bare, M. L., Manasanch, P., Lledo, R., Prat, A. and Salleras, L. l. (1993). "[The quality perceived by the consumers of the outpatient consultation services of a university hospital]." Revista Clinica Espanola 192(7): 346-51.

With the objective to know the perceived quality of the assistance by the customers of the outpatient facilities in a teaching hospital, the information gathered in 1,970 self-administered, volunteer, anonymous questionnaires was analyzed, being obtained from the 4,756 consultations done in the outpatients department during a one week period. Different aspects of the physician's visit are discussed, together with the attention received from the paramedic personnel and other viewpoints pertaining to the organization and conditions of the waiting area. There is a high level of satisfaction among the users of the outpatients department, more pronounced in the "medical" area, in relation with the physician's consultation as well as with the attention from paramedics or in the adherence to appointments. The results suggest that in those physicians' offices where the relationship of the patient with the unit is less frequent, users show more criticism in comparison with those offices where almost all patients consult because of chronic ailments. We underline the importance of this type of perceived quality studies within the quality control policies, as a complement of the analysis of technical quality.

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Connor, M., Duncombe, D., Barclay, E., Bartel, S., Borden, C., Gross, E., Miller, C. and Ponte, P. R. (2007). "Organizational change and learning. Creating a fair and just culture: one institution's path toward organizational change." Joint Commission Journal on Quality & Patient Safety 33(10): 617-624.

Background: Health care organizations have begun to move toward a nonpunitive, or "blame-free," process when analyzing medical errors and near misses. The Dana-Farber Cancer Institute's (Boston) "Principles of a Fair and Just Culture," define for staff and managers behavioral expectations when an error occurs.

Creating the Principles of a Fair and Just Culture: The principles focus not just on patient safety but on a culture of safety and transparency in all the organization's functional areas, including nonclinical departments such as information services, administration, and research.

Incorporating the Principles into Practice: Introducing the principles is a gradual process, one that requires continual education and discussion among staff at all levels and a commitment to examining and changing many of the systems, policies, and procedures that guide the organization's work. A survey conducted in January 2007 revealed that the clinical areas had sustained higher-than-average scores and that the nonclinical areas showed improvement.

Discussion: Changing a long-standing culture of blame, control, and disrespect to one that embraces principles of fairness and justice and standards of respectful behavior is a major undertaking. Educating and involving clinical and administrative leaders, who work directly with staff and play a pivotal role in translating the principles into practice, is especially important.

Cooke, H. (1994). "The role of the patient in standard setting and audit." British Journal of Nursing 3(22): 1182-90.

This article examines some of the problems and issues involved in quality assurance of nursing care and the measurement of patients' views of health care. It argues that these two endeavours can and indeed should be related.

Coulter, A. and Cleary, P. D. (2001). "Patients' experiences with hospital care in five countries." Health Affairs 20(3): 244-52.

Analysis of patient surveys carried out in Germany, Sweden, Switzerland, the United Kingdom, and the United States in 1998-2000 revealed high rates of problems during inpatient hospital stays. Problems with information and education, coordination of care, respect for patients' preferences, emotional support, physical comfort, involvement of family and friends, and continuity and transition were prevalent in all five countries. These dimensions of patients' experience appear to be salient and relevant in each of the five countries, but attempts to develop international rankings based on this type of evidence will have to overcome a number of methodological problems.

Covinsky, K. E., Bates, C. K., Davis, R. B. and Delbanco, T. L. (1996). "Physicians' attitudes toward using patient reports to assess quality of care." Academic Medicine 71(12): 1353-1356.

Purpose. Patients' reports about their care, including reports about specific physician behaviors, are increasingly being used to assess quality of care. The authors surveyed physicians in an academic environment about their attitudes concerning possible uses of these reports. Method. A survey was conducted of the 540 hospital- and community-based internists and housestaff at Beth Israel Hospital in Boston, Massachusetts, in 1993-94. The survey instrument included seven items designed to assess the physicians' views about potential uses of patient reports about their care. The physicians were asked to rate the items on a five-point scale (ranging from 'strongly agree' to 'strongly disagree'). Results. A total of 343 (64%) of the physicians responded. Eighty-six percent agreed that patient judgments are important in assessing quality of care. There was widespread agreement with four potential uses of patient judgments: for changing a specific physician behavior (94% agreed), for receiving feedback from patients (90%), for use in physician education programs (81%), and for evaluating students and housestaff (72%). However, far fewer of the physicians agreed with two uses over which physicians would have less control: publishing judgments to help patients select physicians (28% agreed) and the use of judgments to influence physician compensation (16%). While the housestaff were less likely to agree with the use of patient reports in housestaff evaluations, the housestaff and faculty had similar opinions about all the other potential uses. Conclusion. The physicians believed that patients' reports about experiences with their physicians are valid indicators of quality. They responded that they would accept using these reports to improve care when the uses are nonthreatening and within the control of physicians. In contrast, there was far less support when the uses are external to physician control and potentially threatening.

Cowan, J. and Anthony, S. (2008). "Problems with complaint handling: expectations and outcomes." Clinical Governance: An International Journal 13(2): 164-168.

Purpose-The purpose of this paper is to contribute to the current debate about problems with the NHS complaints system.

Design/methodology/approach-The paper examines, in light of a recent audit of NHS complaint handling by the Healthcare Commission, the underlying reasons for complaints and for dissatisfaction with the way a complaint is handled. It discusses the implications of various recommendations and research findings for enhancing and improving complaints handling.

Findings-More emphasis is needed on the quality of interpersonal interaction with complainants for successful resolution of complaints. Attending to the process alone will not reduce dissatisfaction among complainants.

Practical implications-Learning from complaints to improve services is important to complainants as well as to healthcare providers and communicating this should be an integral part of the process.

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Originality/value-The value of the paper is that it re-emphasises the important role that complaints can play in the continuous improvement of services. It also sheds light on possible reasons for dissatisfaction with the way complaints are handled.

Cronan, K. (2003). "Patient complaints in a pediatric emergency department: Averting lawsuits." Clinical Pediatric Emergency Medicine 4(4): 235-242.

All emergency departments (EDs) receive complaints from patients and their families. Consumers of pediatric emergency care are becoming more astute about the care they receive, and the malpractice climate is rapidly changing. In order to improve patient care services and reduce the frequency of lawsuits, it is crucial that pediatric emergency medicine physicians become facile at preventing and managing such complaints. All ED physicians should have a well-defined complaint management process in place. Lessons learned from the complaints should be shared with the ED health care providers. Complaints can illustrate the deficiencies in the provision of care and serve as an opportunity for improvement. copyright 2003 Elsevier Inc. All rights reserved.

Crow, R., Gage, H., Hampson, S., Hart, J., Kimber, A., Storey, L. and Thomas, H. (2002). "The measurement of satisfaction with healthcare: implications for practice from a systematic review of the literature." Health Technology Assessment (Winchester, England) 6(32): 1-244.

Cullen, R. and Mason, D. (1995). "Quality assurance in health sciences literature searching: applying the ISO 9000 quality standard." Health Libraries Review 12(3): 173-189.

Medicine is a literature-based discipline. Ensuring that the literature review which precedes a significant piece of medical research has met predetermined standards is essential. A list of items reviewed carries no guarantees that all appropriate items have been included in the survey of the literature, or that appropriate sources have been efficiently searched. This would be a matter for concern in any discipline. In medicine it is a matter of life and death. Quality assurance procedures that offer guarantees of the standards built into the process, rather than quality control which measures only outputs, can provide the necessary reassurance. The ISO 9000 quality standard offers a much needed quality assurance process. A methodology for applying the ISO 9000 standard to the task of searching the medical literature is outlined in this paper. A new role for medical librarians in promoting a rigorous methodology in the literature review equal to that of the research it supports is defined.

Cunningham, W. (1198). "The immediate and long-term impact on New Zealand doctors who receive patient complaints." New Zealand Medical Journal 117(1198).

Aim: To analyse the impact of receiving a medical complaint on doctors in New Zealand. Methods: A questionnaire was sent to New Zealand doctors - randomly selected to include vocationally registered general practitioners, vocationally registered hospital-based specialists, and general registrants. Results: 221 doctors (who had received a medical complaint) completed the questionnaire. They indicated that, in the immediate period after receiving a complaint, they experienced emotions including anger, depression, shame, guilt, and reduced enjoyment of the practice of medicine. Around one in three doctors reported reduced trust and sense of goodwill towards patients (other than the complainant), and reduction in tolerance of uncertainty and of confidence in clinical practice. In the long-term, the impact of a complaint softened - but feelings of persisting anger, reduction in trust of patients, and of reduced feelings of goodwill toward patients was reported. No differences were found between doctors practising in different vocational groups. Conclusions: This study indicates that receiving a medical complaint has a significant negative impact on the doctor, and on important components of the doctor-patient relationship. It suggests that in the first few days and weeks after receiving a complaint, a doctor may need emotional and practising support. This study finds no evidence that the receipt of a complaint improves the delivery of patient care. copyright NZMA.

Curka, P. A., Pepe, P. E., Zachariah, B. S., Gray, G. D. and Matsumoto, C. (1995). "Incidence, source, and nature of complaints received in a large, urban emergency medical services system." Academic Emergency Medicine 2(6): 508-12.

OBJECTIVE: To document the incidence, source, and reasons for all complaints received by a large municipal emergency medical services (EMS) program. METHODS: A retrospective review of all complaints received during three consecutive years (1990-1992) in a centralized EMS system serving a large municipality (population 2 million). All cases were categorized by year, source, and nature of the complaint. RESULTS: In the three study years, EMS responded to 416,892 incidents with nearly a half-million patient contacts. Concurrently, 371 complaints were received (incidence of 1.12 per thousand); 132 in 1990, 129 in 1991, and 110 in 1992. Most complaints involved either: 1) allegations of "rude or unprofessional conduct" (34%), 2) "didn't take patient to the hospital" (19%), or 3) "problems with medical treatment" (13%). Only 1.6% (n = 6) were response-time complaints. Other complaints included "lost/damaged property," "taken to the wrong hospital," "inappropriate billing," and "poor driving habits." The most common sources were patient's families (39%) and the patients themselves (30%). Only 7.8% were from health care providers. CONCLUSION: Reviews of complaints provide information regarding EMS system performance and reveal targets for quality improvement. For the EMS system examined, this study suggests a future training focus on interpersonal skills and heightened sensitivities, not only toward patients, but also toward bystanders and family members.

Curry, A. and Stark, S. (2000). "Quality of service in nursing homes." Health Services Management Research 13(4): 205-15.

This paper illustrates the relevance of using the Servqual instrument as a service quality measurement tool in

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the healthcare context. The expectations and perceptions of nursing home residents and their relatives are compared and contrasted to determine the priorities and satisfaction levels of both groups with respect to the services provided. Some interesting differences emerged between the two respondent groups, which gave more accurate and relevant pointers as to potential areas of future improvement. Because a number of nursing homes were surveyed, it was also possible to ascertain which homes might serve as useful examples of the best practice and which were in need of improvement action. In frail, elderly respondent groups it is not especially easy to elicit views as to quality of service. Servqual, carefully and sympathetically designed and applied, proved appropriate for this task.

Curry, R. (2006). "Vision to reality: using patients' voices to develop and improve services." British Journal of Community Nursing 11(10): 438.

The NHS is being transformed into a patient led service requiring radical new ways of gathering patient's views. Sunderland Teaching Primary Care Trust (TPCT) demonstrated its commitment to this change by introducing an action research project in parallel to the introduction of a new nurse led urgent care team (UCT). The project used a qualitative methodology to collect views from initial UCT service users, patients with chronic obstructive pulmonary disease (COPD). Views were analysed using a thematic framework analysis. A multi-disciplinary action research group considered emerging themes and literature finding solutions and taking action to deliver service improvements. The research provides evidence of the quality of the new service and highlighted a service gap for housebound patients with chronic disease. This needs to be used positively to make improvements for patients in line with the NHS Improvement Plan and long-term conditions agenda.

Dagdeviren, N. and Akturk, Z. (2004). "An evaluation of patient satisfaction in Turkey with the EUROPEP instrument.[erratum appears in Yonsei Med J. 2005 Jun 30;46(3):following 447]." Yonsei Medical Journal 45(1): 23-8.

Seeking to understand patient perspectives is an important step in the efforts to improve the quality of health care. Developed by the EQuiP Task Force on Patient Evaluations of General Practice Care, the EUROPEP instrument aims to collect information on patient evaluations of general practice care. In order to expose the current state of patient satisfaction and make international comparisons, a study was conducted with relevant data collected from Turkey. The Turkish version of the EUROPEP instrument was administered to 1160 patients in six different Turkish cities. Thirty-three medical practices were included in the study. In every practice, a minimum of 30 adult patients who visited the practice for a consultation were consecutively included. The results were compared with previous values from European countries. "Helping you understand the importance of following his or her advice", "Getting through to the practice on the telephone", and "Providing quick services for urgent health problems" were evaluated best (76.7%, 76.3%, and 76.2%, 'good or excellent' ratings, respectively) and "Helping to deal with emotional problems related to the health status" was rated the worst (60.2%, 'good or excellent'). Other areas which had low ratings were: "Waiting time in the waiting room" (63.0%), "Quick relief of symptoms" (61.3%), and "Involving patients in decisions about medical care" (61.3%). Patient evaluations can help to educate medical staff about their achievements as well as their failures, assisting them to be more responsive to their patients' needs. In order to get the best benefit from EUROPEP, national benchmarking should be started to enable national and international comparisons.

Dagher, M., Kelbert, P. and Lloyd, R. J. (1995). "Effective ED complaint management." Nursing Management 26(12): 48B.

Handling patient complaints is possibly one of the most delicate tasks any manager must face. Although managing patient complaints is never a pleasant experience, a detailed plan can make it easier and more uniform, resulting in less stress and anxiety. Before improvements can be accomplished, deficiencies in the system must be corrected. Only after the department's processes have been deemed stable can the quality of care be improved and the customer satisfied.

Darby, D. N. (1996). "Medical general practice: influencing clients' levels of satisfaction." Journal of Quality in Clinical Practice 16(4): 215-25.

A general practice consultation involves a variety of doctor-client interactions. Commonly, a diverse range of clients attend a general practice. Further, general practices vary in their design and in service provision. There are significant risks that clients' experiences may not match prior expectations, resulting in lower levels of satisfaction with the consultation. This study describes the pilot testing of the widely used Model of Service Quality adapted to a general practice context. The results suggest that the adapted model may be used to help improve practice design and, consequently, client satisfaction with the service provided.

Davies, E., Shaller, D., Edgman-Levitan, S., Safran, D. G., Oftedahl, G., Sakowski, J. and Cleary, P. D. (2008). "Evaluating the use of a modified CAHPS survey to support improvements in patient-centred care: lessons from a quality improvement collaborative." Health Expectations 11(2): 160-76.

OBJECTIVES: To evaluate the use of a modified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to support quality improvement in a collaborative focused on patient-centred care, assess subsequent changes in patient experiences, and identify factors that promoted or impeded data use. BACKGROUND: Healthcare systems are increasingly using surveys to assess patients' experiences of care but little is established about how to use these data in quality improvement. DESIGN: Process evaluation of a quality improvement collaborative. SETTING AND PARTICIPANTS: The CAHPS team from Harvard Medical School and the Institute for Clinical Systems Improvement organized a learning collaborative including eight medical groups in Minnesota. INTERVENTION: Samples of patients recently visiting each group completed a

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modified CAHPS survey before, after and continuously over a 12-month project. Teams were encouraged to set goals for improvement using baseline data and supported as they made interventions with bi-monthly collaborative meetings, an online tool reporting the monthly data, a resource manual called The CAHPS Improvement Guide, and conference calls. MAIN OUTCOME MEASURES: Changes in patient experiences. Interviews with team leaders assessed the usefulness of the collaborative resources, lessons and barriers to using data. RESULTS: Seven teams set goals and six made interventions. Small improvements in patient experience were observed in some groups, but in others changes were mixed and not consistently related to the team actions. Two successful groups appeared to have strong quality improvement structures and had focussed on relatively simple interventions. Team leaders reported that frequent survey reports were a powerful stimulus to improvement, but that they needed more time and support to engage staff and clinicians in changing their behaviour. CONCLUSIONS: Small measurable improvements in patient experience may be achieved over short projects. Sustaining more substantial change is likely to require organizational strategies, engaged leadership, cultural change, regular measurement and performance feedback and experience of interpreting and using survey data.

Davies, H. T. O., Washington, A. E. and Bindman, A. B. (2002). "Health care report cards: implications for vulnerable patient groups and the organizations providing them care." Journal of Health Politics, Policy & Law 27(3): 379-99.

Standardized public reporting on the quality of health care (report cards) offers an opportunity to empower purchasers and consumers so that they can make choices that can result in better health care for less money. However, not all population subgroups are equally well served by the publication of such data. In particular, vulnerable patient groups such as the poor, the less educated, the chronically sick, and members of ethnic or linguistic minorities may find issues of importance to them largely neglected. In addition, the way that report card data are collected, analyzed, and presented may further marginalize the experiences of these groups who in any case are already underserved by the health system. This observation also has important implications for health care providers who serve primarily large numbers of vulnerable patients. The differential impacts of report card data on vulnerable patient groups (and their providers) need to be addressed by researchers and policy makers if access issues are not to be damaged further by the providers' pursuit of quality and value.

Davis, B. A. and Bush, H. A. (1995). "Developing effective measurement tools: a case study of the Consumer Emergency Care Satisfaction Scale." Journal of Nursing Care Quality 9(2): 26-35.

Development of valid and reliable instruments to assist nurse researchers and clinicians in meeting the needs of consumers is an avenue toward continuous quality improvement (CQI). This article explains validity and reliability and the process of constructing a valid and reliable scale. The development of the Consumer Emergency Care Satisfaction Scale, a measure of quality nursing care in the emergency department, is used as the example.

Davis, B. A., Kiesel, C. K., McFarland, J., Collard, A., Coston, K. and Keeton, A. (2005). "Evaluating instruments for quality: testing convergent validity of the consumer emergency care satisfaction scale." Journal of Nursing Care Quality 20(4): 364-8.

Having reliable and valid instruments is a necessity for nurses and others measuring concepts such as patient satisfaction. The purpose of this article is to describe the use of convergence to test the construct validity of the Davis Consumer Emergency Care Satisfaction Scale (CECSS). Results indicate convergence of the CECSS with the Risser Patient Satisfaction Scale and 2 single-item visual analogue scales, therefore supporting construct validity. Persons measuring patient satisfaction with nurse behaviors in the emergency department can confidently use the CECSS.

Davis, K. (1999). "International health policy: common problems, alternative strategies: a multinational symposium allowed analysts and officials to compare notes on their common ground and to debate solutions to problems in their health care systems." Health Affairs 18(3): 135-143.

Davis, S., Byers, S. and Walsh, F. (2008). "Measuring person-centred care in a sub-acute health care setting.[see comment]." Australian Health Review 32(3): 496-504.

OBJECTIVE: A more appropriate tool to measure the client experience of person-centred care is required to complement other existing measures of quality. A tool developed in the United Kingdom was trialled to determine its utility with a frail older Australian population. DESIGN: A random sample of clients recently discharged from a sub-acute setting over a 6-month period in 2005 were sent a questionnaire and invited to respond, a reply-paid envelope being provided for the return of the questionnaire. The questionnaire comprised the 20-item tool and space to provide additional qualitative comments. SETTING: The inpatient wards of a sub-acute facility in Melbourne. PARTICIPANTS: From the random sample of 144 discharged clients, 78 responded to the questionnaire. MAIN OUTCOME MEASURE: 20-item Patient-Centred Inpatient Scale (P-CIS) developed by Coyle and Williams (2001). RESULTS: Overall, there was a fundamental core of person-centredness as demonstrated by a ratio score of 0.68. Personalisation and respect dimensions are the main strengths of person-centred care in the health care setting in which the P-CIS was trialled, with personalisation scoring 0.75 and respect scoring 0.77. The miscellaneous components scored 0.69. The findings show that areas of the client experience warranting priority quality improvement effort are specific to the dimensions of empowerment (0.58), information (0.58) and approachability/availability (0.43). CONCLUSIONS: The P-CIS demonstrates the potential to be a contributing component that informs the monitoring and improvement of quality person-centred care in Australian inpatient health care settings.

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Davis, S. L. and Adams-Greenly, M. (1994). "Integrating patient satisfaction with a quality improvement program." Journal of Nursing Administration 24(12): 28-31.

Meeting and exceeding customers' expectations is the heart of any quality improvement program. The authors describe the development of a survey tool designed to assess patient satisfaction and its role in the hospital's total quality management initiative.

Dawn, A. G. and Lee, P. P. (2003). "Patient satisfaction instruments used at academic medical centers: results of a survey." American Journal of Medical Quality 18(6): 265-9.

As physicians and health administrators increasingly incorporate patients' perspectives into health care, patient satisfaction has become a significant health care outcome. However, there is limited knowledge regarding the patient satisfaction instruments being used by leading academic medical centers. The objective of this study was to determine the types of patient satisfaction instruments used by leading academic medical centers. We conducted a telephone survey of 16 leading academic medical centers across the United States to determine the types of patient satisfaction instruments used at each institution for outpatient and inpatient care. Among the institutions surveyed, a significantly higher proportion used internally developed surveys for satisfaction measurement among outpatients than for satisfaction measurement among inpatients. Although much attention has been focused on patient satisfaction in recent years, there is little standardization of the patient satisfaction instruments currently being used at the academic medical centers surveyed, particularly for outpatient care. This lack of standardization limits opportunities for benchmarking of patient satisfaction data among peer institutions and may limit efforts to improve care.

de Flon, S., Ramm, K. and Piene, H. (1995). "Quality assurance -- a tool for improving information to patients." Journal of Cancer Care 4(1): 17-20.

Due to a rising demand for information from patients about their disease and treatment, we wanted to improve the information systems addressed to our patients. Cancer patients, struggling to cope with an unfamiliar and distressing situation, are particularly in need of comprehensive information. We developed a quality assurance (QA) programme including written information and check lists related to diagnostic procedures, chemotherapy, radiotherapy and discharge. Evaluation of the standards was based on a questionnaire, filled in by all new patients. The results regarding information about diagnostic procedures illustrated clearly the positive achievement gained by setting an information standard. Implementation of the QA process in our department has proved to be a stimulating working method for improving information to patients.

de Vries, H., Elliott, M. N., Hepner, K. A., Keller, S. D. and Hays, R. D. (2005). "Equivalence of mail and telephone responses to the CAHPS Hospital Survey." Health Services Research 40(6 Pt 2): 2120-39.

OBJECTIVE: To estimate the effect of survey mode (mail versus telephone) on reports and ratings of hospital care. DATA SOURCES/STUDY SETTING: The total sample included 20,826 patients discharged from a group of 24 distinct hospitals in three states (Arizona, Maryland, New York). We collected CAHPS data in 2003 by mail and telephone from 9,504 patients, of whom 39 percent responded by telephone and 61 percent by mail. STUDY DESIGN: We estimated mode effects in an observational design, using both propensity score blocking and (ordered) logistic regression on covariates. We used variables derived from administrative data (either included as covariates in the regression function or used in estimating the propensity score) grouped in three categories: individual characteristics, characteristics of the stay and hospital, and survey administration variables. DATA COLLECTION/EXTRACTION METHODS: We mailed a 66-item questionnaire to everyone in the sample and followed up by telephone with those who did not respond. PRINCIPAL FINDINGS: We found significant ($p<.01$) mode effects for 13 of the 21 questions examined in this study. The maximum magnitude of the survey mode effect was an 11 percentage-point difference in the probability of a "yes" response to one of the survey questions. Telephone respondents were more likely to rate care positively and health status negatively, compared with mail respondents. Standard regression-based case-mix adjustment captured much of the mode effects detected by propensity score techniques in this application. CONCLUSIONS: Telephone mode increases the propensity for more favorable evaluations of care for more than half of the items examined. This suggests that mode of administration should be standardized or carefully adjusted for. Alternatively, further item development may minimize the sensitivity of items to mode of data collection.

Deiker, T., Osborn, S. M., Distefano, M. K., Jr. and Payer, N. W. (1981). "Consumer accreditation: developing a quality assurance patient evaluation scale." Hospital & Community Psychiatry 32(8): 565-7.

The 1979 Consolidated Standards for Psychiatric Facilities of the Joint Commission on Accreditation of Hospitals are performance-oriented, with emphasis on the identification and resolution of problems interfering with treatment goals. Nearly 200 of these criteria can be rated directly by patients. Converted into questions, these items can provide the basis for simple, inexpensive, and effective measures of patient care flexible enough to meet the needs of individual agencies. When used in this way, the standards also provide a format by which a psychiatric program and the Joint Commission can focus collaboratively on quality assurance issues relevant to accreditation.

Delbanco, T. L., Stokes, D. M., Cleary, P. D., Edgman-Levitan, S., Walker, J. D., Gerteis, M. and Daley, J. (1995). "Medical patients' assessments of their care during hospitalization: insights for internists." Journal of General Internal Medicine 10(12): 679-85.

OBJECTIVE: To assess, from the patient's perspective, selected aspects of the quality of inpatient hospital care in the United States. DESIGN: A cross-sectional survey, using telephone interviews of patients discharged from the medical services of a probability sample of 62 public and private, nonprofit, nonfederal

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acute care hospitals in the United States. The participating patients reported; discrete, clinically important elements of hospital care; preferences for involvement in care; health status; sociodemographic characteristics; and overall satisfaction with their hospitalization. PATIENTS/PARTICIPANTS: 2,839 patients drawn as a probability sample. INTERVENTIONS: None. MEASUREMENTS AND MAIN RESULTS: For 32 of the 50 questions about potential problems encountered during hospitalization, at least 10% of the patients gave a response indicating a problem. One-third of the patients having a physician (31.8%) reported that that physician did not care for them during hospitalization. Other frequently reported problems included not receiving information about the hospital routine (45.1%), not being told whom to ask for help (33.9%), having pain that could have been relieved by more prompt attention (19.9%), and not being given adequate information and guidance about activities and care after discharge from the hospital (21.4-36.1%). Most patients preferred to be informed about important aspects of their care (94.7%), but their preferences for involvement in care varied widely. CONCLUSIONS: Information from hospitalized medical patients identified several areas of concern that should be the focus of attention and could lead to systematic restructuring of hospital-based care.

Demir, C. and Celik, Y. (2002). "Determinants of patient satisfaction in a military teaching hospital." Journal for Healthcare Quality 24(2): 30-4.

The purpose of this study was to determine the aspects of hospital services that are most likely to affect patient satisfaction in a military teaching hospital in Turkey. Although there have been many studies on patient satisfaction in Turkey and other countries, few studies have been done in military hospitals. A patient satisfaction questionnaire using a 4-point Likert scale was mailed to 500 patients after discharge, and 316 questionnaires were returned. The findings indicated that satisfaction with physician, nursing, physical plant, and food services were the main determinants of overall satisfaction with the hospital. The type of clinic in which the patients stayed also was an important determinant. The effect of patients' demographic characteristics on overall satisfaction with the hospital was also examined, and only lower education level was a statistically significant determinant.

DePalma, J. A. (2000). The consumer's perspective of quality health care, Duquesne University: 123 p.

Measuring quality health care is especially important in today's health care system with the pressure to provide more efficient and less costly services. Proof of quality is being demanded of health care systems by many legislative bodies and regulatory agencies but no standard definition exists. Health care providers often assumed that they know what consumers value and expect, and what promotes the consumer's satisfaction with health care experiences. Therefore, a lack of consumer involvement in the determination of quality indicators has existed. The purpose of this study was to explore the experiences of quality and non-quality health care in an acute care setting from the consumer's perspective through the relating of critical incidents. The qualitative method used for this study, Critical Incident Technique (CIT), was adapted from the field of marketing which has used this methodology extensively to study service encounters. Ninety-two individuals provided 127 interviews, quality (n = 55) and non-quality (n = 72) experiences. Three broad categories and eleven subcategories emerged from the narratives which identified key aspects of quality and non-quality acute health care experiences. These broad categories were: Core Expected Services, Care Givers' Attributes and Behaviors, and Organizational Processes. Core Expected Services included the subcategories of lack of competence, pain management and response to service delivery failure. Care Givers' Attributes and Behaviors included attitude, communication, availability, individualized care, response to special needs and extraordinary behaviors. Organizational Processes included timeliness and insurance-based occurrences. Nurses were included in 81% of the incidents and physicians in 35%. Nurses, in situations where service delivery failures had occurred, were able and expected to compensate for the failure. The most frequently occurring combination of care givers' attributes and behaviors was attitude, communication, availability, and individualized care. These attributes were addressed in 53-67% of the quality incidents and 36-58% of the non-quality incidents. Many of the subcategories are similar to those derived from marketing studies, supporting the assumption that critical aspects of perceived service quality are comparable across all service industries.

Desombre, T. and Eccles, G. (1998). "Improving service quality in NHS Trust hospitals: lessons from the hotel sector." International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services 11(1): 21-6.

This article looks to review recent practice undertaken within the UK hotel sector to improve customer service, and suggests ideals that could be implemented within National Health (NHS) Trust hospitals. At a time of increasing competition, hotel firms are using service enhancement as a means to gain competitive advantage, and therefore developing a range of techniques to measure levels of service quality improvement. With continued change in the health service, where greater focus now lies with patient satisfaction, so there is a requirement for managers to adapt techniques presently being offered in other service industries to improve levels of customer service and ensure patients are targeted to define their levels of satisfaction.

Diemath, H. E. (2007). "Patient complaints and liability cases in Austria." Neurosurgery Quarterly 17(2): 132-133.

In Austria, as in many other countries, patient complaints have been increasing by about 15% annually. To maintain control over this problem, several institutions have been founded: arbitration boards, mediation agencies, complaints departments, and legal institutions specialized in medical malpractice. These handle the majority of the complaints, so that they are not brought before a court. These institutions have a compensation fund at their disposal. This fund allows compensation to be paid for malpractices that occur without being anybody's fault, in cases in which these are not covered by insurance because, by legal definition, insurance

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payment is made in case of fault. In Austria, a cause of liability requires 3 factors: damage, causality, and illegality. In most cases, illegality is caused by the lack of or an inadequacy of clarification (eg, the prerequisite of a legally valid consent from the patient). Ninety percent of the cases belong to the sphere of clarification. Lawsuits regarding medical malpractices are rare and amount to about 2% to 3% of the complaints. Convictions according to the criminal law are exceptional in Austria. copyright 2007 Lippincott Williams & Wilkins, Inc.

Dijcks, B. P. J., Wessels, R. D., de Vlieger, S. L. M. and Post, M. W. M. (2006). "KWAZO, a new instrument to assess the quality of service delivery in assistive technology provision." Disability & Rehabilitation 28(15): 909-14.

PURPOSE: Currently no well validated instrument exists to assess the quality of the assistive technology delivery from the client's perspective. An instrument was developed called KWAZO, consisting of seven questions related to accessibility, knowledge, coordination, efficiency, flexibility and influence of the user. KWAZO, meaning "quality of care", can be completed by the clients without any assistance. In this study, the feasibility, internal consistency and convergent validity of KWAZO were examined. METHOD: The data stem from a large monitoring study into non-use of and satisfaction with assistive technology (n = 4637) using a mailed questionnaire. Feasibility was tested by studying the rate of non response for each of the questions. To test convergent validity the KWAZO total score was compared to answers on a question about overall satisfaction with service delivery of D-QUEST. RESULTS: Only few missing values were seen (3.1 - 7.5%). Cronbach's alpha was good (0.89), indicating that KWAZO reliably measures one concept. Convergent validity was shown by a moderately strong correlation between KWAZO and the D-QUEST question (0.54; $p < 0.001$). A difference of about 2.5 points seems to reflect a relevant difference in user satisfaction. CONCLUSIONS: KWAZO is a new questionnaire to assess the quality of an assistive technology provision process from a client's perspective. KWAZO has decent measurement properties and its self-report format makes it an easy-to-use tool for assessment of the quality of assistive technology provision.

Dolinsky, A. L. (1995). "Complaint intensity and health care services." Journal of Health Care Marketing 15(2): 42-7.

The author extends his Complaint Intensity Outcome Framework by including a customer-need component and applying the model to a sample of elderly health care consumers. The results indicate that immediate action should be taken to improve complaint mechanisms and performance related to the quality of physicians. Other attributes require less dramatic action, and some require none at all. [References: 21]

Donawa, M. E. (1997). "Complying with US and European complaint handling requirements." Medical Device Technology 8(7): 12-5.

The importance of customer complaints for providing valuable information on the use of medical devices is clearly reflected in United States (US) and European quality system requirements for handling complaints. However, there are significant differences in US and European complaint handling requirements. This article will discuss those differences and methods for ensuring compliance. [References: 8]

Drachman, D. A. (1996). "Benchmarking patient satisfaction at academic health centers." Joint Commission Journal on Quality Improvement 22(5): 359-67.

BACKGROUND: In 1991 the University HealthSystem Consortium (UHC), an alliance of 70 academic health centers, began its patient satisfaction benchmarking project. The survey, adapted from the Picker Institute survey, was pilot tested in 1992 and has been in use since 1993. Each year the project's steering committee refines the survey on the basis of member needs and survey item performance. KEY FINDINGS: Findings have shown that the survey can document the effects of specific quality improvement efforts, that patients from different medical services report different levels of satisfaction with their care, and that physician and nursing care have had the greatest impact on overall satisfaction. USING THE RESULTS: Each participating organization receives concise narrative reports of the survey results, with priorities for improvement efforts clearly highlighted. A five-to six-page Executive Summary provides the organization's executive team with a quick overview of the results, as well as a summary of the areas where quality improvements are most needed. A longer Managers' Report provides a more detailed analysis of the findings for quality managers and department heads. Sections for each major area of care can be copied and distributed as "stand alone" reports to the appropriate decision makers. For example, the section on nursing care can be distributed to the chief nursing officer and nurse managers. For each key aspect of the patient's experience, best practices for maintaining patient satisfaction are identified from across the hospitals and compiled into a catalogue. LESSONS LEARNED: The UHC patient satisfaction benchmarking program has created ongoing communication among the participating hospitals, whose staff members have been willing to share problems encountered and possible solutions.

Drain, M. (2001). "Quality improvement in primary care and the importance of patient perceptions." Journal of Ambulatory Care Management 24(2): 30-46.

Increasing consumerism poses many challenges for health care providers, particularly for those in primary care. Quality improvement to meet patients' heightened demand for service excellence will require effective, continuous measurement of patient perceptions. The study described in this article evaluated the psychometric properties of a new instrument designed to survey patients' experiences with the delivery of primary care and assessed the factors that contribute to patient retention and likelihood to return. By systematically measuring patient satisfaction and perceptions of quality, medical practices can increase the effectiveness of primary care, improve patient outcomes, and control costs.

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Drain, M. and Clark, P. A. (2004). "Measuring experience from the patient's perspective: implications for national initiatives." Journal for Healthcare Quality: Promoting Excellence in Healthcare 26(4): W4-6-w4-16.

There are significant differences between "patient experience" and "patient satisfaction" surveys. Instruments that measure experiences using patient reports require patients to recall and estimate the frequency of certain events. By contrast, instruments that capture patient evaluations of care using ratings take both performance and relative importance into consideration. Hospitals and other healthcare organizations in the United States increasingly will be called to survey patients for public report. This article investigates the differences between patient reports and patient ratings, addresses common misconceptions with satisfaction surveys, and provides recommendations for the appropriate measure of patient experiences for national initiatives.

Draper, M., Cohen, P. and Buchan, H. (2001). "Seeking consumer views: what use are results of hospital patient satisfaction surveys?" International Journal for Quality in Health Care 13(6): 463-8.

There has been increasing emphasis on the use of patient satisfaction surveys in publicly funded health services to assess elements of quality of care. However, how these surveys are used to change policy and services has received less attention. This paper reports on two different surveys conducted in Victoria, Australia and how these have developed and been used at a policy level. One is a survey of recent mothers, repeated three times over the course of the decade. The other is an inpatient survey developed over the past 5 years. The results of the surveys are publicly available and arc one means of obtaining consumer views, influencing health care quality and reporting to the public.

Druss, B. G., Rosenheck, R. A. and Stolar, M. (1999). "Patient satisfaction and administrative measures as indicators of the quality of mental health care." Psychiatric Services 50(8): 1053-8.

OBJECTIVE: Although measures of consumer satisfaction are increasingly used to supplement administrative measures in assessing quality of care, little is known about the association between these two types of indicators. This study examined the association between these measures at both an individual and a hospital level. METHODS: A satisfaction questionnaire was mailed to veterans discharged during a three-month period from 121 Veterans Administration inpatient psychiatric units; 5,542 responded, for a 37 percent response rate. These data were merged with data from administrative utilization files. Random regression analysis was used to determine the association between satisfaction and administrative measures of quality for subsequent outpatient follow-up. RESULTS: At the patient level, satisfaction with several aspects of service delivery was associated with fewer readmissions and fewer days readmitted. Better alliance with inpatient staff was associated with higher administrative measures of rates of follow-up, promptness of follow-up, and continuity of outpatient care, as well as with longer stay for the initial hospitalization. At the hospital level, only one association between satisfaction and administrative measures was statistically significant. Hospitals where patients expressed greater satisfaction with their alliance with outpatient staff had higher scores on administrative measures of promptness and continuity of follow-up. CONCLUSIONS: The associations between patient satisfaction and administrative measures of quality at the individual level support the idea that these measures address a common underlying construct. The attenuation of the associations at the hospital level suggests that neither type can stand alone as a measure of quality across institutions.

Dull, V. T., Lansky, D. and Davis, N. (1994). "Evaluating a patient satisfaction survey for maximum benefit." Joint Commission Journal on Quality Improvement 20(8): 444-53.

BACKGROUND: Patient satisfaction surveys are now in use in some form at most hospitals and health care systems. Yet, it is unclear how well information collected meets the needs of all groups who might benefit from patient feedback. An evaluation was conducted at the Center for Outcomes Research, Sisters of Providence Health System (Portland, Ore), to determine the extent to which the survey, then almost three years in use, was satisfying its internal consumers and to guide redesign of the entire survey process. METHOD: The evaluation of the survey process was designed to address several questions: who uses the results (consumers); what are their objectives (goals); what results are useful (product); and what is done with the results (intervention utility). Techniques such as interviews, literature reviews, and supplemental data collection, were used to explore the needs of each consumer group. CONCLUSION: The evaluation has led to a number of changes in the patient satisfaction survey process. Large-scale patient satisfaction surveys result in large-scale costs and therefore must be beneficial to multiple users in multiple ways.

Durieux, P., Bissery, A., Dubois, S., Gasquet, I. and Coste, J. (2004). "Comparison of health care professionals' self-assessments of standards of care and patients' opinions on the care they received in hospital: observational study." Quality & Safety in Health Care 13(3): 198-202.

OBJECTIVES: To compare the views of healthcare professionals and patients regarding compliance with standards of care concerning patient information. DESIGN: Self-rated questionnaire survey. SETTING: Nine wards in short stay French hospitals. PARTICIPANTS: 939 patients and 359 healthcare professionals (physicians, nurses, assistants and other professionals). MAIN OUTCOME MEASURE: Patients' and healthcare professionals' views of compliance with 20 standards of patient care described in the French accreditation manual. Comparison of the rank order of the standards within the two samples. RESULTS: The response rate was 61.5% in the patient group and 85.8% in the healthcare professionals. The rank orders for the 20 items were similar in both groups (Spearman rank order correlation 0.6, p = 0.004). The two items ranked highest by healthcare professionals ("consent request for a surgical procedure" and "the doctors ask the visitors to leave the room before examining a patient") were also the two ranked highest by the patients. Three items were ranked low by both groups: "consent request for students to be present", "health education given to patients", and "possibility to express satisfaction during discharge". Patients were more satisfied with their pain management than were healthcare providers. Professionals were more satisfied with the social

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services than the patients. CONCLUSION: There are both similarities and differences between patients' and healthcare professionals' views of care. Accurate assessments of quality performed during the accreditation procedure require that both patients' and professionals' views be taken into account.

Dwore, R. B. (1993). "Managing hospital quality performance in two related areas: patient care and customer service." Hospital Topics 71(2): 29-34.

The Joint Commission on Accreditation of Healthcare Organization's new emphasis on continuous quality improvement provides hospitals with an opportunity to enhance both customer service as well as patient care. Both are expected by patients and delivered by providers. Patient care is the core product; customer service augments it by adding value and providing the opportunity for a competitive advantage. This article discusses issues for administrators to consider before including customer service as a component of continuous quality improvement and then presents methods for bringing about change. [References: 17]

Dyck, D. (1996). "Gap analysis of health services. Client satisfaction surveys." AAOHN Journal 44(11): 541-9.

Measurement of client satisfaction is an important component of an effective occupational health service. The key to providing an effective health service is meeting or exceeding what clients expect from the service. 2. Gap analysis, a methodology for measuring service quality gaps, consists of identifying the type of gap(s) (1 through 5) that exist, preventing client satisfaction with the service(s) provided. 3. Although it has limitations, the SERVQUAL instrument is a valid and reliable tool that can be adapted to measure service quality gaps in occupational health services. [References: 7]

Edlund, M. J., Young, A. S., Kung, F. Y., Sherbourne, C. D. and Wells, K. B. (2003). "Does satisfaction reflect the technical quality of mental health care?" Health Services Research 38(2): 631-45.

OBJECTIVE: To analyze the relationship between satisfaction and technical quality of care for common mental disorders. DATA SOURCE: A nationally representative telephone survey of 9,585 individuals conducted in 1997-1998. STUDY DESIGN: Using multinomial logistic regression techniques we investigated the association between a five-level measure of satisfaction with the mental health care available for personal or emotional problems and two quality indicators. The first measure, appropriate technical quality, was defined as use of either appropriate counseling or psychotropic medications during the prior year for a probable depressive or anxiety disorder. The second, active treatment, indicated whether the respondent had received treatment for a psychiatric disorder in the past year. Covariates included measures of physical and mental health and sociodemographic indicators. PRINCIPAL FINDINGS: Appropriate technical quality of care was significantly associated with higher levels of satisfaction. The strength of the association was moderate. CONCLUSIONS: Satisfaction is associated with technical quality of care. However, profiling quality of care with satisfaction will likely require large samples and case-mix adjustment, which may be more difficult for plans or provider groups to implement than measuring technical indicators. More importantly, satisfaction is not the same as technical quality, and our results suggest that at this time they cannot be made to approach each other closely enough to eliminate either.

Edwards, C., Staniszweska, S. and Crichton, N. (2004). "Investigation of the ways in which patients' reports of their satisfaction with healthcare are constructed." Sociology of Health & Illness 26(2): 159-83.

A characteristic feature of patient satisfaction research is the consistently high level of satisfaction recorded. More reliable and relevant inquiry tools are constantly being developed, but underlying psychological and social pressures that could promote such a consistent and undiscriminating response have been little investigated. Williams et al. (1998) explored the phenomenon and concluded that, by considering issues of duty and culpability, patients could make allowances for poor care, and avoid evaluating it negatively. Their study was in community mental health. This study follows up their work within elective orthopaedic surgery, and investigates the pressures promoting such apparent transformation of opinion. Using a longitudinal design, and in-depth qualitative interviews, the patient's process of reflection was explored. Three psycho-social pressures were identified that appear to work together to make the transformation of opinion almost the default process. They are: the relative dependency of patients within the healthcare system; their need to maintain constructive working relationships with those providing their care; and their general preference for holding a positive outlook. It is suggested that, while it is the patient's prerogative to re-interpret the quality of their care positively, it is not the prerogative of the inquirer to accept this re-interpretation as representative of the patient's experience. Methods of inquiry are needed which access something of patients' development of opinion, and thereby something of their initial, often more negative, untransformed responses to their healthcare experiences.

Edwards, C. and Titchen, A. (2003). "Research into patients' perspectives: relevance and usefulness of phenomenological sociology." Journal of Advanced Nursing 44(5): 450-60.

BACKGROUND: The dominant epistemology underpinning much inquiry in the field of patient evaluation of health care is positivist, with categorization and quantification being high priorities, despite the highly personal and dynamic nature of people's responses to their health care experiences. The mis-match between underpinning theoretical assumptions and the nature of the subject under investigation has led to ineffectiveness in much current inquiry into patients' perspectives. More needs to be learnt about patients' processes of evaluation prior to any summary assessment of the quality of their care. AIMS: This paper documents the search for a close fit between a study's research questions and a theoretical perspective with which to underpin the research. It describes the benefits of identifying a specifically relevant

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perspective, in this case phenomenological sociology, and discusses the potential of that particular perspective to underpin research within health care. METHODS: Research questions relating to patients' processes of evaluation were established. The possible contribution of a range of interpretative methodologies was considered. While all were relevant to some degree, phenomenological sociology was identified as having considerable specific potential to illuminate the patient's process of evaluation. FINDINGS: The particular strengths of phenomenological sociology relevant to the investigation of patients' processes of reflection are in highlighting the importance of subjectivity; its insistence on a clear link from theoretical development right back to the raw data; its wealth of evocative ideas and concepts that support the investigation of the development of interpretation; and the relatively accessible language and style of its texts. CONCLUSION: Time spent evaluating the potential contribution of different theoretical perspectives to a study is worthwhile, as a good choice can not only support but also enhance the quality of the research. Phenomenological sociology has much potential to underpin research into patient evaluation of health care and in nursing research more widely. [References: 34]

Edwards, H., Courtney, M. and Spencer, L. (2003). "Consumer expectations of residential aged care: reflections on the literature." International Journal of Nursing Practice 9(2): 70-77.

The decision-making process that accompanies aged-care home placement is complex and there is a paucity of literature documenting the experiences of those who undertake the activity. The deficiency extends to an understanding of consumer expectations about the quality of the services they encounter once admission has been obtained. Although fewer than 7% of Australian women and 3% of Australian men aged 65 years occupied residential aged care places in 1999-2000, the probability that they will do so at some point in their lives is 0.42 and 0.24, respectively. This study examined 20 papers on this subject found through an extensive search of the literature. Themes identified include the search and selection process of residential aged-care facilities, consumer expectations and satisfaction of placement outcomes, and global and community expectations of quality of care.

Ehnfors, M. and Smedby, B. (1993). "Patient satisfaction surveys subsequent to hospital care: problems of sampling, non-response and other losses." Quality Assurance in Health Care 5(1): 19-32.

Patient questionnaires are commonly used to assess patient satisfaction. This study reports on methodological experiences based on practical use of a Swedish questionnaire. The material consists of questionnaires from five different studies at some 60 wards in three hospitals. Four of the studies were performed by "routine procedure", while one was performed specially to study sampling, non-response and other losses. The results showed that a large number of patients were not given a questionnaire despite the fact that they should have been included according to the sampling criteria. In the special study barely half of those discharged answered a questionnaire corresponding to only about one in four in some studies performed routinely. Many of the patients excluded were probably in a difficult situation and their needs ought to be particularly noticed. This was true of patients who were old or confused, had language difficulties, were seriously ill, or who died during the care episode.

Ekwall, A., Gerdtz, M. and Manias, E. (2008). "The influence of patient acuity on satisfaction with emergency care: perspectives of family, friends and carers." Journal of Clinical Nursing 17(6): 800-809.

Aims and objectives. To investigate the factors that influence satisfaction with emergency care among individuals accompanying patients to the emergency department and explore agreement between the triage nurse and accompanying person regarding urgency. Background. Many patients seeking treatment in hospital are escorted by an accompanying person, who may be a friend, family member or carer. Several factors influence patient satisfaction with emergency care, including waiting time and time to treatment. It is also influenced by provision of information and interpersonal relations between staff and patients. Research on satisfaction has focused on the patient perspective; however, individuals who accompany patients are potential consumers. Knowledge about the ways accompanying persons perceive the patient's medical condition and level of urgency will identify areas for improved patient outcomes. Design and methods. A prospective cross-sectional survey with a consecutive sample (n = 128 response rate 83.7%) was undertaken. Data were collected in an Australian metropolitan teaching hospital with about 32,000 visits to the emergency department each year. The Consumer Emergency Satisfaction Scale was used to measure satisfaction with nursing care. Results. Significant differences in perceptions of patient urgency between accompanying persons and nurses were found. Those people accompanying patients of a higher urgency were significantly more satisfied than those accompanying patients of a lower urgency. These results were independent of real waiting time or the accompanying person's knowledge of the patients' triage status. In addition, older accompanying persons were more satisfied with emergency care than younger accompanying persons. Discussion. Little attention has been paid to the social interactions that occur between nurses and patients at triage and the ways in which these interactions might impact satisfaction with emergency care. Relevance to clinical practice. Good interpersonal relationships can positively influence satisfaction with the emergency visit. This relationship can contribute to improved patient care and health outcomes.

Elliott, K. M., Hall, M. C. and Stiles, G. W. (1992). "Service quality in the health care industry: how are hospitals evaluated by the general public?" Journal of Hospital Marketing 7(1): 113-24.

This paper investigates the "expectations" aspect of service quality in the health care industry. Specifically, an examination is made of the importance of various hospital characteristics to consumers, the dimensionality of service quality, and the relative importance of these dimensions across demographic groups. The results suggest that the competency and the behavior of physicians are the most important characteristics in the minds of consumers. Moreover, it was found that hospitals are evaluated along: (1)

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interpersonal, (2) amenities, (3) capabilities, and (4) accessibility dimensions. These findings are consistent with previous research in this regard. Additionally, significant differences in the importance of these factors were found across respondent gender, age, income, and education.

Elliott, M. N., Haviland, A. M., Kanouse, D. E., Hambarsoomian, K. and Hays, R. D. (2009). "Adjusting for subgroup differences in extreme response tendency in ratings of health care: impact on disparity estimates." Health Services Research 44(2 Pt 1): 542-61.

OBJECTIVE: Adjust for subgroup differences in extreme response tendency (ERT) in ratings of health care, which otherwise obscure disparities in patient experience. DATA SOURCE: 117,102 respondents to the 2004 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Medicare Fee-for-Service survey. STUDY DESIGN: Multinomial logistic regression is used to model respondents' use of extremes of the 0-10 CAHPS rating scales as a function of education. A new two-stage model adjusts for both standard case-mix effects and ERT. Ratings of subgroups are compared after these adjustments. PRINCIPAL FINDINGS: Medicare beneficiaries with greater educational attainment are less likely to use both extremes of the 0-10 rating scale than those with less attainment. Adjustments from the two-stage model may differ substantially from standard adjustments and resolve or attenuate several counterintuitive findings in subgroup comparisons. CONCLUSIONS: Addressing ERT may be important when estimating disparities or comparing providers if patient populations differ markedly in educational attainment. Failures to do so may result in misdirected resources for reducing disparities and inaccurate assessment of some providers. Depending upon the application, ERT may be addressed by the two-stage approach developed here or through specified categorical or stratified reporting.

Epstein, K. R., Laine, C., Farber, N. J., Nelson, E. C. and Davidoff, F. (1996). "Patients' perceptions of office medical practice: judging quality through the patients' eyes." American Journal of Medical Quality 11(2): 73-80.

With increasing pressure to measure quality, patient-based assessments of medical care are becoming increasingly important. Patients offer a unique perspective for evaluating the nontechnical aspects of medical care. This study reviews the importance of utilizing patients' perceptions to measure quality of care in office settings. It also reviews the principles required to conduct a well done survey. The concept of patient perceptions differs from the more commonly measured concept of patient satisfaction, in that perceptions measure whether a patients' needs and expectations are met, in addition to satisfaction. One of the most accurate and efficient means of measuring patients' perceptions is through the use of surveys. As with all standardized data collection, creating and performing high quality surveys of patients' perceptions can be challenging. Valid and reliable patient survey data can enable practitioners to identify areas for improvement, and demonstrate to external reviewers the quality of care they provide to their patients.

Eriksson, U. and Svedlund, M. (2007). "Struggling for confirmation--patients' experiences of dissatisfaction with hospital care." Journal of Clinical Nursing 16(3): 438-46.

AIM: The aim of the study was to illuminate patients' experiences of dissatisfaction with hospital care. BACKGROUND: During the last decade, interest in measuring patient satisfaction has become an important indicator of the quality of care. Researchers have, however, criticized the concept theoretically and methodologically. Subsequently, researchers have increasingly argued that the focus of attention should shift to explore patient dissatisfaction. DESIGN: A qualitative approach. METHODS: Narrative interviews were conducted with six people who had experienced dissatisfaction during a hospital care episode. The interview text was analysed using qualitative content analysis. RESULTS: The results show the patients' struggle for confirmation, the feeling of distrust in health care and what they have been forced to sacrifice because of lack of treatment. A feeling of being a troublesome patient is also apparent. At the same time a positive encounter is described, as well as situations of confirmation from caregivers. The results also show hope and a will to get on with life. CONCLUSIONS: Dissatisfaction relating to aspects of encounter is a common problem in health care and conceivable causes and possible solutions are discussed from different perspectives. RELEVANCE TO CLINICAL: PRACTICE: Caregivers as well as patients are in need of confirmation. If management were to take notice of and confirm caregivers this could consequently help them to gain the strength and energy necessary to provide care permeated with confirmation. A veritable, trustworthy care can be established through personal presence. To take notice of, confirm and listen to patients, creates opportunities for providing them with a positive experience of human encounter, which in the long run is rewarding from all perspectives.

Ervin, N. E. (2006). "Does patient satisfaction contribute to nursing care quality?" Journal of Nursing Administration 36(3): 126-30.

The use of patient satisfaction tools is routine in healthcare facilities. What actually do the results of patient satisfaction surveys tell us about the quality of nursing care? The purpose of this article is to provide a discussion about patient satisfaction and nursing care. Recommendations are offered about how patient satisfaction may be used to improve nursing care and what changes may be needed to achieve a high level of patient satisfaction. [References: 41]

Esperidiao, M. A. and Trad, L. A. B. (2006). "[User satisfaction assessment: theoretical and conceptual concerns]." Cadernos de Saude Publica 22(6): 1267-76.

The present article develops a critical analysis of the scientific output on user satisfaction in health services, focusing specifically on theoretical and conceptual aspects. The article discusses the understanding of satisfaction as a concept and its theoretical references and determinants and application of the concept to

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the field of services. A total of 56 articles were analyzed, published mainly in periodicals indexed in MEDLINE and Web of Science from 1970 to 2005. The concepts identified in this literature review come mainly from marketing and social psychology, emphasizing the theory of attitude, fulfillment of expectations or needs, and equity. There is a loss of analytical usefulness in the concept of satisfaction insofar as it is extended to various dimensions of health services. [References: 62]

Etter, J. and Perneger, T. V. (1997). "Validating a satisfaction questionnaire using multiple approaches: a case study." Social Science & Medicine 45(6): 879-885.

We examined the validity of a questionnaire designed to measure the satisfaction of users of health services, using multiple tests of construct validity. Members of 2 health insurance plans in Geneva (Switzerland) answered a mailed questionnaire in 1992 (n = 1007) and 1993 (n = 1424). Response rates were 82% participants were 18-44 years old in 1992. The questionnaire included 22 questions on satisfaction with medical care received during the past 12 months. Most items were adapted from the Patient Satisfaction Questionnaire. Four dimensions of satisfaction were measured: satisfaction with physician services (8 items), communication (8 items), access (4 items) and insurance services (2 items). Reliability (Cronbach's alpha) was satisfactory for the 2 former dimensions (alpha = 0.81 and 0.82 respectively), but lower than desired for the 2 latter (alpha = 0.63 and 0.49 respectively). Participants who gave positive open-ended comments had satisfaction scores 0.7-1.2 standard deviation units higher than participants who gave negative comments. Satisfaction scores were weakly correlated with satisfaction with private life, which indicates that the instrument did not simply measure a general tendency to be satisfied. Participants who said that care received in 1993 was worse than care received in 1992 (retrospective assessment) experienced a decrease in satisfaction scores between 1992 and 1993 (prospective assessment). Most validation procedures provided independent but partial evidence for the validity of the instrument. Triangulation of several validation methods, as illustrated in this paper, may greatly improve the understanding of an instrument's properties.

Evans, R. G., Edwards, A., Evans, S., Elwyn, B. and Elwyn, G. (2007). "Assessing the practising physician using patient surveys: a systematic review of instruments and feedback methods." Family Practice 24(2): 117-27.

BACKGROUND: Individual physician performance assessment is a vital part of the medical regulation debate. In this context, the patient perspective is seen as a potentially valid component. Yet, the theoretical and empirical evidence base for such patient assessments is unclear. OBJECTIVES: To identify and evaluate instruments designed to assess patients' experiences with an individual practising physician, and to provide performance feedback at the individual level. METHODS: Nine electronic databases were searched with no language restrictions: PubMed (1985-), Embase (1985-), PsycInfo (1985-), SIGLE (1985-), HMIC (1985-), ASSIA (1985-), CINAHL (1985-), Cochrane (1985-) and Dare (1985-). STUDY SELECTION: Inclusion: (i) completed by patients; (ii) assess practising doctors; (iii) have capacity to assess individual doctors for performance feedback; and (iv) used for individual performance feedback. Exclusion: (i) completed by colleagues, observers or third parties; (ii) assess medical students, nurses or non-physicians; (iii) assess purely at an organizational level; and (iv) not been used for individual feedback. All electronic outputs were independently assessed by three reviewers. Data were extracted independently by two of three reviewers using a defined template. RESULTS: Six instruments met the inclusion criteria. They all combine evaluation at both organizational and individual level and implementation methods lack standardization. There is limited data on their construct validity or correlations with other attributes. The purpose and method of individual feedback are not well specified, and the evidence to date about the effectiveness of feedback to obtain improvement indicates professional resistance. CONCLUSIONS: For formative goals, more clarity is needed about the aim of providing patient assessments feedback to individual doctors: 'who' should do it and 'how' to do so to best effect. We need to know whether feedback improves doctor performance and how these evaluations correlate with other physician attributes. For summative purposes more research is required on validity and reliability. [References: 91]

Faber, M., Bosch, M., Wollersheim, H., Leatherman, S. and Grol, R. (2009). "Public reporting in health care: how do consumers use quality-of-care information? A systematic review." Medical Care 47(1): 1-8.

BACKGROUND: One of the underlying goals of public reporting is to encourage the consumer to select health care providers or health plans that offer comparatively better quality-of-care. OBJECTIVE: To review the weight consumers give to quality-of-care information in the process of choice, to summarize the effect of presentation formats, and to examine the impact of quality information on consumers' choice behavior. The evidence is organized in a theoretical consumer choice model. DATA SOURCES: English language literature was searched in PubMed, the Cochrane Clinical Trial, and the EPOC Databases (January 1990-January 2008). STUDY SELECTION: Study selection was limited to randomized controlled trails, controlled before-after trials or interrupted time series. Included interventions focused on choice behavior of consumers in health care settings. Outcome measures referred to one of the steps in a consumer choice model. The quality of the study design was rated, and studies with low quality ratings were excluded. RESULTS: All 14 included studies examine quality information, usually CAHPS, with respect to its impact on the consumer's choice of health plans. Easy-to-read presentation formats and explanatory messages improve knowledge about and attitude towards the use of quality information; however, the weight given to quality information depends on other features, including free provider choice and costs. In real-world settings, having seen quality information is a strong determinant for choosing higher quality-rated health plans. CONCLUSIONS: This review contributes to an understanding of consumer choice behavior in health care settings. The small number of included studies limits the strength of our conclusions. [References: 49]

Finkelstein, B. S., Singh, J., Silvers, J. B., Neuhauser, D. and Rosenthal, G. E. (1998). "Patient and hospital

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characteristics associated with patient assessments of hospital obstetrical care." Medical Care 36(8 Suppl): AS68-78.

OBJECTIVES: The goals of this study were to examine the relationship of patient assessments of hospital care with patient and hospital characteristics. In addition, the authors sought to assess relationships between patient assessments and other patient-derived measures of care (eg, how much they were helped by the hospitalization and amount of pain experienced). METHODS: The authors surveyed 16,051 women (response rate, 58%) discharged after labor and delivery from 18 hospitals during the study period of 1992 to 1994. Patient assessments were obtained using a previously validated survey instrument, Patient Judgment of Hospital Quality, that includes eight scales assessing different aspects of the process of care (eg, physician care, discharge procedures) and other single item assessments (eg, overall quality). For this study, we utilized five of the scales (physician care, nursing care, information, discharge preparation, global assessments [willingness to brag, recommend or return to the hospital]). For analysis, items were rated on a five-point ordinal scale from poor to excellent. For scoring purposes, responses were transformed to linear ratings, ranging from 0 to 100 (eg, 0 = poor care, 100 = excellent care). RESULTS: In multivariable analyses, the authors found that patients who were older, white, not married, uninsured or had commercial insurance, and in better health status were significantly more likely to give higher assessments ($P < 0.01$), although very little of the variance in assessment scores was explained by these characteristics (2%-3%). In bivariate analyses, patient assessments were higher in nonteaching hospitals and those with fewer beds, fewer deliveries, lower cesarean-section (C-section) rates, fewer patients with Medicaid, and higher rates of vaginal births after C-section deliveries. When these variables were utilized as independent predictors in multivariable analyses using adjusted nested linear regression (to account for clustering of patients), few of the hospital characteristics reached a level of statistical significance. Finally, correlations between the five scales and other patient assessments of quality, such as how much they were helped by the hospitalization, were statistically significant ($P < 0.01$) and high in magnitude, ranging from 0.47 to 0.61. CONCLUSIONS: Although hospital scores differed according to several patient and hospital characteristics, the magnitude of the associations was relatively small. The findings suggest that, with respect to obstetric care, patient assessments may represent a robust measure that can be applied to diverse hospitals and patient casemix.

Fitzpatrick, R. and White, D. (1997). "Public participation in the evaluation of health care... including commentary by Fairhurst K." Health & Social Care in the Community 5(1): 3-10.

Of the many concepts and issues that have dominated debates in western health care systems in the last 20 or so years few can have had as much currency as that of "patient satisfaction". The word "patient" is loaded and often deliberately substituted so that reference is made to the satisfaction of the "user", "consumer", "community", "public" or "lay person". All versions draw attention to a universal concern that modern health care is inherently prone to failure to meet the wants, needs, demands and expectations of the recipients of health care. "Patient satisfaction" as a policy issue is invariably viewed as a problem in need of urgent solutions. For some analysts it is the most urgent of all problems for health care systems the primary purpose of which is to satisfy users and potential users of health care.

Flesh, L. H. and Van Riper, J. S. (2005). "Tracking complaints. Prevent future service problems by identifying their source." Healthcare Executive 20(5): 32-3.

Fong, J., Marsh, G. M., Stokan, L. A., Sang, W., Vinson, C. and Ruhl, L. (2008). "Hospital quality performance report: an application of composite scoring." American Journal of Medical Quality 23(4): 287-295.

To assess the performance of its contracted hospitals, Highmark developed the Hospital Quality Performance Report, which used 4 databases (patient satisfaction, patient safety, quality indicators, and hospital compare data) to assess patient safety and quality of care. Our study found little pairwise correlation among any of the databases used in the Hospital Quality Performance Report, highlighting the importance of assessing performance across multiple measures. Regression analysis of a set of common characteristics used to describe hospitals revealed an association between hospital bed size and the composite score, patient satisfaction score, patient safety score, and hospital compare data score and an association between hospital accreditation with the composite score, patient safety score, and hospital compare data score. Additional study is necessary to assess whether the report, as currently constructed, is sufficient to advance patient safety and quality of care in hospitals.

Ford, R. C., Bach, S. A. and Fottler, M. D. (1997). "Methods of measuring patient satisfaction in health care organizations." Health Care Management Review 22(2): 74-89.

Patient perceptions of the quality of services provided is a key factor (along with cost effectiveness) in determining a health care organization's competitive advantage and survival. This article examines the advantages, disadvantages, and problems associated with nine different methods of measuring patient satisfaction with service quality. The appropriateness of each of these techniques under different organizational conditions is also discussed. The article concludes with guidelines for measurement of patient satisfaction and implementation of managerial follow-up. [References: 41]

Fottler, M. D., Ford, R. C. and Bach, S. A. (1997). "Measuring patient satisfaction in healthcare organizations: qualitative and quantitative approaches." Best Practices & Benchmarking in Healthcare: A Practical Journal for Clinical & Management Applications 2(6): 227-239.

Patient perceptions of the quality of services provided are a key factor in determining a healthcare organization's competitive advantage and survival. This article examines the advantages, disadvantages,

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and problems associated with nine different qualitative and quantitative methods of measuring patient satisfaction with service quality and concludes with guidelines for measurement of patient satisfaction and implementation of managerial follow-up.

Fowler, E., MacRae, S., Stern, A., Harrison, T., Gerteis, M., Walker, J., Edgman-Levitan, S. and Ruga, W. (1999). "The built environment as a component of quality care: understanding and including the patient's perspective." Joint Commission Journal on Quality Improvement 25(7): 352-62.

BACKGROUND: Although there has been little systematic assessment of how the built environment of health care facilities affects the quality of care, the built environment is a major element of structure of care--one of three facets of quality. Yet in contrast to the growing trend of using consumer perceptions of both processes and outcomes of care in QI activities, quality assessments of the structure of care do not currently rely on patient feedback. PURPOSE OF PROJECT: During the initial phase of a multiphase project, nine focus groups were conducted in 1997 to identify the salient dimensions of experience from the patient's perspective. The content of these focus groups guided the development of assessment tools in the second phase of the project, which began in February 1998. FINDINGS: Participants in three focus groups that were held in each of three settings--ambulatory care, acute care, and long term care--described in detail a variety of reactions to the built environment. Analysis revealed eight consistent themes in what patients and family member consumers look for in the built environment of health care. In all three settings, they want an environment, for example, that facilitates a connection to staff and caregivers, is conducive to a sense of well-being, and facilitates a connection to the outside world. DISCUSSION: Data derived from the focus group research has guided the development of quantitative survey and assessment tools. For each setting, patient-centered checklists and questionnaires are designed to help institutions set priorities for the improvement of facility design from the patient's perspective.

Franchignoni, F. (1998). "A new questionnaire for in-patient satisfaction in rehabilitation medicine: A validity and reliability study. [Italian]." Minerva Medica 89(3): 57-64.

Background. The aim of this study was to examine some psychometric properties of a new questionnaire measuring patients' satisfaction with respect to the quality of care during stay in a rehabilitation unit. The instrument (called SAT-16) is composed of 16 four-level items and 2 open- ended questions. The construct validity of the 16-item section was already demonstrated in a previous study based on factorial analysis. In this study the concurrent validity, further aspects of the construct validity and test- retest reliability were analyzed. Methods. The SAT-16 was administered to 339 inpatients, admitted consecutively to a Rehabilitation Center. Results. 262 questionnaires (77%) were returned, of which 221 with all items filled in. The SAT-16 correlated well with two other measures of satisfaction (CSQ-8 and global satisfaction regarding the hospital stay). The answers to two open- ended questions came out to be consistent with those to the 16 closed-ended questions. The high values for the indices of test-retest reliability (ICC and kappa) are evidence of the stability of the scores in two repeated administrations. Conclusions. The SAT-16 was found to be provided with good psychometric characteristics. It can be proposed as a valid instrument for use in clinical practice for the continuous quality improvement of inpatient medical rehabilitation programmes.

Franchignoni, F., Ottonello, M., Benevolo, E. and Tesio, L. (2002). "Satisfaction with hospital rehabilitation: is it related to life satisfaction, functional status, age or education?" Journal of Rehabilitation Medicine 34(3): 105-108.

Satisfaction with care, functional and cognitive status, life satisfaction, anxiety, and sociodemographic variables were correlated in 55 in-patients admitted to a rehabilitation unit after hip or knee surgery. The study aimed at investigating whether, as an index of care quality, patient satisfaction can be considered as a distinct domain or instead is subsidiary to other patient characteristics. Patient satisfaction with rehabilitation care was measured through a questionnaire, SAT-16. The SAT-16 scores were moderately correlated with a short form of the Life Satisfaction Index (LSI-11: r[s] = 0.41, p = 0.001), but did not correlate with either the Functional Independence Measure (FIM), the STAI form X (the Spielberger State-Trait Anxiety Inventory), age or educational level. According to the "discrepancy model", the fair degree of correlation between SAT-16 and LSI-11 could be explained by connecting both expressions of satisfaction with personal background expectations and their perceived degree of fulfilment. The results confirm, also for rehabilitation care, that patient satisfaction should be considered as a valuable specific outcome, independent of most of the patient characteristics investigated (functional and cognitive status, anxiety, age, and education).

Freil, M., Lorentzen, J., Rasmussen, L., Gut, R. and Knudsen, J. L. (2005). "[Patient-experienced quality assessed in two national surveys]." Ugeskrift for Laeger 167(46): 4375-9.

INTRODUCTION: Surveys of patients' experiences can be used for other purposes than to disclose patients' overall satisfaction. They can, for example, also be used to select focus areas in the health care sector. In this article two large national surveys of patient-experienced quality are compared. The advantages and disadvantages of the applied methods and various applications of the surveys are discussed. MATERIALS AND METHODS: The Danish National Patient Satisfaction Survey was based on a questionnaire with questions about patients' experiences. The questionnaires were sent to the patients after discharge. All 62 public Danish hospitals were included. The Patient Reports Survey was based on a questionnaire with questions about whether the patient had received certain services. The questionnaire was given to each patient on the day of discharge and returned before the patient left the hospital. All medical wards were invited to participate in the survey. RESULTS: Despite differences in questions, design and methods, the two surveys showed agreement in the areas where patients experienced flaws in the quality of services. CONCLUSION: In future surveys the advantages and disadvantages of data feedback,

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inclusion on the basis of data registers, sample sizes and the possibility of being supplied with ward-specific data should be taken into consideration. The advantages and disadvantages of involving employees should be counterbalanced in each survey. The Danish National Patient Satisfaction Survey is suitable for external evaluation and benchmarking between hospitals, while the applied methods in the Patient Reports Survey are best suited to internal self-evaluation and quality improvement within hospital departments.

Friesner, D., Neufelder, D., Raisor, J. and Bozman, C. S. (2009). "How to improve patient satisfaction when patients are already satisfied: a continuous process-improvement approach." Hospital Topics 87(1): 24-40.

The authors present a methodology that measures improvement in customer satisfaction scores when those scores are already high and the production process is slow and thus does not generate a large amount of useful data in any given time period. The authors used these techniques with data from a midsized rehabilitation institute affiliated with a regional, nonprofit medical center. Thus, this article functions as a case study, the findings of which may be applicable to a large number of other healthcare providers that share both the mission and challenges faced by this facility. The methodology focused on 2 factors: use of the unique characteristics of panel data to overcome the paucity of observations and a dynamic benchmarking approach to track process variability over time. By focusing on these factors, the authors identify some additional areas for process improvement despite the institute's past operational success.

Friesner, D. and Rosenman, R. (2005). "The relationship between service intensity and the quality of health care: an exploratory data analysis." Health Services Management Research 18(1): 41-52.

This paper provides an empirical check of some assumptions used to define the quality of care in the health services literature. Specifically, we test (i) whether service intensity is the only important determinant of a provider's quality and (ii) whether higher service intensity always causes higher quality. Using a panel of hospitals from Washington State, we find evidence that rejects both of these assumptions. As a result, further work is needed to postulate a more general definition that does not rely on these assumptions.

Gal, I. and Doron, I. "[Patterns of client complaints in Israel's healthcare system]." Harefuah 146(6): 439-43.

OBJECTIVES: Israel's National Health Law of 1994 established the rights of citizens to receive quality health services. The Law set several mechanisms for treating clients' complaints. This study examined complaint patterns and reasons, complaint channels, and knowledge regarding complaints among citizens insured by Israeli health services, with the goal of contributing to the usage of complaints as a tool for improving medical services to citizens. METHOD: The study was conducted using a telephone survey, with national probability sample of N = 1500 respondents aged 21+. FINDINGS: About 75% of respondents did not have a cause to complain over the last 12 months, 25% reported a cause to complain, but only 9.5% (143 of 1500) actually complained. Approximately half of the causes for complaint concerned structural problems such as payments, waiting lists or eligibility. Causes regarding processes and interactions, or medical treatment and its outcomes, each accounted for a quarter of causes. Most complainers, about 75%, submitted their grievances informally at the local level. Only a minority (17%) appealed to official bodies established by Israel's National Health Law at the Ministry of Health or at the HMOs. Clients' awareness regarding rights to complain was found to be low. CONCLUSIONS: There is a need to improve clients' knowledge and change complaint patterns, develop means for analyzing existing knowledge about client complaints already available to front-line employees. Furthermore, there is a need to plan organizational mechanisms for capturing and using future complaints submitted on a local level or informally, which are the bulk of the complaints.

Garbutt, J., Bose, D., McCawley, B. A., Burroughs, T. and Medoff, G. (2003). "Soliciting patient complaints to improve performance." Joint Commission Journal on Quality & Safety 29(3): 103-12.

BACKGROUND: A study was conducted in 2000 to describe service quality problems in a large tertiary care teaching hospital and evaluate the effect of a pre-discharge program for active complaint surveillance and resolution on patient satisfaction. METHODS: The pre-post intervention study with temporal controls was conducted at a tertiary care teaching hospital in St Louis. Eighty-four percent (1,023 of 1,218) of patients admitted to a general medical unit between October 2, 2000, and December 22, 2000, were interviewed by a patient advocate to identify and address patient complaints about service quality. Patient satisfaction was measured, using a validated instrument administered by telephone interview 7-10 days after discharge. RESULTS: The advocate completed 1,233 patient interviews and received 695 complaints about service quality. Half of the complaints concerned local unit care, most frequently delays in response to patient requests. Patients also complained about food, delays in admission and discharge, and inadequate communication about procedures. Concurrently, the hospital's formal reporting system received 12 complaints. Patients satisfaction scores were unchanged during the intervention. DISCUSSION: Active surveillance using predischarge patient interviews by a patient advocate identified many local and systemwide service quality problems in a large tertiary care teaching hospital that needed to be addressed to improve the quality of patient care. However, patient satisfaction scores were unchanged.

Garson, A., Jr., Yong, C. M., Yock, C. A. and McClellan, M. B. (2006). "International differences in patient and physician perceptions of "high quality" healthcare: a model from pediatric cardiology." American Journal of Cardiology 97(7): 1073-5.

Although the quality of health care would logically seem to be a universal concept, this study hypothesized that physicians and their patients could differ in their perceptions of "high-quality care" and that those beliefs might vary by country. Such a mismatch in beliefs may be especially important as clinical practice guidelines developed in the United States are globalized. A survey of 20 statements describing various components of

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health care delivery and quality was sent to pediatric cardiologists in 33 countries, who ranked the statements in order of priority for ideal health care. Each participating physician administered the questionnaire to the parents of children with congenital heart disease; 554 questionnaires were received and analyzed. A subanalysis of 9 countries with the largest number of responses was done (Canada, the Czech Republic, France, Germany, Italy, The Netherlands, Sweden, the United Kingdom, and the United States). Doctors and parents rated the same 4 statements among the top 5: "the doctor is skillful and knowledgeable"; "the doctor explains health problems, tests, and treatments in a way the patient can understand"; "a basic level of healthcare is available to all citizens regardless of their ability to pay"; and "treatment causes the patient to feel physically well." Overall, parents' responses differed more among countries than those of physicians; the magnitude of the difference between parents and physicians varied by country. This discrepancy highlights a potential mismatch between patients' and physicians' views about the desired components of health care delivery, in particular the application of American quality standards for health care to systems in other countries.

Gasquet, I., Villeminot, S., Estaquio, C., Durieux, P., Ravaud, P. and Falissard, B. (2004). "Construction of a questionnaire measuring outpatients' opinion of quality of hospital consultation departments." Health & Quality of Life Outcomes 2: 43.

BACKGROUND: Few questionnaires on outpatients' satisfaction with hospital exist. All have been constructed without giving enough room for the patient's point of view in the validation procedure. The main objective was to develop, according to psychometric standards, a self-administered generic outpatient questionnaire exploring opinion on quality of hospital care. METHOD: First, a qualitative phase was conducted to generate items and identify domains using critical analysis incident technique and literature review. A list of easily comprehensible non-redundant items was defined using Delphi technique and a pilot study on outpatients. This phase involved outpatients, patient association representatives and experts. The second step was a quantitative validation phase comprised a multicenter study in 3 hospitals, 10 departments and 1007 outpatients. It was designed to select items, identify dimensions, measure reliability, internal and concurrent validity. Patients were randomized according to the place of questionnaire completion (hospital v. home) (participation rate = 65%). Third, a mail-back study on 2 departments and 248 outpatients was conducted to replicate the validation (participation rate = 57%). RESULTS: A 27-item questionnaire comprising 4 subscales (appointment making, reception facilities, waiting time and consultation with the doctor). The factorial structure was satisfactory (loading >0.50 on each subscale for all items, except one item). Interscale correlations ranged from 0.42 to 0.59, Cronbach alpha coefficients ranged from 0.79 to 0.94. All Item-scale correlations were higher than 0.40. Test-retest intraclass coefficients ranged from 0.69 to 0.85. A unidimensional 9-item version was produced by selection of one third of the items within each subscale with the strongest loading on the principal component and the best item-scale correlation corrected for overlap. Factors related to satisfaction level independent from departments were age, previous consultations in the department and satisfaction with life. Completion at hospital immediately after consultation led to an overestimation of satisfaction. No satisfaction score differences existed between spontaneous respondents and patients responding after reminder(s). CONCLUSION: Good estimation of patient opinion on hospital consultation performance was obtained with these questionnaires. When comparing performances between departments or the same department over time scores need to be adjusted on 3 variables that influence satisfaction independently from department. Completion of the questionnaire at home is preferable to completion in the consultation facility and reminders are not necessary to produce non-biased data.

Gay, S., Bradshaw, K., O'Bourke, T., Chuah, Y., Probert, C. and Mayberry, J. (1993). "Patients' satisfaction survey: a review of in-patient attitudes towards care during a 12 month period." Journal of the Royal Society of Health 113(3): 121-3.

In order to assess the value of medical and nurse team meetings in a programme designed to improve the quality of care given on a general medical ward, a 33% sample of recent in-patients was asked to complete a questionnaire about the quality of care that they received from doctors and nurses. Regular meetings were convened to respond to criticisms and improve overall care. During the year of the programme there was no significant change in the quality of care as perceived by patients and it is clear that this approach to improving care is ineffective.

Gerteis, M., Gerteis, J. S., Newman, D. and Koepke, C. (2007). "Testing consumers' comprehension of quality measures using alternative reporting formats." Health Care Financing Review 28(3): 31-45.

CMS has publicly reported nursing home quality measures since 2002, but research has shown that many users do not understand them. Alternative visual displays may improve comprehension. We developed seven reporting templates in different formats, including bar graphs like those displayed on the CMS Nursing Home Compare Web site www.medicare.gov, and tested them with 90 individuals age 45-75, using structured protocols. Tests of significance were conducted, and statistically significant findings identified. Fewer than one-half the respondents accurately interpreted bar graphs as currently displayed on the Nursing Home Compare Web site. Respondents made fewest errors on templates using words to characterize performance as better, average, or worse.

Giardino, B. (2000). "Management of patient grievances based on HCFA and Joint Commission rules." QRC Advisor 16(4): 1-5.

It has long been recognized that the patient loses "control" in the hospital setting as we as health care providers become the caregivers. Through informed consent, advance directives, and patient involvement with care management planning, we have attempted to return some of that control back to the patient.

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Grievance resolution is simply another way to give back to the patient some of the control that may have been lost in the complexity of health care institutions. Patients and their families deserve a process that adequately addresses their concerns about their hospitalization, and HCFA and the Joint Commission have now addressed the specifics of how that process should occur. Although the process appears cumbersome, time-consuming, and costly, I believe it allows for some interpretive leeway for hospitals to develop their own policies and procedures to comply with the COPs. [References: 7]

Gingerich, B. S. (2005). "Resource review. Resolving patient complaints." Home Health Care Management & Practice 17(4): 348-350.

Glazer, J., McGuire, T. G., Cao, Z. and Zaslavsky, A. (2008). "Using global ratings of health plans to improve the quality of health care." Journal of Health Economics 27(5): 1182-95.

Global ratings, such as those based on consumer satisfaction, are a commonly used form of report on the performance of health plans and providers. A simple averaging of the global rating by plan members leads to a problem: it gives a plan greater incentives to improve services used by low-cost members than services used by high-cost members. This paper presents a formal model of consumer formation of global ratings and the incentives these rating convey to plans. We use this model to characterize weights on consumer respondents to correct the incentive problem. We implement our proposed solution using data from the Consumer Assessments of Health Care Providers and Systems (CAHPS) and the Medicare Current Beneficiary Survey (MCBS). Our correction is low-cost, easily implemented on an on-going basis, and insensitive to assumptions about why health plans care about quality ratings.

Gonzalez, M., Prat, A., Matiz, M. C., Carreno, J. N., Adell, C. and Asenjo, M. A. (2001). "Management of client complaints in the hospital quality program. [Spanish]." Revista de Calidad Asistencial 16(8): 700-704.

Introduction: Clients complaints represent an important opportunity for quality improvement of the given services. The development of Institutes for clinical administration can become a model of organization capable of changing the role that these entities have in hospitals plans for quality improvement. Materials and methods: This is an epidemiological descriptive study that includes the complaints presented by patients during 1997, 1998 and 1999 in the Patient Attention Unit (Technical Direction) of "Hospital Clinico Universitario de Barcelona", To classify the different type of complaints we have used the definitions established by the "Servicio Catalan de la Salud". The rate of complaints per clinical activity performed has been quantified and the median response time has been measured as evaluation parameters. Results: A total of 2.479 complaints have been placed during the study period. The rate of complaints has diminished from 2,54 per thousand clinical activities in 1997 to 1,53 per thousand in 1999. Also the median response time of 20 days in 1997 has diminished to 13 in 1999. Conclusions: The implication of these Institutes in the process of complaint resolution and the use of precise and measurable parameters that facilitate the integration of the new units in the quality program, allowed us to improve the results of this important matter.

Gonzalez-Llinares, R. M., Arrue-Aldanondo, B., Perez-Boillos, M. J., Sanchez-Gonzalez, E., Ansotegui-Perez, J. C. and Letona-Aramburu, J. (2003). "Information management of patient complaints and claim processes in the Basque health service (Spain). [Spanish]." Revista de Calidad Asistencial 18(7): 591-597.

Objectives: To monitor and systematize information management of patient complaints and claim processes and to improve this process in the Basque Health Service. Materials and methods: We performed an incidence study in which the process was planned by using the management process tool. Indicators were identified, deployment and assessment of the results of the entire network of the Basque Health System between 2001 and 2002 were performed, and areas requiring improvement were identified. The process was reviewed and modifications were communicated to all the participants. Result: In 2002 there were 13,199 complaints (741 fewer than in the previous year) and 11,199 claims (2,171 fewer than in the previous year). The percentage of claims resolved in less than 30 days was 86.7% and 85.6% in 2001. The mean delay in resolution was 14.8 days in 2001 and 13.3 days in 2002. Reasons for claims: 31.4% were motivated by "waiting list/delay" (27.0% in 2001), 27.1% by "organization/coordination" (26.5% in 2001), and 20.9% by "health care" (16.4% in 2001). Claims source: primary care centers (36.4% in 2001 and 22.3% in 2002) and hospitals (21.0% in 2001 and 10.77% in 2002). In 200, 21.1% of claims originated from intrahospital consultations and 24.2% from extra-hospital consultations compared with 9.5 and 17.5% in the previous year.

Graber, D. R. (1993). The influence of nursing home characteristics and task environment on complaints and survey performance, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL: 178 p.

Previous analyses of nursing homes have typically been limited to evaluating the influence of structural indicators on a quality measure. In this dissertation, patterns of nursing care and patient population characteristics were employed to gain a more comprehensive understanding of nursing home violations and complaints. Two outcome measures--Nursing home survey violations (or deficiencies) and complaints in 1991 were collected for a sample of 195 North Carolina nursing homes. Nonprofit facilities were observed to receive about 2 fewer deficiencies than proprietary facilities. Religious-affiliated nonprofit facilities received significantly fewer complaints than other nonprofit nursing homes and proprietary nursing homes. Negative binomial regression models were employed to test the influence of structural and process measures on the two dependent variables. Facility size, admission rate, and the proportion of patients with decubitus ulcers were found to be positively and significantly related to violations and complaints. An interaction of RN staffing and admission rate was found to be significantly related to violations. Facilities in metropolitan statistical areas (MSAs) were associated with more complaints. A path analysis model indicated a positive association between the proportion of catheterized patients, the proportion of intubated patients, and

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admission rate and the dependent variable--the proportion of patients with decubitus ulcers. RN staff levels were associated with lower proportions of patients with decubitus ulcers. The use of this model revealed several significant indirect effects on violations and complaints (through decubitus patients), which were not apparent from the initial direct effects regression.

Grabowski, D. C. (2005). "Consumer complaints and nursing home quality.[comment]." Medical Care 43(2): 99-101.

Greco, M., Sweeney, K., Brownlea, A. and McGovern, J. (2001). "The practice accreditation and improvement survey (PAIS): what patients think." Australian Family Physician 30(11): 1096-1100.

BACKGROUND: The Practice Accreditation and Improvement Survey (PAIS) is an endorsed instrument by the Australian General Practice Accreditation Limited (AGPAL) for seeking patient views as part of the accreditation of Australian general practices. METHOD: From September 1998 to August 2000, a total of 53,055 patients completed the PAIS within 449 general practices across Australia, which is about 8% of all Australian general practices. The validity and reliability of the PAIS instrument was assessed during the study. Patient views were also analysed via 27 items relating to doctors' interpersonal skills, access, availability and patient information. RESULTS: PAIS was found to have sound validity and reliability measures. Patient evaluations showed a range of scores for the 27 items (69-91%). Lower scoring areas were issues about access, availability and availability of information for patients. DISCUSSION: Users of general practice rate the doctors' interpersonal skills (capability) more highly than other practice service issues (capacity). There is, in patients' views, much more room for improving these capacity aspects of general practice. CONCLUSION: Future research should explore how practices act on the results of patient feedback, and which practice based strategies are more effective in raising standards of care from a patient's perspective.

Greenwood, L. (2003). "Patient involvement. Complain and simple." Health Service Journal 113(5857): 24-5.

Complainants have been involved in designing a new system for addressing and preventing patient concerns. Many have become volunteer members of patient involvement groups. Formal and Informal complaints have dropped significantly in the past two years. Addressing issues when 'they are going wrong, rather than have gone wrong' has been emphasised.

Gremigni, P., Sommaruga, M. and Peltenburg, M. (2008). "Validation of the Health Care Communication Questionnaire (HCCQ) to measure outpatients' experience of communication with hospital staff." Patient Education & Counseling 71(1): 57-64.

OBJECTIVE: All healthcare workers' communication skills are recognised as valuable indicators of quality of care from the patient's perspective. Most of the studies measure doctor-patient communication, giving scarce attention to other professionals. This study is aimed at developing and providing preliminary validation of a questionnaire to measure outpatients' experience of communication with hospital personnel other than doctors. METHODS: Small groups of outpatients and hospital staffs were involved in identifying the domains and generating the items. A quantitative validation phase involving 401 outpatients followed in order to verify the hypothesised dimensionality of selected items and to measure reliability. RESULTS: A 13-item questionnaire emerged, comprising four components of outpatients' experience in the healthcare communication domain: problem solving, respect, lack of hostility, and nonverbal immediacy. Psychometric tests were promising as regards factorial validity, evaluated with confirmatory factor analysis, and scales reliability. Factor scores were independent of patients' gender, age, and education. CONCLUSION: The developed Health Care Communication Questionnaire (HCCQ) is a self-administered brief measure with good psychometric properties. PRACTICE IMPLICATIONS: The HCCQ gives information that could be taken as an indirect and subjective indicator of the quality of hospital services as provided by non-medical staff. This aspect may have a role in local quality improvement initiatives.

Griffey, R. T. and Bohan, J. S. (2006). "Healthcare provider complaints to the emergency department: a preliminary report on a new quality improvement instrument." Quality & Safety in Health Care 15(5): 344-6.

OBJECTIVES: Patient complaints to the emergency department (ED) have been well studied as indicators of quality. However, no study of complaints from healthcare providers (physicians, nurses and hospital administrators) has been published. Given their experience and expertise, healthcare providers are uniquely positioned to provide informed opinions about patient care. We present 1 year's results from a system initiated to capture healthcare providers' complaints, respond systematically, and integrate them into our quality program. METHODS: Complaints by healthcare providers to the ED for calendar year 2002 generated a "Care Concern" addressed by the involved emergency physician within 7 days. These were reviewed by two quality managers who assigned one of eight categories to the primary complaint and evaluated the need for formal peer review. RESULTS: Of 185 complaints, 53 (29%) were from healthcare providers. Of these, 31 (58%) related to medical care: 8 (15%) to diagnostic work-up, 9 (16%) to ED management, and 14 (26%) to consultations. Eleven (21%) related to miscommunication: 7 (13%) to disposition and 4 (8%) concerned infraction of hospital policy. Ten (19%) led to further formal review with two resulting in changes in ED policy. CONCLUSION: Healthcare workers' complaints highlight an aspect of customer care that is sometimes overlooked-that which we provide to other services. The complaints relate primarily to patient care issues, frequently raising concerns requiring intervention. This underused source of information presents a potential wealth of opportunity for quality improvement and customer service in the ED.

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Guth, K. A. and Kleiner, B. (2005). "Quality assurance in the health care industry." Journal of Health Care Finance 31(3): 33-40.

The purpose of this article is to explore the quality assurance methods commonly used in the health care industry. Factors that influence the delivery of quality patient care is explored as well as factors that affect implementation of quality control measures. The importance of quality patient care to the economic success of the health care industry is described. Quality improvement efforts that are utilized by health care institutions are described including: independent performance audits, internal audits, outcomes analysis, consumer reports, industry guidelines, and consumer satisfaction surveys. Highly effective hospital managers exhibit management roles, behaviors, and a range of activities that correlate strongly to institutional commitment to quality and improved patient care outcomes. By reinforcing their involvement in quality improvement efforts, hospital managers were able to enhance their effectiveness in promoting and sustaining quality care. Copyright Â© 2005 by Aspen Publishers, Inc.

Guzman, P. M., Sliepcevich, E. M., Lacey, E. P., Vitello, E. M., Matten, M. R., Woehlke, P. L. and Wright, W. R. (1988). "Tapping patient satisfaction: a strategy for quality assessment." Patient Education & Counseling 12(3): 225-33.

Participant satisfaction is an important measure of program effectiveness. In hospitals, patient satisfaction is a measure that is compatible with quality assurance. This article focuses on the revision, implementation and analysis of a patient satisfaction questionnaire that was designed as a tool for assessing the quality of non-physician encounters in a small hospital. The Patient Satisfaction Questionnaire (PSQ), which contained a 30-item rating scale, was designed to collect data about admissions, nursing care and seven other hospital services. The 686 PSQs that comprised a 4-month sample of 2156 instruments (31.8%) completed in a selected year were analyzed. Results show no less than 90% of patient ratings reflecting satisfaction. In addition, open-ended responses were overwhelmingly laudatory. The content and process of this collaborative effort demonstrate compatibility between research and management when goals and purposes are clearly delineated.

Hacquebord, H. (1994). "Health care from the perspective of a patient: theories for improvement." Quality Management in Health Care 2(2): 68-75.

The future of health care will depend on the ability of providers to produce health services that satisfy the needs of all customers at prices they can afford. This implies both innovation and improvement of quality. Quality has to start with the provider. The patients do not know what they want, although they are fast learners and can judge what they have received. Patient feedback is important, but it is only a small part of the many facets of transformation needed in health care. Improvement involves prediction and prediction depends on theory. This article describes some theories for improvement based on a patient's hospital experience.

Halsel, D. (1993). "Handling patient complaints." Missouri Medicine 90(10): 645-7.

Hanson, R., Clifton-Smith, B. and Fasher, B. (1994). "Patient dissatisfaction in a paediatric accident and emergency department." Journal of Quality in Clinical Practice 14(3): 137-43.

This paper presents a review of the patient complaints and those who walked out prior to receiving care in the Accident and Emergency (A&E) Department of the Children's Hospital, Camperdown. The walkout rate was 1.7% (424/27,082) in 1992. Walkouts were greatest in winter when the department was busiest, peak period being between 2000 and 0200 hours. The waiting time was presented as the main reason for walking out. Most parents were prepared to wait the advertised waiting time before leaving. The presenting complaints of children who were not seen covered a spectrum of illnesses with the potential for significant morbidity. The majority, however, were triaged as non-urgent cases. Despite attempts to follow up on walkouts, the outcome for 53% of patients was unknown. Written complaints were fewer in number and tended to focus more on the quality of care (66.6%). There were few recorded compliments. With the increasing customer focus on health, greater attention needs to be given to system failures.

Hargraves, J. L., Wilson, I. B., Zaslavsky, A., James, C., Walker, J. D., Rogers, G. and Cleary, P. D. (2001). "Adjusting for patient characteristics when analyzing reports from patients about hospital care." Medical Care 39(6): 635-41.

OBJECTIVES: To determine which patient characteristics are associated with reports and ratings of hospital care, and to evaluate how adjusting reports and ratings for hospital differences in such variables affects comparisons among hospitals. DESIGN: A telephone survey of a sample of patients hospitalized in 22 hospitals in a single city and a statewide mail survey of hospitalized patients. MEASURES: The surveys assessed: respect for patients' preferences, coordination of care, information exchange between patient and providers, physical care, emotional support, involvement of family and friends, and transition and continuity. The surveys also asked patients to rate their doctors, nurses, and other hospital staff. RESULTS: The variables with the strongest and most consistent associations with patient-reported problems were age and reported health status. Patient gender and education level also sometimes predicted reports and/or ratings. Models including these variables explained only between 3% and 8% of the variation in reports and ratings. CONCLUSIONS: The impact of adjusting for patient characteristics on hospital rankings was small, although a larger impact would be expected when comparing hospitals with more variability in types of patients. Nevertheless, we recommend adjusting at least for the most important predictors, such as age and health status. Such adjustment helps alleviate concerns about bias. It also may be useful to present data for

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certain groups of patients (ie, medical, surgical, obstetric) separately to facilitate interpretation and quality improvement efforts.

Harmsen, J. A., Bernsen, R. M., Bruijnzeels, M. A. and Meeuwesen, L. (2008). "Patients' evaluation of quality of care in general practice: what are the cultural and linguistic barriers?" Patient Education & Counseling 72(1): 155-162.

OBJECTIVE: Increased migration implies increased contacts for physicians with patients from diverse cultural backgrounds who have different expectations about healthcare. How satisfied are immigrant patients, and how do they perceive the quality of care? This study investigated which patient characteristics (such as cultural views and language proficiency) are related to patients' satisfaction and perceived quality of care. METHODS: Patients (n=663) from 38 general practices in Rotterdam (The Netherlands) were interviewed. General satisfaction with the general practitioner (GP) was measured by a report mark. Perceived quality of care was measured using the 'Quote-mi' scale (quality of care through the patient's eyes-for migrants), which contains an ethnic-specific subscale and a communication process subscale. Using multilevel regression techniques, the relation between patient characteristics (ethnicity, age, education, Dutch language proficiency, cultural views) and satisfaction and perceived quality of care was analysed. RESULTS: In general, patients seemed fairly satisfied. Non-Western patients perceived less quality of care and were less satisfied than Dutch-born patients. The older the patients and the more modern cultural views they had, the more satisfied they were about the GP in general, as well as about the communication process. However, non-Western patients holding more modern views were the most critical regarding the ethnic-specific quality items. The poorer patients' Dutch language proficiency, the more negative they were about the communication process. CONCLUSION: It is concluded that next to communication aspects, especially when the patient's proficiency in Dutch is poor, physician awareness about the patient's cultural views is very important during the consultation. This holds especially true when the immigrant patient seems to be more or less acculturated. PRACTICE IMPLICATIONS: Medical students and physicians should be trained to become aware of the relevance of patients' different cultural backgrounds. It is also recommended to offer facilities to bridge the language barrier, by making use of interpreters or cultural mediators.

Harrington, C., Hanawi, N., Ramirez, T., Parker, M., Giammona, M., Tantaros, M. and Newman, J. (2001). "Study of medicare beneficiary complaint procedures." Quality Management in Health Care 10(1): 65-65.

New procedures for reviewing a sample of Medicare beneficiary complaints about quality of care are compared with traditional procedures at a peer review organization (PRO) for 1998-1999. These new procedures included: (1) expanded communications with complainants and providers, (2) changed data collection methods, (3) integrated concurrent review findings from other agencies, (4) expedited review procedures, and (5) changed the medical review procedures. The findings showed improved beneficiary satisfaction with the new procedures over the traditional procedures and shorter time periods for processing the reviews. Even with the new procedures, beneficiaries continued to be concerned that the review time frames were too lengthy, the reviews generally failed to confirm their complaints, and the PROs generally did not disclose the findings to the beneficiaries.

Harrington, C., Merrill, S. and Newman, J. (2001). "Factors associated with Medicare beneficiary complaints about quality of care." Journal for Healthcare Quality 23(3): 4-14.

This article examines the number and types of formal complaints about quality of care that were made by Medicare beneficiaries and submitted to the California Peer Review Organization (PRO) during the period July 1, 1995-December 30, 1996. Logistic regression models were used to analyze the complaints in terms of sociodemographic factors, enabling factors (income and health maintenance organization [HMO] membership), diagnoses, and primary service providers. The complaint rate was found to be very low, and only 13% of complaints were confirmed by the PRO. HMO members and members receiving physician care and outpatient/emergency room care were more likely to complain about denials of or delays in services or the failure to be referred to specialists than were members in fee-for-service plans and those receiving other types of provider care. Complaints about poor nursing care were associated with receiving skilled nursing/rehabilitation care. Complaints about care that resulted in injury were associated with the denial of care, failure to be referred to a specialist, poor medical care, and poor communications. Complaints about care that led to disability were associated with medical errors, whereas those that led to death were associated with misdiagnosis and premature hospital discharge. It would be valuable for PROs to focus their complaint review efforts on common types of complaints in different settings. A review of PRO procedures should be undertaken to understand why so few complaints are submitted and confirmed.

Harrington, C., Weinberg, J., Merrill, S. and Newman, J. (2000). "Medicare beneficiary complaints about quality of care." American Journal of Medical Quality 15(6): 241-50.

This study examined all Medicare beneficiary complaints about quality of care submitted to the California Peer Review Organization (PRO) over 18 months. The complaint rate was low, and a medical record review by the PRO only confirmed 13% of the complaints. Managed Care Organization (MCO) members filed significantly more complaints about denial and/or delays in receiving services and the failure to refer to specialists. Fee-for-service complaints focused on inpatient hospital services, particularly premature discharge, discharge planning, admission necessity, and unnecessary tests. The PRO review process took over 7 months, and the findings were generally not released to the complainants.

Harris, L. E., Swindle, R. W., Mungai, S. M., Weinberger, M. and Tierney, W. M. (1999). "Measuring patient satisfaction for quality improvement." Medical Care 37(12): 1207-13.

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BACKGROUND: Surveys used for health plan quality reporting are generally administered annually to health plan enrollees to assess satisfaction with both the health plan and health care services. Therefore, surveys may lack sensitivity to measure the effects of patient-focused, quality improvement initiatives that could demonstrate results in a shorter time period. OBJECTIVES: We describe the development and testing of a multidimensional, visit-specific measure of satisfaction with primary care that may be used in quality improvement. METHODS: Conducted in five adult and pediatric primary care sites serving a commercial, largely managed-care population, the survey includes the Medical Outcomes Study Visit-Specific Questionnaire, the American Board of Internal Medicine Patient Satisfaction Questionnaire, and locally developed items. We assessed the instrument's reliability, validity, and utility for quality improvement. RESULTS: For both adult and pediatric samples, three factors emerged: satisfaction with the provider, satisfaction with access, and satisfaction with the office. Satisfaction with the provider and with the office were independently correlated with overall satisfaction in both samples; satisfaction with access was significantly correlated with overall satisfaction only for adults. For adults, patients who disenrolled from the health plan were less satisfied with the office compared with patients who remained with the health plan. Finally, for adults, we detected significant differences across practice sites in terms of satisfaction with office and access; for children, there were intersite differences in terms of satisfaction with provider, office, and access. CONCLUSIONS: We have support for the reliability and validity of this instrument that has identified differences in satisfaction between practice sites that may be used for quality improvement.

Harvey, G. (1991). "An evaluation of approaches to assessing the quality of nursing care using (predetermined) quality assurance tools." Journal of Advanced Nursing 16(3): 277-286.

This paper examines the implementation of four of the most common approaches to nursing quality assurance in England, namely Monitor, Qualpacs, nursing audits and a patient satisfaction questionnaire entitled "What the Patient Thinks". The primary aim of the study was to look more closely at the context, processes and outcomes of selecting and implementing specific quality assurance tools. Data were analysed at three distinct levels. The findings are presented around the structure of this three-level framework and indicate that the process of implementing a quality assurance tool is more important than the tool itself. It is suggested that a bottom-up approach to implementation, which locates ownership and control of the quality assurance tool with practitioners, is seen to result in more favourable staff responses and positive programme outcomes. The implementation of Qualpacs is used to illustrate some of the tensions that can occur between the inherent principles of the tool and the method of implementation. In studying the factors that might influence the method of implementing a quality assurance tool, a number of organizational and managerial factors are identified.

Hays, R. D., Eastwood, J.-A., Kotlerman, J., Spritzer, K. L., Ettner, S. L. and Cowan, M. (2006). "Health-related quality of life and patient reports about care outcomes in a multidisciplinary hospital intervention." Annals of Behavioral Medicine 31(2): 173-8.

BACKGROUND: Patient perceptions of care and health-related quality of life (HRQOL) are important outcomes for hospitalized patients. PURPOSE: This study examined patient experiences with hospital care and HRQOL in individuals hospitalized at a west coast teaching hospital. METHODS: We assessed patient experiences with care and HRQOL using interviews with 1,207 hospitalized, general medicine patients participating in a multidisciplinary provider team intervention at a large academic medical center. Patient outcome variables included the Picker dimensions of hospital care (Continuity and Transition, Coordination of Care, Emotional Support, Information and Education, Involvement of Family and Friends, Physical Comfort, Respect for Patient Preferences, Overall Impression), the Health Utilities Index Mark 3 (HUI-3), and the SF-12 physical (PCS-12) and mental health (MCS-12) summary scores. RESULTS: Patients randomized to a multidisciplinary intervention reported higher emotional support (b = 3.32), t(903) = 2.01, p =.044, and physical comfort (b = 3.49), t(863) = 2.25, p = .025, from health care providers than did the control group, but these effects became nonsignificant after adjusting for multiple comparisons. The HUI-3, PCS-12, and MCS-12 summary scores improved significantly from baseline to the 30-day, ts(943, 919, 860) = 4.94, 2.20, and 5.31, ps < .0001, = .03, and < .0001, respectively, and the 4-month follow-ups, ts(871, 919, 943) = 7.25, 8.68, and 8.08, ps < .001, < .001, and < .0001, respectively, but change on these measures did not differ between intervention and control patients. Baseline health was significantly associated with patient evaluations of hospital care, but patient evaluations did not predict future health. CONCLUSIONS: There were no differences in reports and ratings of hospital care or HRQOL between the control and the intervention groups. Hence, the behavioral changes in hospital staff in the intervention group had no effect on patient-reported outcomes. Mental health at baseline was predictive of patient evaluations of the hospitalization, but evaluations of care were not associated with subsequent HRQOL. Thus, it may be important to adjust patient evaluations of hospital care for case-mix differences in health.

Hays, R. D., Shaul, J. A., Williams, V. S., Lubalin, J. S., Harris-Kojetin, L. D., Sweeny, S. F. and Cleary, P. D. (1999). "Psychometric properties of the CAHPS 1.0 survey measures. Consumer Assessment of Health Plans Study." Medical Care 37(3 Suppl): MS22-31.

OBJECTIVES: Consumer surveys are being used increasingly to assess the quality of care provided by health plans, physician groups, and clinicians. The purpose of the Consumer Assessment of Health Plans Study (CAHPS) is to develop an integrated and standardized set of surveys designed to collect reliable and valid information about health plan performance from consumers. This article reports psychometric results for the CAHPS 1.0 survey items in samples of individuals with Medicaid or private health insurance coverage. METHODS: Reliability estimates for CAHPS 1.0 measures were estimated in a sample of 5,878 persons on Medicaid and 11,393 persons with private health insurance. Correlations of the CAHPS global rating of the health plan with willingness to recommend the plan and intention to re-enroll were estimated in a sample of 313 persons on Medicaid. The association of the rating of the health plan with ratings using a 5-

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point Excellent-to-Poor response scale also was investigated in the latter sample and in a sample of 539 persons with private health insurance. RESULTS: The CAHPS measures appeared to have good reliability, particularly at the health-plan level. Responses from 300 consumers per health plan tend to yield estimates that are reliable enough for health plan comparisons, especially among the privately insured. The global health plan rating was significantly correlated with consumers' willingness to recommend the plan to family and friends and to their intention to re-enroll in the plan if given a choice. CONCLUSIONS: The CAHPS 1.0 survey instrument appears to have excellent psychometric properties.

Hayward, R. A., Bernard, A. M., Rosevear, J. S., Anderson, J. E. and McMahon, L. F., Jr. (1993). "An evaluation of generic screens for poor quality of hospital care on a general medicine service.[see comment]." Medical Care 31(5): 394-402.

In this study, 675 general medicine admissions at a university teaching hospital were reviewed to evaluate six potential generic quality screens: 1) in-hospital death; 2) 28-day early readmission; 3) low patient satisfaction; 4) worsening severity of illness (as determined by an increase in Laboratory Acute Physiology and Chronic Health Evaluation APACHE-L); and 5) deviations from expected hospital length of stay; and 6) expected ancillary resource use. The quality of care for a stratified random sample of admissions were evaluated using structured implicit review (inter-rate reliability, Kappa = 0.5). Patients who died in-hospital were substantially more likely than those who were discharged alive to be rated as having had substandard care (30% vs. 10%; P < 0.001). In contrast, cases who had subsequent early readmissions did not have poorer quality ratings. Similarly, lower patient satisfaction was not associated with poorer ratings of technical process of care. Cases with lower-than-expected ancillary resource use (case-mix adjusted for diagnosis-related group) were more likely to be rated as having received substandard care than those with higher-than-expected resource use (16% vs. 6%; P < 0.05), and there was a similar trend for cases with shorter than expected length of stays. Associations between worsening severity of illness, as determined by APACHE-L scores, and quality were confounded because such patients were more likely to have died in-hospital.(ABSTRACT TRUNCATED AT 250 WORDS)

Henderson, A., Caplan, G. and Daniel, A. (2004). "Patient satisfaction: the Australian patient perspective." Australian Health Review 27(1): 73-83.

The literature reveals little Australian academic study of the phenomenon of patient satisfaction and identifies several problems in current research practice. A theoretical discussion about the phenomenon of patient satisfaction' is for the most part absent, the rigour in the methods applied is often dubious, a definition of patient satisfaction is not agreed and the patient experience is often not the focus of research. To address some of these issues inductive research was conducted with Australian patients to explore what they considered important for patient satisfaction to exist. A series of 52 interviews were conducted with twenty elective surgery patients in an Australian teaching hospital Patients were interviewed on admission to hospital, within one week of discharge from hospital and between six and eight weeks after discharge. Research with patients identified 16 themes that were important to make a patients hospital stay satisfactory. Qualitative data have provided a foundation to better understand what patient satisfaction' means in its everyday use. Such an approach is faithful to the concerns and priorities of the patients who are the users of health care services.

Henderson, R. F., North, N. and Patterson, G. (2005). "Investigations of complaints and quality of health care." Journal of Law & Medicine 12(3): 366-72.

Malpractice law is frequently justified by the claim that it improves health care services but this belief remains untested. Using a multiple case study in 16 remote rural areas in New Zealand, this study examined the effects of formal quasi-judicial investigations on the quality of health care services. The study found that the fragile local health systems were damaged by the quasi-judicial investigations of the medical disciplinary body and became less efficient and less user-friendly. A few doctors left rural practice and were difficult to replace. The remaining health workers responded to the investigations in a negative manner, losing confidence, enthusiasm and motivation for work; they performed in a less efficient manner, working more slowly, setting up barriers to access, ordering more tests and referring more to secondary care. Complainants also appeared to have been disadvantaged as a consequence of having complained.

Hendriks, A. A., Vrielink, M. R., Smets, E. M., van Es, S. Q. and De Haes, J. C. (2001). "Improving the assessment of (in)patients' satisfaction with hospital care." Medical Care 39(3): 270-83.

BACKGROUND: A self-report questionnaire is the most widely used method to assess (in)patients' satisfaction with (hospital) care. However, problems like nonresponse, missing values, and skewed score distributions may threaten the representativeness, validity, and reliability of results. We investigated which of alternative item-response formats maximizes desired outcomes. DESIGN: Five formats were compared on the basis of sample characteristics, psychometric properties at the scale and item levels, and patients' opinions of the questionnaire. SUBJECTS: Consecutively discharged patients (n=784) were sampled, of which a representative (sex, age, length of hospital stay) subsample of 514 (65%) responded. MEASURES: A 54-item satisfaction questionnaire addressing 12 aspects of care was used. Patients responded using either a 10-step evaluation scale ranging from "very poor" to "excellent" (E10), a 5-step evaluation scale ranging from "poor" to "excellent" (E5), or a 5-step satisfaction scale ranging from "dissatisfied" to "very satisfied" (S5). The 5-step scales were administered with response options presented as either boxed scale steps to be marked or words to be circled. RESULTS: E5 scales yielded lower means than S5 scales. However, at the item level, the S5 scale showed better construct validity, more variability, and less peaked score distributions. Circling words yielded fewer missing item scores than marking boxes. The E5 scale showed more desirable score distributions than the E10 scale, but construct validity and reliability were

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lower. CONCLUSIONS: No large differences among formats were found. However, if individual items are important carriers of information, a (5-step) satisfaction response scale, with response options presented in words next to each item, appears to be the optimal format.

Hendriks, A. A. J., Oort, F. J., Vrielink, M. R. and Smets, E. M. A. (2002). "Reliability and validity of the Satisfaction with Hospital Care Questionnaire." International Journal for Quality in Health Care 14(6): 471-82.

OBJECTIVE: To establish the psychometric properties of the Satisfaction with Hospital Care Questionnaire (SHCQ) for measuring patient satisfaction and evaluations of hospital care quality. DESIGN AND PARTICIPANTS: Patients (n = 275) and staff members (n = 83) of four hospital wards completed the 57-item SHCQ addressing 13 aspects of care. Staff members completed the SHCQ from the patient's perspective. The data were analyzed within the framework of generalizability theory. MAIN OUTCOME MEASURES: Generalizability coefficients (GCs) and standard errors of measurement (SEs). RESULTS: GCs indicating differentiation among patients with different overall levels of satisfaction (SHCQ mean scores) were high (> 0.90). GCs indicating differentiation among patients as to satisfaction with aspects of care (SHCQ scale scores) were generally satisfactory (> 0.75) to high. Patients agreed well on overall level of hospital care quality (GCs > 0.90) and differentiated reliably (GCs > 0.80) among aspects of care. No differentiation among wards was found with respect to quality of care. Patients and staff agreed to a considerable extent (0.78) on ranking the SHCQ items on care quality, but staff ratings were lower. Reliability and validity of patients' evaluations of quality of hospital care varied according to aspect of care. CONCLUSIONS: The SHCQ reliably establishes both patient satisfaction and overall quality of hospital care. Whereas patients' ratings may be too lenient, their ranking of the items on care quality appears to be valid, and is therefore suitable for monitoring and improving hospital care. Within scales, however, results should be interpreted more cautiously: for some items, patients cannot really tell the difference in quality of care.

Hendriks, A. A. J., Smets, E. M. A., Vrielink, M. R., Van Es, S. Q. and De Haes, J. C. J. M. (2006). "Is personality a determinant of patient satisfaction with hospital care?" International Journal for Quality in Health Care 18(2): 152-8.

OBJECTIVE: We investigated to what extent personality is associated with patient satisfaction with hospital care. A sizeable association with personality would render patient satisfaction invalid as an indicator of hospital care quality. DESIGN: Overall satisfaction and satisfaction with aspects of care were regressed on the Big Five dimensions of personality, controlled for patient characteristics as possible explanatory variables of observed associations. PARTICIPANTS: A total of 237 recently discharged inpatients aged 18-84 years (M = 50, SD = 17 years), 57% female, who were hospitalized for an average of 8 days. INSTRUMENTS: The Satisfaction with Hospital Care Questionnaire addressing 12 aspects of care ranging from admission procedures to discharge and aftercare and the Five-Factor Personality Inventory assessing a person's standing on Extraversion, Agreeableness, Conscientiousness, Emotional stability, and Autonomy. RESULTS: Agreeableness significantly predicted patient satisfaction in about half of the scales. After controlling for shared variance with age and educational level, the unique contribution of Agreeableness shrank to a maximum of 3-5% explained variance. When one outlier was dropped from the analysis, the contribution of Agreeableness was no longer statistically significant. CONCLUSION: Patient satisfaction seems only marginally associated with personality, at least at the level of the broad Big Five dimensions.

Hendriks, A. A. J., Vrielink, M. R., van Es, S. Q., De Haes, H. J. C. and Smets, E. M. A. (2004). "Assessing inpatients' satisfaction with hospital care: should we prefer evaluation or satisfaction ratings?" Patient Education & Counseling 55(1): 142-146.

Heuer, A. J. (2004). "Hospital accreditation and patient satisfaction: testing the relationship." Journal for Healthcare Quality: Promoting Excellence in Healthcare 26(1): 46-51.

This article describes a study that examines the relationship between two principal measures of institutional healthcare quality: accreditation scores and independently measured patient satisfaction ratings. This study involved a retrospective review and comparison of summative and selected categorical hospital accreditation scores from the Joint Commission on Accreditation of Healthcare Organizations and independently measured patient satisfaction ratings. A total of 41 acute care, 200-plus bed, not-for-profit hospitals in New Jersey and eastern Pennsylvania were included. Correlation and multiple-regression statistical methods were employed. The results revealed no relationship between these quality indicators on a summative level and no meaningful pattern categorical relationships. This finding suggests a disassociation between these two quality indicators, thus supporting the use of a balanced scorecard approach to hospital quality management. The study also revealed certain shortcomings in these two quality indicators, relating to insufficient score variability, which should be considered by those using such data to manage quality outcomes.

Hickson, G. B., Federspiel, C. F., Blackford, J., Pichert, J. W., Gaska, W., Merrigan, M. W. and Miller, C. S. (2007). "Patient complaints and malpractice risk in a regional healthcare center." Southern Medical Journal 100(8): 791-6.

OBJECTIVE: To study the association between physicians' complaint records and their risk management experiences in a regional healthcare center. DATA SOURCES: Patient complaints about physicians in a large border state medical center's hospital and outpatient clinics were recorded and coded. The study period was from January 2001 through December 2003. These records were linked to the counterpart

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physicians' data covered by the institutions' risk management plan through June 2004. STUDY DESIGN AND DATA COLLECTION: All physicians at the institution who had contact with patients during the study period were identified as surgeons or non-surgeons. Complaints for these physicians were recorded by the institution's Office of Patient Relations (OPR) and independently coded using a standardized protocol to characterize the nature of the problem and to uniquely identify the person complained about. The complaint records were then linked to the risk management files (RMFs) for the defined physician cohort. In addition, these data were supplemented with clinical service values (RVUs) which were available for 338 members (76%) of the 445 member cohort. PRINCIPAL FINDINGS: Both patient complaints and risk management events were higher for surgeons than for non-surgeons. This was true for the number of RMFs, those involving expenditures, and for lawsuits. Logistic regression was used to assess the effects of complaint counts, practice type and volume of clinical activity. All were statistically significant in predicting the number of RMF openings, RMF openings with expenditures and lawsuits. Predictive concordance was 75% or greater for each of the three risk management outcomes. CONCLUSIONS: Expressions of patient dissatisfaction and practice type are significantly related to risk management experiences in a regional medical center. Associations of risk management experiences with volume of clinical activity (RVUs) for surgeons in the regional medical center environment were not as strong as those found in a similar study reported from an academic medical center.

Hsieh, S. Y., Thomas, D. and Rotem, A. (2005). "The organisational response to patient complaints: a case study in Taiwan." International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services 18(4-5): 308-20.

PURPOSE: To explore and evaluate how hospital staff respond to patient complaints. DESIGN/METHODOLOGY/APPROACH: A teaching hospital with 1,500 beds in Taiwan was purposefully chosen as a case study of hospital response to patients' complaints. Data was obtained through interviews with quality surveying managers (n = 53), government managers (n = 4), staff of non-government organizations (n = 3) and a senior social worker, as well as analysis of documents (September 2001-April 2002). FINDINGS: Using the managerial-operational-technical framework developed by the researchers, the study demonstrated problematic aspects of handling complaints at the case hospital. It was revealed that: complaint handlers were not sufficiently empowered, information sharing was limited within the organization, communication among professional staff and with management was inadequate, the physical safety of workers had been threatened, and improvements could not be sustained. Moreover, it became apparent that the case study hospital generally responded to patient complaints in a reactive and defensive manner. ORIGINALITY/VALUE: It is evident that the hospital did not use patient complaints as a source of learning that could have promoted higher standards of care. The case study reveals some of the constraints and identifies requirements for appropriate use of information and feedback from patients. The study raises some issues requiring further research to ensure more appropriate use of patient complaints to improve quality of care.

Hunt, M. T. and Glucksman, M. E. (1991). "A review of 7 years of complaints in an inner-city accident and emergency department." Archives of Emergency Medicine 8(1): 17-23.

In 7 years between 1982-88, 122 complaints were lodged against the Accident and Emergency department of King's College Hospital. A high percentage mentioned more than one aspect per complaint. Commonest were those regarding attitude (37.7%), missed diagnosis (36.6%), waiting time (32.8%), cursory examination (14.7%) and poor communication (11.5%). These causes of complaint are amenable to improvement. Training in interpersonal skills may reduce complaints of attitude. A high index of suspicion for the unusual and careful examination of patients would reduce complaints of missed diagnosis. Sufficient medical and nursing staff would reduce waiting time and improvements in communication with patients would keep this aspect to a minimum. Complaint investigation can be time consuming, when dissatisfaction is expressed explanations at the time of presentation by senior staff members may head-off a formal complaint.

Hyrkas, K., Paunonen, M. and Laippala, P. (2000). "Patient satisfaction and research-related problems (Part 1). Problems while using a questionnaire and the possibility to solve them by using different methods of analysis." Journal of Nursing Management 8(4): 227-36.

INTRODUCTION: This article comprises two parts describing a research project for validating quality monitoring tools. This is part 1. AIM: To examine the problems of patient satisfaction inquiries by means of the literature, earlier research and an example. BACKGROUND: The topic is of current interest, since quality management by way of research-based knowledge has become an increasingly common demand. In this context, patient satisfaction inquiries are a central method of data collection. Although the problems relating to the reliability of the methods and results of these inquiries have been identified, their comprehensive examination is yet to be done. Quality management is none the less a challenge to nursing administrators requiring a broad-based utilization of feedback data, and this calls for a critical examination of the reliability of these results. METHODS: The exemplary material were collected using a questionnaire from patients (n = 282) on three different hospital wards. Different statistical methods and content analysis were used in the analysis. FINDINGS: The example used in the study indicates that the results of the inquiry were highly positive time after time. The reliability of the instrument presented a problem. The low amount of information collected in the open-ended question was another problem that can be criticised in relation to the amount of work required in the analysis. The results of the factor analysis showed that the questionnaire needs further development. CONCLUSIONS: To conclude, patient satisfaction inquiries yield a relatively small and limited amount of information on quality management and improvement, but this information is necessary specifically for ward sisters for the follow-up of long-term trends in patient satisfaction. The second part of this article (part 2) examines the description of patient satisfaction by means of triangulation.

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Isenberg, S. F. and Stewart, M. G. (1998). "Utilizing patient satisfaction data to assess quality improvement in community-based medical practices." American Journal of Medical Quality 13(4): 188-94.

Our objective was to quantitatively measure the effect of quality improvement-based intervention on the improvement in patient satisfaction with physicians, office visits. A prospective nonrandomized case-control protocol was used at a multiple-site community-based medical and surgical office practices of members of Project Solo/Physicians Information Exchange. The study subjects were convenience samples of new and return patients seen between July 1996 and July 1997. One group of physicians (control group) surveyed patient satisfaction with office visits on two separate occasions with no intervention between the two occasions, except for seeing their own results after the first survey. A second group of physicians (intervention group) also surveyed patient satisfaction with office visits on two separate occasions, but were provided with a quality improvement poster between surveys. Changes in patient satisfaction between the two surveys were measured. The visit rating questionnaire, a nine-item patient-based questionnaire, was used to measure patient satisfaction; percentage excellent responses in the summary categories of patient access, physician attributes, and overall visit were used. Overall, 6088 patients from 59 physicians' offices participated; 3815 patients from 29 physicians in the control group, and 2273 patients from 30 physicians in the intervention group. The control group demonstrated small and nonsignificant changes in patient satisfaction between the two survey periods (0.6-1.4% increase, P = NS), and the intervention group demonstrated statistically significant improvements in patient satisfaction between the two survey periods (4.2-5.7% increase, P = 0.05-0.001). In addition, the two groups were compared directly using a stratified chi 2 analysis, and the differences were also statistically significant (chi 2 = 3.7-8.3, P = 0.05-0.004). We conclude that the use of a quality improvement-based intervention had a significant positive effect on patient satisfaction with office visits, when compared to a group of physicians who did not use any intervention.

Ito, H. and Sugawara, H. (2005). "Relationship between accreditation scores and the public disclosure of accreditation reports: a cross sectional study." Quality & Safety in Health Care 14(2): 87-92.

OBJECTIVE: To examine the association between accreditation scores and the disclosure of accreditation reports. DESIGN: A cross sectional study. SETTING: Hospitals participating in an accreditation programme in Japan. PARTICIPANTS: 547 of the 817 hospitals accredited by the Japan Council for Quality Health Care (JCQHC) by January 2003. MAIN OUTCOME MEASURES: Data on participation in public disclosure of accreditation reports through the JCQHC website were obtained from the JCQHC database. Comments on the disclosure were obtained using a questionnaire based survey. RESULTS: A total of 508 (93%) of the participating hospitals disclosed their accreditation reports on the JCQHC website. Public hospitals were significantly more committed to public disclosure than private hospitals, and larger hospitals were significantly more likely to participate in public disclosure than smaller hospitals. Accreditation scores were positively related to the public disclosure of hospital accreditation reports. Scores for patient focused care and efforts to meet community needs were significantly higher in actively disclosing hospitals than in non-disclosing hospitals. Among the large hospitals, scores for safety management were significantly higher in hospitals advocating disclosure than in non-disclosing hospitals. CONCLUSIONS: There was a positive correlation between accreditation scores and public disclosure. Our results suggest that the public disclosure of accreditation reports should be encouraged to improve public accountability and the quality of care. Future studies should investigate the interaction between public disclosure, processes and outcomes.

Jackovitz, D. S. (1999). "Ambulatory patient satisfaction: a systematic approach to collecting and reporting information." Journal for Healthcare Quality 21(6): 12-7; quiz 60.

The importance of outpatient services to most hospitals continues to escalate. The number of ambulatory outpatients is much larger than the number of inpatients, and revenues from outpatient services are predicted to equal or exceed inpatient revenues in the near future. The ability to provide outpatient services with exceptional quality is paramount to long-term survival of hospitals. This article describes a methodology for systematically collecting and reporting patient satisfaction information from a wide array of hospital ambulatory care services. By systematically measuring satisfaction, hospitals can determine the outpatient areas and service dimensions in need of performance improvement.

Jackson, J. L. and Kroenke, K. (1997). "Patient satisfaction and quality of care." Military Medicine 162(4): 273-7.

As the Department of Defense initiates Tricare, its new system of integrated health delivery, outcome assessment will become increasingly important. Traditional outcomes have focused on disease and its more serious consequences, disability and death. Patient satisfaction is only recently emerging as an important measure of the quality of health care delivery. In this paper, we focus on patient satisfaction, exploring its historical roots, its evolution as an outcome measure, and its potential utilities and weaknesses in quality assessment. [References: 79]

Jaipaul, C. K. and Rosenthal, G. E. (2003). "Do hospitals with lower mortality have higher patient satisfaction? A regional analysis of patients with medical diagnoses." American Journal of Medical Quality 18(2): 59-65.

Although patient satisfaction is a widely used indicator of quality, relationships between satisfaction and other indicators are poorly studied. The current study examined hospital-level correlations between patient satisfaction and severity-adjusted mortality for 29 hospitals in northeastern Ohio during 1993-1997. Satisfaction with 6 dimensions of care was measured using a validated survey of 42,255 randomly selected patients with medical diagnoses. Severity-adjusted mortality rates were determined for 200,562 consecutive patients with 6 high-volume medical diagnoses. Analyses found that satisfaction scores were inversely

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correlated with mortality rates. For the cumulative 5-year period, correlations were significant or of borderline significance for 5 of the 6 dimensions (coordination [R = -0.40; P = .03], discharge instructions [R = -0.39; P = .04], overall quality [R = -0.38; P = .04], information provided [R = -0.37; P = .05], and nursing [R = -0.35; P = .06]). The correlation was weakest for physician care (R = -0.07; P = .72). These findings indicate that hospitals with higher patient satisfaction also tended to have lower severity-adjusted mortality. Associations were strongest for dimensions of satisfaction measuring patient communication, coordination of care, and nursing care and weakest for physician care.

Jatulis, D. E., Bundek, N. I. and Legorreta, A. P. (1997). "Identifying predictors of satisfaction with access to medical care and quality of care." American Journal of Medical Quality 12(1): 11-8.

Satisfaction with access to medical care and quality of care were compared using a survey instrument adapted from the Group Health Association of America Consumer Satisfaction Survey. Participants were members of a large health maintenance organization employed by an employer group (Company) and other non-company members (Control). Overall, members reported high satisfaction with both access to medical care and quality of care. There were no significant differences in satisfaction between Company and Control respondents. Stepwise regression identified the strongest predictor of satisfaction with access to care as ease of arranging appointments. Satisfaction with quality of care was predicted most strongly by outcomes of medical care. These findings indicate that items with which members are least satisfied (access to doctor after hours, office waiting time, and time for routine appointment) do not predict either satisfaction with access to care or satisfaction with quality of care. Managed care organizations must develop and utilize evidence-based evaluation tools such as this one to assess the quality of care.

Javetz, R. and Stern, Z. (1996). "Patients' complaints as a management tool for continuous quality improvement." Journal of Management in Medicine 10(3): 39-48.

Continuous quality improvement focuses on the customer and, therefore, requires attention to customers' feedback as a vital input. Customers' feedback in general hospitals includes utilization statistics of various services, patient satisfaction surveys and patients' complaints. The role of complaint data as a management tool, and particularly as applied to quality improvement, has received little attention in the literature. As a quality control tool, complaints are investigated on the individual, unit and organizational levels. Repeated complaints about the same units, procedures or individuals, are especially important for quality review. The role of the hospital administration is to draw on the human, technological and procedural resources at its disposal, along a solution time interval (immediate, short and long term), in designing its policy for quality improvement. Presents three examples of policy changes. The aggregate of complaint data serves, in addition, for follow-up of the effect of changes introduced by policy decisions.

Jenkinson, C., Coulter, A. and Bruster, S. (2002). "The Picker Patient Experience Questionnaire: development and validation using data from in-patient surveys in five countries." International Journal for Quality in Health Care 14(5): 353-8.

OBJECTIVE: The purpose of this study was to develop and test a core set of questions to measure patients' experiences of in-patient care. Questions were selected from the bank of items developed for use in in-patient surveys undertaken by the Picker Institute for the purposes of assessing the quality of care. DESIGN: The data reported here come from surveys of patients who had attended acute care hospitals in five countries: the United Kingdom, Germany, Sweden, Switzerland, and the USA. Questionnaires were mailed to patients' homes within 1 month of discharge, either to all patients, or to a random sample, discharged during a specified period. SAMPLE: A total of 62 925 questionnaires were returned, with response rates of 65% (UK), 74% (Germany), 63% (Sweden), 52% (Switzerland), and 46% (USA). RESULTS: Fifteen items were selected from the bank of questions included in the Picker in-patient questionnaires. These items have a high degree of face validity and when summed to an index they show a high degree of construct validity and internal reliability consistency. DISCUSSION: Fifteen items derived from the longer form Picker in-patient survey have been found to provide a meaningful picture of patient experiences of health care, and constitute the 15-item Picker Patient Experience Questionnaire. These questions comprise a core set that should be measured in all in-patient facility surveys. The Picker Patient Experience Questionnaire represents a step forward in the measurement of patient experience as it provides a core set of questions around which further optional modules may be added. Scores are easy to interpret and actionable. CONCLUSION: This small set of questions could be incorporated into in-patient surveys in different settings, enabling the comparison of hospital performance and the establishment of national or international benchmarks.

Johansson, P., OlÃ©ni, M. and Fridlund, B. (2002). "Patient satisfaction with nursing care in the context of health care: a literature study." Scandinavian Journal of Caring Sciences 16(4): 337-344.

To evaluate and improve the quality of care provided, it is of vital importance to investigate the quality of care in the context of health care. Patient satisfaction is a significant indicator of the quality of care. Consequently, quality work includes investigations that map out patient satisfaction with nursing care. To improve the quality of nursing care, the nurse needs to know what factors influence patient satisfaction. The aim of this literature study was to describe the influences on patient satisfaction with regard to nursing care in the context of health care. In the description of nursing care, we have used Henderson's nursing care model. The results describe eight domains that have an influence on patient satisfaction with nursing care: the socio-demographic background of the patients, patients' expectations regarding nursing care, the physical environment, communication and information, participation and involvement, interpersonal relations between nurse and patient, nurses' medical-technical competence, and the influence of the health care organization on both patients and nurses. The bulk of the literature included in the study came from the UK,

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Sweden and the USA. This means that the results should be applicable to health care in the western world. An important implication for future research is to continue to elucidate the factors that influence satisfaction with nursing care, as seen from the patient's perspective.

Jones, J. A., Meehan-Andrews, T. A., Smith, K. B., Humphreys, J. S., Griffin, L. and Wilson, B. (2006). ""There's no point in complaining, nothing changes": rural disaffection with complaints as an improvement method." Australian Health Review 30(3): 322-332.

OBJECTIVE: To validate earlier findings that lack of access to health services is the most likely issue of complaint by rural consumers, and that lack of knowledge about how to make effective complaints and scepticism that responses to complaints bring about service improvement account for the under-representation of complaints from rural consumers. DESIGN: Unaddressed reply-paid mail survey to 100% of households in small communities, and 50%, 20% or 10% in progressively larger communities. SETTING: Eight communities in the Loddon-Mallee region of Victoria. PARTICIPANTS: 983 householders most responsible for the health care of household members, responding to a mailed questionnaire. MAIN OUTCOME MEASURES: Issues of complaints actually made; issues of unsatisfactory situations when a complaint was not made; reasons for not complaining; to whom complaints are made; and plans for dealing with any future complaint. RESULTS: Earlier findings were confirmed. Lack of access to health services was the most important issue, indicated by 54.8% of those who had made a complaint, and 72% of those who wanted to but did not. The most common reason given for not complaining was that it was futile to do so. Lack of knowledge of how to make effective complaints which might contribute to the quality assurance cycle was evident. CONCLUSIONS: Rural consumers' disaffection with health complaints as a means to quality improvement poses a significant barrier to consumer engagement in quality assurance processes. Provider practices may need to change to regain community confidence in quality improvement processes.

Jones, J. G. (1996). "Monitoring and dealing with customer complaints." Water Supply 14(1): 145-157.

Jonsson, P. M. and Ovretveit, J. (2008). "Patient claims and complaints data for improving patient safety." International Journal of Health Care Quality Assurance 21(1): 60-74.

PURPOSE: The purpose of this paper is to describe patient complaints and claims data from Swedish databases and assess their value for scientific research and practical health care improvement. DESIGN/METHODOLOGY/APPROACH: The article first describes previous research into patient claims and similar schemes. It then presents three types of data on patient claims and complaints in Sweden: data generated by the Patient Insurance Fund, the Medical Responsibility Board and the Patients' Advisory Committees and considers methodological issues in using the data. FINDINGS: The databases' value is problems related to spontaneous reporting, which makes it difficult to know how much the data correspond to general injury rates and health care patterns. Another issue is the balance between the size of study materials and the timeliness, e.g. when diagnosis-specific analysis requires data pooling over several years in order to reach adequate case numbers. Adjustment for confounders not present in the databases, e.g. data on hospital case-mix, may add to difficulties using the data in comparative analyses of safety performance. RESEARCH LIMITATIONS/IMPLICATIONS: The databases' safety analysis and quality improvement value depends on understanding their function, data collection method and their limitations as a source of data about the true incidence and prevalence of injuries and safety problems. ORIGINALITY/VALUE: This is the first thorough review of the possibilities and limitations associated with the use of claims and complaints data in health care research and improvement.

Jorde, R. and Nordoy, A. (1999). "Improvement in clinical work through feedback: intervention study." BMJ 318(7200): 1738-9.

Kent, A. (2007). "Repression or repair? Managing complaints." British Journal of Healthcare Management 13(6): 210-212.

Kent, A. (2008). "Dismissing the disgruntled: Swedish patient complaints management." International Journal of Health Care Quality Assurance 21(5): 487-94.

PURPOSE: Over the past decade the Swedish system for dealing with patient complaints has come under increasingly intense scrutiny from both healthcare providers and consumers. This article summarizes contemporary Swedish viewpoints on the debate by using sociological theory combined with anthropological field data. Its purpose is to prompt radical reappraisal of some attitudes underlying the current handling of patient complaints in Sweden and perhaps elsewhere. DESIGN/METHODOLOGY/APPROACH: The material presented here is partly a collation of literature and contemporary debate articles. A number of cases are explored including material taken from ongoing anthropological fieldwork among patients who are or have lodged complaints. Fieldwork was begun in May 2006 and consists of in-depth, semi-structured interviews, thus far with six patients, about their experiences lodging complaints. Contact with patients is ongoing as their stories continue to unfold. Interviews have also been conducted with representatives of patient support organizations and medico-legal specialists. The material is analyzed using recent sociological theory concerned with trust. FINDINGS: Patients who lodge complaints about their care are interested in achieving moral redress and trust restoration. The major authorities dealing with patient complaints in this case may, however, be mistrusted by those who have experience of them: practitioners and patients alike. In general, they seem to fail to fulfill patients' expectations of guaranteeing ethical standards within healthcare and they are felt to act as a disincentive to honest reporting of adverse incidents by practitioners. RESEARCH LIMITATIONS/IMPLICATIONS: This study is case specific and the particular

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findings are not readily generalizable to other countries. However, themes concerned with trust reparation that become evident pose questions about situations elsewhere that are analogous though not identical. Conclusions drawn are, therefore, intended not necessarily to be extrapolated but rather to provoke reflection about similar issues in other cases. PRACTICAL IMPLICATIONS: If practices and healthcare regulation structures are to become increasingly sensitive to patients' experience then it is essential that patients' stories and struggles are aired in those forums that influence decision makers' attitudes. This article attempts to bring patients' rights, expectations and perspectives to the fore in discussion about healthcare quality assurance. ORIGINALITY/VALUE: By presenting patients as subject rather than object, the article intends to engage the reader in the patient's quest for moral reparation when trust is breached. The use of anthropological method helps give the perspectives or experience of those who are relatively disempowered their rightful place at the heart of discussions about healthcare quality.

Kline, T. J. B., Baylis, B. W., Chatur, F., Morrison, S. A., White, D. E., Flin, R. H. and Ghali, W. A. (2007). "Patient satisfaction: evaluating the success of hospital ward redesign." Journal for Healthcare Quality: Promoting Excellence in Healthcare 29(3): 44-49.

Patients who were moved from a traditional medical ward to a new state-of-the-art medical ward were surveyed regarding their perceptions of quality during their hospitalization. Respondents rated the environment of the state-of-the-art facility, as well as the overall quality of their hospital stay, more positively. However, fewer differences in perceptions of the quality of the broader hospital environment and little difference in the perceived quality of staff-patient interactions were found. Findings indicated that enhancing the facilities of the patient care environment improved patients' overall perceptions of the quality of their hospital stay.

Kline, T. J. B., Willness, C. and Ghali, W. A. (2008). "Predicting patient complaints in hospital settings." Quality & Safety in Health Care 17(5): 346-50.

BACKGROUND: The prediction of patient complaints is not clearly understood. This is important in so far as patient complaints have been shown to correlate with other adverse outcomes of interest in acute care facilities. OBJECTIVES: To evaluate the complexity of the patient case and patient safety culture as predictors of patient complaints. DESIGN: A matched case-control analysis of data from patients filing complaints (cases) and matched patients who did not file complaints (controls) in 2005. Staff surveys were used to measure the Patient Safety Culture on individual units. SETTING: 45 inpatient acute care units from four general hospitals in a large metropolitan centre in western Canada. SAMPLE: 586 patients registering complaints in 2005. METHOD: The primary outcome was patient complaints (number and type). Predictors included unit-level measures of patient safety culture based on a survey and patient admission characteristics (including age, gender, treatment unit, primary diagnosis, case resource intensity). RESULTS: The probability of a patient complaint was positively associated with cases of higher complexity (beta = 0.145, p = 0.032; odds ratio = 1.16; CI 0.994 to 1.344). The culture of patient safety within hospital units was not related to the probability of complaints within a given unit. CONCLUSIONS: Patient complaints are associated with higher clinical complexity. However, the confidence interval around the odds ratio for this association just crosses 1.0 and is thus not "significant" in a traditional framework of dichotomously judging statistical significance at the 95% confidence level. The lack of association with a unit's safety culture, meanwhile, implies that the non-modifiable clinical complexity factor is a more important determinant of patient complaints.

Klotz, T., Zumbe, J., Velmans, R. and Engelmann, U. (1996). "[The determination of patient satisfaction as a part of quality management in the hospital]." Deutsche Medizinische Wochenschrift 121(28-29): 889-95.

BASIC PROBLEM AND OBJECTIVE OF STUDY: Patient-satisfaction is an important part of the quality of results of medical treatment in hospital. Such satisfaction can be measured with a standardised multi-dimensional questionnaire which takes into account all relevant parts of a hospital. An enquiry was undertaken on patients in a university department of urology to find out whether a scientifically based measurement of patient-satisfaction is possible and whether organisational improvement can result from it. PATIENTS AND METHODS: Dimensions of patients-satisfaction included "care by doctors", "care by nursing staff", "food and accommodation", and "administration and daily activity". A questionnaire with a scale for answers (total of 65 items with closed answers) was developed for each of the dimensions. A one-month pretest served to ascertain acceptance and understanding of the questionnaire. In the three-month main test period questionnaires were given to all in-patients over 16 years old on admission. Participation was voluntary and anonymous. RESULTS: 232 patients took part (172 men, 60 women; median age 57 years), a response rate of 61%. The scales were shown to have a high internal consistency. The answers provided, for example, the means for simple and directly applicable improvement in patient information and the organisation of daily routine. Making the results known had a positive effect on the motivation of the staff. CONCLUSION: The work and cost involved in such a study are reasonable. This is the more so since in future investigation on patient-satisfaction will be undertaken every year or two as part of the demanded quality management in hospitals. However, scientific principles in the methodology must be taken into account when evaluating the results.

Knoll, M. and Saal, S. (2008). "Nursing scientific development of a concept for the evaluation of complaint management systems for hospitals [German]." PR-Internet fur die Pflege 10(4): 214-218.

Against the background of rising cost pressure and the increasing competition in the in-patient healthcare sector, the importance of customeroriented acting grows steadily. In this context, the systematic dealing with customer complaints becomes a central issue. At the moment, complaint management is an essential element of all currently important quality management concepts. The search for suitable methodical

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procedures for the evaluation of structures, processes and results within the scope of complaint management stands at the centre of attention. Further, it is being researched how central tasks of complaint management should ideally be designed in the in-patient healthcare sector in order to ensure its success. In the context of the qualitative, non-experimental approach a literature research acts as content-related exploration of the present state of science and hence as the foundation for the subsequent concept development. Supported by the qualitative content analysis (Mayring 1994) relevant literature is being structured as to enable the categorisation of the central tasks of complaint management. All excerpted assessment procedures for complaint management systems will subsequently be confronted with each other in a meta-analysis and weighted according to their suitability for the employment in in-patient facilities.

Koska, M. T. (1989). "Be aware, not afraid, of JCAHO complaint standards." Hospitals 63(23): 40.

How does your hospital handle complaints? You better have a good answer to this question. As of this January, the Joint Commission on Accreditation of Healthcare Organizations, Chicago, will require hospitals to formalize their methods of responding to patient complaints.

Kuosmanen, L., Kaltiala-Heino, R., Suominen, S., Karkkainen, J., Hatonen, H., Ranta, S. and Valimaki, M. (2008). "Patient complaints in Finland 2000-2004: a retrospective register study." Journal of Medical Ethics 34(11): 788-92.

Today, monitoring of patient complaints in healthcare services is being used as a tool for quality assurance systems and in the future development of services. This nationwide register study describes the number of all complaints processed, number of complaints between different state provinces, healthcare services and healthcare professionals, and outcomes of complaints in Finland during the period 2000-2004. All complaints processed at the State Provincial Offices and the National Authority for Medicolegal Affairs were analysed by statistical methods. Complaints about mental healthcare were explored in greater detail. The analysis showed that the number of patient complaints increased considerably during the study period. There were changes in the number of complaints between study years in different provinces. Out of different healthcare services, an especially marked increase was seen in private healthcare. Nearly all complaints were lodged against physicians, and over half of the complaints were made because of medical error. In mental health care, patients more often complained about unsatisfactory certificates and statements and the use of compulsory hospital care. An analysis of the outcomes revealed that in mental health care complaints more seldom led to consequences. The results need to be utilised when planning interventions for advanced supervision, prevention of adverse events and patient safety in healthcare, and especially in mental health care. From the patients' perspective, it is important to create a culture where most problem situations are handled where the treatment was provided, thus avoiding a complex complaints process.

Labarere, J. and Francois, P. (1999). "Goals and methodological issues in hospital patient satisfaction surveys. Analysis of the literature. [French]." Revue d'Epidemiologie et de Sante Publique 47(2): 175-184.

Assessment of hospital patient satisfaction is henceforth a statutory obligation in France. The purpose of this study was to define the main settings of patient satisfaction surveys and to describe methods for assessing patient satisfaction, through a literature review. Published works have mainly been based on experts opinions; few studies have used appropriate methodology. On the whole, their authors consider that patient satisfaction assessment should provide a useful feedback to the quality improvement system of hospitals. Surveys should associate qualitative and quantitative techniques and analysis of patient complaints and letters. Patient satisfaction surveys should not be separated from theoretical work on the foundations of this concept and its measurement.

Lambert, C. C. (1990). "A comparison of patients and patient complaints at six chiropractic teaching clinics (I)." Journal of Manipulative and Physiological Therapeutics 13(2): 112.

Larsson, B. W. and Larsson, G. (2002). "Development of a short form of the Quality from the Patient's Perspective (QPP) questionnaire." Journal of Clinical Nursing 11(5): 681-687.

Patients' views on the quality of care are important and it is desirable that these can be assessed using short, yet valid and reliable instruments. The aim of the work reported here was to develop and test a short version of an established questionnaire: Quality from the Patient's Perspective (QPP). Patients (n=162, 79% response rate) receiving care at medical and surgical departments in two Swedish hospitals responded to the original QPP as well as to a newly developed short version. An ethical research committee approved the study. Pearson correlations were computed between the long and short forms and differences between means were analysed with t-tests. Reliability was estimated by computing Cronbach alpha coefficients. Correlations of acceptable size were found between the short form and the original QPP. The short form also had acceptable reliability coefficients. The strengths of the work are that the items in the short version are derived from a patient perspective and are formulated in words used by patients; the items still have a theoretical foundation, which makes the interpretation of results more meaningful; global formulations such as "What do you think about your care?" have been avoided; the short format should make the questionnaire more attractive for many patients to respond to. Limitations are that results indicate that the short form does not fully measure what the long form does. Therefore, when the short form is used in practice, a two-step procedure is suggested, where a follow-up is done with a selection of items from the original long form. This selection could be restricted to areas where problems may be suspected, based on the results from the short form.

Larsson, B. W., Larsson, G., Chantereau, M. W. and von Holstein, K. S. (2005). "International comparisons

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of patients' views on quality of care." International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services 18(1): 62-73.

PURPOSE: To compare patients' views on quality of care in different countries using a theory-based instrument, while at the same time controlling for the following potential confounders: type of care system (private vs public), type of care (kind of health problem), gender, age, and subjective wellbeing. DESIGN/METHODOLOGY/APPROACH: Patients capable of communicating in wards (medical and surgical departments) and day surgery departments in England, France, Norway, and Sweden were recruited consecutively, to participate in a programme run by the health-care company Capio. Ward patients: England (n=1236), France (n=1051), Norway (n=226), and Sweden (n=428). Day surgery patients: England (n=887), France (n=544), Norway (n=101), and Sweden (n=742). Average response rate across settings: approximately 75 per cent. Patients evaluated the quality of the care they actually received and the subjective importance they ascribed to different aspects of care. The questionnaire "Quality from the patient's perspective" (QPP) was used (modified short version). FINDINGS: Cross-national comparisons were made within each of the two care contexts (wards and day surgery) separately for men and women. Quality of care evaluations were adjusted for age and subjective wellbeing. English and French patients scored significantly higher than Norwegian and Swedish on both kinds of ratings (perceived reality and subjective importance), in both kinds of care contexts, and in both sexes. ORIGINALITY/VALUE: Cross-national comparisons of patients' views on care can give meaningful guidance for practitioners only if they are context-specific and if well-known confounders are controlled for.

Larsson, G. and Larsson, B. W. (2003). "Quality improvement measures based on patient data: some psychometric issues." International Journal of Nursing Practice 9(5): 294-299.

Existing methods for handling patients' opinions as a basis for quality improvement measures tend to be too sophisticated for practical nursing and/or weak psychometrically. An Index of Measures was developed by combining patients' perceptions of actual care conditions with the subjective importance they ascribed to these conditions. Data from Swedish somatic inpatients (n = 4002) indicated that this index gave added value compared to patients' ratings of actual care conditions only. Interpretation of the Index of Measures focused on the proportion of patients who receive the value "deficiency." This value is obtained if a given patient has a subjective importance rating on a given item which is higher than the mean subjective importance score for the whole patient group on that item, as well as a perceived reality rating on the item in question which is lower than the mean perceived reality rating for the whole group on that item. Guidelines are suggested on when improvement actions are necessary and when they are not necessary.

Larsson, G., Larsson, B. W. and Munck, I. M. (1998). "Refinement of the questionnaire 'quality of care from the patient's perspective' using structural equation modelling." Scandinavian Journal of Caring Sciences 12(2): 111-8.

In 1994, the questionnaire 'Quality of Care from the Patient's Perspective' (QPP) was developed using a conventional factor analytical approach (Wilde et al. 1994). The items and conceptual framework of this questionnaire were derived from a theoretical model, which, in turn, was developed from qualitative patient interviews, using a grounded theory method of analysis (Wilde et al. 1993). The aims of this study were to develop further the dimensionality of the QPP using structural equation modelling combined with advances in factor analysis modelling, and to refine the instrument. This comparatively new methodology extracts more information out of questionnaire data and is considered to be superior to traditional scaling methods. The sample consisted of 611 somatic inpatients from four departments at a Swedish hospital. Data collected with the QPP were explored with the new tool tracing the dimensions postulated in the theoretical model underlying the QPP. A nested factor model was developed fulfilling statistical criteria for adjustment between model and data. The model consists of a general factor and 16 subordinate factors. Most of the original QPP scales were reproduced with the new statistical technique. However, some content changes were made which appear to bring the QPP scales closer to patients' meaning representations of the area. Some changes were also made to the response format, changes which appear to strengthen the psychometric properties of the instrument. The refined QPP will hopefully contribute to a more differentiated picture of quality of care when applied in the field. All scales, items, and response formats of the revised QPP are presented in an appendix.

Laschinger, H. S., Hall, L. M., Pedersen, C. and Almost, J. (2005). "A psychometric analysis of the patient satisfaction with nursing care quality questionnaire: an actionable approach to measuring patient satisfaction." Journal of Nursing Care Quality 20(3): 220-30.

Patient satisfaction with nursing care quality is an important indicator of the quality of care provided in hospitals. This study tested a newly developed patient-centered measure of patient satisfaction with nursing care quality within a random sample of 14 hospitals in Ontario, Canada. Results of this study revealed that the newly developed instrument had excellent psychometric properties. Total scores on satisfaction with nursing care were strongly related to overall satisfaction with the quality of care received during hospitalization. The results of this study yielded actionable, patient-focused results that can be used by managers to address areas requiring improvement.

Leino-Kilpi, H. and Vuorenheimo, J. (1992). "Patient satisfaction as an indicator of the quality of nursing care." Nordic Journal of Nursing Research & Clinical Studies / VÃ¥rd i Norden 12(3/4): 22.

This paper deals with the patient satisfaction, as an indicator of the quality of nursing care. The literature review and a Finnish empirical illustration, using patient interviews, are included in the article. The results indicate a high level of satisfaction. However, there is no basis to use the measurement of patient satisfaction as a sole indicator of the quality of care, because the satisfied patients expressed also reasons

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for dissatisfaction.

Leino-Kilpi, H. and Vuorenheimo, J. (1994). "The patient's perspective on nursing quality: developing a framework for evaluation." International Journal for Quality in Health Care 6(1): 85-95.

This article describes a new framework for the evaluation of the quality of nursing care. The preliminary framework developed on the basis of nurse data was tested with Finnish surgical patients (n = 132). The model was then restructured around four dimensions or levels: actor, activities, aims and preconditions for quality nursing care. For the patients it is important that the actor or nurse possesses technical, task-oriented skills. Activities are divided into two categories: human and task-oriented. The patients emphasize the importance of educational and technical activities as well as respecting and caring. The most important determinants of nursing activity are trustworthiness and adherence to basic principles. A central precondition for quality nursing, according to patients, is the training and education of nurses and access to adequate resources. The framework developed has some elements in common with the previous studies.

Leinonen, T., Leino-Kilpi, H., Stahlberg, M. R. and Lertola, K. (2001). "The quality of perioperative care: development of a tool for the perceptions of patients." Journal of Advanced Nursing 35(2): 294-306.

AIM OF THE STUDY: To find out how surgical hospital patients (n=874) perceived the quality of perioperative care they received in an operating department and in the recovery room. BACKGROUND: Patients' perceptions of the perioperative care have not been included systematically in the improvement of the care. Accordingly, there is no standardized, valid, and reliable instrument or system in common use that we could use for the evaluation. The nursing care in operating departments has an important role in modern health care, and therefore more research concerning perioperative care quality is needed urgently and the development of the measurement tool is urgent. METHOD: The data were collected using a structured questionnaire in five operating departments in southern Finland during 1998. RESULTS: Physical activities (such as pain management and temperature maintenance) were rated as excellent, as were staff characteristics and the physical and social environment. The most critical comments were made with regard to supporting patient initiative, encouragement and educational activities. Patients stated they would have liked more information and it was felt that they should have been encouraged to ask more questions about unclear matters. Some of the patients said they had only very limited influence over their own care. The patients were very pleased with their care in the recovery room. There were only minor differences between the views of patients from different departments. CONCLUSIONS: Overall the quality of care was considered extremely good, but comparisons of different quality categories did reveal some problems. Although it has already proved to be a useful tool, the questionnaire needs to be developed and tested further.

Lewis, J. R. (1994). "Patient views on quality care in general practice: literature review." Social Science & Medicine 39(5): 655-70.

The present paper examines research on patient satisfaction and the factors which influence patient attitudes regarding quality in general practice. Although data are used from U.S. and other sources, conclusions are drawn with a specific focus on a U.K. general practice context. This is a research area with a growing literature, much of it based on unsystematic research. The purpose of this paper is to make a contribution to the process or ordering the data in a manner which will be of utility to those involved in the provision of healthcare and the assessment of that provision. The data suggest conclusions in two broad areas: (1) methods by which patient satisfaction may be assessed; specific published instruments are reviewed, and (2) factors which have been indicated, by the research to date, to influence patient satisfaction. Most consistently identified as being of particular value to patients are interpersonal skills on the part of the practitioner. It is suggested that such techniques should receive wider acknowledgement as a basic element of the practitioner's technical repertoire. [References: 91]

Liao, H. (2007). "Do it right this time: the role of employee service recovery performance in customer-perceived justice and customer loyalty after service failures." Journal of Applied Psychology 92(2): 475-89.

Integrating justice and customer service literatures, this research examines the role of customer service employees' behaviors of handling customer complaints, or service recovery performance (SRP), in conveying a just image of service organizations and achieving desirable customer outcomes. Results from a field study and a laboratory study demonstrate that the dimensions of SRP--making an apology, problem solving, being courteous, and prompt handling--positively influenced customer satisfaction and then customer repurchase intent through the mediation of customer-perceived justice. In addition, service failure severity and repeated failures reduced the positive impact of some dimensions of SRP on customer satisfaction, and customer-perceived justice again mediated these moderated effects. (c) 2007 APA, all rights reserved.

Lim, H. C., Tan, C. B., Goh, L. G. and Ling, S. L. (1998). "Why do patients complain? A primary health care study." Singapore Medical Journal 39(9): 390-5.

BACKGROUND/AIM OF STUDY: Patient complaints are indications of their dissatisfaction with the service received. With increasing patient expectations, we need to address this issue for a more satisfying relationship between healthcare provider and user. The objective of this study was to analyse the basis of patients' complaints and to make recommendations to reduce its incidence. METHOD: This is a retrospective descriptive study of all complaints to the Family Health Service between January 1994 and December 1995. All complaints, investigations and replies to complainants were examined and analysed by the authors to determine the reasons for complaints and their justification. RESULTS: There were 226

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complaint cases out of 5,620,834 attendances in two years, giving the complaints rate of 4 per 100,000 attendances per year. The complaint rate was highest for the 20-59-year age group and lowest in the 10-19-year age group (3.7 and 2.0 per 100,000 attendances respectively). Sixty-four percent of complaints were verbal and the rest were written. Forty-seven percent of the complaints were made by relatives and 46% were self-complaints. The main reasons for complaints were related to attitude/conduct (28.8%), professional skills (17.8%), patient expectations (16.2%), waiting time (10.0%) and communication (7.8%). Forty-three percent of complaints were evaluated as justifiable, 38% not justifiable and 19% inconclusive. There were no particular sex or ethnic group differences. CONCLUSION: The rate of complaints in Family Health Service was low. Healthcare personnel need to pay attention to areas related to attitude/conduct, professional skills, patient expectations, waiting time and communication.

Limerick, S. R. (2000). "The NHS complaints procedure. Perceptions of a recent convener." Journal of the Royal College of Physicians of London 34(3): 261-5.

The purpose of the NHS complaints procedure is to investigate complaints in a way that is satisfactory to the complainant, while being fair to staff and learning any lesson for service improvement. The current complaints procedure was implemented on 1 April 1996. It covers complaints about primary care practices as well as hospital and community health services, and includes matters arising from clinical judgement. An evaluation of its effectiveness is being undertaken by the London School of Hygiene and Tropical Medicine, York University (York Health Economics Consortium) and Public Attitude Surveys, and a report is due after the end of 2000. This personal view of the complaints procedure, from the perspective of a trust convener, discusses recent proposals for reform from the House of Commons Health Committee and their relevance to the hospital physician.

Lin, B. and Kelly, E. (1995). "Methodological issues in patient satisfaction surveys." International Journal of Health Care Quality Assurance 8(6): 32-7.

Examines some of the methodological problems encountered in conducting patient satisfaction surveys, including the sampling frames, quality of survey data and instruments, non-response problems, and reporting and interpretation of results. Proposes guidelines and lays out an agenda for future research. [References: 55]

Lin, C. (1996). "Patient satisfaction with nursing care as an outcome variable: dilemmas for nursing evaluation researchers." Journal of Professional Nursing 12(4): 207-216.

Evaluation is one of the most critical phases of the nursing process because it supports the basis of the usefulness and effectiveness of nursing practice. Nursing practice is patient driven and patient centered. Accordingly, patient satisfaction has been strongly advocated by nursing professionals to be an important indicator of quality of nursing care delivery. This article discusses the conceptualization and measurement of patient satisfaction with nursing care. Also, this article examines numerous dilemmas related to conceptualization and methodology that nursing evaluation researchers confront when attempting to use patient satisfaction as an outcome variable. Based on the current knowledge regarding the nature of patient satisfaction, implications for future nursing evaluation research are proposed and discussed to overcome these dilemmas in measuring patient satisfaction as an indicator of quality of nursing care. Copyright (c) 1996 by W.B. Saunders Company

Long, J. P. (1993). "Trends in complaints against the medical profession: an analysis of the work of the SMS commission on Mediation and Peer Review." Wisconsin Medical Journal 92(5): 249-51.

Luther, K., Pais, M. B. and Silberblatt, G. (1997). "Promoting positive outcomes from patient complaints." Orthopaedic Nursing 16(5): 39-42.

Complaints from patients often indicate their difficulty in coping with the health care system. Nurses need to acknowledge these complaints and help the patient resolve the problem. They need to see complaints as part of a continuous dialogue with their patients and their families. In addition, nurses need to use these complaints to assess the needs of the patient and to evaluate the care and delivery of services. This article presents nine steps the nurse can take when a patient or family member has a complaint.

MacDavitt, K., Chou, S. and Stone, P. W. (2007). "Organizational climate and health care outcomes." Joint Commission Journal on Quality & Patient Safety 33(11): 45-56.

Background: Relationships between organizational climate--which reflects the employees' perception of the organizational culture and is easily measured through employee questionnaires--and patient and employee out-comes were examined in a literature review.

Methods: A systematic search was conducted, with the review limited to primary research published between January 1995 and June 2007. An integrative model of organizational climate was used to guide the search and organize evidence.

Findings: Twenty studies, all cross-sectional in design, were identified. Samples ranged from 632 clinicians in 3 hospitals to almost 250,000 providers in 168 hospitals. Most researchers studied nurses in hospitals, but other providers were also surveyed. Perceptions of process-es such as scheduling practices, collaboration, and autonomy were associated with nurse outcomes (for example, job satisfaction, turnover, occupational safety). There was some evidence that aspects of organizational climate were associated with patient outcomes, but the results were inconsistent. Measurement of the organizational climate factors and outcomes varied across studies.

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Conclusions: The evidence that organizational climate influences nurse outcomes is more robust than is the evidence that it influences patient outcomes. The findings underscore the importance of promoting a positive organizational climate.

Mace, S. E. (1998). "An analysis of patient complaints in an observation unit." Journal of Quality in Clinical Practice 18(2): 151-8.

All complaints relating to patients treated in a 20 bed observation unit of a large teaching hospital over a 26-month period are reviewed. From May 1994 to July 1996, 11,042 patients were admitted to the observation unit. During this period there were 28 patient complaints. These complaints consisted of staff attitude/behavior (42.9%), discharge processes (25%), environmental concerns (17.9%), difficulties with diagnostic investigations (10.7%), and miscellaneous issues (3.6%). The type and frequency of complaints were similar to those received in other areas of the hospital, although the profile of complaints was different to those commonly experienced in the emergency department. Observation units are frequently considered to be an extension of the emergency department. Patient complaints received in relation to care received in an observation unit are similar in nature to those recorded in inpatient units as opposed to those received in emergency departments.

Magari, E. S., Hamel, M. B. and Wasson, J. H. (1998). "An easy way to measure quality of physician-patient interactions." Journal of Ambulatory Care Management 21(3): 27-33.

This article describes a simple method for rating the patient-clinician interaction from the perspective of the older adult patient, with the goal of improving patient outcomes. A measure for rating the quality of an interaction with a patient who is bothered by a problem is called the Functional Education Index or FNXEI. Usually, sicker patients are known to be less satisfied with their medical care. What is unique about the FNXEI is that it is not affected by a patient's overall health, giving clinicians an accurate account of their interactions with patients. Considering this, the FNXEI becomes a useful tool for improving care because it has face validity and specificity about the type of care clinicians are providing for their older adult patients.

Mangan, P. (1995). "Complaints can improve care." Nursing Times 91(41): 32.

Complaints are often seen as being entirely negative. However, they could be turned to the advantage of an organisation by allowing it to rectify its shortcomings. A complaints procedure can form part of a quality improvement cycle. This paper discusses why nurses are often unable to see the benefits of complaints and how they can be used to improve patient care in the future.

Marshall, M. N. and Romano, P. S. (2005). "Impact of reporting hospital performance." Quality & Safety in Health Care 14(2): 77-78.

Marshall, M. N., Shekelle, P. G., Davies, H. T. O. and Smith, P. C. (2003). "Public reporting on quality in the United States and the United Kingdom." Health Affairs 22(3): 134-48.

The public reporting of comparative information about health care quality is becoming an accepted way of improving accountability and quality. Quality report cards have been prominent in the United States for more than a decade and are a central feature of British health system reform. In this paper we examine the common challenges and differences in implementation of the policy in the two countries. We use this information to explore some key questions relating to the content, target audience, and use of published information. We end by making specific recommendations for maximizing the effectiveness of public reporting.

Mayor, S. (1996). "Patient complaints: new procedure." Practice Nurse 11(4): 216-217.

From 1 April patient complaints against practice nurses, GPs and other staff will be dealt with in the practice itself. Susan Mayor reports on the new system.

Merkouris, A., Ifantopoulos, J., Lanara, V. and Lemonidou, C. (1999). "Patient satisfaction: a key concept for evaluating and improving nursing services." Journal of Nursing Management 7(1): 19-28.

AIMS: The main purpose of this review was to explore the meaning of patient satisfaction and present the theoretical background and the definitions which developed in nursing. BACKGROUND: Today, there is an increasing interest in patient satisfaction which is considered a valid indicator of the quality of care. ORIGINS OF INFORMATION: An extensive literature review was performed by using the MEDLINE database. DATA ANALYSIS: Data was classified and analysed by using the content analysis approach. KEY ISSUES: The principal finding of this review was the lack of attention to the meaning of patient satisfaction, the development of theoretical frameworks and the psychometric properties of the developed instruments. CONCLUSIONS: Nurses need to develop valid and reliable instruments to measure patient satisfaction in order to improve the quality of care and make their work visible. [References: 80]

Miller, M. and Wax, D. (1999). "Instilling a mediation-based conflict resolution culture." Physician Executive 25(4): 45-51.

Conflict thrives and grows in the increasingly competitive and uncertain health care environment. Conflict impacts health care organizations' performance in several areas: (1) patient grievances and health plan member disputes; (2) internal employee and management disputes; and (3) payer, provider, and vendor disputes. "Grief Budgets," the hard costs and soft costs due to disputes that are poorly handled and conflicts

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that are ignored, detract from an organizations health mission and erode its bottom line. This article offers a strategy to solve conflict at an early stage in all three areas, with measurable results that strengthen profits and improve customer service by instilling a mediation-based conflict resolution culture throughout the organization. Mediation is non-adversarial, neutral, proactive, and collaborative. It is also confidential and always protects the future relationship between the parties. The challenge, therefore, is to strategically implant mediation into the health care organization's structure, to intercept and solve conflict early on. The article provides an overview of the steps needed to install a dispute resolution program.

Minnick, A. F., Roberts, M. J., Young, W. B., Kleinpell, R. M. and Marcantonio, R. J. (1997). "What influences patients' reports of three aspects of hospital services?" Medical Care 35(4): 399-409.

OBJECTIVES: Market forces make it essential to know what policies and actions influence patients' reports of hospital services. No studies have examined the role of patient characteristics, labor quality and staff characteristics, nonlabor resources, managerial practices, and employee attitudes within a single investigation. METHODS: The authors collected, simultaneously, data about labor, management and service processes, nonlabor resources, and employee attitudes on 117 nonintensive medical-surgical inpatient units in 17 hospitals selected from a pool of 69 institutions within a metropolitan area by a stratified random sample. Of the 2,595 patients who agreed to participate, 2,051 (79%) completed telephone interviews regarding their experiences with physical care, education, and pain management services within 26 days of hospital discharge. RESULTS: A significant amount of variation in patients' service reports was explained (adjusted R2 = 0.41 physical care, 0.35 pain management, 0.44 education). Although the predictors varied for each service report, patient characteristics, especially those related to personal resources, had a large explanatory role. A labor assignment pattern that could explain why earlier studies found labor quality and staff characteristics to have only a weak role in the prediction of patients' service reports was noted. CONCLUSIONS: The results related to patient characteristics may indicate opportunities to improve care by confronting service design strategies that erroneously rely on a homogeneous patient population. Measurement challenges identified by this study must be addressed to determine the role of labor quantity and staff characteristics.

Mira, J. J., Rodriguez-Marin, J., Peset, R., Ybarra, J., Perez-Jover, V., Palazon, I. and Llorca, E. (2002). "Causes of patients' satisfaction and dissatisfaction. [Spanish]." Revista de Calidad Asistencial 17(5): 273-283.

Introduction: Various methodological approaches (both quantitative as qualitative) are used in the health sector to identify the aspects of health care that are most important to the patients. These studies have been used to design instruments to evaluate patients' satisfaction, identifying the dimensions that should be evaluated to better determine their opinions. Objective: To detect the aspects identified by patients as causes of satisfaction and dissatisfaction in several medical departments. Method: Qualitative design combining the methods of nominal and focus groups. In total, 20 working groups with patients from 10 hospitals and four primary health centers were formed. Subjects: A total of 171 patients participated in our study. The patients had received medical care from the departments of medicine and surgery, obstetrics, pediatrics, as well as from outpatient clinics, the emergency department and primary care. Results: Independently of the group in which they participated, patients identified the following factors as causes of satisfaction: human and personalized dealings with staff, empathy, responsiveness, the quality of the information received and comfort. In addition, patients considered the following factors as causes of dissatisfaction: lack of coordination between health personnel, waiting lists, and delays in receiving care, obtaining the results of tests and in receiving the diagnosis. Conclusions: Empathy, personalized treatment, and comfort are the most frequent reasons cited as "good experiences" while accessibility and certain organizational aspects are the dimensions that patients most commonly mentioned as causes of dissatisfaction.

Monrad Aas, I. H. (1991). "Malpractice." Quality Assurance in Health Care 3(1): 21-39.

The problem of malpractice suits and patient complaints is frequently mentioned in discussions concerning the quality of health care. The present paper reviews the following aspects of this problem: the magnitude of the problem, the categories of cases, insurance and legal aspects, effects on medical practice, institutionalized possibilities for solving conflicts, an answer to the question of why patients complain and sue, and risk management. [References: 76]

Montini, T., Noble, A. A. and Stelfox, H. T. (2008). "Content analysis of patient complaints." International Journal for Quality in Health Care 20(6): 412-20.

OBJECTIVE: To develop a standard taxonomy for inpatient complaints that could be adopted in a wide array of health service institutions. DESIGN: A taxonomy was developed by merging the coding schemes from eight prior studies of patient complaints, and then by revising the received coding scheme in light of the codes and clarifications that emerged from a content analysis of patient complaints. SETTING: Two Boston area hospitals. PARTICIPANTS: Stratified random sample of 1216 complaints from patients in 2004. INTERVENTION: s) None. Main outcome measure(s) Patient complaints codes, provider codes and inter-rater reliability. RESULTS: A taxonomy comprising 22 patient complaint codes and five provider codes was developed. Inter-rater agreement for complaint codes was good (median Kappa statistic 0.66, interquartile range 0.55-0.80). Four codes were each used in more than 10% of the patient complaints filed: unprofessional conduct (19%); poor provider-patient communication (17%); treatment and care of patient (16%); and, having to wait for care (11%). Of the coding for the profession of the person complained about, 47% of the patient complaints were about staff in general or did not specify a particular profession; 22% identified a physician or dentist; 12% nursing staff; 11% administrative or support staff and 8% allied clinical

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health professionals. CONCLUSIONS: Standardized coding of patient complaint data may provide an opportunity for quality improvement, patient satisfaction and changes in patient care.

Mulholland, J. and Dawson, K. (1998). "Can we make it better?" Journal of Quality in Clinical Practice 18(3): 217-220.

The range and nature of patient complaints that resulted from the services provided in Southland base hospital over a 1-year period were studied. The data were assessed in the hope that they would provide new and important information to further develop quality assurance in the hospital service. There were 146 complaints, 15 of which were significant. Ten of these involved clinical care standards. There were 132400 patient contacts during this time. The most common complaints related to the attitudes of health professionals, as perceived by the patient, and about information and other aspects that pertained to their individual care. These patient complaints did not provide unique information but would be useful if combined with other methods to determine patient dissatisfaction with the service provided.

Mulholland, J. and Dawson, K. P. (1998). "A complaints management system: strengths and weaknesses." New Zealand Medical Journal 111(1061): 77-9.

AIMS: To describe the complaints management process in a base hospital and to outline its guiding principles. METHOD: A review and analysis of the complaints lodged during 1996 with the Complaints Management System of the hospital. RESULTS: There were 146 complaints lodged after 132,400 patient contacts. Overall resolution time was 14 days, but 24 appeals were lodged against the initial opinion and were all subsequently resolved satisfactorily. CONCLUSION: The complaints process should be user friendly, result in a quick response and be seen as a quality rather than a disciplinary tool.

Murff, H. J., France, D. J., Blackford, J., Grogan, E. L., Yu, C., Speroff, T., Pichert, J. W. and Hickson, G. B. (2006). "Relationship between patient complaints and surgical complications." Quality & Safety in Health Care 15(1): 13-6.

BACKGROUND: Patient complaints are associated with increased malpractice risk but it is unclear if complaints might be associated with medical complications. The purpose of this study was to determine whether an association exists between patient complaints and surgical complications. METHODS: A retrospective analysis of 16,713 surgical admissions was conducted over a 54 month period at a single academic medical center. Surgical complications were identified using administrative data. The primary outcome measure was unsolicited patient complaints. RESULTS: During the study period 0.9% of surgical admissions were associated with a patient complaint. 19% of admissions associated with a patient complaint included a postoperative complication compared with 12.5% of admissions without a patient complaint (p = 0.01). After adjusting for surgical specialty, co-morbid illnesses and length of stay, admissions with complications had an odds ratio of 1.74 (95% confidence interval 1.01 to 2.98) of being associated with a complaint compared with admissions without complications. CONCLUSIONS: Admissions with surgical complications are more likely to be associated with a complaint than surgical admissions without complications. Further research is necessary to determine if patient complaints might serve as markers for poor clinical outcomes.

Murray, D. "Turn patient complaints into patient pleasers." Medical Economics 72(12): 74.

Natangelo, R. (2007). "Clinicians' and managers' responses to patients' complaints: a survey in hospitals of the Milan area." Clinical Governance: An International Journal 12(4): 260-266.

Purpose - The purpose of this paper is to discuss the analysis of complaints lodged by patients and how the complainants' letters are handled by health boards and clinicians. Design/methodology/approach - A retrospective analysis of patients' complaints lodged with an independent voluntary citizens' association in Milan and, at the same time, against the hospital administration offices or the consultants and responses returned by the hospitals in reply to the patients. The authors assessed: the reasons for the complaints according to the citizen; the nature of the complaint according to a medical expert revue; and the handling of the complaint process by managers. Findings - For 83 of 151 people (55 per cent), the reason was compensation for injury or pain. According to the medical review, in 54 cases (35.7 per cent), the main themes emerging were mainly "perceived" poor quality of care. Together, or alone, were problems of "technical" quality of care. A total of 94 complaints (62.2 per cent) had been dealt with by the Health Boards, but 48 cases (31.7 per cent) were dealt with by the legal office or the insurance company who replied without showing evidence that they had discussed events with clinicians. Many times the managers did not undertake a systematic investigation, leaving complainants dissatisfied with the process and the outcome. Originality/value - This paper is the first to report the results of an assessment process of complaints lodged via an independent citizens' association in Italy.

Natowicz, M. R. and Hiller, E. H. (2002). "Addressing consumer grievances in medicine: Policies and practices of newborn screening programs in the United States." Genetic Testing 6(1): 31-38.

Newborn screening programs collectively administer the largest genetic testing initiative in the United States. The redress of grievances is an important mechanism for consumers to provide input into clinical and public health programs. In this study, we evaluated mechanisms for addressing consumer grievances in newborn screening programs. To do this, we surveyed all 50 state plus the District of Columbia newborn screening programs by questionnaire regarding protocols for receipt and redress of problems reported by parents of newborns and ascertained the existence and nature of complaints and how complaints were documented and addressed. Pertinent state and federal legislation and regulation were also reviewed. Six

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of 49 newborn screening programs reported having formal policies for handling consumer grievances. Four states reported having pertinent legislation or regulation. Thirty-eight of 49 states reported having received complaints from 1993 to 1995. Thirteen of 49 newborn screening programs reported that they actively seek feedback from consumers. Consumer grievances ranged from minor complaints to potentially life-threatening concerns. In general, complaints are managed on an ad hoc basis; formal policies are typically lacking. As newborn screening programs affect a vast number of Americans, a proactive and comprehensive approach, including solicitation of consumer feedback, could benefit both newborn screening programs and the public served by them.

Nelson, E. C. and Larson, C. (1993). "Patients' good and bad surprises: how do they relate to overall patient satisfaction?" Qrb Quality Review Bulletin. 19(3): 89-94.

The literature documents little research regarding patients' good and bad surprises in the hospital. Such experiences may inform a patient's future decisions about recommending or returning to the hospital. Utilizing a database of survey respondents, the authors conducted qualitative and quantitative analyses of patients' self-reported surprises about their hospital stay and the relationship between those surprise experiences and their overall feelings of satisfaction. Analysis of these data shows that patients do experience surprises during their hospital stays, that specific events are associated with these surprises, and that these surprises influence patient satisfaction. These results suggest that in order for health care providers to continuously improve and meet patients' needs and expectations, providers must determine steps to take to delight their patients, to avoid patient disappointments, and to meet patients' basic expectations.

Nguyen Thi, P. L., Briancon, S., Empereur, F. and Guillemin, F. (2002). "Factors determining inpatient satisfaction with care." Social Science & Medicine 54(4): 493-504.

The objective of the study was to identify factors associated with satisfaction among inpatients receiving medical and surgical care for cardiovascular, respiratory, urinary and locomotor system diseases. Two weeks after discharge, 533 patients completed a Patient Judgments Hospital Quality questionnaire covering seven dimensions of satisfaction (admission, nursing and daily care, medical care, information, hospital environment and ancillary staff, overall quality of care and services, recommendations/intentions). Patient satisfaction and complaints were treated as dependent variables in multivariate ordinal polychotomous and dichotomous logistic stepwise regressions, respectively. Patient sociodemographic, health and stay characteristics as well as organization/ activity of service were used as independent variables. The two strongest predictors of satisfaction for all dimensions were older age and better self-perceived health status at admission. Men tended to be more satisfied than women. Other predictors specific for certain dimensions of satisfaction were: married, Karnofsky index more than 70, critical/serious self-reported condition at admission, emergency admission, choice of hospital by her/himself, stay in a medical service, stay in a private room, length of stay less than one week, stay in a service with a mean length of stay longer than one week. The factors associated with inpatient satisfaction elucidated in this study may be helpful in interpreting patient satisfaction scores when comparing hospitals, services or time periods, in targeting patient groups at risk of worse experiences and in focusing care quality programs.

Orme, C. N., Parsons, R. J. and McBride, G. Z. (1992). "Customer information and the quality improvement process: developing a customer information system." Hospital & Health Services Administration 37(2): 197-212.

As growing numbers of health care organizations institute quality improvement programs, the demand within these organizations for reliable information about customers increases. By establishing a customer information system (CIS)--a model for collecting, archiving, and accessing customer information--health care organizations can eliminate the duplication of research, ensure that customer information is properly collected and interpreted, and provide decision makers access to better, more reliable customer information. Customer-supplier relationships are defined, guidelines for determining information needs are provided, and ways to set up and manage a CIS are suggested.

Oswald, S. L., Turner, D. E., Snipes, R. L. and Butler, D. (1998). "Quality determinants and hospital satisfaction. Perceptions of the facility and staff might be key influencing factors." Marketing Health Services 18(1): 18-22.

Perceptions of service quality ultimately affect consumer satisfaction, but objective measures of quality can be hard to come by when evaluating the quality of clinical care in a hospital. To determine if dimensions other than those found in models such as SERVQUAL were at play, the authors undertook a survey of 472 consumers, who were divided into two groups: those who had been hospital patients within the last three years (users) and those who were visitors (observers). The results suggest that facilities-related and human-factor related considerations helped shape the quality assessments of both groups, with observers generally giving higher marks to the hospitals with which they were familiar on the dimension of facilities-related quality and users expressing a less critical view of the human-factor dimension.

Otani, K. and Kurz, R. S. (2004). "The impact of nursing care and other healthcare attributes on hospitalized patient satisfaction and behavioral intentions." Journal of Healthcare Management 49(3): 181-96; discussion 196-7.

Healthcare organizations in the United States are struggling to find ways to survive in their uncertain and competitive environments. One of the survival strategies used by those organizations is to increase patient satisfaction. This article presents research on factors that influence hospitalized patients' satisfaction and

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their intention to return to and recommend the hospital. The first objective of this study was to find out, using a comprehensive set of healthcare attributes, which attributes play a more important role in increasing patient satisfaction and behavioral intentions. The second objective was to analyze the relative importance of those attributes and the nature of the relationships across the values of the attributes. More specifically, this study attempted to identify any existing curvilinear relationships among these variables. If any curvilinear relationships exist, do they show an increasing or a decreasing marginal-utility function? Included in this article is an example, featuring a hospital-discharged patient, that explains the importance and uniqueness of this curvilinear relationship. This study found that among six attributes, nursing care showed the largest parameter estimate for the patient satisfaction and behavioral intentions models. Thus, simply improving the nursing care attribute seems to be the most effective manner to enhancing patient satisfaction and behavioral intentions. However, nursing care also showed a diminishing marginal-utility function for both models. To assess the effect of this diminishing marginal-utility function, the impact of nursing care was computed for each unit of improvement together with other attributes. The finding from this study provides information needed to increase patient satisfaction and behavioral intentions and should result in more effective and efficient healthcare management.

Otani, K., Kurz, R. S., Burroughs, T. E. and Waterman, B. (2003). "Reconsidering models of patient satisfaction and behavioral intentions." Health Care Management Review 28(1): 7-20.

Otani, K., Kurz, R. S. and Harris, L. E. (2005). "Managing primary care using patient satisfaction measures." Journal of Healthcare Management 50(5): 311-24; discussion 324-5.

Our study aimed to identify which attributes of a primary healthcare experience have the most impact on patient satisfaction as well as which aspects of each attribute are most significant in patients' response to the services they receive. The three attributes examined in this study were access, staff care, and physician care. Analyses of the aspects of each attribute controlled for age, gender, and race. Data used in this study were obtained through a survey questionnaire with random sampling, resulting in the sample size of 8,465. The psychometric properties of the questionnaire were also examined and showed appropriate reliability and validity. The multiple regression analysis showed that among the three attributes, physician care was most influential, closely followed by staff care, with access having much less influence. Further analyses revealed that specific aspects of each attribute were more influential on patient satisfaction. Within the physician care attribute, patients were found to be rational consumers who were looking for surrogate indicators of correct diagnosis and treatment options among the measures available to them. They were much less likely to be influenced by so-called bedside manner. Within the staff care attribute, willingness and compassionate behaviors of staff and prompt service were most important. Within the access attribute, patients sought caring interaction with appointment personnel. After considering the findings, we discuss possible actions for healthcare managers.

Otte, D. I. (1996). "Patients' perspectives and experiences of day case surgery." Journal of Advanced Nursing 23(6): 1228-37.

This qualitative study aimed to examine patients' experiences and views of day case surgery to improve health professionals' knowledge and understanding, in order to make recommendations for improving the quality of this service and to provide information which may be considered when further developing services in the future. The grounded theory methodology was adopted using informal conversational style interviews with eight participants. The constant comparative method was employed to identify coherent patterns and themes in the data. Patients expressed dissatisfaction with the scheduling of their operations and emphasized the importance of planning before admission, during their period of hospitalization and in preparation for discharge. Patients unanimously recognized that they were inadequately prepared for day case surgery in terms of information and educational support and from a perceived knowledge gap within the multi-disciplinary health care team. They also believed that there was a lack of continuity of care during their day case experience, and were unprepared for the increased level of patient empowerment but were interested in developing a collaborative relationship with staff. Patients claimed that they like day case surgery because it resulted in minimal disruption to their personal lives. Patients are consumers of the National Health Service (NHS) and have first-hand experience and knowledge of the services provided. In order to improve satisfaction further, patients' perspectives must be used to reshape and make better use of the limited resources to benefit the service, patients and ultimately the NHS.

Ottosson, B., Hallberg, I. R., Axelsson, K. and Loven, L. (1997). "Patients' satisfaction with surgical care impaired by cuts in expenditure and after interventions to improve nursing care at a surgical clinic.[erratum appears in Int J Qual Health Care 1997 Aug;9(4):311]." International Journal for Quality in Health Care 9(1): 43-53.

Between 1991 and 1994 the number of beds in the surgical clinic at a central hospital in Southern Sweden was cut back by almost 50%. To develop the nursing care and to control the effects of the budgetary cuts, an intervention, including nursing care development, of an organization that would secure continuity in the nurse-patient relationship, individually planned care and quality assurance for aspects believed to be crucial to the quality of nursing care was implemented. The aim of this study was to analyse patients' satisfaction with surgical nursing care between, under and after the last cut in expenditure and the concluded intervention. A patient satisfaction questionnaire covering such areas as: patient satisfaction with information and decision-making; patient satisfaction with contact and the staff-patient relationship; patient satisfaction with ward facilities and the physical treatment or examination and patient satisfaction with various other aspects of care, was administered (1993 n = 131; 1994 n = 128). Subsample analysis showed lower scores for patient satisfaction if the respondents were women, young, or acutely ill when admitted. While surveys carried out between 1991 and 1993 showed an overall improvement in the quality of care, as

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measured by patient satisfaction, it remained at the same level in 1994 as in 1993, or decreased, regarding patient contacts with staff and physicians, involvement in decision-making, anxiety before examination/treatment, anxiety regarding professional secrecy, opportunity to influence the solution to their physical problems, chance to get sleep without being disturbed, physical nursing care and preparations before discharge. Thus a deterioration in quality seemed to take place in 1994 indicating that the cuts in expenditure may have been too hard and had been made at the expense of patient satisfaction.

Owens, D. J. and Batchelor, C. (1996). "Patient satisfaction and the elderly." Social Science and Medicine 42(11): 1483-1491.

There is considerable current interest in patient satisfaction surveys; among other things they are often used to measure quality in health care. However, there are many unresolved issues concerning them, including how they might best be conducted. Some have challenged their raison d'etre, arguing that they rely on unproven assumptions. In this paper we examine some of these assumptions in the light of a recent study of elderly patients' experience of the District Nursing Service. In doing so we argue that users' capacity, or willingness, to evaluate health care services cannot be taken for granted; that patients may have few if any expectations on which to base an evaluation of the care they receive; that the sense of dependency that patients have on service providers can impact on expressions of satisfaction and that, outside the acute sector in particular, we need to take into account the varied nature of the relationships that emerge between patient and service providers. We also argue that elderly patients cannot be treated as consumers unproblematically. While they may be seen as an extreme example, we argue, nevertheless, that many of the issues raised are relevant to much wider populations. This has general implications for research and we suggest that appropriately chosen qualitative methods can provide a useful starting point in studies which aim to establish how, to what extent and whether patients evaluate health services.

Oxler, K. F. (1997). "Achieving patient satisfaction: resolving patient complaints." Holistic Nursing Practice 11(4): 27-34.

Patients demand to be active participants on and partners with the health care team to design their care regimen. Patients bring unique perceptions and expectations and use these to evaluate service quality and satisfaction. If customer satisfaction is not achieved and a patient complaint results, staff must have the skills to respond and launch a service recovery program. Service recovery, when done with style and panache, can retain loyal customers. Achieving patient satisfaction and resolving patient complaints require commitment from top leadership and commitment from providers to dedicate the time to understand their patients' needs.

Oz, M. C., Zikria, J., Mutrie, C., Slater, J. P., Scott, C., Lehman, S., Connolly, M. W., Asher, D. T., Ting, W. and Namerow, P. B. (2001). "Patient evaluation of the hotel function of hospitals." Heart Surgery Forum 4(2): 166-71.

BACKGROUND: A means of measuring patient satisfaction is essential in the effort to improve the quality of health care delivered in our nation's hospitals. Accurate feedback allows employers to better meet patients' needs and allows hospital administrators to improve service delivery. Patients are empowered by having a voice in the manner in which their health care is delivered. Moreover, improving the efficiency of the health care delivery system decreases health care costs. Hospital comparisons can be made readily available to a large audience through the Internet, resulting in empowerment of the patient and a universal improvement in hospital care. This is the first multi-institutional analysis of patient satisfaction among New York City and northern New Jersey area tertiary care hospitals. In this study, we evaluated the patient-assessed hotel function of hospitals in a single geographic region to determine whether clinically and statistically significant differences would be revealed that could provide beneficial information to stakeholders in the healthcare system. METHODS: Patients (n = 261) who had spent a night during the past year in one of eleven hospitals within 60 miles of New York City were chosen at random from doctors' waiting rooms. On average, 24 patients from each hospital were surveyed. They were asked to complete a questionnaire that rated the various departments in the hospital on qualities such as courtesy, promptness, and cleanliness. The questionnaire also rated important characteristics of the patient experience, such as the ease of parking and the taste of the food. Each item on the survey was coded on a scale of 1 to 10 with 10 being the most positive response. The 26 specific questions were divided into 14 domains. Averages in each domain were compared by gender, age, and hospital identity, attractiveness, and setting. All statistical calculations were performed using SPSS/PC, and means were compared using t-tests. RESULTS: Analysis designed to evaluate outcomes between each of the possible 54 pairs of hospitals comparisons revealed statistically significant differences as often as 44% of the time in some outcomes measures (logistics), but as rarely as 7% of the time in others (billing function). Clinically significant differences (>2 units per scale) were frequently evident, although the ranges differed dramatically depending on the domains surveyed. Although age, gender, and race/ethnicity were generally not predictive of satisfaction, non-urban setting was correlated with greater patient satisfaction. CONCLUSION: By having access to patient satisfaction comparisons among hospitals, patients are empowered to make better choices, employers can identify and adapt to patient preferences, and administrators can improve the services delivered and decrease health care costs by improving efficiency. Although our study was somewhat limited by patient selection biases, the study's results suggest that Internet-based tools of comparison will enable patients to make free and informed decisions about their health care by comparing local hospitals and voting on their impressions of the facilities from which they receive care.

Paiva, S. M. A. and Gomes, E. L. R. (2007). "Hospital care: assessment of users' satisfaction during hospital stay." Revista Latino-Americana de Enfermagem (RLAE) 15(5): 973-979.

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Health care teams have followed the National Health System's (SUS) principles to ensure quality improvement in healthcare, and patient satisfaction is one of the instruments used to evaluate quality. This study aimed to evaluate patient satisfaction regarding the assistance to their needs during hospitalization, in a general hospital of a city in the interior of SÃ£o Paulo. Data were collected through participant observation and use of focal group techniques in this qualitative research. A theme guide was used and a total of 20 subjects participated in the study. Data were analyzed through content analysis and interpreted through triangulation. Study results demonstrate that patients were satisfied with the care rendered. However, the researcher concluded that the institution's work organization is not directed to the attainment of quality.

Pakgohar, M., Evanaki, J. F., Mehran, A. and Akbaritorkestani, N. (2004). "Parents' satisfaction of infant health care." HAYAT: The Journal of Tehran Faculty of Nursing & Midwifery 10(21): 90-90.

Introduction: Evaluation of health care services is an essential step in improving health care quality and without it such an improvement could not be achieved.

Material and Methods: In this descriptive study, parent's satisfaction of child's health care in the health and treatment centers affiliated to Tehran University of Medical Sciences was evaluated. Four hundred parents who had attended 25 health and treatment centers were participated in this research. A questionnaire was completed through the interview with parents of 1 to 12 months old children. Analytical and descriptive statistics were used for the analysis of data.

Results: The finding of this study showed that the majority of parents had average levels of satisfaction concerning communication's skills of health care providers and high levels of satisfaction about availability of these cares. Satisfaction of parents in the section of the vaccination was high and majority of samples had average levels of satisfaction about growth monitoring of children. There was a relationship between infant's age and parent's satisfaction.

Conclusion: Based on these findings recommendations have been made for future research. The findings of this study can be utilized in public health planning in order to improve the quality of the infant's health care services. This abstract was translated into English by the publisher or author.

Palacio Lapuente, F., Marquet Palomer, R., Oliver Esteve, A., Castro Guardiola, P., Bel Reverter, M. and Pinol Moreso, J. L. (2003). "[Expectations of patients: what aspects of a health centre do they value? A qualitative-quantitative study]." Atencion Primaria 31(5): 307-14.

OBJECTIVES: To identify the factors valued by users of health centres; to weigh the relative importance of each factor. DESIGN: Qualitative stage (4 focus groups) to identify the factors valued. Quantitative stage (questionnaire to 225 people) to weigh their relative importance. SETTING: Primary care. PARTICIPANTS: Citizens from middle-high and middle-low social classes, urban, rural and over 65, were chosen through key informants for their interest in the health services. They were recruited with the assistance of various residents' associations and town councils. METHOD: The factors valued were identified through focus groups and classified in categories. Their relative importance was weighed through a questionnaire and a factorial analysis to identify the main components was run. RESULTS: 60 factors that could be valued by patients were identified. Eight of these referred to the centre and concrete assets, nine to organisation and acessibility, 18 to relationship with the health professionals, and 25 to the services available. The most highly valued factor was: "The centre has sufficient material available for cures, minor surgery, bandages, etc." The factorial analysis confirmed the categories established. Organisation and accessibility, and relationship with professionals were the most highly valued dimensions. CONCLUSIONS: The combination of qualitative and quantitative methods seems very fitting for this kind of study. Although many of the factors were to be expected, other little-expected ones emerged. In addition, users seem to value certain factors in a different way from how the professionals do.

Panting, G. (2008). "Clear communication can help to avoid and mitigate complaints." Guidelines in Practice 11(9): 49-50.

Dr Gerard Panting discusses the impact on healthcare professionals of patient grievances, how to avoid them happening, and how to cope with the outcomes.

Pasquarella, A., Marceca, M., Casagrande, S., Gentile, D., Zeppilli, D., Buonaiuto, N., Cozzolino, M. and Guasticchi, G. (2007). "[Customer satisfaction in home care: methodological issues based on a survey carried out in Lazio]." Annali di Igiene 19(2): 121-9.

Home care customer satisfaction has been, until now, rarely evaluated. After illustrating the main italian regional surveys on this issue, the article presents a customer satisfaction survey carried out in the district of Civitavecchia (Local Health Unit 'Rome F'), Lazio, regarding 30 home care beneficiaries. Methodological aspects emerging from the survey are basically focused on: advantages and disadvantages of quantitative and qualitative approaches (possibly associated each other); main criteria of eligibility of people selected for interviewing, both patients or caregivers; conditions that maximize answers reliability, including training on interviewers. Authors highlight opportunity of using such kind of survey, integrated with other different tools, into a systemic vision, for promoting management changes coming from suggested problems, aimed at total quality management.

Paterson, R. (2004). "Complaints and quality: handle with care![comment]." New Zealand Medical Journal 117(1198): U970.

Patterson, J. B. and Marks, C. (1992). "The client as customer: achieving service quality and customer

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satisfaction in rehabilitation." Journal of Rehabilitation 58(4): 16-21.

When rehabilitation clients are viewed as customers, service quality and customer satisfaction become critically important considerations in delivering rehabilitation services. This article describes the differences between clients and customers and reviews business literature on services marketing that is directly relevant to the achievement of service quality and customer satisfaction in the delivery of rehabilitation services. Characteristics of services, determinants of service quality, and the differences between professional and generic services are defined, and direct implications for rehabilitation professionals are discussed.

Pavlova, M., Groot, W. and van Merode, G. (2003). "The importance of quality, access and price to health care consumers in Bulgaria: a self-explicated approach." International Journal of Health Planning & Management 18(4): 343-61.

One approach to the problem of low patient satisfaction in Bulgaria is to identify attributes of health care services that the consumers value most and to focus on their improvement. Based on data from a household survey, this paper examines the importance that health care consumers attach to quality, access and price. The survey was conducted in 2000 among the population of the region of Varna (the third largest city in Bulgaria). The elicitation of attribute importance was based on a self-explicated method. To analyse the data, an ordered logit regression was performed. The analysis shows that clinical quality is the most valued characteristic by Bulgarian health care consumers compared with social quality, access and price. Given the poor quality of health care provision in Bulgaria, the allocation of revenues to its improvement appears to be essential in order to raise patient satisfaction and to enhance social efficiency.

Payne, C. (1990). "Complaints. Could we do better?" Nursing Times 86(36): 26-31.

Payne, S. D. and Warren, R. A. (1990). "Patient complaints against an inner city accident and emergency department." Medico-Legal Journal 58(Pt 3): 153-6.

Peak, T. and Sinclair, S. V. (2002). "Practice forum. Using customer satisfaction surveys to improve quality of care in nursing homes." Health & Social Work 27(1): 75-79.

Pearson, A., Hocking, S., Mott, S. and Riggs, A. (1993). "Quality of care in nursing homes: from the resident's perspective." Journal of Advanced Nursing 18(1): 20-24.

This paper derives from a study conducted by the Deakin Institute of Nursing Research between 1988 and 1990, whose major objective was to determine the impact of staffing mix on nursing residents' quality of care and life. Resident satisfaction with life in the nursing home is a key element in determining the quality of care and quality of life provided. Both the literature review and the study objectives supported the view that resident outcome can be collected through assessing the quality of care and quality of life, through assessment by informed observers using instruments derived from explicitly stated standards, and through eliciting the perceptions of residents themselves. A schedule designed to measure satisfaction with care was developed and resident interviews were undertaken using this measure and the Life Satisfaction Index (A). The majority of responses to the resident satisfaction schedule were positive. The high percentage of positive responses did not correlate with the observations of the research assistants and there was some concern that while residents were able to assess care they were reluctant to criticize the staff or their behaviour.

Peltier, J. W., Boyt, T. and Schibrowsky, J. A. (1998). "Relationships building. Measure service quality across health care encounters." Marketing Health Services 18(3): 16-24.

The relationships between service quality and satisfaction is a function of multiple service encounters across a wide variety of exchange partners within a health care organization. Studying the patient provider relationship leads to improved service quality. The authors report their findings from a study that tests a relationship-building framework that integrates service quality issues across multiple internal health care publics. Strategies for developing a strong patient-provider relationship bond are also discussed.

Perneger, T. V., Chamot, E. and Bovier, P. A. (2005). "Nonresponse bias in a survey of patient perceptions of hospital care.[see comment]." Medical Care 43(4): 374-80.

BACKGROUND: Incomplete participation is of particular concern for surveys of patient perceptions of care because patients who have negative opinions may be least likely to participate. OBJECTIVE: We sought to examine indirect evidence of nonresponse bias. DESIGN: We re-analyzed data from a cross-sectional patient survey. SUBJECTS: Our subjects were patients discharged from a Swiss hospital (n = 2156). MEASURES: We measured the following: (1) an observed problem score, based on 15 key items of the Picker Patient Experience questionnaire, (2) a predicted problem score, and (3) a participation propensity score. The latter scores were computed for all eligible patients, including those who did not return the survey, from routinely available baseline data. RESULTS: The participation rate was 70% (n = 1518), and the mean problem score was 29.9 (SD 23.8). Early respondents reported significantly fewer problems than late respondents (28.6 versus 32.9, P = 0.001). Participation propensity scores were progressively lower in early respondents (mean 74.2), late respondents (70.7), and nonrespondents (63.9, P < 0.001); the pattern was similar for predicted problem scores (early respondents: 29.5; late respondents: 30.5; nonrespondents: 33.4, P < 0.001). The propensity to participate was negatively associated with the problem score (Pearson r = -0.19). Finally, predictors of participation were similar to predictors of problem scores. CONCLUSIONS:

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The tendency to participate in the survey was negatively associated with the report of problems during hospitalization. Nevertheless, increasing participation from 30% to 70% had only a modest influence on the final conclusions of the survey.

Perreault, M., Leichner, P., Sabourin, S. and Gendreau, P. (1992). "Psychometric characteristics of the French-Canadian version of a satisfaction scale for hospitalized psychiatric patients. [French]." Canadian Journal of Psychiatry 37(4): 221-227.

This paper presents the results of a content and convergent validity study of the French-Canadian version of a standardized satisfaction scale for hospitalized psychiatric patients. One hundred and twenty-two patients underwent an interview during which they completed the translated version of the Client Satisfaction Questionnaire, developed by Distephano et al, and answered open-ended questions on their satisfaction with the services they received. The results revealed strong correlations between these measures of satisfaction and a high level of internal consistency for the Distefano scale, suggesting satisfactory psychometric characteristics for this French version. As for the original questionnaire, the factorial structure yielded at least two distinct satisfaction dimensions. These results, and those of the content analysis, based on answers from the open-ended questions, helped to identify aspects mentioned by the patients but not covered by the items included in the satisfaction scales. The units' cleanliness, therapist's work and attitudes and privacy on the units are examples of these dimensions.

Persse, D. E., Jarvis, J. L., Corpening, J. and Harris, B. (2004). "Customer satisfaction in a large urban fire department emergency medical services system." Academic Emergency Medicine 11(1): 106-10.

OBJECTIVES: The purpose of this study was to determine if emergency medical services (EMS) customer satisfaction could be assessed using telephone-survey methods. The process by which customer satisfaction with the EMS service in a large, fire department-based EMS system is reported, and five month results are presented. METHODS: Ten percent of all patients transported during the period of October 15, 2001, through March 15, 2002, were selected for study. In addition, during the same period, all EMS incidents in which a patient was not transported were identified for contact. Customer-service representatives contacted patients via telephone and surveyed them from prepared scripts. RESULTS: A total of 88,528 EMS incidents occurred during the study period. Of these, 53,649 resulted in patient transports and 34,879 did not. Ten percent of patients transported (5,098) were selected for study participation, of which 2,498 were successfully contacted; of these, 2,368 (94.8%) reported overall satisfaction with the service provided. Of the 34,879 incidents without transport, only 5,859 involved patients who were seen but not transported. All of these patients were selected for study. Of these, 2,975 were successfully contacted, with 2,865 (96.3%) reporting overall satisfaction. The most common reason given for nonsatisfaction in both groups was the perception of a long response time. CONCLUSIONS: It is possible to conduct a survey of EMS customer satisfaction using telephone-survey methods. Although difficulties exist in contacting patients, useful information is made available with this method. Such surveys should be an integral part of any EMS system's quality-improvement efforts. In this survey, the overwhelming majority of patients, both transported and not transported, were satisfied with their encounter with EMS.

Peterson, W. E. and DiCenso, A. (2002). "A comparison of adolescent and adult mothers' satisfaction with their postpartum nursing care." Canadian Journal of Nursing Research 34(4): 117-27.

The purpose of this matched-cohort survey was to determine whether there is a difference between unmarried adolescent mothers and married adult mothers in terms of satisfaction with inpatient postpartum nursing care. Eighty adolescent/adult postpartum mother pairs from a mid-sized teaching hospital were matched according to parity, mode of delivery, infant health status, and infant feeding method. Adolescents scored lower than adults on both the Experiences of Nursing Care Scale and the Satisfaction with Nursing Care Scale of the Newcastle Satisfaction with Nursing Scales. Among the adolescents, post-caesarean mothers were less satisfied than mothers who had delivered vaginally. Adolescent mothers' dissatisfaction with nurse availability and nurse-client communication are possible explanatory factors. Future qualitative studies will inform the design of interventions to improve satisfaction among adolescent mothers.

Pettersen, K. I., Hofoss, D. and Sjetne, I. S. (2003). "[Patient experiences in Norwegian hospitals--changes over time?]." Tidsskrift for Den Norske Laegeforening 123(24): 3600-3.

BACKGROUND: Patient experience has been identified as a national indicator of hospital quality. We describe the changes in patient experiences 1996-2000 for seven Norwegian hospitals. MATERIAL AND METHODS: A patient experience questionnaire was sent to medical and surgical patients in a stratified random sample of hospitals in 1996. The same questionnaire was used in similar surveys in 1998 and 2000. Responses from hospital wards included in all three surveys were compared on ten summated rating scales. Changes were identified by multiple linear regression. RESULTS: Responses from a total of 10 600 patients were analysed. For six scales no change was noted: general satisfaction, information on medication, information on examinations, nursing services, doctor services, and organization. Statistically significant improvement was found for three indices: communication, contact with next-of-kin, and information regarding future complaints. For one scale, scores changed for the worse: hospital and equipment. All changes were small. INTERPRETATION: Patient experiences with Norwegian hospitals did not change much between 1996 and 2000. On some indices, our data indicate slight improvement. Patient assessment of buildings and equipment changed negatively.

Pettersen, K. I., Veenstra, M., Guldvog, B. and Kolstad, A. (2004). "The Patient Experiences Questionnaire: Development, validity and reliability." International Journal for Quality in Health Care 16(6): 453-463.

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Objectives. To describe the development of the Patient Experiences Questionnaire (PEQ) and to evaluate reliability and validity of constructed summed rating scales. Design. Literature review, focus groups and pilot surveys. Two national cross-sectional studies performed in 1996 and 1998. Setting. Two postal surveys in a national sample of 14 hospitals stratified by geographical region and hospital size. Subjects. Patients consecutively discharged from surgical wards and wards of internal medicine. The surveys included 36 845 patients and 19 578 responded (53%). Results. We constructed 10 summed rating scales based on factor analysis and theoretical considerations: Information on future complaints, Nursing services, Communication, Information examinations, Contact with next-of-kin, Doctor services, Hospital and equipment, Information medication, Organization and General satisfaction. Eight scales had a Cronbach alpha coefficient of >0.70, the remaining two were >0.60. Repeatability was >0.70 for five scales and >0.60 for the remaining scales. Conclusions. The PEQ is a self-report instrument covering the most important subjects of interest to hospital patients. Results are presented as 10 scales with good validity and reliability. It emphasizes practicability and comprehensibility while at the same time providing sufficient information about domains applicable to most patients admitted to medical and surgical wards. copyright International Society for Quality in Health Care and Oxford University Press 2004; all rights reserved.

Pettit, L. S. and White, C. L. (1991). "Providers' and consumers' perceptions of quality health care." Journal of Nursing Staff Development 7(1): 5-10.

This article describes a study that explored perceptions of quality health care among physicians, nurses, patients, and hospital administrators. A self-report questionnaire evaluating interpersonal relationships, needs fulfillment, and education as dimensions of health care was developed. Results indicated that all groups differed in their perceptions of quality health care. Staff development educators should be particularly mindful of such differences. Making nurses aware of these differences during orientation and continuing education programs can assist them more effectively to deliver quality nursing care and meet patients' perceived needs.

Piccirillo, J. F. (1996). "The use of patient satisfaction data to assess the impact of continuous quality improvement efforts." Archives of Otolaryngology -- Head & Neck Surgery 122(10): 1045-8.

OBJECTIVE: To quantitatively compare patient satisfaction with the visit to an academic otolaryngology office before and after quality improvement efforts. DESIGN: Survey research of convenience sample of new patients. SETTING: Outpatients offices of the Department of Otolaryngology at Washington University School of Medicine, St Louis, Mo. PATIENTS: New patients seen between November 1993 and March 1994 (phase 1) and November 1995 and February 1996 (phase 2). INTERVENTION: Numerous department-wide quality improvements efforts were begun between phase 1 and phase 2. The Visit Rating Questionnaire, a 9-item patient-based questionnaire, was used to measure patient satisfaction. MAIN OUTCOME MEASURE: The percentage of patients who rated their visit overall as excellent. RESULTS: Overall, 973 patients participated. The percentage of patients who rated their overall visit as excellent was 570 (58%) of 1067, while it was 200 (41%) of 491 for phase 1 and 370 (64%) of 576 for phase 2 (chi 2 = 63.8; P < .001). Using a process control chart for the percentage of patients who rated the visit as excellent demonstrated special cause variation, indicating that the continuous quality improvement efforts had made an impact on patient satisfaction. CONCLUSIONS: The impact of continuous quality improvement efforts can be documented with patient satisfaction measures. The techniques of statistical process control, including the use of control charts, can transform the data from these measures into information that allows for the evaluation of the effectiveness of continuous quality improvement efforts.

Pichert, J. W., Federspiel, C. F., Hickson, G. B., Miller, C. S., Gauld-Jaeger, J. and Gray, C. L. (1999). "Identifying medical center units with disproportionate shares of patient complaints." Joint Commission Journal on Quality Improvement 25(6): 288-99.

BACKGROUND: A pilot study was conducted to learn whether an academic medical center's database of patient complaints would reveal particular service units (or clinics) with disproportionate shares of patient complaints, the types of complaints patients have about those units, and the types of personnel about whom the complaints were made. RESULTS: During the seven-year (December 1991-November 1998) study period, Office of Patient Affairs staff recorded 6,419 reports containing 15,631 individual complaints. More than 40% of the reports contained a single complaint. One-third of the reports contained three or more complaints. Complaints were associated with negative perceptions of care and treatment (29%), communication (22%), billing and payment (20%), humaneness of staff (13%), access to staff (9%), and cleanliness or safety of the environment (7%). Complaints were not evenly distributed across the medical center's various units, even when the data were corrected for numbers of patient visits to clinics or bed days in the hospital. The greatest proportion of complaints were associated with physicians. DISCUSSION: Complaint-based report cards may be used in interventions in which peers share the data with unit managers and seek to learn the nature of the problems, if any, that underlie the complaints. Such interventions should influence behavioral and systems changes in some units. SUMMARY AND CONCLUSIONS: Further experience should indicate how different types of complaints lead to different kinds of interventions and improvements in care. Tests of the system are also currently under way in several nonacademic community medical centers.

Pichert, J. W., Miller, C. S., Hollo, A. H., Gauld-Jaeger, J., Federspiel, C. F. and Hickson, G. B. (1998). "What health professionals can do to identify and resolve patient dissatisfaction." Joint Commission Journal on Quality Improvement 24(6): 303-12.

BACKGROUND: Patient satisfaction affects consistency of self-care, health outcomes, level of service utilization, choice of health professionals, and decisions to sue in the face of adverse outcomes.

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Understanding patients' specific dissatisfactions may help health professionals and administrators identify and rectify organizational deficiencies before they become costly. COMMON CAUSES OF COMPLAINTS: As part of a series of research projects, more than 12,000 patient/family complaint narratives were examined in which patients or patients' family members told interviewers or patient advocates about the care they received from their health professionals in both inpatient and outpatient settings. Complaints may be categorized as involving issues of care and treatment, communication, humaneness, access and availability, environment, and billing/payment. STRATEGIES FOR RESOLVING COMPLAINTS: Even though caregivers may not have control over all the factors that lead to dissatisfaction, they can often hear and address complaints. As a result, they may not only contribute to quality of care but improve the systems in which they practice. The challenges are how to prevent dissatisfaction in the first place, and, if it does occur, to identify and if possible rectify patient concerns. Three case studies are provided. CONCLUSION: All health professionals must be involved in efforts to resolve problems that compromise patient care. Some problems could be prevented if administrators and leaders used complaint data to recommend new policies and procedures or to identify and counsel with health care team members who generate disproportionate numbers of complaints. If all are involved in both prevention and problem solving, resources devoted to uncovering, understanding, and resolving patient complaints are likely to prove cost-effective.

Pickering, W. G. (1993). "Patient satisfaction: an imperfect measurement of quality medicine." Journal of Medical Ethics 19(2): 121-2.

Pieniazek, B., Rachwal, S. and Kubler, A. (2007). "Quality assessment of anaesthesia care using perioperative patient satisfaction." Anestezjologia Intensywna Terapia 39(2): 68-72.

Background. In order to gauge the quality of anaesthetic services, we have assessed patients' preoperative anxiety, expectations levels and satisfaction. Methods. Fifty-six adult patients, of both sexes, undergoing various surgical, orthopaedic and gynaecologic procedures completed the Amsterdam Preoperative Anxiety and Information Scale (APAIS) and the Quality of Recovery (QoR) Score questionnaires. Postoperative pain was scored using a Visual Analogue Scale (VAS). The following parameters were analyzed: extension of surgery, sex, age, previous anaesthetic experiences, and postoperative pain level. Results. Women and elderly patients and those having more extensive surgery were more anxious and required detailed information, when compared to other groups. Patients who had undergone large operations and those with higher pain scores had lower satisfaction levels. Conclusion. The APAIS the QoR scores proved to be useful for assessment of the needs of patients, and for identification of groups requiring more assistance from the anaesthesia service. copyright PTAiIT, Borgis.

Pietroni, P. C. and De Uray-Ura, S. (1994). "Informal complaints procedure in general practice: First year's experience." British Medical Journal 308(6943): 1546-1548.

Objective - To evaluate the first year's experience of an informal patient complaints system that encourages extensive patient participation. Design - Audit of an informal complaints procedure. Setting - The Marylebone Health Centre, London. Subjects - 39 complaints received over the audit period. Main outcome measures - types of complaints (administrative, about doctors or medical care or both, staff about patients, mixed, other) and resolution of complaints (how complaints were dealt with and their resolution). Results - 37 of the 39 complaints were resolved within two weeks. Two complaints sent direct to the family health services authority were resolved (with patients' agreement) by the informal complaints procedure. Conclusions - The informal complaints procedure was more cost effective than the family health services authority system and was comparatively straightforward to implement within the practice without major organisational restructuring. The two way process of the procedure ensured patients received a quick response to complaints and helped morale of health centre staff.

Pines, J. M., Garson, C., Baxt, W. G., Rhodes, K. V., Shofer, F. S. and Hollander, J. E. (2007). "ED crowding is associated with variable perceptions of care compromise." Academic Emergency Medicine 14(12): 1176-1181.

OBJECTIVES: The authors measured the association between emergency department (ED) crowding and patient and provider perceptions about whether patient care was compromised. METHODS: This was a cross-sectional study of patients admitted from the ED and their providers. Surveys of patients, nurses, and resident physicians were linked. The primary outcome was agreement or strong agreement on a five-item scale assessing whether ED crowding compromised care. Logistic regression was used to determine the association between the primary outcome and measures of ED crowding. RESULTS: Of 741 patients approached, 644 patients consented (87%); 703 resident physician surveys (95%) and 716 nursing surveys (97%) were completed. A total of 106 patients (16%), 86 residents (12%), and 173 nurses (24%) reported that care was compromised by ED crowding. In 252 cases (35%), one or more respondents reported that care was compromised. There was poor agreement over whose care was compromised. For patients, independent predictors of compromised care were waiting room time (odds ratio [OR], 1.05 for each additional 10-minute wait [95% confidence interval {CI} = 1.02 to 1.09]) and being surveyed in a hallway bed (OR, 2.02 [95% CI = 1.12 to 3.68]). Predictors of compromised care for nurses included waiting room time (OR, 1.05 for each additional 10-minute wait [95% CI = 1.01 to 1.08]), number of patients in the waiting room (OR, 1.05 for each additional patient waiting [95% CI = 1.02 to 1.07]), and number of admitted patients waiting for an inpatient bed (OR, 1.08 for each additional patient [95% CI = 1.03 to 1.12]). For residents, predictors of compromised care were patient/nurse ratio (OR, 1.39 for a one-unit increase [95% CI = 1.09 to 1.20]) and number of admitted patients waiting for an inpatient bed (OR, 1.14 for each additional patient [95% CI = 1.10 to 1.75]). CONCLUSIONS: ED crowding is associated with perceptions of compromised emergency care. There is considerable variability among nurses, patients, and resident physicians over which factors are associated with compromised care, whose care was compromised, and how care was

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compromised.

Pinkerton, J. A. and Bush, H. A. (2000). "Nurse practitioners and physicians: patients' perceived health and satisfaction with care." Journal of the American Academy of Nurse Practitioners 12(6): 211-7.

The advent of managed care has created changes in the health care environment and nurse practitioners have found a need to evaluate their care. Perceived health and patient satisfaction were measured in a multiethnic sample of 160 clinic patients, ages 18 to 89, in a managed care setting. Results of the Medical Outcomes Study SF-20 and the Nurse Practitioner Satisfaction Instrument indicated no statistically significant difference in perceived health and satisfaction with care, whether the care was given by a nurse practitioner or a primary care physician. The findings warrant further study and may mean that nurse practitioners placed in managed care environments can be expected to perform as effectively as they have in non-managed care environments.

Podesta, J. R. and Watt, R. G. (1996). "A quality assurance review of the patient referral process and user satisfaction of outpatient general anaesthesia services for dental treatment." Community Dental Health 13(4): 228-31.

In many parts of the United Kingdom the Community Dental Service (CDS) receives a consistently high level of referrals for general anaesthetic (GA) provision from general dental practitioners (GDPs), predominantly for the treatment of pain in young children. To provide a safe and effective service it is essential to have an appropriate and satisfactory referral process. As part of the established quality assurance programme in the East Kent CDS two surveys utilising self-complete postal questionnaires were conducted, the first to assess GDP's opinions and to examine their referral procedure, the second to gauge user satisfaction with the overall care provided by the CDS-GA service. The main findings suggested a lack of effective communication both between health professionals and with their patients. Over 80 per cent of the GDPs considered either the existing CDS referral guidelines needed clarification or did not even know such guidelines existed. Parents of referred children reported a high level of satisfaction with the service provided by the CDS, but some were critical of a lack of immediate access for children in pain. The finding of greatest concern was that 50 per cent of the parents stated their child's GDP did not explain the possible risks of general anaesthesia prior to referral and 70 per cent were offered no alternative form of treatment to a general anaesthetic. The results of this study should be fed into the continuing quality assurance programme to enable the effective and appropriate development of the CDS-GA service.

Polevoi, S. K., Quinn, J. V. and Kramer, N. R. (2005). "Factors associated with patients who leave without being seen." Academic Emergency Medicine 12(3): 232-236.

OBJECTIVES: Patients who leave without being seen (LWBS) can be an indicator of patient satisfaction and quality for emergency departments (ED). The objective of this study was to develop a model to determine factors associated with patients who LWBS. METHODS: A modified case-crossover design to determine the transient effects on the risk of acute events was used. Over a four-month period, time intervals when patients LWBS were matched (within two weeks), according to time of day and day of week, with time periods when patients did not LWBS. Factors considered were percentage of ED bed capacity, acuity of ED patients, length of stay of discharged patients in the ED, patients awaiting an admission bed in the ED, inpatient floor capacity, intensive care unit capacity, and the characteristics of the attending physician in charge. McNemar test, Wilcoxon signed-rank test, and conditional logistic regression analyses were used to determine significant variables. RESULTS: Over the study period, there were 11,652 visits, of which 213 (1.8%) resulted in patients who LWBS. Measures of inpatient capacity were not associated with patients who LWBS and ED capacity was only associated when >100%. This association increased with increasing capacity. Other significant factors were older age ($p < 0.01$) and completion of an emergency medicine residency ($p < 0.01$) of the physician in charge. When factors were considered in a multivariate model, ED capacity >140% (odds ratio, 1.96; 95% confidence interval = 1.22 to 3.17) and noncompletion of an emergency medicine residency (odds ratio, 1.85; 95% confidence interval = 1.17 to 2.93) were most important. CONCLUSIONS: ED capacity >100% is associated with patients who LWBS and is most significant at 140% capacity. ED capacity of 100% may not be a sensitive measure for overcrowding. Physician factors, especially emergency medicine training, also appear to be important when using LWBS as a quality indicator.

Polluste, K., Kalda, R. and Lember, M. (2004). "Evaluation of primary health care reform in Estonia from patients' perspective: acceptability and satisfaction." Croatian Medical Journal 45(5): 582-7.

AIM: To analyze the population's view of the primary health care reform five years after the formal implementation of the reform investigating the acceptability of the primary health care system, patients' preferences, and satisfaction with their family doctors. METHODS: Face-to-face interviews using structured questionnaires were preformed with a random sample of the Estonian residents aged 15-74 years (n=999). RESULTS: Out of 999 respondents, 35% prefer to first see their family doctor and if necessary to get a referral or a recommendation to see a specialist. The referral to the specialist by the family doctor is more preferred by older respondents, rural people, by the respondents with a lower level of education and income as well as by people who were more satisfied with their family doctor. The people who were more satisfied with their family doctor found that the whole health care system was functioning better than the previous primary health care system. Out of all the respondents who have had a contact with their family doctor during the last 12 months 87% (n=585) were satisfied with his work. The overall satisfaction with the family doctor depended on 1) perceived competence of the physician (OR=0.624, 95% confidence interval (CI)=0.419-0.933); 2) understanding the patient's problem (OR=0.699, 95%CI=0.496-0.984); 3) punctuality of the physician (OR=1.533, 95%CI=1.075-2.186); and 4) the location of the primary health care

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center/clinic (OR=0.751, 95%CI=0.574-0.983). CONCLUSION: During the five-year-period most of the Estonian population has accepted the new primary health care system and the satisfaction rate has increased. Family doctors are in the center of the primary health care systems and their professional competence plays a great role in making the system acceptable for the patients.

Polonski, G. J. "Customer complaints: a managed care firm's best weapon in CQI." Medical Interface 8(1): 111-3.

Encouraging customer feedback and developing an automated customer complaint system are two essential steps a health plan must take if it wishes to develop a balanced relationship with the customer. The author explores how the right attitude and appropriate action can ensure that both customers and the company reap the benefits of a comprehensive customer complaint system.

Pontes, M. C. and Pontes, N. M. (1997). "Variables that influence consumers' inferences about physician ability and accountability." Health Care Management Review 22(2): 7-20.

Previous research has shown that the quality of interpersonal care provided by physicians is correlated with the initiation of malpractice litigation. Unfortunately, this research has not controlled for the effects of actual treatment quality or of health outcomes. The research on which this article is based experimentally manipulates three variables: (1) patient involvement with treatment decisions, (2) financial incentives by third party payers to encourage costeffective medicine, and (3) use of new treatment practices that have not been widely adopted by other physicians.

Pothier, D. D. and Frosh, A. (2006). "Do information sheets improve patient satisfaction in the out-patient department?" Annals of the Royal College of Surgeons of England 88(6): 557-561.

Introduction: Time spent waiting to see a doctor in the out-patient department is a significant source of dissatisfaction for patients. Out-patient staff are often repeatedly questioned about the running of the clinic and why a delay has developed. These complaints and requests often result in further delays to the clinic. Patients and Methods: An information sheet was written to answer these questions. We set out to determine if the distribution of these sheets increased patient satisfaction with waiting times in the outpatient setting. Twelve sequential ENT clinics at the Lister Hospital, Stevenage were randomised into two group. Patients attending clinics in Group A (n=103) received an information sheet while those attending clinics in Group B (n=124) received no information sheet. At the end of their clinic visit, all patients completed a questionnaire in which they were asked to provide a rating of their levels of satisfaction with various experiences in the out-patient department on a rating score from 1 to 5. Results: We found levels of satisfaction regarding waiting times to be significantly higher in the group who received information sheets ($P < 0.001$). No verbal complaints were received by the nursing staff at clinics where the information sheet was distributed. Four verbal complaints were received at the clinics where no sheets were distributed. Conclusion: We believe that the use of information sheets is a cost-effective method of improving patient satisfaction and that this is a useful tool both in the primary care setting and in hospital out-patient departments.

Potiriadis, M., Chondros, P., Gilchrist, G., Hegarty, K., Blashki, G. and Gunn, J. M. (2008). "How do Australian patients rate their general practitioner? A descriptive study using the General Practice Assessment Questionnaire." Medical Journal of Australia 189(4): 215-9.

OBJECTIVE: To report patient responses to the General Practice Assessment Questionnaire (GPAQ) as a measure of satisfaction with health care received from Australian general practitioners. DESIGN, SETTING AND PARTICIPANTS: A clustered cross-sectional study involving general practice patients from 30 randomly selected general practices in Victoria. Between January and December 2005, a screening survey, including a postal version of the GPAQ, was mailed to 17 780 eligible patients. MAIN OUTCOME MEASURE: Scores on the six GPAQ items. RESULTS: We analysed data from 7130 patients who completed the screening survey and fulfilled our eligibility criteria. Levels of patient satisfaction with general practice care were generally high: mean GPAQ scores ranged from 68.6 (95% CI, 66.1-71.0) for satisfaction with access to the practice to 84.0 (95% CI, 82.2-85.4) for satisfaction with communication. Intracluster correlations for the GPAQ items ranged from 0.016 for overall satisfaction with the practice to 0.163 for satisfaction with access to the practice. Compared with national benchmarks in the United Kingdom, the GPs and practices participating in our study were rated higher on all six GPAQ items. Multivariable mixed effects linear regression showed that patients who were older, rated their health more highly, visited their GP more frequently and saw the same GP each time tended to express greater satisfaction with their care. CONCLUSION: Generally patients reported high levels of satisfaction with GP care. Greater satisfaction with care was associated with older patients, good health, more frequent contact with the GP, and seeing the one GP consistently.

Poulsen, K. A. and Jacobsen, L. (1994). "[Quality development at an emergency unit--an intervention study based on consumer satisfaction]." Ugeskrift for Laeger 156(35): 4962-5.

A study among the users of an emergency department was carried out to assess user satisfaction, based upon a questionnaire. The study was split into two periods, before and after a change in procedure in the emergency department, namely that a nurse was to give information about waiting time, make coordinations and fix an order of priority of patients (triage) in the waiting room. Fourteen hundred and twenty-six answers were received, 794 before and 632 after the change. The users questioned after this change of procedure felt that they had been better received, that they had waited for a shorter time and described a better general experience as compared to the users questioned before the change, these differences were significant. There were no difference between the two groups concerning opinions on information about

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diagnosis, treatment and outcome, whether there was enough time for examination, treatment and information, whether the staff were obliging or whether their expectations had been fulfilled. It is concluded that such changes in procedure in the emergency department are to be recommended.

Poulsen, K. B. (2008). "SurveillanceMapper: a simple method for creating an overview of quality data." Danish Medical Bulletin 55(1): 69-71.

INTRODUCTION: The amount of quality data continues to increase. To help prioritise resources for quality improvement, managers need thorough reviews to help them decide which indicators are most important to improve. The reality is that data is presented in piles of reports and hundreds of tables and graphs that are very time-consuming to go through and that rarely result in a simple comprehensive overview. This paper presents an empirically tested tool to create a simple overview of complex quality data. METHODOLOGY: Data comes from a questionnaire-based patient satisfaction survey of 13,129 patients and 1,589 staff members at Ribe County Hospital. A method is described: how to use colour coding in order to present the results for 16 indicators, measured both by patients and three staff member groups, for 28 departments and 46 ambulatories, in one page. RESULTS: Data for mean satisfaction scores on all questions are shown for each department in a core map. Aggregated departmental mean satisfaction scores are then calculated, as are hospital mean scores for each question. The same is done for staff members' evaluation and for outpatient care. Few problems are universal and most of the problematic scores are related to a minority of departments, calling for local activities to improve quality. Diversity seems to be the rule. CONCLUSIONS: The SurveillanceMapper-tool proved effective for handling the complexity of quality measures. It is easy to translate hundreds of graphs and tables into the SurveillanceMapper-tool format. The method facilitates easy spotting areas for quality improvements and evaluating the results of intervention.

Pound, P., Gompertz, P. and Ebrahim, S. (1994). "Patients' satisfaction with stroke services." Clinical Rehabilitation 8(1): 7-17.

Patient satisfaction with stroke services is a key aspect of the evaluation of the quality of services but there are no adequate means of assessing satisfaction in this area. A questionnaire derived from in-depth interviews was piloted on two samples. The resulting questionnaire consisted of two sections, one on inpatient services (Hospsat) and the other on services in the community (Homesat). It was sent to 219 patients, who had had a stroke six months previously, along with postal versions of the Barthel ADL index, the Nottingham Extended ADL Scale, the Nottingham Health Profile, the short form of the Geriatric Depression Scale and the Faces Scale. The response rate for the questionnaires was 87%. Test-retest reliability and tests of internal consistency of the satisfaction scales were carried out on a subsample of this population. Convergent and discriminant validity were explored by examining correlations with the above measures. The satisfaction questionnaire had construct validity with significant correlations between the Barthel ADL Index (r = 0.39), the Nottingham Extended ADL Scale (r = 0.38) and the physical mobility subsection of the Nottingham Health Profile (r = -0.36). Internal consistency was high for both sections (Cronbach's Alpha. Hospsat 0.86; Homesat 0.77). Test-retest reliability was fair; the mean difference for total scores was 0.59 (SD = 2.4) for Hospsat, and 0.32 (SD = 2.1) for Homesat. A high level of dissatisfaction was uncovered. Just under half (48%) of people were dissatisfied with some aspect of the care they received in hospital and over half (53%) were dissatisfied with some aspect of the services they received in the community. The highest rate (54%) of dissatisfaction was with the amount of therapy received. Good patient satisfaction measures are useful since they complement 'objective' outcome measures and may highlight areas in need of evaluation and improvement.

Pourat, N., Kagawa-Singer, M. and Wallace, S. P. (2006). "Are managed care Medicare beneficiaries with chronic conditions satisfied with their care?" Journal of Aging & Health 18(1): 70-90.

Objectives: This article compares patient experiences of chronically ill older people in health maintenance organizations (HMOs) with other forms of Medicare supplemental coverage. Method: Using data from the 1996 Medicare Current Beneficiaries Survey, the authors analyzed the experiences of chronically ill elderly with overall quality, access to care, and physicians' technical, interpersonal, and information-giving skills. Logistic models controlled for prevalent chronic conditions, functioning, perceived health status, sociodemographics, region of residence, and county-level Medicare HMO penetration. Results: Satisfaction with quality of overall care and physicians' skills was more likely for many conditions for those with private fee for service and Medicaid supplemental coverage, compared to Medicare HMO population. No insurance effects were found among elders who had none of the examined conditions. Discussion: Managed care may have negatively affected patients' perceptions of overall quality of care and doctor-patient interaction. Including additional and supplementary services to the delivery of care may improve satisfaction rates.

Pourat, N., Kominski, G., Roby, D. and Cameron, M. (2007). "Satisfaction with care and perceptions of quality among injured workers in California's Workers' Compensation system." Journal of Occupational & Environmental Medicine 49(11): 1249-56.

OBJECTIVES: To examine satisfaction and perceptions of quality among injured workers after the 2004 reforms in California's Workers' Compensation system. Also, to investigate the impact of provider occupational medicine orientation and interpersonal behavior, access, and timeliness of care on injured worker satisfaction and quality, and to identify aspects of provider behavior and access with the potential for improving future satisfaction and quality. METHODS: Ordered logistic regression using survey data from a representative sample of workers injured between April 1 and June 30, 2005. RESULTS: Occupational medicine orientation, interpersonal behaviors, choice of provider, timeliness of care, and ease of access to specialists were associated with higher levels of satisfaction. CONCLUSIONS: Injured workers report high levels of satisfaction and quality. Satisfaction and quality can be further improved by focusing on specific

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aspects of provider behavior and access.

Pourin, C., Barberger-Gateau, P., Michel, P. and Salamon, R. (1999). "Measurement of patient satisfaction. Part I: Conceptual considerations and review of the literature. [French]." Journal d'Economie Medicale 17(2-3): 101-115.

Background: As expressed in the law of April 26th, 1996, French public and private hospitals must regularly conduct studies assessing patient satisfaction, regarding in particular admission process and conditions of hospital stay. The Comite de Coordination de l'Evaluation Clinique et de la Qualite en Aquitaine (CCECQA), created by a grouping of public hospitals in Aquitaine proposed to its members to participate in a common project of patient satisfaction assessment. Objectives: The aim of this paper, the first of a series of two, is to present a review of the literature conducted by the CCECQA, previous to the implementation of a regional survey of patient satisfaction. In this paper, the concept of satisfaction is developed and the main studies conducted in France and abroad are described. Results: In opposition to the numerous surveys conducted in the USA and the UK, very few studies have been realised and published in France. The problems most frequently cited by the patients concern communication and patient information, patient' education about drugs and tests, pain management, and hospital discharge planning. Socio-demographic factors, technical aspects of care, and self-perceived health status may influence patient's ratings. Conclusion: Satisfaction is a multidimensional concept. Patient satisfaction and quality of technical care are two complementary approaches. In a second paper, methodological problems encountered when designing and validating satisfaction measures will be discussed.

Pourin, C., Daucourt, V. and Barberger-Gateau, P. "[Use of the critical incident technique in the development of a measurement tool for satisfaction in psychiatry]." Sante Publique 13(2): 169-77.

BACKGROUND: Health care centers will have to set up a regular survey of their patients' satisfaction, in addition to the discharge questionnaire. Few instruments for measuring satisfaction are at present available. A working group associating 10 psychiatric hospitals in Aquitaine conducted a study on the specificity of this measure in psychiatry. AIMS OF THE STUDY: To record the patient's perception on the stay in order to identify areas of satisfaction and dissatisfaction as perceived and reported by himself, using a qualitative approach. METHODS: The critical incident technique was used in 3 volunteer hospitals, in patients hospitalised in psychiatric wards selected by their doctor. Interview using a semi-structured questionnaire were conducted by an investigator external to the departments. Data were analysed in a qualitative way. RESULTS: 32 interviews could be analysed, and 215 events were extracted. These events were classified in 12 themes. CONCLUSION: The events identified from these interviews have allowed identification of new areas of patient satisfaction, which could be used to build additional items centered on patients' preoccupations.

Pouwer, F. and Snoek, F. J. (2002). "Patients' Evaluation of the Quality of Diabetes Care (PEQD): development and validation of a new instrument." Quality & Safety in Health Care 11(2): 131-6.

OBJECTIVES: To develop a brief measure of patients' evaluation of the quality of diabetes care and to study predictors of consumers' rating of the quality of diabetes care. DESIGN: A prospective design. SUBJECTS: 176 adults with type 1 (39%) or type 2 (61%) diabetes. MAIN MEASURES: Demographic variables, HbA1c, number of diabetes complications, satisfaction with diabetes care, diabetes related distress, and fear of hypoglycaemia were assessed by self-report. In addition, satisfaction with diabetes care and evaluations about quality of the care were measured at 16 month follow up. Statistical analysis comprised principal component analyses, Cronbach's alpha, t tests, Pearson's correlation, and linear regression analyses. RESULTS: Results in the literature were used to develop the 14 items of the Patients' Evaluation of the Quality of Diabetes Care (PEQD) scale, assessing the most important aspects of the quality of diabetes care as delivered by the specialist in internal medicine (internist) and the diabetes nurse specialist (DNS). Two principal components analyses (internist/DNS) both yielded one 14 item factor with a high internal consistency. Satisfaction with diabetes care, fewer diabetes related complications, fewer treatment related problems, and a low level of worries about hypoglycaemia were predictors of a more positive evaluation of diabetes care delivered by the internist. Sociodemographic variables were not related to the patients' evaluations of the quality of diabetes care. CONCLUSIONS: The PEQD comprises different aspects of quality of diabetes care and can be regarded as a suitable instrument for evaluating patients' judgements about the quality of their care.

Powell, J., Lovelock, R., Bray, J. and Philp, I. (1994). "Involving consumers in assessing service quality: benefits of using a qualitative approach." Quality in Health Care 3(4): 199-202.

Although important to users, practice standards rarely incorporate users' views of care provided. These views are a valuable source of information, even though there are limits to their value. To improve the standards of care in a 20 bed hospital elderly care unit caring for acute medical conditions a qualitative approach was used. Patients' and carers' perceptions of care and problems with the process of care in the unit were elicited with a specially designed semistructured interview schedule in 83 separate tape recorded interviews with a research nurse in patients' homes. In all, 50 patients and 35 carers were interviewed between 6 June 1991 and 28 May 1992. Of the 50 patients, 33 were female; seven patients were aged less than 80 years, 16, 80-85; 21, 86-90; and six over 90. A total of 16 patients lived with spouses or other carers, two with non-carers, and 32 lived alone, 18 of whom received informal care. Content analysis of the interviews disclosed patients' and carers' general satisfaction with individualised professional care and planning of follow up services on discharge but dissatisfaction in the lack of information about and involvement in treatment and care and about specific staff notes. These findings have prompted remedial changes in clinical practice in the unit; they have also formed the structure of a criterion based survey of

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practice. The authors conclude that the qualitative approach suited elderly users and also provided the basis for the findings to be incorporated into a continuous audit cycle through a process of feedback and standard setting.

Powell, R. A., Holloway, F., Lee, J. and Sitzia, J. (2004). "Satisfaction research and the uncrowned king: challenges and future directions." Journal of Mental Health 13(1): 11-20.

Background: After decades of paternalistic health service provision, National Health Service users in the United Kingdom are encouraged to express preferences for services; "the patient is king". Whilst the mental health service user voice is encouraged in multiple forums, it is in satisfaction research (especially using the survey method) as a commentary on services provided that it is primarily heard. However, methodological concerns exist regarding the use of satisfaction surveys as a measure of healthcare quality.

Aim: To discuss the arguments against and for using satisfaction surveys in mental health research.

Method: A review of the existing literature on satisfaction surveys.

Results: There are a number of significant criticisms of satisfaction surveys and their continued use in mental health research.

Conclusions: Despite these criticisms, the limitations of satisfaction surveys do not merit their abandonment. The authors indicate possible future directions for the satisfaction research agenda.

Price, L. D. M. (2000). Elderly patients' satisfaction with rural hospital discharge planning by a nurse and a social worker-nurse team, University of Sarasota: 232 p.

This study examined elderly patients' and emergency contact persons' reports of satisfaction with discharge planning from a small rural hospital. Reports of satisfaction when discharge plans were prepared by a nurse were compared with reports of satisfaction when discharge plans were prepared by a nurse in collaboration with a social worker. This study also explored whether discharge plans included referrals to community resources and/or involvement of informal supports to assist patients after hospitalization. The patient population for the study consisted of elderly patients discharged during 6 months in 1997 and the corresponding 6 months in 1998. The emergency contact person sample consisted of individuals identified by patients who should be contacted if patients experienced medical emergencies while hospitalized. All patients were discharged to the care of the same home health agency. Patients and emergency contact persons were surveyed by telephone. Both groups were asked to rate their level of satisfaction with discharge planning Both groups were then asked to identify what would have better prepared patients or their caregivers to manage patient care at home.

Analysis of data collected for this study provides evidence that social work involvement in discharge planning resulted in more referrals to community resources. Social work involvement appeared to have no bearing on facilitating use of posthospital informal sources of support for elderly patients. Chi-square was employed to test the statistical significance of the association between the professional orientation of discharge planners and reports of satisfaction by patients and emergency contact persons. There was not statistical evidence at the .05 level of significance for the anticipated relationship between higher patient and emergency contact person satisfaction and involvement of social work in discharge planning. Patients and emergency contact persons provided useful feedback on patient quality of care and suggested changes to improve discharge planning and preparedness for elderly patients returning home.

Proctor, S. (1998). "What determines quality in maternity care? Comparing the perceptions of childbearing women and midwives." Birth 25(2): 85-93.

BACKGROUND: In the current climate of consumer orientation in health care services, a clear need has emerged to understand the extent of consumer focus among primary health care professionals. Few studies have compared the beliefs of health care staff with those of patients. This study sought to identify and compare the perceptions of women and midwives concerning women's beliefs about what constitutes quality in maternity services. METHODS: Focus groups were conducted from July 1994 to June 1997 with 38 pregnant and postnatal women, and 47 midwives who were based in two large maternity units in Yorkshire, England. Transcriptions of data were analyzed to identify broad themes. RESULTS: Ten dimensions of quality were identified. Similarities between midwives and women included beliefs about the importance of the relationship between the two parties, desired attributes of staff, and the environment of care. Key differences included underestimating the importance of information antenatally and postnatally, the importance of continuity during labor, need for control and confidence in adjusting to the maternal role, and involvement of the woman's partner in the delivery of care. CONCLUSIONS: An understanding of the concerns of women by maternity care staff is important in the development of a woman-focused service, in line with current policy recommendations, and has implications for risk management and improving the service quality for those who provide and experience the service.

Proctor, S. and Wright, G. (1998). "Consumer responses to health care: women and maternity services." International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services 11(4-5): 147-55.

The importance of understanding consumer perceptions of services is widely acknowledged. This is becoming more relevant in health care, as attempts to incorporate users' views into service development and evaluation are increasing. This study focused on women's responses to their recent experience of maternity care, and sought to gain insight into the service features they associated with negative and positive reactions. Postal questionnaires were sent to antenatal and postnatal women. Two open questions invited women to note if any aspects of their care had particularly impressed or bothered them. There was variation in the factors identified through the different phases of the service--antenatal, labour and postnatal

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care. However, staff attitudes were a main source of positive comments throughout the service, and lack of information and poor explanations were a consistent source of negative responses. Providing consumers with an opportunity to give feedback on their service experience should be based on issues which are relevant to them, not just on those which are measurable.

Proot, I., Schrijnemaekers, V., van Hoef, L., Courtens, A. and Huijer, H. A. (2006). "Measuring patient and family satisfaction with terminal care: the development and testing of the Maastricht Instrument on Satisfaction with Terminal Care (MITTZ)." Supportive & Palliative Cancer Care 3(1): 7-14.

BACKGROUND: This study deals with the development of a short measurement instrument (MITTZ), aimed at the evaluation of patient and family satisfaction with the care delivered in the terminal phase of illness. PATIENTS AND METHODS: The validity and feasibility of MITTZ has been tested in 43 terminally ill persons and 39 informal caregivers.

RESULTS: The content validity, internal consistency, clinical utility and feasibility of the MITTZ appeared to be good. Explorative factor analysis resulted in seven to eight factors respectively explaining 81% (patients) and 83% (informal caregivers) of the total variance However, underlying constructs have not been identified. Cronbach's alpha was evaluated to be 0.87 and 0.84 respectively.

CONCLUSIONS: This first step in the validation of the MITTZ should be interpreted with caution, because the sample size limits the possibilities for analysis. Further validation of the MITTZ with a larger sample is recommended. The MITTZ provides valuable information to improve daily care for terminally ill people, and may be used as an outcome measure in studies in the field of palliative terminal care as soon as more relevant information is available about its validity.

Pukk, K., Lundberg, J., Gaffney, A., Penaloza-Pesantes, R. V. and Olsson, J. (2003). "Do health care managers know the comparative quality of their care?" Quality Management in Health Care 12(4): 232-9.

Compared with other industries, health care is a high-risk industry. In this study, two national data sets on patient claims and a survey of improvement efforts in Swedish health care were used to investigate the linkage between how health care managers perceive their performance regarding adverse medical events and their performance as reflected in patient malpractice claims rates. The departments' focus on patient safety issues in their improvement efforts was also evaluated. Our results show that Swedish health care department managers underestimate their departments' frequency of adverse medical events relative to that of similar units. Also, there is no correlation between the managers' perception of adverse medical events and their actual frequency of patient malpractice claims. More research is needed on the use of patient-generated malpractice claims and claims rates to promote a higher awareness of the magnitude of the safety problems in health care.

Pukk, K., Lundberg, J., Penaloza-Pesantes, R. V., Brommels, M. and Gaffney, F. A. (2003). "Do women simply complain more? National patient injury claims data show gender and age differences." Quality Management in Health Care 12(4): 225-231.

The Swedish Counties Mutual Insurance (LOF) owns and operates the Swedish Patient Insurance Company, (PSR) a no-blame insurance system that compensates patients for injuries that result from errors in medical practice. We combined malpractice claims data (from PSR) with national hospital discharge registry data (National Board of Health and Welfare-Socialstyrelsen) and determined Swedish inpatient malpractice claims rates for the years 1996-2000. Women have higher claims rates than men, but their claims are adjudicated as valid more often than men's claims. The data are consistent with other lines of evidence suggesting poorer quality of care for women, e.g., heart disease, kidney disease, and cancer. Middle-aged (40- to 59-year-old) patients file malpractice claims at almost twice the national rate, whereas patients younger than 19 years and older than 80 years of age file at significantly below the average rate. Differences in claims rates have major financial and quality of care implications. Further studies are needed.

Puterbaugh, S. (1994). "Commentary on Quality improvement consumer influence on perioperative services [original article by White L appears in AORN J 1993;58(1):96-101]." AONE's Leadership Prospectives 2(1): 21-21.

Topic: Application of the quality-improvement (QI) theories of W. Edwards Deming to perioperative nursing care. Purpose: To show that consumers of a service define and assess quality. Source: The Deming management method and results from implementing a QI program at the author's place of employment. Conclusions: Patient surveys are a valuable tool for assessing quality service when the belief is that quality is determined by the consumer. Quality must be the responsibility of each employee, not just of the manager. Implementing professional practice groups can enhance the provision of quality care.

Pyrah, M., Byrne, J. and Hilton, C. (2008). "Complaints: finding a positive and productive approach." British Journal of Hospital Medicine (17508460) 69(6): 312-313.

Services sometimes fail to provide acceptable care to patients and their families.

Complaints provide free, immediate and useful comment and should be welcomed and used to foster mutual respect, learning and improvement.

Older people, especially those with dementia, are vulnerable to misuse or misunderstanding. They require particular care and attention to matters of communication.

Making Experiences Count is a new approach to handling complaints which brings health and social care systems together in pursuit of these principles.

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Quinche, F. (2001). "[Textual analysis of patients' complaints in the hospital milieu]." Revue Medicale de la Suisse Romande 121(11): 837-43.

The text of patient's complaints in a parisian hospital have been examined in order to describe the recurrent types, but also the argumentation's modalities of both sides. We describe the process of answering by showing the different stages in building the answer. A process of enquiry appears, where the answer has to reconstitute the facts and to relate them with the expressed complaint. This process is especially important in the case of medical and informational complaints, domains where the asymmetry between patient and clinician is especially wide. This drives us to show the deficiencies of a purely written complaint-process. To avoid these insufficiencies, the relevant answers and questions have to be involved in a real dialogue, where both sides can equally contribute in reconstructing the information. This confirms the necessity of introducing conciliation commissions in medical structures, where patients could directly express their complaints.

Quinn, G. P., Jacobsen, P. B., Albrecht, T. L., Ellison, B. A. B., Newman, N. W., Bell, M. and Ruckdeschel, J. C. (2004). "Real-time patient satisfaction survey and improvement process." Hospital Topics 82(3): 26-32.

The purpose of this article is to describe how one multidisciplinary hospital responded to patient-satisfaction issues and improved communication throughout its organization by implementing a real-time assessment of patient and staff satisfaction for a faster and better-focused improvement process. The survey process is based on eliciting information from several different sources in a manner that allows corrective action plans to be made and implemented within 4 to 8 weeks of patient encounters. Organized groups can then review feedback from the implemented action plans within 9 to 16 weeks of patient encounters. This 4-month process is repeated on a quarterly basis, as lessons learned from the previous cycle are fed into the upcoming survey process for continuous patient-satisfaction improvement. Employees, faculty, and administrators have accepted the Real-Time Patient Satisfaction Survey and Improvement Process as a routine activity within the normal operating structure at the Moffitt Cancer Center. This activity of problem identification-action-feedback has been well integrated in the system and will continue to rotate throughout all patient care clinical services at the Moffitt Cancer Center. The program has become a method for goal-setting and establishing management accountability. As an adaptation of continuous quality improvement, The Real-Time Patient Satisfaction Survey and Improvement Process at the Moffitt Cancer Center is applicable for use in other hospitals and cancer centers in the United States. The general design, materials, and analysis plan can be directed toward the needs of the specific institution (and are available for distribution by contacting the authors).

Quintana, J. M., Gonzalez, N., Bilbao, A., Aizpuru, F., Escobar, A., Esteban, C., San-Sebastian, J. A., de-la-Sierra, E. and Thompson, A. (2006). "Predictors of patient satisfaction with hospital health care." BMC Health Services Research 6: 102.

BACKGROUND: We used a validated inpatient satisfaction questionnaire to evaluate the health care received by patients admitted to several hospitals. This questionnaire was factored into distinct domains, creating a score for each to assist in the analysis.We evaluated possible predictors of patient satisfaction in relation to socio-demographic variables, history of admission, and survey logistics. METHODS: Cross-sectional study of patients discharged from four acute care general hospitals. Random sample of 650 discharged patients from the medical and surgical wards of each hospital during February and March 2002. A total of 1,910 patients responded to the questionnaire (73.5%). Patient satisfaction was measured by a validated questionnaire with six domains: information, human care, comfort, visiting, intimacy, and cleanliness. Each domain was scored from 0 to 100, with higher scores indicating higher levels of patient satisfaction. RESULTS: In the univariate analysis, age was related to all domains except visiting; gender to comfort, visiting, and intimacy; level of education to comfort and cleanliness; marital status to information, human care, intimacy, and cleanliness; length of hospital stay to visiting and cleanliness, and previous admissions to human care, comfort, and cleanliness. The timing of the response to the mailing and who completed the questionnaire were related to all variables except visiting and cleanliness. Multivariate analysis confirmed in most cases the previous findings and added additional correlations for level of education (visiting and intimacy) and marital status (comfort and visiting). CONCLUSION: These results confirm the varying importance of some socio-demographic variables and length of stay, previous admission, the timing of response to the questionnaire, and who completed the questionnaire on some aspects of patient satisfaction after hospitalization. All these variables should be considered when evaluating patient satisfaction.

Quist, S. R., Dieckmann-Stocklein, R., Brocker, E.-B. and Weyandt, G. H. (2007). "[Determinants of patient satisfaction in a university clinic of dermatology as a parameter for patient orientation in quality management]." Journal der Deutschen Dermatologischen Gesellschaft 5(7): 598-604.

BACKGROUND: Acquisition of patient's quality perception is an essential element for quality management in a clinic. Determinants important for patient satisfaction at a dermatological university clinic were investigated. PATIENTS AND METHODS: 650 in-patients of a dermatological university clinic were approached in written form at discharge. The questionnaire contained questions to importance and satisfaction, to structures and processes of the clinic orientated at the requirements of KTQ (Cooperation for transparency and quality in the hospital). RESULTS: The response rate was 51 %. 98 % of the patients stated that they would like to be treated in the clinic again. High satisfaction was shown to important items for patients as medical and nursing care and the healing process. In general patient's needs differ little to those derived from other patient questionnaires but they show specialty specific features. Important suggestions can be derived from the attached free text answer. CONCLUSIONS: From the results a lot of steps to improve patient's care could be derived and implemented. Since the results of patient questionnaires are subjected to multiple partially subjective factors, the comparison with other

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hospitals/disciplines (benchmarking) or the exact scientific acquisition is only restrictedly possible. Repetitive investigations in combination with further steps are a valuable instrument on the way to a continuous improvement process.

Raftopoulos, V. (2005). "A grounded theory for patients' satisfaction with quality of hospital care." ICUs & Nursing Web Journal(22): 15p.

Objective: Patient satisfaction with quality of care is a dominant concept in quality assurance and quality improvement programs. Elderly patients are the central users of health care services and therefore the development of a grounded theory that explains how they perceive quality of care is important for strategy planning and health services evaluation. Sample and methods: The study was carried out at two hospitals, a capital hospital and an urban one in Greece. There were 24 elderly patients, with a mean age of 70Â±6.02 years old. The methodology for the data analysis was similar to the one described by Corbin and Strauss for grounded theory analysis. In order to assure the quality of our qualitative research we used triangulation (in-depth interviews, focus group and direct observation). Content analysis of the interviews was primarily based on conceptual analysis of the two main concepts: patients' perceived quality of care and patients' satisfaction with care. Results: After open coding of the data obtained from the interviews, we identified five categories: food, nursing care, medical care, room characteristics, and treatment/diagnosis. These five categories are common whether we measure elderly perceived quality of hospital care or patient satisfaction. Second-level categorization (axial coding) included patients' feelings regarding each of the five care dimensions that are the subcategories of the previous categories. These feelings could be positive, negative, neutral or they may feel indifferent. The final stage of data analysis was selective coding categorization containing direct comments for each category. This third-level categorization contains specific dimensions of nursing and medical care such as: patients' respect as a human being, staff technical skills, staff effective communication, therapeutic touch and empathy. Discussion: Our findings support the need to develop a conceptual framework for patients' satisfaction interpretation, based on their own quality of care assumptions. This is the first step for the development of a valid and reliable scale for measuring quality of care.

Raftopoulos, V. (2005). "Pain, satisfaction with quality of pain management and depressive symptoms in elderly hospitalized patients." ICUs & Nursing Web Journal(21): 17p.

Objective: Our aim was to develop and test the psychometric properties of a scale assessing elderly patients' satisfaction with quality of pain management and to explore whether elderly patients' depression (by using Geriatric Depression Scale) correlates with patients' perceived quality of pain management. Design: We developed a scale of elderly patients' satisfaction with quality of pain management based on the existing literature evidence, on the results of a qualitative research and on a previous developed conceptual framework that described how elderly patients perceive quality of hospital care and defined the determinants of elderly patients' satisfaction. We evaluated the taxonomy and the feasibility of the scales using reliability analyses and a combination of qualitative and quantitative research methods. Setting: Eight Greek hospitals in seven big cities covering all the major counties of Greece. Patients: 380 elderly hospitalized patients participated to the study (209 male, 171 female). The mean age of the sample was 73.07 +/- 6.04 years. Results: 76.6% elderly patients answered they experienced pain during their hospitalization. Pain influenced elderly patients' daily activities, emotional situation, sleep, their relations with the significant others and their walking ability. Elderly patients who have undergone a surgical procedure were 3.9 times more likely to feel pain. Women were half times more likely to feel pain during their hospital stay. The vast majority of elderly patients were totally satisfied with their pain management (92.8%), with the way doctors managed their pain (96.3%) and the way nurses managed their pain (92.1%). Elderly patients' global satisfaction with pain management correlated with: the pain intensity, the region of the hospital with those patients who were hospitalised in the capital being more satisfied (7.38 +/- 1.19) than those in urban hospitals (6.74 +/- 1.41), the global satisfaction of elderly patients with nursing assistance they received, elderly patients? intention to recommend the hospital to a friend of them or to a relative. T-test indicated that mean satisfaction with pain management, with nursing pain management and with medical pain management did not differ among depressed and non-depressed elderly patients. Global satisfaction with nursing pain management was a major predictor of global satisfaction with pain management. Subscales had a very good internal consistency ranging from 0.78 to 0.95 and good criterion validity. Conclusions: Pain and satisfaction with pain management are two multidimensional issues that must be explored in accordance with psychological, regional and other factors. Health care professionals should consider routinely screening of elderly hospitalized patients for depression as a method for exploring pain and its characteristics.

Rahman, Z. and Qureshi, M. N. (2008). "Developing new services using fuzzy QFD: a LIFENET case study." International Journal of Health Care Quality Assurance 21(7): 638-58.

PURPOSE: The purpose of this paper is to suggest the fuzzy quality function deployment (QFD) method to assess LIFENET customers' spoken and unspoken needs in order to achieve the various objectives like: how to decide optimum portfolio for health services strategically; how to assess competitors' market position in order to reckon the market position of LIFENET; and how to set the revised target in order to satisfy the customers' demand and to fetch profit in order to satisfy managers' mission and vision in a competitive market. DESIGN/METHODOLOGY/APPROACH: A fuzzy QFD method has been devised to take care of the various LIFENET objectives. Fuzzy logic's use has been recommended to remove the uncertainty, vagueness, and impreciseness from data obtained to assess customers' spoken and unspoken needs. Symmetric triangular fuzzy numbers (STFNs) may be used to assess various needs to enhance data accuracy. House of quality (HOQ), an in-built QFD matrix, may be constructed to take care of LIFENET's various requirements in order to satisfy internal and external customers. FINDINGS: Fuzzy QFD plays a

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vital role in assessing customers' need in terms of WHATs. Various WHATs thus obtained can be accomplished by incorporating technical parameter HOWs'. The QFD HOQ offers various vital comparisons for instance, WHATs vs HOWs, HOWs vs HOWs, NOWs vs WHATs, etc. to obtain important inferences, which help to revise target to remain competitive in the market Fuzzy QFD helps devise a management strategy to follow customers' needs in health industry successfully. ORIGINALITY/VALUE: Accessing Indian customers' needs poses many challenges as the decision to opt for a given healthcare service is most uncertain because it varies from person to person. The set of parameters that influence individual decisions to opt for healthcare services are costs, treatment response time, disease/risk, and health service satisfaction. Fuzzy QFD may help LIFENET promoters to consider customers' favored health services thereby helping strategically in their attempt for major expansion, in order to get the most benefits of becoming first-movers in the sector. Fuzzy QFD may also help LIFENET to avert major investment decisions that looked attractive in short-term, but in fact were unfruitful, in long-term.

Rahmqvist, M. (2001). "Patient satisfaction in relation to age, health status and other background factors: a model for comparisons of care units." International Journal for Quality in Health Care 13(5): 385-90.

OBJECTIVE: To analyse the relationship between patient satisfaction and background factors such as age, gender, health status and pain. In addition, to use background factors to create less biased ranking in comparisons of patient satisfaction between medical specialities. DESIGN: A questionnaire was sent by post to patients who had recently received inpatient care at a hospital within the County of Ostergotland, Sweden. The questionnaire contained 33 questions, 21 of which concerned the quality of health care and patient satisfaction. SETTING: Inpatient departments at all four hospitals in the County of Ostergotland, Sweden. SUBJECTS: All patients discharged from the hospital during a period of 6 weeks. Approximately 3400 patients aged 1-94 years responded to the questionnaire, resulting in a response rate of 69%. MAIN OUTCOME MEASURES: Patient satisfaction index score (PSI). RESULTS: Of the background factors tested, patient age had the greatest explanatory value regarding the PSI, closely followed by experiencing anxiety during admission. With regard to variations in the PSI, about 20% could be explained by the background factors taken as a whole. Gender did not correlate with the PSI, although males were somewhat more satisfied than females. PSI scores differed among medical specialities and, interestingly, when age and other background factors were controlled for, the picture changed regarding the medical speciality that received the best PSI score. CONCLUSION: The change in ranking among medical specialities after adjustment for background factors emphasizes the importance of including background factors in patient satisfaction analyses in order to obtain less biased comparisons.

Ramsaran-Fowdar, R. R. (2005). "Identifying health care quality attributes." Journal of Health & Human Services Administration 27(4): 428-43.

Evaluating health care quality is important for consumers, health care providers, and society. Developing a measure of health care service quality is an important precursor to systems and organizations that value health care quality. SERVQUAL has been proposed as a broad-based measure of service quality that may be applicable to health care settings. Results from a study described in this paper verify SERVQUAL dimensions, but demonstrate additional dimensions that are specific to health care settings.

Rankin, J. M. (2003). "'Patient satisfaction': knowledge for ruling hospital reform--an institutional ethnography." Nursing Inquiry 10(1): 57-65.

Driven by funding restraint, Canadian health-care has undergone over a decade of significant reform. Hospitals are being restructured, as text-based practices of accountability bring a new business-orientation into hospital and clinical management. New forms of knowledge, generated through records of various sorts, are a necessary resource for managing care in the new environment. This paper's research uses Canadian sociologist Dorothy E. Smith's institutional ethnographic methodology to critically analyse one instance of text-based management. I analyse information about 'patient satisfaction' as it is generated through a patient survey (in which I was implicated through my involvement with a hospitalized family member). Subsequently, I have studied the management environment into which that information would be entered. I argue that in the instance analysed, the information becomes part of a dominant consumer oriented healthcare discourse that subordinates concerns about 'what actually happened' as a professional caregiver would have known it. On this basis, I contend that this sort of taken-for-granted approach to making decisions about quality care in hospitals may be seriously, even dangerously, flawed.

Rantz, M. J., Zwygart-Stauffacher, M., Popejoy, L., Grando, V. T., Mehr, D. R., Hicks, L. L., Conn, V. S., Wipke-Tevis, D., Porter, R., Bostick, J., et al. (1999). "Nursing home care quality: a multidimensional theoretical model integrating the views of consumers and providers.[erratum appears in J Nurs Care Qual 1999 Nov;Spec No:followi]." Journal of Nursing Care Quality 14(1): 16-37; quiz 85-7.

This exploratory study was undertaken to discover the defining dimensions of nursing home care quality from the viewpoint of consumers of nursing home care. Eleven focus groups were conducted in five Missouri communities. The seven dimensions of the consumer multidimensional model of nursing home care quality are: staff, care, family involvement, communication, environment, home, and cost. The views of consumers and families are compared with the results of a previous study of providers of nursing home services. An integrated, multidimensional theoretical model is presented for testing and evaluation. An instrument based on the model is being tested to observe and score the dimensions of nursing home care quality.

Rao, K. D., Peters, D. H. and Bandeen-Roche, K. (2006). "Towards patient-centered health services in India--a scale to measure patient perceptions of quality." International Journal for Quality in Health Care

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18(6): 414-21.

OBJECTIVE: . (i) To develop a reliable and valid scale to measure in-patient and outpatient perceptions of quality in India and (ii) to identify aspects of perceived quality which have large effects on patient satisfaction. DESIGN: Cross-sectional survey of health facilities and patients at clinics. SETTING: Primary health centers, community health centers, district hospitals, and female district hospitals in the state of Uttar Pradesh in north India. MAIN OUTCOME MEASURES: Internal consistency, validity, and factor structure of the scale are evaluated. The association between patient satisfaction and perceived quality dimensions is examined. RESULTS: A 16-item scale having good reliability and validity is developed. Five dimensions of perceived quality are identified-medicine availability, medical information, staff behavior, doctor behavior, and hospital infrastructure. Patient perceptions of quality at public health facilities are slightly better than neutral. Multivariate regression analysis results indicate that for outpatients, doctor behavior has the largest effect on general patient satisfaction followed by medicine availability, hospital infrastructure, staff behavior, and medical information. For in-patients, staff behavior has the largest effect followed by doctor behavior, medicine availability, medical information, and hospital infrastructure. CONCLUSIONS: The scale developed can be used to measure perceived quality at a range of facility types for outpatients and in-patients. Perceived quality at public facilities is only marginally favorable, leaving much scope for improvement. Better staff and physician interpersonal skills, facility infrastructure, and availability of drugs have the largest effect in improving patient satisfaction at public health facilities.

Raper, J. L. (1996). "A cognitive approach to patient satisfaction with emergency department nursing care." Journal of Nursing Care Quality 10(4): 48-58.

The assessment of patient satisfaction is an integral part of any quality improvement activity. In this study, patient satisfaction with emergency department (ED) nursing care was significantly positively related to the patient's self-perceived improvement and to the patient's admission to the hospital. Patient satisfaction with ED nursing care was not significantly related to patient acuity or other individual patient differences (age, gender, marital status, length of stay, type of treatment, number of previous ED visits, race, payer source, pain, or presence of chronic health problems). Psychological safety and information giving were found to contribute significantly to patient satisfaction with the ED nurse. Patient satisfaction with ED nursing care contributed significantly to the patients' intention to return to the ED.

Raspe, H., Voigt, S., Herlyn, K., Feldmeier, U. and Meier-Rebentisch, K. (1996). "[Patient "satisfaction" in medical rehabilitation--a useful outcome indicator?]." Gesundheitswesen 58(7): 372-8.

Within the context of a five-part quality assurance programme for rehabilitation hospitals issued by the German Association of Statutory Pension Scheme Underwriters (Verband Deutscher Rentenversicherungstrager) we developed a multisectional questionnaire to assess patient satisfaction with rehabilitation measures. This questionnaire records the patients' perceptions and ratings of rehabilitation structures and processes as well as the results of then. The article describes basic positions, chances and risks of assessing this measure of satisfaction as well as the development of our questionnaire. The dimensions of patients satisfaction are based on the differentiation between various sectors of clinical output and capacity (Leistungsbereiche) und demands on medical service and capacity (Leistungsanspruche). The questionnaire includes rating and reporting questions. Since it will be complemented by a second part on health outcomes, this "research tool" will be used routinely to compare hospitals on the basis of an annual random sample (15%) of all rehabilitation patients.

Raspe, H., Weber, U., Voigt, S., Kosinski, A. and Petras, H. (1997). "Quality assurance in medical rehabilitation based on patient questionnaires: perceptions and ratings of rehabilitation structures and processes ("rehabilitee satisfaction") [German]." Rehabilitation 36(3): XXXI-xlii.

Since 1994 Germany's statutory pension insurance schemes have been developing a multifaceted programme to assure and optimize the quality of their medical rehabilitation measures. One part aimed at developing a postal questionnaire for patients 8 to 12 weeks after rehab. It comprises two sections: one for the assessment of patients' perceptions and ratings in relation to rehab structures and processes, the other of changes of their health status. The article describes the development of the first part ("rehabilitee satisfaction"). We basically defined relevant sectors and qualities of medical rehab, analysing existing questionnaires, letters of complaint, results of expert interviews and patient focus groups. Mainly based on results from one large study of rehabilitees from two different pension insurance schemes (for blue or white collar workers), we report on psychometric properties of the final instrument, especially its contents, reliability, internal structure, validity and reference values. In February 1997, the instrument was accepted by the association of German pension schemes and may now be used in the routine phase of the quality programme, except for patients with psychosomatic disorders or substance abuse.

Rave, N., Geyer, M., Reeder, B., Ernst, J., Goldberg, L. and Barnard, C. (2003). "Radical systems change. Innovative strategies to improve patient satisfaction." Journal of Ambulatory Care Management 26(2): 159-74.

A project was initiated at Northwestern Memorial Hospital in Chicago focusing on patient satisfaction in the outpatient setting and how to improve it. Eight outpatient diagnostic areas were selected and a steering committee was formed. The team used patient satisfaction scores and patient and staff interviews to identify areas for improvement. Innovations were implemented in communications and information technology, staff role design, and process flow. Successes were realized in patient satisfaction above the 95th percentile, improved staff satisfaction, productivity, and internal and external recognition. The program serves as an organizationwide model supporting the hospital's Best Patient Experience strategic goal. This patient-focused model is being replicated in other areas of the hospital and can be replicated elsewhere.

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Read, D. (1990). "Day surgery: a consumer survey." New Zealand Medical Journal 103(895): 369-71.

Two hundred and eleven day surgical patients admitted to the day procedures area at Hutt Hospital were surveyed after discharge. The level of patient satisfaction was high, and increased with age. Forty-seven percent of adult patients rated their experience as excellent. Seventy-four percent reported no personal disadvantage of day surgery. The most common advantages were minimal disruption to their lifestyle and that of their family, and avoidance of an overnight stay. Twenty-four percent reported problems after discharge, in particular pain.

Reed, L., Blegen, M. A. and Goode, C. S. (1998). "Adverse patient occurrences as a measure of nursing care quality." Journal of Nursing Administration 28(5): 62-9.

OBJECTIVE: The purpose of this study was to describe relationships among adverse patient occurrences aggregated at the unit level of measurement. Relationships between adverse occurrences and a patient acuity measure were also described. BACKGROUND: Adverse patient occurrence data have been traditionally a major indicator of quality care in hospitals; however, few studies have examined relationships among these indicators or the usefulness of these indicators for assessing the quality of nursing care. METHODS: A correlational design was used to examine and describe patterns of relationships among in-patient units in a tertiary care hospital. The results demonstrated positive correlations between medication error rates and patient falls; these adverse occurrences correlated negatively with pressure ulcers, infections, patient complaints, and death. Pressure ulcers, infections, patient complaints and death intercorrelated positively and also related positively to patient acuity levels. RESULTS: An examination of these same rates for a subset of units with similar patient acuity levels revealed that most of the interrelationships among the entire set of adverse occurrence indicators were positive. When patient acuity was taken into account, these adverse outcomes appeared to indicate some common underlying characteristic of the units, such as quality of nursing care. CONCLUSIONS: This study suggests a relationship between the adverse occurrences that were correlated (pressure ulcers, patient complaints, infection, and death) and the severity of patient illness. Medication error rates and patient fall rates were not correlated with patient acuity and are more likely to indicate quality of nursing care across all types of units.

Rees Lewis, J. and Williamson, V. (1995). "Examining patient perceptions of quality care in general practice: Comparison of quantitative and qualitative methods." British Journal of General Practice 45(394): 249-253.

Background. The consultation satisfaction questionnaire and surgery satisfaction questionnaire, and the critical incident technique have been identified as examples of, respectively, quantitative and qualitative (interview) techniques with considerable theoretical merit regarding the measurement of patients' views in a general practice context. Aim. This study set out to assess these techniques in terms of ease of administration and analysis, respondent acceptability, and the extent to which the information provided was useful to the practitioner/practice manager, as well as validity. Method. Patients from three practices completed the interview and questionnaires. Data were provided for each practice giving their own results as well as data from the other two practices and the results of previous research. Results. Both methods were, in the main, received positively by general practitioners, managers and patients. Patient responses to the questionnaires in general followed predictable patterns, variations from which suggested practice-specific problems. Conclusion. There are caveats regarding the use and interpretation of both methods, of which potential users should be aware. This is particularly the case with the consultation satisfaction questionnaire, scores on which, it is suggested, may be on a downward trend over time. It is possible that results from the consultation satisfaction questionnaire/surgery satisfaction questionnaire could be merely demoralizing for practice staff in some instances. Other research supports this notion of demoralization which, although unproven, would reduce the instrument's potential for comparison between studies, and which is, therefore, a finding which requires further attention. Increasing patient expectations are implicated in this.

Rehmani, R. and Amatullah, A. F. (2008). "Quality improvement program in an emergency department." Saudi Medical Journal 29(3): 418-22.

OBJECTIVE: To describe the quality assurance/improvement program in our emergency department ED. METHODS: This program involved monthly data collection and analysis, data-driven process change, staff education in the core concepts of quality, and data reanalysis from the years 2003 to 2006 at the King Abdul-Aziz Hospital, Al-Ahsa, Kingdom of Saudi Arabia. Data captured during the program included census data, chart review, and focused clinical audits. Continuous quality improvement measures collected at the beginning of the program and quarterly included: 1) quality indicators (length of stay [LOS] and rates of left against medical advice [AMA] or left without being seen [LWBS]), 2) percentage of patients that stay > or =3 hours in ED, unscheduled returns within 48 hours, inter-hospital transfer data, sentinel events tracking rates, and 3) nature of patient complaints. RESULTS: During the study period, the program demonstrated improvement in all measured areas. Despite an increase in patient volume of 47% to 51,698 visits/year, the mean monthly LOS remained static, the unscheduled returned visits dropped by 50% (2% to 1%), and patients leaving AMA decreased from 1.5% to 1.2%, and LWBS decreased from 1.6% to 0.8%. The rate of complaints dropped by 5 fold (1.3 per 1000 patients to 0.25). CONCLUSION: Our program demonstrated improvement in all the measured parameters.

Reid, N., Reid, R. and Morris, D. (1995). "Customer complaints in the National Health Service." Journal of Nursing Management 3(6): 295-9.

This paper addresses the role of consumer complaints in the flourishing quality assurance industry within the National Health Service (NHS), and considers the traditional ethos of complaints within the service. The

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advent of the internal market is considered as one of a range of factors which may change attitudes of NHS staff to complaints. In evaluating how complaints services might develop relevant literature is reviewed and recent national data on complaints procedures are cited. [References: 30]

Reiley, P., Pike, A., Phipps, M., Weiner, M., Miller, N., Stengrevics, S. S., Clark, L. and Wandel, J. (1996). "Learning from patients: a discharge planning improvement project." Joint Commission Journal on Quality Improvement 22(5): 311-22.

BACKGROUND: In 1991 Beth Israel Hospital (Boston) joined nine other hospitals in using the Picker/Commonwealth survey instrument to tap patients perceptions of their hospitalization experience. Beth Israel focused on one of the nine dimensions of the instrument-continuity and transition (discharge planning). FOUR WORK TEAMS: In 1992 four multidisciplinary work teams were formed-for cardiac surgical patients, stroke patients, patients on a medical unit, and patients on a medical and surgical unit. Each team conducted a patient/family discussion group, during which recently discharged patients and their families were asked about their preparation for discharge and asked for input on how to improve the process. INTERVENTIONS: Each work team developed interventions on the basis of information specific to their patients. The cardiac work team, for example, developed interdisciplinary practice guidelines for patient care management for the entire postoperative period; the guidelines include a patient education component on what patients and families can expect during hospitalization. OUTCOMES: Clinicians practice differently, inviting more patient feedback and other involvement in care, as a results of their involvement in the project. On the first annual patient survey, administered in 1994, only 6% of 1,179 randomly selected patients (versus 20% of the 100 patients first surveyed in 1993) indicated that they did not receive the information they needed to help themselves recover. CURRENT PROGRESS AND FUTURE DIRECTIONS: A standardized teaching packet containing material developed during the discharge planning improvement project is now distributed. In May 1995 the nursing department launched a patient and family learning center to better meet the health education needs of patients.

Remington, L. (2008). "Patient satisfaction results: an agency tool for improvement across an organization." Remington Report 16(4): 18-20.

Renzi, C., Abeni, D., Picardi, A., Agostini, E., Melchi, C. F., Pasquini, P., Puddu, P. and Braga, M. (2001). "Factors associated with patient satisfaction with care among dermatological outpatients." British Journal of Dermatology 145(4): 617-23.

BACKGROUND: It has been shown that poor patient satisfaction can lead to poor adherence to treatment with consequently poor health outcomes. In order to improve the quality of care perceived by the patient and thus the health outcome, it is important to understand which are the main factors influencing patient satisfaction. OBJECTIVES: To examine factors associated with patient satisfaction with care among dermatological out-patients. METHODS: This longitudinal study is based on a sample of dermatology out-patients. The independent effects on patient's satisfaction of patient characteristics (sociodemographic characteristics, disease severity, quality of life) and of specific aspects of provided health care (the time the physician spent with patients, physician's interpersonal skills, etc.) were examined by multiple logistic regression. RESULTS: A total of 1389 out-patients were selected at random and invited to participate. Of the 722 patients who agreed to participate, 424 fulfilled the inclusion criteria and 396 of these patients (93.4%) completed the study. Overall satisfaction was reported by 60.0% of patients. The likelihood of overall satisfaction was found to be significantly and independently increased by the physician's ability to give explanations and to show empathy for the patient's condition, and by the older age of patients. The likelihood of satisfaction also increased with increasing disease severity, but decreased with symptom-related poor quality of life. The lowest level of satisfaction was found among patients whose symptom-related quality of life was worse than the clinical severity rated by the dermatologist. CONCLUSIONS: Improving the physician's interpersonal skills can increase patient satisfaction, which is likely to have a positive effect on treatment adherence and health outcomes. Dermatologists succeeded better in establishing a good relationship with clinically more severely affected patients than with patients who were clinically mildly affected despite their quality of life being impaired. Thus, the inclusion of a patient-rated quality of life can be a useful measure in dermatology, as it enables clinicians to perceive the patients' perception of their health status.

Rhodes, R. L., Mitchell, S. L., Miller, S. C., Connor, S. R. and Teno, J. M. (2008). "Bereaved family members' evaluation of hospice care: what factors influence overall satisfaction with services?" Journal of Pain & Symptom Management 35(4): 365-371.

As patients near the end of life, bereaved family members provide an important source of evaluation of the care they receive. A study was conducted to identify which processes of care were associated with greater satisfaction with hospice services from the perception of bereaved family members. A total of 116,974 surveys from 819 hospices in the United States were obtained via the 2005 Family Evaluation of Hospice Care, an online repository of surveys of bereaved family members' perceptions of the quality of hospice care maintained by the National Hospice and Palliative Care Organization. Overall satisfaction was dichotomized as "excellent" vs. "other" (very good, good, fair, and poor). Using multivariate logistic regression, the association between overall satisfaction and the individual item problem scores that compose the Family Evaluation of Hospice Care were examined. Bereaved family members were more likely to rate overall satisfaction with hospice services as "excellent" if they were regularly informed about their loved one's condition (adjusted odds ratio [AOR]=3.76, 95% confidence interval [CI]=3.61-3.91), they felt the hospice team provided the right amount of emotional support to them (AOR=2.21, 95% CI=2.07-2.38), they felt that the hospice team provided them with accurate information about the patient's medical treatment (AOR=2.16, 95% CI=2.06-2.27), and they could identify one nurse as being in charge of their loved one's

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care (AOR=2.02, CI=1.92-2.13). These four key processes of care appear to significantly influence an "excellent" rating of overall satisfaction with hospice care. Copyright Â© 2008 U.S. Cancer Pain Relief Committee.

Richman, J. and Charles, E. (1976). "Patient dissatisfaction and attempted suicide." Community Mental Health Journal 12(3): 301-5.

This paper deals with the presence of suicidal behavior in a mental health clinic and psychiatric emergency room, and its relationships to what has been described in the literature as the "dependent-dissatisfied" personality. Procedures included a suicidal potential scale, projective figure drawings, and a brief interview about past and present suicidal behavior. The scale used significantly differentiated between high and low potentially suicidal groups. The high suicidal group showed a significantly greater dissatisfaction with treatment both past and present. The implications for both evaluation and therapy of suicidal patients are discussed.

Rider, E. A. and Perrin, J. M. (2002). "Performance profiles: The influence of patient satisfaction data on physicians' practice." Pediatrics 109(5): 752-757.

Objective. Health maintenance organizations and other payers increasingly use patient satisfaction data to profile physician performance. Little is known about physicians' use of patient satisfaction information or how profiles affect individual physician behaviors. The objective of this study was to examine primary care physicians' perceptions of performance profiles based on patient satisfaction data, whether physicians use profiles to change practice behaviors, and which profile components physicians think are important for assessing quality of care. Methods. A written survey was conducted in 1998 in Massachusetts with 810 primary care physicians (304 pediatricians, 201 family practitioners, 305 internists) who had at least 100 patients in a large managed care plan and had received 1 or more profiles based on patient satisfaction data. Physicians in training were excluded. Physicians' perceptions of profiles and their reported use to change practice behaviors were measured. Results. The response rate was 68%. Twenty-three percent reported that profiles were very or extremely useful for improving care. Only 7% reported using profiles often or always to change care. Although specific profile components related to interpersonal aspects of care were rated more useful, <11% reported using profiles often or always to make changes on any individual component. A majority, 67% to 89%, reported making no or minor changes on profile components. Responses did not vary by specialty, demographics, or practice characteristics. Physicians rated interpersonal factors (eg, ability to communicate with patients, ability to show caring and empathy) as the most important indicators of quality of care; they report having the most control over these factors. Office factors (eg, staying on schedule, ease of scheduling appointments) were ranked as least important for assessing quality of care. Conclusion. Although health maintenance organizations and other payers increasingly use patient satisfaction reports to profile individual physicians and guide physician compensation and health plan participation, <25% of primary care physicians find profiles useful for improving patient care and even fewer report using profiles to change practice. Profiles likely have limited influence on behavior changes. Payers who invest in profiles may find it advantageous to focus on health plans and practice facilities rather than on individual physicians.

Riveros S, J. and Berne M, C. (2007). "[An enquiry on client opinions about quality of care in a public hospital]." Revista Medica de Chile 135(7): 862-70.

BACKGROUND: The level of satisfaction of patients with the services provided by public hospitals is becoming an important issue for health authorities. AIM: To analyze an enquiry applied to patients, about the level of satisfaction with the service provided by a public regional hospital in Chile. Material and methods: An enquiry was applied to 150 ambulatory (76% women) and 50 hospitalized patients (56% women). It included 28 questions about management aspects of health care and 20 questions about client satisfaction. Data was analyzed using factorial analysis and multiple regressions. RESULTS: The manners of hospital personnel were the factor with the highest impact on the perception of patients about global quality of services. Attention timing was the most influential aspect on global satisfaction. CONCLUSIONS: There results confirm those from abroad and can orient an adequate management of public hospital.

Roblin, D. W., Becker, E. R., Adams, E. K., Howard, D. H. and Roberts, M. H. (2004). "Patient satisfaction with primary care: does type of practitioner matter?" Medical Care 42(6): 579-590.

OBJECTIVE: The objective of this study was to evaluate the association of patient satisfaction with type of practitioner attending visits in the primary care practice of a managed care organization (MCO). STUDY DESIGN: We conducted a retrospective observational study of 41,209 patient satisfaction surveys randomly sampled from visits provided by the pediatrics and adult medicine departments from 1997 to 2000. Logistic regression, with practitioner and practice fixed effects, of patient satisfaction versus dissatisfaction was estimated for each of 3 scales: practitioner interaction, care access, and overall experience. Models were estimated separately by department. Independent variables were type of practitioner attending the visit and other patient and visit characteristics. RESULTS: Adjusted for patient and visit characteristics, patients were significantly more likely to be satisfied with practitioner interaction on visits attended by physician assistant/nurse practitioners (PA/NPs) than visits attended by MDs in both the adult medicine and pediatrics practices. Patient satisfaction with care access or overall experience did not significantly differ by practitioner type. In adult medicine, patients were more satisfied on diabetes visits provided by MDs than by PA/NPs. Otherwise, patient satisfaction for the combined effects of practitioner type and specific presenting condition did not differ. CONCLUSIONS: Averaged over many primary care visits provided by many physicians and midlevel practitioners, patients in this MCO were as satisfied with care provided by PA/NPs as with care provided by MDs.

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Rodriguez, L. and Magari, R. T. (2005). "Establishing tolerance levels for customer complaints." Quality Assurance 11(2): 63-73.

Customer complaints data are usually expressed as counts for a period of time and are governed by a Poisson process. This process is stationary when the number of complaints is constant, while a change in these numbers would indicate a potential change in the product performance. In this paper we describe an approach for establishing the maximum tolerance level for the number of complaints received within a month. Tolerance level is based on a relatively stable period of time when the Poisson process is stationary. A change-point analysis is performed to the complaints data that exhibit large changes to partition the relatively stable period from the problematic period. Examples that illustrate this approach are provided.

Rogers, A., Karlsen, S. and Addington-Hall, J. (2000). "'All the services were excellent. It is when the human element comes in that things go wrong': dissatisfaction with hospital care in the last year of life." Journal of Advanced Nursing 31(4): 768-74.

Patient satisfaction surveys are seen as an important way of obtaining 'user views' of health service provision. However, there is a growing body of research and theoretical literature that questions the validity of the concept of 'patient satisfaction' and hence the use of this type of survey. A postbereavement survey of people who registered a random sample of cancer deaths in an inner London health authority was undertaken in 1996/7. The survey questionnaire (VOICES) included 14 open-ended questions which asked respondents to add any comments they felt were relevant about the care of the deceased. This paper uses these data to examine the causes of dissatisfaction with hospital-based care. Of the 229 informants responding to the questionnaire, 138 included some written comment about care in hospital. At least one negative comment was made by 59% (82) of those making any comment. Of these, 55% (44) rated the care given by doctors as 'excellent' or 'good' and 63% (50) rated that given by nurses as 'excellent' or 'good'. Qualitative analysis of responses to open questions suggest that expressions of dissatisfaction arise from a sense of being 'devalued', 'dehumanized' or 'disempowered' and from situations in which the 'rules' governing the expected health professional-patient relationships were broken. As such, the causes of dissatisfaction for this particular group of patients are similar to the causes of dissatisfaction with health care in general reported elsewhere. The palliative care approach emphasizes patient- and family-centred care and aims to promote physical and psychosocial well-being. The study findings suggest that adoption of the palliative care approach could reduce the experience of dissatisfaction for many service users, not only those whose deaths are anticipated.

Rogers, G. and Smith, D. P. (1999). "Reporting comparative results from hospital patient surveys." International Journal for Quality in Health Care 11(3): 251-9.

Externally-reported assessments of hospital quality are in increasing demand, as consumers, purchasers, providers, and public policy makers express growing interest in public disclosure of performance information. This article presents an analysis of a groundbreaking program in Massachusetts to measure and disseminate comparative quality information about patients' hospital experiences. The article emphasizes the reporting structure that was developed to address the project's dual goals of improving the quality of care delivered statewide while also advancing public accountability. Numerous trade-offs were encountered in developing reports that would satisfy a range of purchaser and provider constituencies. The final result was a reporting framework that emphasized preserving detail to ensure visibility for each participating hospital's strengths as well as its priority improvement areas. By avoiding oversimplification of the results, the measurement project helped to support a broad range of successful improvement activity statewide.

Roland, P., Russell, J., Richards, K. C. and Sullivan, S. C. (2001). "Visitation in critical care: processes and outcomes of a performance improvement initiative." Journal of Nursing Care Quality 15(2): 18-26.

When family members became dissatisfied with a restrictive visiting policy in a combined coronary and medical intensive care unit, this situation was seen as an opportunity to better meet patient and family needs. A review of the literature indicated that open visitation policies enhance patient and family satisfaction, while a survey of patients, families, and health care team members revealed a desire for a more open visitation policy. Nursing staff, with input from other disciplines, developed and implemented a less restrictive visitation policy. Post-intervention surveys revealed higher patient and family satisfaction and a marked decrease in formal complaints.

Rosselli, V. R., Santalucia, C. A., Woodward, A. B. and Luecke, R. W. (1996). "Patient satisfaction under managed care: what every financial manager should know." Journal of Health Care Finance 22(4): 61-6.

As the delivery of health care services transitions increasingly to a managed care environment, individual patients will begin to exert influence on the provider panel selection process. Accordingly, it will become more and more important to meet or exceed patient expectations. This article focuses upon patient satisfaction: what drives it and how it can be measured, tracked, and monitored. It also discusses the role the financial manager can play in becoming a champion of patient satisfaction.

Roy, M. J., Herbers Jr, J. E., Seidman, A. and Kroenke, K. (2003). "Improving patient satisfaction with the transfer of care: A randomized controlled trial." Journal of General Internal Medicine 18(5): 364-369.

OBJECTIVE: To determine whether educational sessions with medical residents, with or without letters to their patients, improve patient satisfaction with transfer of their care from a departing to a new resident in an

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internal medicine clinic. DESIGN: Observational study in Year 1 to establish a historical control, with a randomized intervention in Year 2. SETTING. An internal medicine clinic in a teaching hospital. PATIENTS/PARTICIPANTS: Patients of departing residents completed questionnaires in the waiting room at their first visit with a new resident, with mail-administered questionnaires for patients not presenting to the clinic within 3 months after transfer of their care. In Year 1, 376 patients completed questionnaires without intervention. The following spring, we conducted interactive seminars with 12 senior residents to improve their transfer of care skills (first intervention). Half of their patients were then randomized to receive a letter from the new doctor informing them of the change (second intervention). We assessed the efficacy of the interventions by administering questionnaires to 437 patients in the months following the interventions. MEASUREMENTS AND MAIN RESULTS. Multivariate analysis of Year 1 results identified doctors personally informing patients prior to leaving as the single strongest predictor of patient satisfaction (partial R²=.41). In Year 2, our first intervention increased the percentage of patients informed by their doctors from 71% in 1991 to 79% in 1992 (P < .001). Mean satisfaction dramatically improved, with the fraction of fully satisfied patients increasing from 47% at baseline, to 61% with the first intervention alone, and 72% with both interventions (P < .0001). CONCLUSIONS: Simple methods such as resident education and direct mailings to patients significantly ease the difficult process of transferring patients from one physician to another. This has implications not only for residency programs, but for managed care networks competing to attract and retain patients.

Rudzik, A. E. F. (2003). "Examining health equity through satisfaction and confidence of patients in primary healthcare in the republic of Trinidad and Tobago." Journal of Health Population and Nutrition 21(3): 243-250.

Surveys of patient satisfaction are widely used for identifying priorities and problems in healthcare reforms. The present study examined satisfaction and confidence of patients in public healthcare in Trinidad and Tobago. Data were gathered by interviewing a random sample (n=280) of primary healthcare (PHC) patients. Level of patient satisfaction was high but not constant. Results of interviews showed that patients with a higher monthly income (p=0.032) and patients who most recently used private medical care (p=0.037) had lower levels of satisfaction with health services. Employment had an effect on satisfaction (p=0.065), significant among patients who had recently accessed private medical care (p=0.039). Patients using PHC clinics preferred private care to public care. Confidence in public care decreased with increasing complexity of the medical condition. These preliminary results support continued efforts in health-sector reforms and call for the enhancement of data on satisfaction through more comprehensive qualitative data-collection methods.

Ruelas-Barajas, E., Tena-Tamayo, C., Sanchez-Gonzalez, J., Sarabia-Gonzalez, O., Hernandez-Gamboa, L. E. and Campos-Castolo, E. M. (2008). "[Adverse events identified in medical complaints.]." Cirugia y Cirujanos 76(2): 153-60.

Background: "To err is human" (Institute of Medicine, 1999) begun the Patients' Safety movement worldwide. We undertook this study to determine the frequency of patient complaints related to adverse events in the National Health Services. Methods: The National Commission of Medical Arbitration and the Vice-Ministry for Innovation and Quality has the aim of determining the frequency of real adverse events as a reason for complaints by patients and relatives against healthcare professionals and health services. Results: The Emergency Department registered the highest number of events. Negligence and absence of protocols account for more than half of the adverse events. Conclusions: Management protocols in emergency departments are areas of opportunity for improvement that must be considered.

Ruggeri, M. and Dall'Agnola, R. (1993). "The development and use of the Verona Expectations for Care Scale (VECS) and the Verona Service Satisfaction Scale (VSSS) for measuring expectations and satisfaction with community-based psychiatric services in patients, relatives and professionals." Psychological Medicine 23(2): 511-23.

In this paper the global design of a research project aiming at measuring expectations and satisfaction of patients, relatives, and professionals with community-based psychiatric services (CPS) in a multidimensional, sensitive, valid and reliable way is described. Some psychometric properties of two newly developed instruments, partly adapted from the Service Satisfaction Scale (SSS), the Verona Expectations for Care Scale (VECS) and the Verona Service Satisfaction Scale (VSSS), are discussed. Three groups were selected for inclusion in the study: all patients living with their families who had more than 18 contacts in the last three years, according to the South-Verona Psychiatric Case Register; the relative who had been mainly caring for the patient; and all professionals working in the South-Verona CPS for at least one year. Data on 75 patients and 76 relatives are presented and show that VECS and VSSS have good content validity and test-retest reliability in both groups. Notwithstanding some differences, patients and relatives expressed similar expectations and were mostly satisfied. The current study is the first to provide a parallel measurement of expectations and satisfaction in all three above-mentioned groups; moreover, it is the first to investigate consumers' satisfaction with a CPS organized according to the principles of the Italian Psychiatric Reform.

Ruggeri, M., Dall'Agnola, R., Agostini, C. and Bisoffi, G. (1994). "Acceptability, sensitivity and content validity of the VECS and VSSS in measuring expectations and satisfaction in psychiatric patients and their relatives." Social Psychiatry & Psychiatric Epidemiology 29(6): 265-76.

The Verona Expectations for Care Scale (VECS) and the Verona Service Satisfaction Scale (VSSS) are two newly developed, multidimensional instruments that measure expectations and satisfaction with community-based psychiatric services (CPS) in patients, relatives and professionals. This paper reports on the

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acceptability, sensitivity and content validity of the VECS and VSSS in 75 patients and 76 relatives attending the South-Verona CPS. The acceptability of the VECS and the VSSS to subjects was good: most items were easily understood and the vast majority of subjects cooperated and gave accurate evaluations. The VECS and VSSS proved to be sensitive to variation both between groups and across dimensions. We demonstrated that the VECS and VSSS questionnaires had a higher sensitivity than unstructured interviews in measuring service expectations and satisfaction and that a domain-specific measurement had a higher sensitivity than an overall one. The content validity of the questionnaires, according to patients' and relatives' views, was very good. We demonstrated that a key characteristic of the content validity was the questionnaire's multidimensionality, with major contributions from the dimensions "Professionals' Skills and Behaviour" and "Types of Intervention". The findings presented in this paper constitute the first complete study available in the literature on the psychometric properties of the measurement of expectations and satisfaction in a psychiatric setting. They indicated that it is possible to measure such subjective aspects in an acceptable, sensitive and valid way and that the VECS and VSSS have good psychometric properties. The data presented appear promising in the qualitative evaluation of the South-Verona CPS and the method should be of interest to those evaluating CPS in other settings.

Saaiq, M. and Zaman, K. U. (2006). "Pattern of satisfaction among neurosurgical inpatients." Journal of the College of Physicians and Surgeons Pakistan 16(7): 455-459.

Objective: To measure satisfaction among patients receiving indoor neurosurgical care and analyse the profile of the dissatisfied patients. Design: Cross-sectional study. Place and Duration: This study was undertaken at the Department of Neurosurgery Pakistan Institute of Medical Sciences (PIMS), Islamabad from March to April 2005. Patients and Methods: A total of 133 patients were included in the study by convenience sampling technique. All the patients, who received indoor care for a minimum of 24 hours and were discharged home, were included in the study. Patients who remained hospitalized for more than 4 weeks and those not consenting to participate were excluded. A questionnaire was used for the study that covered five fundamental areas of hospital care i.e. availability and behaviour of the staff, communication of information, residential and management issues. A five-point response scale was used to rate responses to the questions in each of these areas. The demographic profile of the patients and respondents, mode of admission, diagnosis, operation and duration of hospitalization were also recorded. The average of the responses to the questions in each of the five areas was taken as the fundamental area score (FAS) and the average of all these individual area scores was taken as the patient satisfaction score (PSS). Overall satisfaction index (OSI) was measured by calculating the average of PSS, willingness to return score and willingness to recommend score. Results: Response rate was 100%. Generally, patients were satisfied with care and rated various areas favourably. Behaviour of the staff was the highest rated area (95% score) while management was the lowest rated area (86.97% score). Dissatisfaction was more frequent among the young, the educated, the male and the relatives. The PSS was 91.32%. Willingness to return score was 97.89% while willingness to recommend score was 95.48%. The OSI was 94.89%. Conclusion: Analysis of patients' dissatisfaction over specific aspects of health care serves to identify areas that could be improved by simple interventions, hence, patient satisfaction surveys should be conducted on regular basis in order to utilize patients' critical feedback for achieving service excellence and improved quality of care.

Sadjadian, A., Kaviani, A., Yunesian, M. and Montazeri, A. (2004). "Patient satisfaction: a descriptive study of a breast care clinic in Iran." European Journal of Cancer Care 13(2): 163-168.

A descriptive study was carried out to examine patient satisfaction among women attending the Iranian Centre for Breast Cancer. A specially designed patient satisfaction questionnaire was distributed to all attendees and they were asked to complete the questionnaire. The questionnaire contained items on satisfaction with care organization, physical environment, personnel communication skills, clinical care, and overall satisfaction. In all, 425 women participated in the study. The mean age of women was 40.4 years (SD = 11.6), most were married (81%) and housewives (69%). A vast majority of women were very satisfied or satisfied with physical environment, personnel communication skills, and clinical care received. Eighty-two per cent of respondents were very satisfied or satisfied with the clinic's overall performance. There was a significant agreement between patients' overall satisfaction and satisfaction with physical environment, personnel communication skills, and clinical care. There was greatest agreement between patients' overall satisfaction and satisfaction with examination room (Kappa = 0.21, P < 0.0001) and with physicians' consultation (Kappa = 0.20, P < 0.0001). None of the demographic variables showed any significant association with patients' overall satisfaction. The findings suggest that the physical environment and physicians' style of consultation contribute most to the patients' overall satisfaction.

Saila, T., Mattila, E., Kaila, M., Aalto, P. and Kaunonen, M. (2008). "Measuring patient assessments of the quality of outpatient care: a systematic review." Journal of Evaluation in Clinical Practice 14(1): 148-54.

RATIONALE, AIMS AND OBJECTIVES: The aim of the study was to answer three questions: first, what methods have been used to measure patient assessments of the quality of care? Second, how do outpatients rate their care? And third, what needs to be taken into account in measuring patient assessments of the quality of care? METHODS: Systematic review of the literature. Electronic searches were conducted on Medline, CINAHL and the Cochrane Database of Systematic Reviews. To be included, articles were to deal with patients' assessments of health care in ambulatory units for somatic adult patients. They were to have been published between January 2000 and May 2005, written in English, Swedish or Finnish with an English abstract, and the research was to have been conducted in Europe. The search terms used were: ambulatory care, ambulatory care facilities, outpatient, outpatients, patient satisfaction and quality of health care. The articles were screened by two independent reviewers in three phases. RESULTS: Thirty-five articles were included. The quality of care was measured using both quantitative and qualitative methods. Only a few studies relied on the single criterion of patient satisfaction for quality

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measurements. It is easy to identify common sources of dissatisfaction in different studies. Sources of satisfaction are more closely dependent on the target population, the context and research design. CONCLUSION: Patient satisfaction is widely used as one indicator among others in assessing the quality of outpatient care. However, there is no single, universally accepted method for measuring this. [References: 58]

Sajid, M. S. and Baig, M. K. (2007). "Quality of health care: an absolute necessity for public satisfaction." International Journal of Health Care Quality Assurance 20(6): 545-8.

PURPOSE: The purpose of this paper is to discuss the value of consumers (patients) to assess the success or failure of a healthcare system. DESIGN/METHODOLOGY/APPROACH: An evaluation of current healthcare in the NHS from a patient perspective culminating in suggestions and methods to achieve a patient responsive system. FINDINGS: The provision of best quality health services to patients is a difficult task especially when NHS budgets are being cut and jobs are being lost. NHS executives and managers claim that these redundancies will improve the quality of healthcare for the patient. However, running the NHS like a corporate organization is questionable as the way forward. There is no question of making profit (as is the norm in any corporate organization) and saving money at the expense of patient care. ORIGINALITY/VALUE: In order to find out the real performance of a healthcare system like the NHS, the satisfaction of the public should be the sole criteria for judgement.

Samuelsson, G. and Wister, A. (2000). "Client expectations and satisfaction of quality in home care services. A consumer perspective." Home Care Provider 5(6): 223-30.

This study examines clients' expectations of quality in home care services and their perceived satisfaction with services among a random sample of 76 home care recipients in Vancouver, Canada. The researchers conducted face-to-face interviews that applied Multiattribute Utility Technology, a procedure that organizes several quality attributes of "ideal" home care into a tree structure to compare their relative importance and ranking from the clients' perspective. Participants also were asked to state their satisfaction or dissatisfaction with the services received in these domains. Among the five main quality attributes identified, the subjects ranked suitability of the home helper and its subset, personal competence, as the most important indicators of quality, followed by continuity in service. In addition, clients tended to have a high level of satisfaction with regard to the attributes of overall home care services. The highest level of satisfaction was reported for elements of personal dispositions of home care staff. The lowest level of satisfaction involved the time/availability components of the service. Finally, comparisons between client expectations and satisfaction of received home care services showed the highest discrepancy for the attributes of influence and time/availability and the greatest congruence for personal attributes of the staff. The results are discussed in terms of their implications for the delivery of home care services.

Sandoval, G. A., Brown, A. D., Sullivan, T. and Green, E. (2006). "Factors that influence cancer patients' overall perceptions of the quality of care." International Journal for Quality in Health Care 18(4): 266-74.

OBJECTIVE: This study outlines predictors of cancer patients' overall perceptions of the quality of care. DESIGN AND SETTING: Our sample included 2790 patients who received cancer care services during 2004 in 15 comprehensive cancer programmes across Ontario, Canada. Patients were classified into three groups: those receiving both chemotherapy and radiotherapy (n = 752), those receiving only chemotherapy (n = 1044), and those receiving only radiotherapy (n = 994). An ordinal logistic regression model for each patient group was performed to determine which variables most affected the probabilities of the patients' overall evaluations of the quality of care. Potential control variables were patients' age, sex, type of cancer, self-assessed health, and who completed the survey. RESULTS: Among seven common predictors of the overall quality perception across the three models, four should be of particular interest because patients perceived them as relatively problematic aspects of care. These are 'was informed about follow-up care after completing treatment', 'knew next step in care', 'knew who to go to with questions', and 'providers were aware of test results'. These predictors explained between 25 and 34% of the variance (depending on the model) of the overall perception of quality. The explanatory power of these predictors did not change across sex and age group. 'Self-assessed health' was the only control variable that remained in all three models. CONCLUSIONS: From a practical perspective, improvement efforts are best focused on factors that are strong predictors as well as on those for which there is a low score. Thus, on the basis of this study, practitioners' improvement efforts might be constructively focused on the four predictors mentioned above.

Sandoval, G. A., Levinton, C., Blackstien-Hirsch, P. and Brown, A. D. (2006). "Selecting predictors of cancer patients' overall perceptions of the quality of care received." Annals of Oncology 17(1): 151-6.

BACKGROUND: The goal of this study was to identify aspects of care (predictors) that can most easily be modified to produce an improvement in the score of patients' overall evaluations of the quality of care received. PATIENTS AND METHODS: Our sample consisted of 2247 cancer patients hospitalized in Ontario acute care hospitals in 1999/2000. We sought predictors of patients' overall perceptions of the quality of care by applying a methodology that minimizes the improvement of the predictors while gaining a desired increase in the score of the dependent variable. This approach tends to ignore items that rate relatively high and focuses on those for which hospitals can more easily modify the score. Two main subgroups were analyzed in this study: patients with malignant and benign neoplasms. RESULTS: 'Skills of nursing staff', 'courtesy of nursing staff', 'courtesy of people who drew blood' and 'cleanliness of hospital in general' were consistently selected by our approach in both cancer groups. CONCLUSIONS: This study identifies an efficient approach to improving the score of patients' overall perceptions of the quality of care received. By focusing on these aspects of care, hospitals may be able to improve the allocation of scarce resources when planning patient satisfaction improvement initiatives.

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Saravanan, B., Ranganathan, E. and Jenkinson, L. R. (2007). "Lessons learned from complaints by surgical patients." Clinical Governance: An International Journal 12(3): 155-158.

Purpose--The purpose of this paper is to analyse the complaints received from surgical patients and provide suggestions to reduce them.

Design/methodology/approach--The authors conducted a retrospective study of 100 complaints received from surgical patients over a two-year period between January 2004 and December 2005. Data was obtained through the complaints department and summaries of all the complaints were analysed.

Findings--There were 47 males and the median age was 58 years (range 13-92). Of complaints, 44 per cent were received from outpatients and 56 per cent from inpatients. The main reasons for complaints from outpatients were appointment delays or cancellations (54.6 per cent), followed by clinical treatment (20.5 per cent), communication issues (13.6 per cent), attitude of staff (9.1 per cent) and miscellaneous (2.25 per cent). For inpatients, the main reasons were clinical treatment (39.3 per cent) followed by delay in admission/investigations (25 per cent), communication (17.9 per cent), attitude of staff (10.7 per cent) and miscellaneous (7.1 per cent). The outpatients complain mostly about administrative problems whereas inpatients complain about clinical care. Communication problems and staff attitude are the next most common in either setting. Providing patients with clear patient information about admission, treatment and waiting times would help to reduce complaints.

Originality/value--The paper shows that adopting an empathetic approach to patients and understanding their concerns and anxieties would improve patient satisfaction.

Sarel, D. and Marmorstein, H. (1999). "The role of service recovery in HMO satisfaction." Marketing Health Services 19(1): 6-12.

Complaint handling and service recovery by HMOs may be more efficient to implement and more determinant of customer satisfaction and retention than other approaches such as improving access to care. The current findings are consistent with research on recovery efforts in other industries. Complaint handling systems must achieve rapid and comprehensive identification and resolution of HMO member problems. Both cultural change and appropriate incentives to re-educate employees within HMO organizations are additional requisites to effective service recovery. The benefits to the HMO of expenditures on service recovery should be more immediate and sustainable than the benefits derived from other methods of increasing member satisfaction.

Sartain, S. A., Maxwell, M. J., Todd, P. J., Haycox, A. R. and Bundred, P. E. (2001). "Users' views on hospital and home care for acute illness in childhood." Health & Social Care in the Community 9(2): 108-17.

This mainly qualitative study compared 40 families' experience of hospital and home care. This is one aspect of a randomised, controlled trial, which aimed to evaluate the clinical and cost effectiveness of a paediatric hospital at home service (HAH) for acute illness in children. This paper builds upon previous work that has aimed to examine parents' and children's views as service users. Forty families from a larger sample population took part in structured interviews. Eleven children aged 5 to 12 years took part in semistructured interviews. A drawing technique was the chosen method of augmentation in the children's interviews. Research findings showed that HAH is an acceptable alternative to hospital care where there are essentially nursing needs. Thirty-six (90%) parents and seven children stated a clear preference for HAH. The parents' preference was based on a perception that their child's illness wasn't serious or life threatening and therefore could be managed at home with appropriate support from health professionals. The social and financial costs of hospital care compared with HAH were the other main drivers, rather than a comparison of the quality of nursing care of their child.

Scardina, S. A. (1994). "SERVQUAL: a tool for evaluating patient satisfaction with nursing care." Journal of Nursing Care Quality 8(2): 38-46.

Rising health care costs and competition among hospital facilities have resulted in the need to recognize patient satisfaction as an important indicator of quality care. Nurses provide the primary service to patients; therefore, their role is influential in overall satisfaction. Several instruments have been developed to measure patient satisfaction with nursing care; however, most of them focus only on patient perceptions. One such approach to evaluating patient satisfaction with nursing care involves an instrument, SERVQUAL, derived from a marketing service perspective. Adapting SERVQUAL for use in evaluating nursing care is the focus of this article. SERVQUAL assesses both patient perceptions and expectations of quality service and permits managers and clinicians to view the gaps between the two; thus, the overall areas of improvement in nursing services can be determined.

Schattner, A., Rudin, D. and Jellin, N. (2004). "Good physicians from the perspective of their patients." BMC Health Services Research 4(1): 26.

BACKGROUND: It is not currently known what is the patient's viewpoint of a "good" physician. We set out to define patient's priorities regarding different physician's attributes in 3 domains important in medical care. METHODS: Patients hospitalized or attending clinics at a large teaching hospital selected the 4 attributes that they considered most important out of 21 listed arbitrarily in a questionnaire. The questionnaire included 7 items each in the domains of patient autonomy, professional expertise and humanism. RESULTS: Participating patients (n = 445, mean age 57.5 +/- 16 years) selected professional expertise (50%), physician's patience and attentiveness (38% and 30%, respectively), and informing the patient, representing the patient's interests, being truthful and respecting patient's preferences (25-36% each) as the most essential attributes. Patient's selections were not significantly influenced by different demographic or clinical

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background. Selections of attributes in the domain of patient's autonomy were significantly more frequent and this was the preferred domain for 31% and as important as another domain for 16%--significantly more than the domain of professional expertise (P = 0.008), and much more than the domain of humanism and support (P < 0.0005). CONCLUSIONS: Patients studied want their physicians to be highly professional and expert clinicians and show humaneness and support, but their first priority is for the physician to respect their autonomy.

Schauffler, H. H. and Mordavsky, J. K. (2001). "Consumer reports in health care: do they make a difference?" Annual Review of Public Health 22: 69-89.

The public release of health care-quality data into more formalized consumer health report cards is intended to educate consumers, improve quality of care, and increase competition in the marketplace The purpose of this review is to evaluate the evidence on the impact of consumer report cards on the behavior of consumers, providers, and purchasers. Studies were selected by conducting database searches in Medline and Healthstar to identify papers published since 1995 in peer-review journals pertaining to consumer report cards on health care. The evidence indicates that consumer report cards do not make a difference in decision making, improvement of quality, or competition. The research to date suggests that perhaps we need to rethink the entire endeavor of consumer report cards. Consumers desire information that is provider specific and may be more likely to use information on rates of errors and adverse outcomes. Purchasers may be in a better position to understand and use information about health plan quality to select high-quality plans to offer consumers and to design premium contributions to steer consumers, through price, to the highest-quality plans. [References: 45]

Schlesinger, M., Mitchell, S. and Elbel, B. "Voices unheard: barriers to expressing dissatisfaction to health plans." Milbank Quarterly 80(4): 709-55.

Consumers dissatisfied with their health plan can either "exit" (switch service providers) or "voice" (complain to the current provider). Policymakers' efforts to help consumers voice their dissatisfaction to health plans or external mediators have been disappointing, in part because little is known about the determinants of voice. This article represents the first comprehensive assessment of voicing in response to problematic experiences with health plans. A national consumer survey from 1999 is used to test hypotheses about characteristics of problems, patients, and settings that might inhibit voice and assess state regulations intended to enhance voice. Although problems associated with plans led to more voice than exit, voice is circumscribed by several factors: certain groups, such as racial minorities, do not express their grievances as often; episodes with severe health consequences for patients are not reported as regularly. The findings suggest that even though regulatory initiatives have not increased the frequency of voice, they have made grievances more effective, at least in jurisdictions where citizens know about the laws.

Schmidt, L. A. (2003). "Patients' perceptions of nursing care in the hospital setting." Journal of Advanced Nursing 44(4): 393-9.

BACKGROUND: Patient satisfaction and patient satisfaction with nursing care data are routinely collected as an indicator of the quality of services delivered. Despite the widespread collection and reporting of these data, the theoretical basis of patient satisfaction and patient satisfaction with nursing care remains unclear. Without a clear theoretical base, interpretation of patient satisfaction findings is hampered and the entire line of patient satisfaction research is of questionable validity. It has been suggested that, to understand patient satisfaction, patient perceptions of their care must first be understood. AIM: The aim of this study was to discover patients' perceptions of the nursing care they receive in the hospital setting. METHOD: Grounded theory method was used in this study of eight medical-surgical patients recently discharged from an academic medical centre in the south-eastern United States of America (USA). Participants were interviewed and the verbatim transcripts analysed using the constant comparative method. FINDINGS: Four categories of patient perceptions of their nursing care emerged from the data. 'Seeing the individual patient' captures the unique nature of the nursing care experience for each patient. 'Explaining' represents the informal explanations given by nursing staff as they provide care. 'Responding' refers to both the character and timeliness of nursing staff's responses to patient requests or symptoms. 'Watching over' represents the surveillance activities of nursing staff. CONCLUSIONS: The categories identified in this study may be used in efforts to further develop a formal theory of patient satisfaction with nursing care. These categories should also be tested with patients possessing a wider range of characteristics, to assess the transferability of the findings.

Schommer, J. C. and Kucukarslan, S. N. (1997). "Measuring patient satisfaction with pharmaceutical services." American Journal of Health-System Pharmacy 54(23): 2721-32; quiz 2741-3.

Common conceptualizations of satisfaction are discussed, and different ways of measuring patient satisfaction with pharmaceutical services are suggested. Patient satisfaction is becoming increasingly popular as an indicator of the quality of health care services, including pharmaceutical services. Satisfaction can be conceptualized as a performance evaluation, disconfirmation of expectations, an affect-based assessment, or an equity-based assessment. A satisfaction measure should have a theoretical base on which the measure's validity can be assessed. The measure chosen must fit the context of an overall research process, and the researcher must have a clear idea of what is to be measured. A large pool of items, or questions, for potential inclusion in a patient-satisfaction questionnaire can then be generated. The researcher should develop a format for each item (e.g., Likert scale). The items should be reviewed by experts for relevance and completeness. Questions that will help validate other questions should be included. To assess reliability and validity, the questionnaire should be given to a representative sample of respondents before being refined into its final format. Finally, the researcher must ensure that the patient-

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satisfaction questionnaire is practical (e.g., in terms of length and complexity). No single standard measure of patient satisfaction is applicable to all pharmacy situations. Researchers should either use an existing measure with demonstrated reliability and validity or develop a new measure by using a systematic process. [References: 65]

SchrÃ¶der, A., AhlstrÃ¶m, G. and Larsson, B. W. (2006). "Patients' perceptions of the concept of the quality of care in the psychiatric setting: a phenomenographic study." Journal of Clinical Nursing 15(1): 93-102.

AIM: The aim was to describe how patients perceived the concept of quality of care in psychiatric care. BACKGROUND: It is important to include patients' experiences in defining quality of care and in the development of instruments measuring quality of psychiatric care, as patients have unique information. But only a limited number of studies have directly involved patients. DESIGN: It was a qualitative interview study with 20 adult in and outpatients from psychiatric care. METHOD: A phenomenographic approach was used for the analysis of the interviews. RESULTS: The results showed that quality of care was perceived as a positive concept, namely as 'good' quality of care. The normative component was striking. Five descriptive categories emerged: The patient's dignity is respected; The patient's sense of security with regard to care; The patient's participation in the care; The patient's recovery; and The patient's care environment. Two conceptions emerged that had not emerged explicitly in earlier studies of quality of care: Being helped to reduce the shame and Being looked upon as like anyone else. CONCLUSIONS: The findings emphasize the importance of the interpersonal relationship between patients and staff. There is a need for further exploration of central aspects of quality in psychiatric care. RELEVANCE TO CLINICAL PRACTICE: It is important that the knowledge about how patients perceived the quality of care in psychiatric care is included in the planning and evaluation of care. The guidelines should designate quality of care from the patient perspective as the goal of interventions.

Schraeder, C., Shelton, P., Britt, T., Parker, R. and Leonard, J. (1997). "Population-based research data as a means to address health outcomes." Journal of Ambulatory Care Management 20(4): 39-46.

Health care restructuring efforts have been influenced by changes in public policy, payment mechanisms, and societal values. In today's environment, leading issues focus on quality and cost-effective care. Health care systems are moving from a concentration on structures and processes of care to an expanded view that encompasses the exploration, documentation, and improvement of patient outcomes. This article presents an overview of the domains of health outcomes, widely used surveys in the measurement of outcomes, methodological issues related to interpreting outcome measures, and trends for clinical practice and future research.

Schroder, A., Larsson, B. W. and Ahlstrom, G. (2007). "Quality in psychiatric care: an instrument evaluating patients' expectations and experiences." International Journal of Health Care Quality Assurance 20(2-3): 141-60.

PURPOSE: The principal aim of this paper is to develop an instrument to measure quality of care in the psychiatric setting from an in-patient perspective and to describe quality of care by means of this instrument. A further aim is to investigate the influence of background variables and expectations on the experience of care. DESIGN/METHODOLOGY/APPROACH: The instrument "Quality in psychiatric care" consists of two parts: one for measuring the patient's expectations regarding quality of care, the other for measuring his or her experiences regarding it. The instrument was derived from an earlier interview study of patients' perceptions of the quality of psychiatric care. A sample of 116 patients from eight in-patient wards in Sweden participated in the present study. FINDINGS: Results indicate a generally high quality of care. Experienced quality of care was significantly lower, however, than expectations in all the dimensions of the instrument: total dimension, dignity, security, participation, recovery and environment. Patients who perceived that the time of discharge was consistent with the stage of their illness experienced significantly higher Recovery; patients with good psychiatric health experienced this too, but also significantly higher participation. RESEARCH LIMITATIONS/IMPLICATIONS: This new instrument needs to be further tested before the psychometric properties can be established. ORIGINALITY/VALUE: The value of the research is that instruments for measuring the quality of in-patient psychiatric care from the patient's perspective and with a theoretical foundation are less common.

Schwartz, L. R. and Overton, D. T. (1992). "The management of patient complaints and dissatisfaction." Emergency Medicine Clinics of North America 10(3): 557-72.

Patient satisfaction is an integral component of the measurement of health care quality. Proper attention to patient complaints is one part of a patient satisfaction management strategy aimed at revealing and alleviating the causes of patient dissatisfaction. [References: 51]

Schwarz, M., Landis, S. E., Rowe, J. E., Janes, C. L. and Pullman, N. (2000). "Using focus groups to assess primary care patients' satisfaction." Evaluation & the Health Professions 23(1): 58-71.

The present report describes the use of patient focus groups by a primary health care facility. We review our rationale for using focus groups and the process we used to prepare for and conduct them. We then highlight the results and lessons learned through this experience. Focus groups can be an excellent method for primary care practices to assess the complexities of patient satisfaction issues and engage patients in the continuous quality improvement process. Focus groups can uncover unanticipated issues that surveys fail to identify. Our experience demonstrated that this benefit can be critical in identifying and prioritizing quality of care improvements and that focus group results can be used to make immediate improvements in the quality of care, even though this type of study is not intended to generalize.

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Seclen-PalacÃ-n, J. A., Benavides, B., Jacoby, E., VelÃ¡squez, A. and Watanabe, E. (2004). "Is there a link between continuous quality improvement programs and health service users' satisfaction with prenatal care? An experience in Peruvian hospitals [Spanish]." Revista Panamericana de Salud PÃºblica 16(3): 149-157.

OBJECTIVES: 1. To compare the level of health service user satisfaction (US) with antenatal care in hospitals where a program of continuous quality improvement (CQI) was implemented, in comparison to a reference group of patients seen at hospitals that did not participate in the program. 2. To compare the reasons for dissatisfaction in both groups of users. 3. To identify the factors associated with US. METHODS: A quasi-experimental study of a representative sample of pregnant women attending prenatal care services. The women in the intervention group (n = 191) and the reference group (n = 185) were interviewed on leaving the prenatal care clinic. The dependent variable was satisfaction with prenatal care, and the independent variables were satisfaction of expectations, amiability, level of health information, perception of the equipment, waiting time, cleanliness and comfort. Descriptive and multivariate statistics were calculated. RESULTS: The intervention group showed higher rates of US (67.5% versus 55.1% in the reference group, P = 0.014). The main reasons for dissatisfaction were long waiting times and discourteous treatment, which were more frequent in the reference group. The multivariate analysis identified cordiality of the health professionals, information provided during the visit, satisfaction of expectations and implementation of the CQI program as the factors that were significantly associated with US. CONCLUSIONS: Our findings show that the CQI program in maternal and perinatal health services was positively associated with US. These results reinforce the need for cordiality during prenatal care contacts with providers, and the need to provide appropriate information to the user, in order to help increase acceptability of and adhesion to health care recommendations among pregnant women.

Segest, E. (1988). "Patients' dissatisfaction with medical treatment and their reaction." Medicine & Law 7(3): 205-10.

Segest, E. (1996). "Patients' complaint procedures, in a Scandinavian perspective." European Journal of Health Law 3(3): 231-54.

Seibert, J. (1996). "Patient surveys and quality improvement." Radiology Management 18(5): 45-7.

Patient satisfaction may be the ultimate measure of quality but it is only part of the quality measurement and improvement equation. Customers may be good at telling you what needs fixing but they cannot be expected to tell you how to fix the problem. It is important to let patient satisfaction measures guide the focus of your process improvement efforts, but these efforts must include the appropriate process measurement tools. A customer-focused survey will be valid only if it emphasizes key quality characteristics (KQCs), as defined by patients. You'll need to develop a sampling plan that will produce useable data. The design of the questionnaire and the reliability of the survey tool are critical to using patient surveys for quality improvement (QI). Surveys that don't meet standard criteria have a greater potential for error. Another challenge is the report format and analysis that are used to understand the patient responses. Having an external benchmark is critical to accurate measurement in patient surveys. Comparative data can also help prioritize QI projects. In summary, a well designed patient survey system can identify key quality characteristics, determine which KQCs have the most impact, help prioritize QI efforts, and measure patients' satisfaction in a reliable manner.

Seibert, J. H., Brien, J. S., Maaske, B. L., Kochurka, K., Feldt, K., Fader, L. and Race, K. E. H. (1999). "Assessing patient satisfaction across the continuum of ambulatory care: a revalidation and validation of care-specific surveys." Journal of Ambulatory Care Management 22(2): 9-26.

The need to develop reliable and valid measures of patient satisfaction in ambulatory care settings is underscored by the rapid growth and changes in this health care arena as well as the requirement to monitor and gauge quality of care. The purpose of this article is to provide evidence for the reliability and validity of patient satisfaction questionnaires designed specifically for three points of care across the ambulatory care continuum. These points are outpatient testing and physical therapy services, outpatient surgery, and home health care. The present effort represents an evaluation of revised questionnaires for the first two points and an initial assessment of the psychometric properties of the questionnaire for the third. The present results support the internal reliability and construct validity of each questionnaire. In addition, differences were found on select facility characteristics based on each questionnaire. Copyright (c) 1999 by Aspen Publishers, Inc.

Seibert, J. H., Strohmeyer, J. M. and Carey, R. G. (1996). "Evaluating the physician office visit: In pursuit of a valid and reliable measure of quality improvement efforts." Journal of Ambulatory Care Management 19(1): 17-37.

In an effort to develop a patient questionnaire with sufficient validity and reliability to be used to measure patient perceptions of quality, over 30,000 patients from 178 solo and group practices completed the Physician Office Quality of Care Monitor (QCM). The study found strong evidence of construct validity, predictive validity, and internal consistency for the questionnaire. Physician interactions were the most important aspect of office care while coordination of care over time was found to be the best issue to differentiate patients likely to recommend a practice from those less likely to recommend. An inverse relationship was found between practice size and patient satisfaction. Health maintenance organization (HMO) patients reported lower satisfaction, as did younger patients.

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Seymour, J., Ingleton, C., Payne, S. and Beddow, V. (2003). "Specialist palliative care: patients' experiences." Journal of Advanced Nursing 44(1): 24-33.

BACKGROUND: Nursing research generally, and palliative care research in particular, has been criticized for generating numerous small scale, often qualitative and/or evaluative studies, from which it is difficult to draw generalizations. AIMS: Our aim in this study was to conduct a synthesis of three evaluative studies of palliative care services in the United Kingdom (UK), to ascertain patients' reported expectations and experiences of specialist care. We also demonstrate how secondary data analysis and synthesis can identify commonalities and differences between services. METHODS: Secondary qualitative data analysis was conducted on interview data gathered from 37 patients during three evaluation studies of specialist palliative care services. All studies used formative evaluation methodology. FINDINGS: Four themes were identified: (1) knowledge and information about services, (2) meeting practical and psychosocial needs, (3) lack of control, and (4) family atmosphere. Data are presented to illustrate the presence or absence of these themes in patients' accounts of their expectations and experiences of each service. STUDY LIMITATIONS: Data were collected at different times between 1998 and 2000, and interviews were conducted by different researchers. CONCLUSIONS: Synthesizing findings from small scale qualitative studies offers the possibility of demonstrating their applicability beyond local and specific contexts. It is imperative to listen to the experiences of patients and carers as a basis for developing interventions and guidelines for services. The methods proposed in this paper offer the potential for these voices of experience to be heard more widely. [References: 30]

Shaikh, B. T. and Rabbani, F. (2005). "Health management information system: a tool to gauge patient satisfaction and quality of care." Eastern Mediterranean Health Journal 11(1-2): 192-8.

The health management information system (HMIS) is an instrument which could be used to improve patient satisfaction with health services by tracking certain dimensions of service quality. Quality can be checked by comparing perceptions of services delivered with the expected standards. The objective of the HMIS would be to record information on health events and check the quality of services at different levels of health care. The importance of patient assessment is a part of the concept of giving importance to patient's views in improving the quality of health services. Expected benefits include enhancing patient satisfaction through improved communication; greater provider sensitivity towards patients; enhanced community awareness about the quality of services; and overall better use of services in the health system. [References: 34]

Shannon, S. E., Mitchell, P. H. and Cain, K. C. (2002). "Patients, nurses, and physicians have differing views of quality of critical care." Journal of Nursing Scholarship 34(2): 173-179.

PURPOSE: To compare patient, nurse, and physician assessments of quality of care and patient satisfaction in selected critical care units. DESIGN: As part of a study of patient outcomes from critical care, data were collected between December 1991 and March 1993 from 489 patients, 518 nurses, and 515 physicians in 25 critical care units located in 14 hospitals in the U.S. Pacific Northwest. METHODS: Views of patient satisfaction and quality of care were measured using standardized instruments. All data were aggregated to the unit level (N = 25) and were normalized to a common scale for analysis. FINDINGS: Physicians rated quality of care higher than did either patients or nurses within the same critical care unit, and nurses had the lowest perceptions of quality. Nurses and patients had similar views of patient satisfaction, but physicians tended to overestimate patients' satisfaction. However, physicians', nurses', and patients' scores varied considerably within and between units. Physicians' and nurses' views of quality and patient satisfaction were strongly related to processes such as MD-RN collaboration and outcomes such as nurses' job satisfaction. CONCLUSIONS: Patients, nurses, and physicians viewed quality of care and patient satisfaction differently. Nurses' and physicians' perspectives were more related to their views of the work environment than to organizational factors, patient characteristics, or commonly used outcome measures.

Sharp, T. (1999). "Handling complaints in a constructive way." Nursing Times 95(18): 50-1.

This article offers advice on dealing with specific complaints and looks at the nurse's role and responsibilities in handling and resolving them.

Sheahan, M. (1999). "Customer focus: patient, organization and EQuIP in collaboration. Evaluation and Quality Improvement Program." Journal of Quality in Clinical Practice 19(3): 139-44.

The Australian Council on Healthcare Standards (ACHS) Evaluation and Quality Improvement Program (EQuIP) calls on healthcare organizations to increase their focus on patients by using leadership to coordinate, and continuous improvement to guide, care delivery. At a large acute care private facility in Melbourne, a program has been developed to create a 'care partnership', characterized by shared decision making, collaboration and conciliation. This program enhances patient care through the coordination of three strategies, a patient communication strategy, an evaluation strategy and a quality improvement strategy. The program has resulted in patient guided reforms such as redesign of a patient information booklet, a hospital-wide discharge planning improvement initiative and a hospital-wide strategy to improve pain management. Through the creation of a care partnership, this program helps an acute care hospital focus its services and processes on one of its key customer groups, patients.

Sheridan, A., Hegarty, I., Flanagan, E., Dooley, M., Bedford, D. and Howell, F. (2004). "Consumer satisfaction with child health clinics." Irish Medical Journal 97(5): 143-5.

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Consumer satisfaction surveys are used to assist in monitoring the quality of health care service delivery. In order to capture the views of those attending child health clinics in the community setting, a cohort of attendees to child health clinics in a health board region was sent a pre-piloted questionnaire enquiring about the clinic type attended, appointment details, facilities and environment of the health centre attended and experiences of communication and information at the clinic. Of 3,424 parents/guardians contacted, 2,402 (70.1%) replied. Two thousand (83.3%) had an appointment, with 61.1% attending first appointment within 3 months of referral. Median time spent in the centre was 25.0 minutes (ranging from 5 to 150 minutes). Respondents were satisfied with structural facilities with the exception of baby-changing facilities. Respondents agreed that their child's condition (92.1 %) and treatment options (88.7%) were fully explained, with adequate time for discussion (87.8%). Only 44% (n=736) reported receiving written takeaway information regarding their child's condition. Respondents agreed their child was put at ease by staff (85.7%), and the visit was worthwhile (93.9%). This study has identified key areas where administration and health care professionals can improve the quality of what is already perceived to be a good service.

Sherman, S. G. (2002). "Change leadership behaviors to change performance results: the foundation of top customer satisfaction." Clinical Leadership & Management Review 16(5): 320-4.

Raising customer satisfaction in health-care organizations has been a priority for the past 5 years or more. Articles and books continue to be written on the topic and speeches and presentations are given to eager audiences of professionals who have a deep desire to improve customer satisfaction. Yet research indicates that customer satisfaction, on average, in the health-care industry barely has improved. This column will examine why some organizations, using the same best practice techniques and approaches for top customer satisfaction, achieve wonderful results as most others achieve meager results, at best. The answer to achieving top customer satisfaction lies in the leadership of the organization. When leaders change their thinking and behaviors, results will change.

Shian, L. L. (1990). A study of the relationship of quality circles to job satisfaction, absenteeism and turnover of nurses and patients' satisfaction with nursing care in Taiwan, GEORGE MASON UNIVERSITY: 171 p.

Quality circles (QCs), part of the popular "Japanese Management" concept, are being adopted successfully by several American hospitals in an attempt to boost output and raise productivity as well as improve quality control. The purpose of this study was two fold: (1) to describe the relationship between nurses' job satisfaction, absenteeism and turnover on nursing units where QCs were used as a management tool and on units where QCs were not used, (2) to describe patients' satisfaction with nursing care on units where QCs were used and on units where QCs were not used. Fifty-eight QC nurses from four QC units and fifty-four non-QC nurses from four non-QC units were surveyed after implementation of the QC program in Taiwan. Stamps & Piedmont's Index of Work Satisfaction (IWS) was used to examine the nurses' job satisfaction. Hospital records were used to check the data of absenteeism and turnover among nurses. Eighty patients of four QC units and eighty patients of four non-QC units were randomly selected to explore the difference in patient satisfaction between the two groups. The results indicate that quality circle programs in a Taiwan hospital did have a significant positive impact on nurses' satisfaction, reduced absenteeism, a lower turnover, and with patients' satisfaction with nursing care. These findings support other findings reported in the literature. These findings also support the linkage between the dependent variables and the outcomes of the QC model used in the study.

Shiozaki, M., Morita, T., Hirai, K., Sakaguchi, Y., Tsuneto, S. and Shima, Y. (2005). "Why are bereaved family members dissatisfied with specialised inpatient palliative care service? A nationwide qualitative study." Palliative Medicine 19(4): 319-327.

BACKGROUND: In order to improve the quality of palliative care, we can learn from bereaved families who were dissatisfied with the care they received. The primary aim of this study was to explore why bereaved families were dissatisfied with specialized inpatient palliative care. METHODS: This qualitative study formed part of a nationwide questionnaire survey administered to 1225 bereaved family members of cancer patients who died in certified palliative care units in Japan. The participants were 22 consecutive family members who reported a greater need for improvement in care. Data were analysed by the content analysis. RESULTS: The reasons that the bereaved families listed are classified into 27 categories and seven themes: (1) lack of perceived support for maintaining hope; (2) lack of perceived respect of individuality, especially in attitudes toward death; (3) perceived poor quality of care, especially psychological care, not being treated with dignity and inadequate explanation from physicians; (4) inadequate staffing and equipment, especially physician availability; (5) unavailability of timely administration; (6) lack of accurate information about palliative care units; and (7) family's practical and economic burden. CONCLUSIONS: This study identified the multiple sources of dissatisfaction with specialized inpatient palliative care for bereaved families. These findings could be useful in developing a more desirable system of specialised inpatient palliative care.

Shipley, K., Hilborn, B., Hansell, A., Tyrer, J. and Tyrer, P. (2000). "Patient satisfaction: a valid index of quality of care in a psychiatric service." Acta Psychiatrica Scandinavica 101(4): 330-3.

OBJECTIVE: To assess patients', clinicians' and referrers' satisfaction with care in newly referred psychiatric patients and to compare these with standard quality indicators such as waiting times used by the service. METHOD: A random sample of all new adult psychiatric patients presenting over a 4-month period in 2 successive years to an inner-city psychiatric service was assessed. RESULTS: One hundred and thirteen (68%) of 167 randomly selected patients were seen. Independent evidence of service performance showed that patient satisfaction, but not clinician or referrer satisfaction, was a more accurate indicator of quality of care than standard indicators. CONCLUSION: Simple ratings of patient satisfaction alone may be

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useful indicators of quality of psychiatric care.

Siegrist, K., Schlebusch, P. and Trenckmann, U. (2002). "Let us ask the consumer - Patient satisfaction and quality management. [German]." Psychiatrische Praxis 29(4): 201-206.

Objective: Our study explores possibilities to do quality management by routinely assessing patient satisfaction in hospital. Which aspects of treatment and setting are vital for patients and how do they evaluate them? Do hospital departments differ concerning profiles of patient satisfaction? Does the analysis over time reveal relevant differences in quality? Which use can be made of the results in terms of quality management? Method: We report results of routine assessment of patient satisfaction by means of a questionnaire with adaquate teststatistical properties. 2858 patients could be included. Results: Interpersonal aspects of treatment are vital for patients. We find differences between departments and over time. Feedback to the therapeutic teams have a practical impact. Conclusion: It is possible to integrate routine assessment of patient satisfaction into quality management.

Simmons, S. F., Schnelle, J. F., Uman, G. C., Kulvicki, A. D., Lee, K. O. and Ouslander, J. G. (1997). "Selecting nursing home residents for satisfaction surveys." Gerontologist 37(4): 543-50.

Many cognitively impaired nursing home (NH) residents are excluded from interviews measuring quality of life or care based on the belief that these residents cannot accurately answer questions. These exclusions are based on subjective criteria and ignore individual differences among cognitively impaired NH residents. This study describes a screening rule based on four minimum data set (MDS) indicators that provides an objective method for identifying residents capable of accurate report. Sixty percent of a sample of 83 NH residents who could answer yes or no questions about their care could do so accurately. Eighty-one percent of the sample was correctly classified by the MDS indicators.

Simpson, R. G., Scothern, G. and Vincent, M. (1995). "Survey of carer satisfaction with the quality of care delivered to in-patients suffering from dementia." Journal of Advanced Nursing 22(3): 517-527.

Quality assurance in British National Health Service provision stresses the importance of taking account of the consumer's viewpoint. Elderly patients with dementia are not always able to contribute usefully to satisfaction surveys. Therefore, their carers' views were sought in order to assess the quality of services offered to this client group. Forty-one carers of patients discharged from the eight wards for the elderly mentally ill in Leicestershire, England, were randomly selected. Individual focused interviews were conducted in carers' own homes. Both quantitative and qualitative data were obtained by use of a questionnaire designed to tap the patients'/carers' experiences from preadmission, through hospital stay to post-discharge. Interviewees were asked to describe their favourable/unfavourable impressions of, and reactions to, all aspects of hospital care. These interviews were tape-recorded. Analysis of the data included quantitative measurements of scale ratings. Grounded theory was used to analyse qualitative data. A wealth of information was uncovered using this research technique. Much that was positive about the service was elicited. However, carers highlighted areas where they felt the quality of care could be improved within all the foci discussed. Twenty-two recommendations for quality improvements in service provision were made in the report as a result of this survey.

Sims, B. (2007). "Streamlining complaints." Nursing & Residential Care 9(9): 398-398.

Beccy Sims reports on an initiative that is seeking to improve health and social care services by helping people make complaints where necessary.

Singleton, E. (1994). "Critique of Consumer satisfaction and perceived quality of outpatient health services [original article by Peyrot M et al appears in J HEALTH CARE MARKET 1993;13(1):24-33]." Nursing Scan in Research 7(1): 20-21.

SYNOPSIS: These investigators hypothesized that quality of service would lead to higher patient satisfaction and that satisfaction would then produce greater willingness to recommend the provider. Nontechnical characteristics of a medical service encounter were grouped into the domains of staff behavior (friendly, courteous, helpful, informative); atmospherics (comfort, convenience, facility appearance); and patient information (medical, logistical). Medical services such as the imaging procedures were judged in terms of examination comfort and perceived worth. The service encounter was divided into five phases: pre-arrival, waiting room, dressing room, examination, and departure. This study was conducted in a free-standing facility that offered magnetic resonance imaging (MRI) and computed axial tomography (CT). Patients did not see a physician. Of 2,200 consecutive persons who received service, 1,366 (60%) completed a questionnaire and returned it in a stamped envelope addressed to an independent evaluation organization. Multivariate logistic regression showed the following factors to be statistically significant in terms of consumer satisfaction and willingness to recommend the provider: appointment convenience, pre-examination comfort and convenience, prior and total information, examination comfort (the most significant factor), and perceived worth. Staff behavior significantly influenced consumer satisfaction; explaining the report significantly influenced consumers recommending the service.

Sitzia, J. and Wood, N. (1997). "Patient satisfaction: a review of issues and concepts." Social Science & Medicine 45(12): 1829-1843.

This review presents issues arising from an analysis of over 100 papers published in the field of patient satisfaction. The published output appearing in the medical and nursing literature which incorporated the term "patient satisfaction" rose to a peak of over 1000 papers annually in 1994, reflecting changes in service management especially in the U.K. and U.S.A. over the past decade. An introductory section discusses the

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setting and measurement of patient satisfaction within this wider context of changes in service delivery. Various models are examined that have attempted to define and interpret the idea of determining individual perceptions of the quality of health care delivered. Determinants of satisfaction are examined in relation to the literature on expectations, and demographic and psychosocial variables. These are distinguished from the multidimensional components of satisfaction as aspects of the delivery of care, identified by many authors. The review highlights the complexity and breadth of the literature in this field, the existence of which is often not acknowledged by researchers presenting the findings of studies.

Sixma, H. J., Kerssens, J. J., van Campen, C. and Peters, L. (1998). "Quality of care from the patients' perspective: from theoretical concept to a new measuring instrument." Health Expectations 1(2): 82-95.

Introduction: Patient views on quality of care are of paramount importance with respect to the implementation of quality assurance (QA) and improvement (QI) programmes. However, the relevance of patient satisfaction studies is often questioned because of conceptual and methodological problems. Here, it is our belief that a different strategy is necessary. Objective: To develop a conceptual framework for measuring quality of care seen through the patients' eyes, based on the existing literature on consumer satisfaction in health care and business research. Results: Patient or consumer satisfaction is regarded as a multidimensional concept, based on a relationship between experiences and expectations. However, where most health care researchers tend to concentrate on the result, patient (dis)satisfaction, a more fruitful approach is to look at the basic components of the concept: expectations (or 'needs') and experiences. A conceptual framework--based on the sequence performance, importance, impact--and quality judgements of different categories of patients derived from importance and performance scores of different health care aspects, is elaborated upon and illustrated with empirical evidence. Conclusions: The new conceptual model, with quality of care indices derived from importance and performance scores, can serve as a framework for QA and QI programmes from the patients' perspective. For selecting quality of care aspects, a category-specific approach is recommended including the use of focus group discussions.

Sixma, H. J., van Campen, C., Kerssens, J. J. and Peters, L. (2000). "Quality of care from the perspective of elderly people: the QUOTE-elderly instrument.[see comment]." Age & Ageing 29(2): 173-8.

BACKGROUND: patient views on the quality of care are usually assessed by means of patient satisfaction questionnaires. AIM: to develop an instrument that would: (i) produce data related to the expectations and experiences of noninstitutionalized elderly people, (ii) contain items that had been formulated in collaboration with elderly people, (iii) measure quality from the perspective of the users of health care services and (iv) produce data on generic quality aspects and quality aspects specifically related to the needs of elderly people. METHODS: we developed the instrument for measuring quality of care from the perspective of non-institutionalized elderly people (QUOTE-Elderly) by using a combination of qualitative and quantitative methods. We obtained empirical data on the opinions and experiences of 338 elderly people. We evaluated the taxonomy of the instrument, internal consistency of (sub)scales and the feasibility of the instrument using explorative and confirmative factor analyses and reliability analysis. RESULTS: using scale optimization, we produced a self-administered questionnaire on quality of health care from the perspective of elderly people. This contains scientific characteristics and provides specific information for practical quality-assurance policies.

Siyambalapitiya, S., Caunt, J., Harrison, N., White, L., Weremczuk, D. and Fernando, D. J. S. (2007). "A 22 month study of patient complaints at a National Health Service hospital." International Journal of Nursing Practice 13(2): 107-10.

Patient complaints are an important source of information for service improvements. We audited patient complaints made about medical care in a National Health Service District general hospital over a 22 month period. Complaints were about medical care, nursing care, attitudes of staff, poor communication, clinical delay (9%) and hospital environment. The complaints department closed 66% complaints within 20 days. The majority of the complaints were directly related to clinical care, poor communication, attitudes of staff and nursing care. However, 99% of patients were satisfied with an explanation and an apology indicating that almost all have been due to a lack of good communication than due to real deficiencies in the clinical care. The hospital management has investigated the majority of cases within 20 days and has made several policy changes after the investigations.

Smith, C., McCreadie, M., Unsworth, J., Wickings, H. I. and Harrison, A. (1995). "Patient satisfaction: an indicator of quality in disablement services centres." Quality in Health Care 4(1): 31-6.

OBJECTIVES--To develop a patient satisfaction system for disablement services centres and to report on how the initial findings have been used in audit to improve their quality of care and services. DESIGN--Interview survey of randomly selected users attending in three centres: Birmingham (centre X), Oxford (centre Y), and Cambridge (centre Z) to establish core topics for developing a patient satisfaction questionnaire with incorporation into a computer patient satisfaction system (PATSAT) to enable collation of responses to the questionnaire. A pilot of the questionnaire was undertaken in the centres to assess the sensitivity of the questionnaire, which was subsequently used as part of clinical audit process during June 1991 and April 1992 in centre X and the patient satisfaction system used to monitor changes in routine practice. PATIENTS--123 amputees in the development phase, selected by cluster sampling, and 1103 amputees in the pilot study. MAIN MEASURES--Satisfaction scores for components of the service. RESULTS--The questionnaire included 16 core topics contributing to quality of care and services, including comfort of limbs, appointments, interpersonal aspects of care, a system of support and counselling, and organisation. The pilot survey demonstrated high satisfaction scores for aspects of interpersonal care, organisation, and physical surroundings of the centres and lower satisfaction for counselling services,

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comfort of the limb and the number of alterations made before the limb was considered acceptable. During the audit in centre X these results prompted changes to care and services which produced significant improvements in satisfaction. CONCLUSIONS--The early results suggest that the questionnaire, coupled with PATSAT software system, enable users' views to be expressed, collated, and fed back to staff; the information provided has already prompted change, and the system is sufficiently sensitive to measure changes in satisfaction with the service.

Smith, J. E., Fisher, D. L. and Endorf-Olson, J. J. (2000). "Integrating patient satisfaction into performance measurement to meet improvement challenges." Joint Commission Journal on Quality Improvement 26(5): 277-86.

BACKGROUND: A Value Compass has been proposed to guide health care data collection. The "compass corners" represent the four types of data needed to meet health care customer expectations: appropriate clinical outcomes, improved functional status, patient satisfaction, and appropriate costs. Collection of all four types of data is necessary to select processes in need of improvement, guide improvement teams, and monitor the success of improvement efforts. INTEGRATED DATA AT BRYANLGH: BryanLGH Medical Center in Lincoln, Nebraska, has adopted multiple performance measurement systems to collect clinical outcome, financial, and patient satisfaction data into integrated databases. Data integration allows quality professionals at BryanLGH to identify quality issues from multiple perspectives and track the interrelated effects of improvement efforts. A CASE EXAMPLE: Data from the fourth quarter of 1997 indicated the need to improve processes related to cesarean section (C-section) deliveries. An interdisciplinary team was formed, which focused on educating nurses, physicians, and the community about labor support measures. Physicians were given their own rates of C-section deliveries. RESULTS: The C-section rate decreased from 27% to 19%, but per-case cost increased. PickerPLUS+ results indicated that BryanLGH obstetric patients reported fewer problems with receiving information than the Picker norm, but they reported more problems with the involvement of family members and friends. CONCLUSIONS: The data collected so far have indicated a decrease in the C-section rate and a need to continue to work on cost and psychosocial issues. A complete analysis of results was facilitated by integrated performance management systems. Successes have been easily tracked over time, and the need for further work on related processes has been clearly identified.

Smith, M. F. and Coladangelo, R. C. (2001). "Avoiding patient complaints and claims against doctors: Ask the patients." Pharmaceutical Visions(4): 56-58.

MF Smith and RC Coladangelo present original research into patient complaints against doctors which posits the routine surveying of patients for clinical practices as an avoidance strategy. The authors look at the implications of their results for the pharmaceutical sector.

Soberman, L. R., Murray, M., Norton, P. G., van Maris, B. and Tasa, K. (1997). "Satisfaction of residents and families in long-term care: III. Dissemination of results." Quality Management in Health Care 5(3): 63-71.

Dissemination of new information to caregivers in ways that enhance the care they deliver is central to quality improvement in health care. This article describes several strategies that have been employed in one long-term care setting and discusses evidence of their success.

Sobo, E. J., Billman, G., Lim, L., Murdock, J. W., Romero, E., Donoghue, D., Roberts, W. and Kurtin, P. S. (2002). "A rapid interview protocol supporting patient-centered quality improvement: hearing the parent's voice in a pediatric cancer unit." Joint Commission Journal on Quality Improvement 28(9): 498-509.

BACKGROUND: The Institute of Medicine's 2001 report on quality delimits six dimensions of optimal care: safety, effectiveness, efficiency, timeliness, patient centeredness, and equity. In fall 2001 parents of pediatric cancer patients were interviewed to determine how well they thought these dimensions were addressed with respect to medication administration. Immediate goals were to identify system weaknesses and devise strategies to prevent future errors. A higher-order goal was to develop and demonstrate a model protocol for rapid-cycle interview assessments. METHODS: Hematology/oncology directors worked with a research expert to develop a semistructured interview protocol. After training, which included directed reading, oral instruction, and role-playing, a convenience sample of 20 English- and Spanish-speaking parents of inpatients was recruited. Parents were asked to characterize current medication administration practices and to describe problems that they had experienced or witnessed. Rapid content analysis techniques were used to identify issues of importance to the parents. FINDINGS: Parents' medication concerns centered on their children's comfort. Parents called for communication improvements, standardization of all nursing procedures and techniques, and a guide or an outline providing a clear understanding of what to expect when and from whom. Viewing these concerns in relation to the Institute of Medicine's quality domains allowed the department to frame an improvement action plan aligned with organizational and national priorities. IMPLICATIONS: With good supervision and limited focused training, inexperienced staff can successfully administer semistructured qualitative interviews and help analyze findings for rapid cycle improvement purposes. The protocol can be adapted for use in organizations interested in rapid qualitative assessments of patient and parent preferences.

Soliman, A. A. (1992). "Assessing the quality of health care: a consumerist approach." Health Marketing Quarterly 10(1-2): 121-41.

Recent investigations show that nontechnical interventions influence patients' ratings of the quality of health care, and that these aspects of the medical encounter are as important to the patient as the technical

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aspects; perhaps more important. This paper adopts a consumerist approach and measures patients' perceptions of health care quality using a scale adapted from the consumer behavior literature (SERVQUAL). The study measures health care quality as well as five of its individual dimensions. The findings indicate that, for the whole sample, patients' ratings of overall quality as well as the ratings of four of the five dimensions of care are negative. Further analysis indicates that many individual aspects (scale items) are rated negatively by each of two age groups (25-65 and over 65 years old), but the gap between perceptions of the younger group and their expectations is greater than that of the senior group. The two dimensions of "assurance" and "empathy" are found to be the most discriminating dimensions between the two groups. Other analyses indicate that age, annual household income, and work status significantly relate to overall quality rating. Marketing and strategic planning implications of the results are discussed.

Sorlie, T., Sexton, H. C., Busund, R. and Sorlie, D. (2000). "Predictors of satisfaction with surgical treatment." International Journal for Quality in Health Care 12(1): 31-40.

Objective. To investigate prospectively which medical, psychosocial or treatment-related factors predicted treatment satisfaction and to evaluate the adequacy of a preceding retrospective study which had examined the same factors. Furthermore, to examine the predictors and the stability of the major determinants of patient treatment satisfaction. Design. Assessments made before admission, at discharge and 2 and 4 months after discharge were used to predict both the level and the rate of change in satisfaction with different aspects of treatment. Setting. Three surgical departments at a University Hospital. Study participants. Four-hundred and eighty-two patients electively admitted for several surgical conditions. Results. The central treatment-related measures were the same in the retrospective and prospective studies: global satisfaction with treatment (GS), perceived quality of contact with the nursing (QCN) and medical staff (QCM) and provision of adequate treatment information (INF). More of the variance in GS was explained in the prospective study (48.7% versus 36.3%). GS was most influenced by treatment-related factors with QCN as the strongest predictor in both studies. Only a small portion of the variance in QCN and QCM could be accounted for by the characteristics of the patents. INF was predicted by characteristics of the patients, their illness and life situation and by treatment-related factors. QCN was the strongest predictor of INF. The relationships with the nursing and medical personnel appear to be the major determinants of both patient treatment satisfaction and patients' reception of adequate information about their condition and its treatment.

Spath, P. "Using customer concerns to improve quality. Part 1." Hospital Peer Review 28(4): 57.

Spath, P. (1996). "Verbal complaints key for monitoring satisfaction." Hospital Peer Review 21(10): 140-3.

Patient complaints often do not get recorded or collected for meaningful interpretation or reaction. Informal complaint data should be compiled organization-wide, not department-wide. An institution-wide policy and procedure concerning patient complaints can keep staff aware of importance of patient complaints and how they should respond. A standardized, hospital-wide method for handling complaints enhances the public's image of the hospital and substantiates the hospital's concern for high-quality patient care and services.

Spath, P. (2000). "How to formalize your grievance response. Part 2." Hospital Peer Review 25(2): 23-5.

It's unlikely that the mechanism used in many facilities to handle patient complaints is as well-defined as it must be in order to meet the Health Care Financing Administration's Conditions of Participation. In this month's column, part two of a three-part series, we describe the first steps in the grievance process, when a grievance is filed and the hospital responds.

Spath, P. (2000). "How to manage patient grievances. Part 3." Hospital Peer Review 25(3): 37-8.

Spath, P. (2003). "Improve performance by taking outsiders' view. Part 2." Hospital Peer Review 28(1): 12-3.

Spath, P. (2003). "Responding to customer concerns improves quality. Part 2." Hospital Peer Review 28(5): 69-72.

Spierer, M., Sims, H. W., Micklitsch, C. N. and Lewis, B. E. (1994). "Assessment of patient satisfaction as part of a physician performance evaluation: the Fallon Clinic experience." Journal of Ambulatory Care Management 17(3): 1-7.

Patient satisfaction surveys were used as part of the physician evaluation process in a 300-member physician group practice with a largely health maintenance organization (HMO) patient population. The surveys were incorporated into the review process at the request of physicians who wanted to be evaluated by patients. Results were shared with physicians to identify problem areas for improving patient care. One year later, follow-up surveys showed improvement in patient ratings of participating physicians. In addition, physicians indicated that the surveys significantly improved the evaluation process.

Stacey, M. (1974). "Consumer complaints procedures in the British National Health Service." Social Science & Medicine 8(8): 429-35.

Stallard, P. (1995). "Parental satisfaction with intervention: differences between respondents and non-

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respondents to a postal questionnaire." British Journal of Clinical Psychology 34(Pt 3): 397-405.

Parental satisfaction with a child and adolescent psychology service was assessed by postal questionnaire. Follow-up interviews were conducted with 88 percent of the sample, 36 postal questionnaire respondents and 21 non-respondents. Questionnaire non-respondents were more likely to have dropped out of therapy, had fewer appointments, evaluated the service more negatively and differed from respondents in their particular sources of dissatisfaction. They were significantly more dissatisfied with where they met the psychologist and in what family composition they were seen whereas questionnaire respondents were more dissatisfied with the wait before first appointment and the total number of appointments offered. The implications for future studies are discussed and the need to assess the satisfaction of postal non-respondent emphasized.

Stallard, P. (1996). "The role and use of consumer satisfaction surveys in mental health services." Journal of Mental Health 5(4): 333-348.

The role and use of consumer satisfaction surveys to evaluate mental health services is examined. Although satisfaction would appear a useful way of evaluating outcome and monitoring service quality significant methodological shortfalls severely limit the conclusions of many studies. Issues of reliability and validity are seldom considered, response rates are low, and studies are typically one-off events which render comparisons between or within services extremely difficult. Recommendations for future research are highlighted in order to address these issues.

Stallard, P. (1996). "Validity and reliability of the Parent Satisfaction Questionnaire." British Journal of Clinical Psychology 35(Pt 2): 311-8.

The development of a postal consumer satisfaction questionnaire for a child and adolescent psychology service is reported. A preliminary analysis of content, construct and concurrent validity suggests that the questionnaire has an acceptable degree of validity. Factor analysis identified five factors with three being identifiable as relating to the outcome of contact, appointments and the timing of contact. The remaining two factors were minor dyads which were difficult to interpret. The reliability and utility of the questionnaire is good, proving a useful way of identifying service shortfalls and directing service change. The need to methodologically evaluate consumer satisfaction questionnaires is stressed and their routine use in monitoring and assuring service quality highlighted.

Stamp, B. and Musgrave, P. (2007). "Patients redefine "quality" for healthcare organizations: why in the hospital boardroom, the chief nursing officer should be most interested -- and concerned -- about H-CAHPS." Nurse Leader 5(1): 15-17.

Stamps, P. L. and Finkelstein, J. B. (1981). "Statistical analysis of an attitude scale to measure patient satisfaction with medical care." Medical Care 19(11): 1108-35.

Patient satisfaction with medical care is concept that is viewed as important to consider but difficult to measure. The most widely reported and most standardized measure of patient attitudes toward medical care is the scale developed by Hulka et al. The purpose of this article is first to present the results of three separate administrations of this scale and, second, to detail the statistical analysis performed using these data sets. The results of these three administrations show remarkable similarity of results, thus leading to an inference of high reliability. Through the statistical analysis of the validity of the scale, however, it is demonstrated that further work is needed before the attitude scale can be generally used. The three phases of the statistical analysis include an item analysis, a Guttman scalogram analysis and a factor analysis. The results of these three validity analyses do not support the attitude scale in its current form. The result of this work leads us to conclude that this attitude scale is not ready to be used in a community setting for predictive purposes, as has been suggested. Our results indicate that further revision and analysis are necessary before we can approach a valid as well as reliable attitude scale to measure patient satisfaction with medical care. Although this suggests the need for extensive theoretical research, the effort is clearly worthwhile, as a valid and reliable measurement of patient satisfaction will provide us with invaluable insights into the process of health care delivery.

Staniszewska, S. and Ahmed, L. (1999). "The concepts of expectation and satisfaction: do they capture the way patients evaluate their care?" Journal of Advanced Nursing 29(2): 364-72.

The measurement of patient satisfaction has become a common way to elicit patients' views of their health care. However, difficulties arising from the limited theoretical underpinning of satisfaction, the difficulty in defining expectations and satisfaction and the methodological problems associated with their measurement have cast doubt on the validity of studies. This paper reviews the methodological and theoretical difficulties in measuring these concepts and argues that a better understanding of expectations and satisfaction, which is based in patient experience, must first be achieved before theoretical modelling and valid measurement can progress. It presents the findings of a study which attempted to clarify the concepts of expectations and satisfaction by exploring the experience of cardiac patients. The findings are discussed in the context of the key issues in this area.

Staniszewska, S. H. and Henderson, L. (2005). "Patients' evaluations of the quality of care: influencing factors and the importance of engagement." Journal of Advanced Nursing 49(5): 530-7.

AIMS: This paper reports a study exploring the process of patient evaluation and identifying the factors which influence this. BACKGROUND: Patient experiences of health care have become a central focus for researchers, policymakers, clinicians and patient groups in many countries. While surveys of patient

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experiences have become increasingly common internationally, concerns about the validity of concepts such as satisfaction have cast doubt on the utility of their findings. These concerns reflect our limited understanding of patient evaluation and the factors that can influence this process. METHODS: A qualitative design was adopted, using semi-structured interviews with a sample of outpatients in their homes in one county in England. In total, 41 patients participated in the study and were interviewed before their appointment. Of these patients, 37 were interviewed again after their appointment. Six of the latter were then re-interviewed 6 weeks after the appointment to explore whether evaluations had changed. FINDINGS: Patient evaluation was influenced by a number of factors, including gratitude, faith, loyalty, luck and equity. The overall effect was to prompt positive evaluation, even when care was poor. These factors should be accounted for in the interpretation of patient experiences surveys. Patient experiences were further influenced by their sense of engagement with the system. A negative sense of engagement could have a major impact on the patient, resulting in disappointment or fear and a desire to leave the health care system, and in a negative evaluation of a specific aspect of care. CONCLUSIONS: Engagement may provide a more appropriate indicator of negative experience than dissatisfaction. The influence of these factors should be considered in future attempts to develop more sensitive and appropriate methods of eliciting patient experiences.

Starfield, B., Cassady, C., Nanda, J., Forrest, C. B. and Berk, R. (1998). "Consumer experiences and provider perceptions of the quality of primary care: implications for managed care." Journal of Family Practice 46(3): 216-26.

BACKGROUND: The purpose of this study was to determine the extent to which consumer and provider reports of primary care differ according to particular characteristics of the primary care setting. METHODS: A random sample of consumers was surveyed by telephone in a defined geographic area of Washington, DC, to determine their experiences with care provided to a randomly chosen child. The primary care provider of each respondent was sent a parallel survey. Scores were obtained for each of two subdomains in the four cardinal primary care domains (first contact, longitudinality, comprehensiveness, and coordination) and for three related domains (family centeredness, community orientation, and cultural competence). Differences between settings that did or did not impose limitations on autonomy for referrals and between fee-for-service and capitated settings were ascertained. RESULTS: Both consumers and their providers in settings characterized by high degrees of limitation on physician autonomy or by capitation reported better first-contact accessibility and a greater range of services available than did consumers in settings with low degrees of limitation, or by fee-for-service reimbursements to physicians. Consumers but not providers reported better family centeredness in these settings. Most other differences favored these settings as well, but these were not consistently statistically significant for both providers and consumers in both types of settings. CONCLUSIONS: The quality of primary care services in different settings can be ascertained by using an instrument with demonstrated reliability and convergent validity. Although certain types of settings, in the particular geographic area studied, appear to perform better in several key aspects of the primary care, replication of the study in other areas would be useful judging the performance of the newer types of settings to be superior to more conventional care for general populations.

Steele, L. L., Mills, B., Long, M. R. and Hagopian, G. A. (2002). "Patient and caregiver satisfaction with end-of-life care: does high satisfaction mean high quality of care?" American Journal of Hospice & Palliative Medicine 19(1): 19-27.

The purpose of this study was to determine patient and caregiver satisfaction with a hospice program of care. The setting for the study was a home-care hospice in the southeastern United States that provides a full range of services for patients with life-limiting illness and supportive services for family caregivers. Two Likert-type instruments were used to determine satisfaction with staff, communication, education, information provided, symptom management, promptness with service, and overall satisfaction. Some 321 patients and 443 caregivers completed surveys over a two-year period of time. Data indicates the majority of patients and their caregivers were very satisfied with hospice services and the care they received. Providing quality care at the end of life is the goal of hospice. Satisfaction with delivery of care, management of symptoms, and communication with staff are all components of quality care and contribute to quality of life.

Steven, I. D. (1991). "A Patient Satisfaction Questionnaire as a teaching and comparative audit tool." Quality Assurance in Health Care 3(1): 41-9.

This paper explores the development and use of a Patient Satisfaction Questionnaire which was chosen by members of the South Australian Quality Assurance Research Officers' Association (SAQAROA) as a method of learning how to undertake quality assurance. Overall this process was rated as being successful by the members. Use of the Questionnaire revealed high overall satisfaction with services being provided. However, for most questions one or more hospitals returned comparatively high dissatisfaction rates, the significance of which was not appreciated until comparative data became available.

Stevens, M., Reininga, I. H. F., Boss, N. A. D. and van Horn, J. R. (2006). "Patient satisfaction at and after discharge. Effect of a time lag." Patient Education & Counseling 60(2): 241-245.

OBJECTIVE: Patient satisfaction is an important outcome measure for evaluating the quality of medical care. It is remarkable that consistently high satisfaction ratings have been reported over the last 30 years. There are indications that the time point of administration of a patient satisfaction questionnaire has an influence on satisfaction ratings. This study aimed at investigating whether the assessment of patient satisfaction at different time points resulted in different outcomes. METHODS: Patient satisfaction was measured twice. The sample consisted of 152 orthopedic patients who filled in the questionnaire at hospital

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discharge and one to 12 months after discharge. RESULTS: At follow-up, satisfaction ratings decreased significantly. Satisfaction with postoperative information decreased the most after discharge. CONCLUSION: The results of this study indicate that the time point of administration of a patient satisfaction questionnaire does influence satisfaction ratings. PRACTICE IMPLICATIONS: Patient satisfaction outcomes collected during hospitalization and after discharge may not be interpreted similarly.

Stevenson, D. G. (2005). "Nursing home consumer complaints and their potential role in assessing quality of care.[see comment]." Medical Care 43(2): 102-11.

BACKGROUND: State survey agencies collect and investigate consumer complaints for care in nursing homes and other health care settings. Complaint investigations play a key role in quality assurance, because they can respond to concerns of consumers and families. OBJECTIVE: This study uses 5 years of nursing home complaints data from Massachusetts (1998-2002) to investigate whether complaints might be used to assess nursing home quality of care. RESEARCH DESIGN: The investigator matches facility-level complaints data with On-Line Survey Certification and Reporting (OSCAR) data and Minimum Data Set Quality Indicator (MDS QI) data to evaluate the association between consumer complaints, facility and resident characteristics, and other nursing home quality measures. RESULTS: Consumer complaints varied across facility characteristics in ways consistent with the nursing home quality literature. Complaints were consistently and significantly associated with survey deficiencies, the presence of a serious survey deficiency, and nurse aide staffing. Complaints were not significantly associated with nurse staffing, and associations with 6 MDS QIs were mixed. The number of complaints was significantly predictive of survey deficiencies identified at the subsequent inspection. CONCLUSION: Nursing home consumer complaints provide a supplemental tool with which to differentiate nursing homes on quality. Despite limitations, complaints data have potential strengths when used in combination with other quality measures. The potential of using consumer complaints to assess nursing home quality of care should be evaluated in states beyond Massachusetts. Evaluating consumer complaints also might be a productive area of inquiry for other health care settings such as hospitals and home health agencies.

Stevenson, D. G. (2006). "Nursing home consumer complaints and quality of care: a national view." Medical Care Research & Review 63(3): 347-68.

This study uses 5 years of national data on investigated nursing home complaints (1998-2002) to evaluate whether complaints might be used to assess nursing home quality of care. On-Line Survey Certification and Reporting (OSCAR) data are used to evaluate the association between consumer complaints, facility and resident characteristics, and other nursing home quality measures. The analyses are undertaken in the context of considerable cross-state variation in nursing home complaint processes and rates. Complaints varied across facility characteristics in ways consistent with the nursing home quality literature. Complaints were significantly positively associated with survey deficiencies and the presence of serious survey deficiencies, and significantly negatively associated with nurse and nurse aide staffing. Complaints performance was significantly predictive of survey deficiencies at subsequent inspections. This study presents the first national evidence for using consumer complaints to assess nursing home quality of care. Despite limitations, nursing home complaints appear to offer a real-time signal of quality concerns.

Stewart, A. L., Napoles-Springer, A. M., Gregorich, S. E. and Santoyo-Olsson, J. (2007). "Interpersonal processes of care survey: patient-reported measures for diverse groups." Health Services Research 42(3 Pt 1): 1235-56.

OBJECTIVE: To create a patient-reported, multidimensional physician/patient interpersonal processes of care (IPC) instrument appropriate for patients from diverse racial/ethnic groups that allows reliable, valid, and unbiased comparisons across these groups. DATA SOURCE/DATA COLLECTION: Data were collected by telephone interview. The survey was administered in English and Spanish to adult general medicine patients, stratified by race/ethnicity and language (African Americans, English-speaking Latinos, Spanish-speaking Latinos, non-Latino whites) (N=1,664). Study DESIGN/METHODS: In this cross-sectional study, items were designed to be appropriate for diverse ethnic groups based on focus groups, our prior framework, literature, and cognitive interviews. Multitrait scaling and confirmatory factor analysis were used to examine measurement invariance; we identified scales that allowed meaningful quantitative comparisons across four race/ethnic/language groups. PRINCIPAL FINDINGS: The final instrument assesses several subdomains of communication, patient-centered decision making, and interpersonal style. It includes 29 items representing 12 first-order and seven second-order factors with equivalent meaning (metric invariance) across groups; 18 items (seven factors) allowed unbiased mean comparison across groups (scalar invariance). Final scales exhibited moderate to high reliability. CONCLUSIONS: The IPC survey can be used to describe disparities in interpersonal care, predict patient outcomes, and examine outcomes of quality improvement efforts to reduce health care disparities.

Stichler, J. F. and Schumacher, L. (2003). "A gift of customer complaints." Marketing Health Services 23(4): 14-5.

Stodel, E. J. and Chambers, L. W. (2006). "Assessing satisfaction with care in long-term care homes: current and best practices." Healthcare Management Forum 19(3): 45-52.

Given the increased call for accountability and quality of care in long-term care, it is important that government and long-term care provider organizations contemplate resident and family satisfaction with long-term care. This article highlights important considerations and provides practical recommendations for conducting satisfaction surveys in long-term care homes in terms of content, method of implementation and analysis, and use of findings. We conclude by recommending three surveys worthy of consideration by the

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government and long-term care provider organizations in Canada.

Stone, S. (2007). A retrospective evaluation of the Planetree patient centered model of care program's impact on inpatient quality outcomes, University of San Diego: 94 p.

This retrospective quasi experimental study evaluated the effectiveness of Planetree's patient-centered model of care. Donabedian's model linking structure and process to outcome was used to frame this study. The structure variable is the inpatient acute care hospital unit and the process variable consists of the Planetree patient-centered model of care. Outcomes are (1) patient satisfaction, (2) length of stay, (3) readmission, (4) cost per case, and (5) productive nursing hours per patient day.

All data for patient satisfaction, length of stay, readmission, cost per case and productive nurse hours per patient day were retrospective, no participant recruitment was needed. Data were obtained electronically by the primary investigator from multihospital system and individual entity organizational fiscal and clinical data bases following approval from the educational and organizational Institutional Review Boards.

When comparing the control unit to the treatment unit the questions to be addressed were: (1) what is the impact of the Planetree patient-centered model of care on patient satisfaction, (2) what is the impact of the Planetree patient-centered model of care on clinical outcomes (length of stay and readmission), and (3) what is the impact of the Planetree patient-centered model of care on the cost of providing care (cost per case and productive nursing hours per patient day).

The patient satisfaction composite mean score evaluation, length of stay evaluation and the cost per case evaluation demonstrate that the treatment unit is different from the control group (p=<.05 with Eta squared = >.01). This evidence validates that the Planetree patient-centered model of care had a positive impact on patient satisfaction, length of stay and cost per case.

Stoop, A. P., VrangbÃ¦k, K. and Berg, M. (2005). "Theory and practice of waiting time data as a performance indicator in health care: a case study from The Netherlands." Health Policy 73(1): 41-51.

In this article we investigate the use of waiting time data as a performance indicator in health care in The Netherlands. We explain why the current publication of waiting time data fails to achieve one of the main goals: to have consumers and general practitioners act upon this information. The reason, we claim, is that even seemingly clear-cut, easily measurable and objective numbers such as waiting times need interpretation to become meaningful. Discussing four themes - the patient behind the number, the treatment behind the number, the strategy behind the number, and the specificity of the number - we will discuss just how deeply this need for interpretation affects the usability of "waiting times" for purposes such as informing consumers. We will argue that this problem is due to not making a clear distinction between performance indicators for internal use and for external use. We conclude that the usefulness of the publication of waiting time data for consumers strongly increases when waiting times are guaranteed and related to treatment options like booking possibilities and other performance indicators such as patient satisfaction.

Strasen, L. (1988). "Incorporating patient satisfaction standards into quality of care measures." Journal of Nursing Administration 18(11): 5-6.

Strasser, S., Schweikhart, S., Welch, G. E., 2nd and Burge, J. C. (1995). "Satisfaction with medical care. It's easier to please patients than their family members and friends." Journal of Health Care Marketing 15(3): 34-44.

The authors conducted a multi-site study to compare the level of satisfaction with medical care and services between patients and their family/friends. Hierarchical regression results controlling for patient age, gender, medical service performed, and other factors suggest that inpatients are more satisfied with the care rendered by physicians and nurses, as well as with their overall hospital stay, than are their family members and friends. The authors speculate about why this is so and what health care providers can do about it.

Straten, G. F. M. and Friele, R. D. (1998). "The law on complaints hinders the Dutch Medical Inspectorate in its supervisory task. [Dutch]." Acta Hospitalia 38(1): 27-37+85.

It is the task of the Dutch Medical Inspectorate of Health to monitor the health care system. Patient complaints constitute an important source of information in carrying out this task. This situation has changed because of the enactment of a law on right of complaint of clients of health care in 1995. Until 1995, patients could submit complaints directly to the Inspectorate. The new law states that patient complaints are to be dealt with by a committee set up by the health-care provider. The law gives only a broad outline of the procedures to be followed. Many decisions about concrete actions are left to the health-care provider. In the new situation the Inspectorate does not obtain information directly from patients but just an annual overview of those complaints. The Inspectorate commissioned NIVEL to conduct an inventory study on the way the law is functioning in practice with emphasis on the information-processing process. Based on 25 interviews with representative of organizations of Dutch health-care institutions, organizations of health-care professionals, and health-care providers, the authors conclude that the Inspectorate is significantly hampered in the use of patient complaints in the monitoring the health-care system.

Stutts, A. (2001). "Developing innovative care models: the use of customer satisfaction scores." Journal of Nursing Administration 31(6): 293-300.

With the increased emphasis on accountability, cost, and quality in healthcare, models of care delivery are being restructured. The author examines the planning, implementation, and evaluation of a model of care delivery for neonates based on customer, staff nurse, nurse practitioner, and attending physician

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perceptions of care and their suggestions for improvement.

Sulmasy, D. P., McIlvane, J. M., Pasley, P. M. and Rahn, M. (2002). "A scale for measuring patient perceptions of the quality of end-of-life care and satisfaction with treatment: the reliability and validity of QUEST." Journal of Pain & Symptom Management 23(6): 458-70.

We report on the adaptation and evaluation of a previously developed patient-centered instrument that we call the Quality of End-of-life care and Satisfaction with Treatment (QUEST) scale. In a separate group of 30 inpatients, test-retest reliability for QUEST items ranged from 63% agreement (kappa = 0.43) to 93% agreement (kappa = 0.86) and construct validity was evidenced by correlations with a somewhat related satisfaction scale ranging from 0.38 to 0.47. QUEST was then administered to 206 consecutive medical inpatients (or their surrogates) with DNR orders and to a comparison group of 51 medical inpatients without DNR orders at 2 academic medical centers. Among these main study patients, internal consistency was reflected by Cronbach alphas of 0.88 to 0.93. QUEST scores showed modest inverse correlations with severity of symptoms, but were uncorrelated with severity of illness, anxiety, or depression, suggesting an appropriate relationship to symptom control but divergence of the underlying construct from degree of physical illness or affective state. QUEST scores were lower for patients with DNR orders compared to those without DNR orders (P = 0.02 to 0.06). Surrogate ratings of satisfaction and quality were uncorrelated with patient ratings. Although preliminary, these findings suggest that QUEST may be useful in assessing quality and satisfaction with the care rendered by physicians and nurses to hospitalized patients at the end of life.

Summers, L. and McCartney, M. (2005). "Liability concerns: a view from the American College of Nurse-Midwives." Journal of Midwifery & Women's Health 50(6): 531-5.

The national office of the American College of Nurse-Midwives (ACNM) is the center of day-to-day administration for the professional organization. Staff members respond to requests for information and assistance from certified nurse-midwives or certified midwives and facilitate the work of the Board, Divisions, and Committees. This article reviews the questions most frequently asked of the Professional Services department about risk management and professional liability issues and summarizes the most important lessons learned from the calls received. The focus is on 5 topic areas: 1) collaboration confusion, 2) systems needed to implement and effectively track diagnostic tests and referrals, 3) expansion of services beyond the core competencies, 4) patient satisfaction and patient complaints, and 5) maintaining medical malpractice coverage. [References: 18]

Summers, M. and Happell, B. (2002). "The quality of psychiatric services provided by an Australian tertiary hospital emergency department: a client perspective." Accident & Emergency Nursing 10(4): 205-213.

The mainstreaming of psychiatric services within the general health care system has created fundamental changes to the manner in which clients access acute psychiatric services. A review of the literature suggests that this process has been problematic. The current study involved the conduct of telephone interviews with psychiatric clients (n = 136) to ascertain their level of satisfaction with the services received in the emergency department of a Melbourne Metropolitan Hospital. The results were analysed using descriptive statistics. The study participants indicated a high level of satisfaction. Particular emphasis was placed upon the availability of staff with psychiatric qualifications and experience to provide treatment, support and care. Dissatisfaction was noted by some clients regarding lengthy waiting times, lack of privacy in the triage area and negative attitudes of emergency department staff. These findings support the value of psychiatric consultancy services in the emergency department, and further identify the need for triage guidelines to be tailored to the needs of mental health clients.

Sutherland, H. J., Lockwood, G. A., Minkin, S., Tritchler, D. L., Till, J. E. and Llewellyn-Thomas, H. A. (1989). "Measuring satisfaction with health care: a comparison of single with paired rating strategies." Social Science & Medicine 28(1): 53-8.

One of the central problems in studies of patient satisfaction with health care is the development of reliable and valid methods to determine the relative importance of different aspects of health care. Two techniques, paired comparisons and rating on a visual analogue scale, were compared in terms of their consistency with logical assumptions, test-retest reliability, and convergent validity. Thirty women with breast cancer were asked to assess brief hypothetical scenarios describing out-patient clinic visits to a tertiary cancer care centre. Each scenario incorporated three variables related to satisfaction with care: staff attitude, control over treatment decisions, and continuity of medical supervision. The paired choice method showed marginally better reliability and logical consistency than the rating method. Of the three variables assessed, continuity of medical supervision was consistently ranked highest in importance, and control over treatment decisions lowest. These preference assessment techniques appear to be suitable for use in the development of patient satisfaction indices, and for studies designed to examine variations in the priority given to different aspects of satisfaction with care.

Swaine, B. R., Dutil, E., Demers, L. and Gervais, M. (2003). "Evaluating clients' perceptions of the quality of head injury rehabilitation services: development and validation of a questionnaire." Brain Injury 17(7): 575-87.

OBJECTIVE: The objective of this research was to develop a tool to assess clients' perception of the quality of head injury rehabilitation services. METHODS AND RESULTS: A questionnaire PQRS-Montreal 1.0 was developed in Montreal, Quebec using a standardized methodology that incorporated a new technique to reach consensus regarding the tool's contents. Five dimensions of care (i.e. ecological approach, client-

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centred approach, accessibility, quality of the service providers and continuity) and their corresponding standards were identified as pertinent to include in the tool and were subsequently validated by experts. A phase of item generation followed that led to the development of an 87-item prototype of the questionnaire. The questionnaire is to be administered during an interview and employs a 5-point rating scale. DISCUSSION AND CONCLUSION: The implications for the use of PQRS-Montreal 1.0 in the accreditation process of head injury rehabilitation services are discussed, as well as plans for future quantitative research in the development of the tool.

Swan, J. E., Richardson, L. D. and Hutton, J. D. (2003). "Do appealing hospital rooms increase patient evaluations of physicians, nurses, and hospital services?" Health Care Management Review 28(3): 254-264.

This article investigates the effects of appealing hospital rooms on patient evaluations of hospital services. A field study contrasting appealing and typical rooms finds that appealing rooms result in more positive patient evaluations of physicians and nurses, as well as more favorable patient judgments of the service.

Swanson, K. A., Andersen, R. and Gelberg, L. (2003). "Patient satisfaction for homeless women." Journal of Women's Health 12(7): 675-86.

BACKGROUND: Patient satisfaction is a key quality of care indicator for which little is known for the homeless women population. We hypothesized that homeless women who last visited homeless-focused healthcare sites (shelter/outreach clinics and mobile vans) will have higher satisfaction ratings than homeless women who last visited county/government clinics. This association was also tested using the Gelberg-Andersen Behavioral Model for Vulnerable Populations. METHODS: Data were gathered on 974 homeless women aged 15-44 in a probability cluster sample of 60 shelters and 18 meal programs in Los Angeles County. The homeless women participated in 45-minute interviews. RESULTS: Our hypothesis was partially supported, as shelter and outreach clinics were positively and significantly associated with greater quality satisfaction (beta = 10.2, $p < 0.001$). Healthcare at private doctors' offices was also associated with quality, access, and appointment satisfaction when compared with care received at county/government clinics (beta = 15.9, $p < 0.001$; beta = 8.6, $p < 0.05$; beta = 16.3, $p < 0.01$). CONCLUSIONS: Policymakers should encourage healthcare sites that serve homeless women to improve their care by learning from shelter/outreach clinics and private doctors.

Swanson, K. A., Bastani, R., Rubenstein, L. V., Meredith, L. S. and Ford, D. E. (2007). "Effect of mental health care and shared decision making on patient satisfaction in a community sample of patients with depression." Medical Care Research & Review 64(4): 416-30.

This study sought to understand if shared decision making and/or receipt of mental health care was associated with patient satisfaction for patients with depression and to determine whether gender modified this relationship. The data are from the Quality Improvement for Depression study, a national collaborative study of 1,481 patients diagnosed with major depression in managed care settings. The cross-sectional analyses were performed using multiple logistic regression on a sample of 1,317 patients who answered both the baseline and month six questionnaires. Shared decision making and receipt of mental health care were both positively associated with patient satisfaction. Gender was not a moderator of this relationship. Health plans may be able to improve patient satisfaction levels by teaching physicians the importance of shared decision making. Contrary to expectations, patient gender made no difference in the effects of quality of care on patient satisfaction.

Swanson, M. (1995). "The use of patient complaints to improve service delivery." Nursing Times 91(41): 29-32.

In this paper changes to the procedures involved in making complaints are outlined. The alterations in the process follow on from the Department of Health's response to the Wilson report. The new guidelines for dealing with complaints are designed to be simpler and more explicit in order to encourage members of the public to make their concerns known. The ways in which complaints can be used positively to improve on services are outlined.

Swinehart, K. D. and Smith, A. E. (2004). "Customer focused health-care performance instruments: making a case for local measures." International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services 17(1): 9-16.

In the face of increasing pressure to improve patient satisfaction, the health-care industry must continue to seek improved methods to measure the effects of its continuous improvement efforts. While measurement instruments in this area abound, most are global in perspective and inflexible in form, sometimes leading to less than optimally germane outputs. Patient satisfaction information is critically important to the health-care provider, and this paper presents the results provided by an instrument that was locally designed to provide the most utile aggregation and presentation of patient satisfaction information for individual health-care providers. These results provide substantial evidence to support the notion that local, rather than global, measurement instruments are needed to provide the most relevant and useful results when assessing patient satisfaction as part of a continuous improvement effort.

Tabish, S. A. and Dawarki, F. H. (1999). "Patient satisfaction survey of Emergency Department at a large teaching hospital." JK Practitioner 6(3): 247-249.

Quality improvement in hospitals requires effective measurement of patient satisfaction. Patients satisfaction information identifies areas of strength and weaknesses in the organization. Patient satisfaction

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is a significant issue for Emergency Departments. For many patients, the visit is their first to the particular Emergency Department. Moreover, one-quarter to one-half of all inpatients are typically admitted through the Emergency Department. The special nature of the emergency encounter calls for a sound understanding of factors that have most influence on patient satisfaction. A study was conducted in the Emergency Department of a large teaching Hospital to determine the patient's perception of the care received by them in Emergency by analyzing the results of responses to a questionnaire and also to determine the relative importance of several components of patient satisfaction with services. The study revealed that personalized care rendered by doctors and paramedics, waiting time, public relations etc. are the key factors that drive satisfaction.

Tabrizi, J. S., O'Rourke, P. K., Wilson, A. J. and Coyne, E. T. (2008). "Service quality for Type 2 diabetes in Australia: the patient perspective." Diabetic Medicine 25(5): 612-7.

AIMS: To assess the service quality of care as perceived by people with Type 2 diabetes mellitus. METHODS: A cross-sectional survey using a self-administered questionnaire was carried out among members of Diabetes Australia-Queensland with Type 2 diabetes. For 12 aspects of service quality derived from a literature review and focus group research, patients scored the relative importance of the aspects and their perception of quality of received care. A measure of service quality was derived by combining the relative importance and actual performance. RESULTS: A total of 603 people with Type 2 diabetes participated. Of the 12 aspects of care, communication, availability of support group, safety and prevention had the highest scores for importance; support group and basic amenities had the highest average performance values; but the highest service quality values were for support group, basic amenities, dignity and confidentiality. Younger participants had lower service quality scores ($P = 0.001$) and participants with good control of their diabetes had higher scores ($P < 0.001$). Compared with the reference population, our sample had 8.7% fewer people under 65 years old. CONCLUSIONS: From the perspective of people with Type 2 diabetes, there is a notable gap between their expectations and what they have actually received in most aspects of provided care. In addition, overall service quality and six aspects of service quality (choice of care provider, accessibility, prevention, continuity, timeliness and safety) were identified to be of inadequate quality. Hence, this study demonstrates a significant opportunity to improve quality of healthcare services.

Tabrizi, J. S., Wilson, A. J., Coyne, E. T. and O'Rourke, P. K. (2007). "Clients' perspective on service quality for type 2 diabetes in Australia." Australian & New Zealand Journal of Public Health 31(6): 511-5.

OBJECTIVES: To explore the needs, expectations, feelings and experiences of people with type 2 diabetes for developing quantitative instruments for a questionnaire study of service quality. METHODS: Using two focus group discussions (n=33), potential service quality dimensions for type 2 diabetes were assessed for Australian relevance. These included 11 indicators identified from a systematic literature review: communication, autonomy, choice of care provider, continuity of care, quality of basic amenities, dignity, timeliness, prevention and early detection, safety, confidentiality and availability. RESULTS: The focus group discussions supported the importance of the 11 service quality indicators but gave more importance to education, diet, communication, autonomy, choice of care provider and support group and less to confidentiality and availability. Three new themes were generated from the discussions: education, diet and support group. CONCLUSION: Measuring service quality for type 2 diabetes requires considering health system, culture and disease-specific factors.

Taliaferro, E. (1983). "A case study in management: the patient complaint." Journal of Emergency Medicine 1(2): 151-3.

The complaints of dissatisfied patients provide useful tools for monitoring the effectiveness of medical care delivered in the emergency department. To facilitate responsiveness to individual complaints and to also capture valuable feedback information, a standardized approach is recommended. Presented here is one example of a patient complaint and the manner in which it was handled.

Tamblyn, R., Abrahamowicz, M., Dauphinee, D., Wenghofer, E., Jacques, A., Klass, D., Smee, S., Blackmore, D., Winslade, N., Girard, N., et al. (2007). "Physician scores on a national clinical skills examination as predictors of complaints to medical regulatory authorities." Journal of the American Medical Association 298(9): 993-1001.

Context: Poor patient-physician communication increases the risk of patient complaints and malpractice claims. To address this problem, licensure assessment has been reformed in Canada and the United States, including a national standardized assessment of patient-physician communication and clinical history taking and examination skills. Objective: To assess whether patient-physician communication examination scores in the clinical skills examination predicted future complaints in medical practice. Design, Setting, and Participants: Cohort study of all 3424 physicians taking the Medical Council of Canada clinical skills examination between 1993 and 1996 who were licensed to practice in Ontario and/or Quebec. Participants were followed up until 2005, including the first 2 to 12 years of practice. Main Outcome Measure: Patient complaints against study physicians that were filed with medical regulatory authorities in Ontario or Quebec and retained after investigation. Multivariate Poisson regression was used to estimate the relationship between complaint rate and scores on the clinical skills examination and traditional written examination. Scores are based on a standardized mean (SD) of 500 (100). Results: Overall, 1116 complaints were filed for 3424 physicians, and 696 complaints were retained after investigation. Of the physicians, 17.1% had at least 1 retained complaint, of which 81.9% were for communication or quality-of-care problems. Patientphysician communication scores for study physicians ranged from 31 to 723 (mean [SD], 510.9 [91.1]). A 2-SD decrease in communication score was associated with 1.17 more retained

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complaints per 100 physicians per year (relative risk [RR], 1.38; 95% confidence interval [CI], 1.18-1.61) and 1.20 more communication complaints per 100 practiceyears (RR, 1.43; 95% CI, 1.15-1.77). After adjusting for the predictive ability of the clinical decision-making score in the traditional written examination, the patient-physician communication score in the clinical skills examination remained significantly predictive of retained complaints (likelihood ratio test, P < .001), with scores in the bottom quartile explaining an additional 9.2% (95% CI, 4.7%-13.1%) of complaints. Conclusion: Scores achieved in patient-physician communication and clinical decision making on a national licensing examination predicted complaints to medical regulatory authorities. copyright2007 American Medical Association. All rights reserved.

Tapper, R., Malcolm, L. and Frizelle, F. (2004). "Surgeons' experiences of complaints to the Health and Disability Commissioner.[see comment]." New Zealand Medical Journal 117(1198): U975.

AIMS: To investigate details of patient complaints to the Health and Disability Commissioner about surgeons-to identify factors in the patient-surgeon interaction that might make a complaint more likely, and to consider ways of improving the complaints environment. METHODS: A questionnaire was developed asking specific questions about surgeons and their practice, number of complaints since 1996 and specific questions about their last Health and Disability Commissioner complaint. The questionnaire was mailed to surgeons on the mailing lists of the New Zealand Orthopaedic Association and The New Zealand Association of General Surgeons. Anonymous responses were entered into an Microsoft Access database. RESULTS: Responses were received from 280 (86%) of the 325 people contacted. Of these 280 replies, 259 were eligible for analysis. 149 (58%) of these 259 responses were from doctors who had received a complaint. There were 282 complaints, which gives an annual rate of complaints per person (inclusive of all respondents) of 0.16 over the 7 years: 1996 to 2002--but during 2000 to 2002 this rate was 0.34. The peak of complaints was in 2000. Those in mid-career (ie, 10-15 years of practice) and in private practice were at increased risk. Patients who complained were more likely to be female (58%) and in older ages. Respondents presented a very negative impression of their experience of the complaints process. In 91.1% of cases, either no action was taken or the surgeon was not in breach. Only 2.2% of cases were referred for disciplinary proceedings. CONCLUSION: Complaints against surgeons are common. The 'highest-risk surgeon' is a subspeciality general surgeon in private practice. The most likely people to complain are middle-class, white females aged 35-70 years. It would appear likely that the present system does not resolve issues for the patient or the surgeon. Radical changes are needed, and are beginning to occur, in the complaints environment. Especially needed is acceptance and disclosure of harm and error (away from a culture of blame and discipline). Therefore, if medical practitioners are to move with confidence into this more open environment, a more supportive political/media/organisational culture is needed, with a focus on valuing disclosure and learning from mistakes.

Tasa, K., Baker, G. R. and Murray, M. (1996). "Using patient feedback for quality improvement." Quality Management in Health Care 4(2): 55-67.

This article describes the results of a study designed to understand h how health care organizations use patient feedback. The article examines the organizational factors and the barriers that influence patient feedback use and concludes with propositions that can serve to guide future action and research in this area.

Tasso, K., Behar-Horenstein, L. S., Aumiller, A., Gamble, K., Grimaudo, N., Guin, P., Mandell, T. and Ramey, B. (2002). "Assessing patient satisfaction and quality of care through observation and interview." Hospital Topics 80(3): 4-10.

The purpose of this study was to investigate patient satisfaction using an in-depth approach rather than the more common patient survey method. The authors conducted patient interviews and participant-oriented observations between patients, family members, and medical staff in a large teaching hospital to assess patients' perceptions of the quality of care provided on a medical-surgical unit. The observations were classified according to the Donabedian model of quality of care: technical care, interpersonal care, and amenities of care. Technical interactions (92.5%, or n = 123) were most common, followed by interpersonal interactions (5%, or n = 7) and interactions related to amenities of care (2%, or n = 3). Of the patients interviewed, 89% (n = 40) were satisfied with the treatment and quality of care they received. Of the 10% (n = 9) of patients who reported dissatisfaction with the hospitalization, most of the complaints were related to surgical procedures. Observations and patient interviews may provide a more informative and accurate assessment of patient satisfaction than a reliance on patient surveys as the sole measure.

Taylor, B. B., Marcantonio, E. R., Pagovich, O., Carbo, A., Bergmann, M., Davis, R. B., Bates, D. W., Phillips, R. S. and Weingart, S. N. (2008). "Do medical inpatients who report poor service quality experience more adverse events and medical errors?" Medical Care 46(2): 224-8.

PURPOSE: Service quality deficiencies are common in health care. However, little is known about the relationship between service quality and the occurrence of adverse events and medical errors. We hypothesized that patients who reported poor service quality were at increased risk of experiencing adverse events and medical errors. SUBJECTS AND METHODS: Patients were interviewed during and after their admissions regarding problems experienced during the hospitalizations. We used this information to identify service quality deficiencies. We then performed a blinded, retrospective chart review to independently identify adverse events and errors. We used multivariable methods to analyze whether patients who reported service quality deficiencies (obtained by patient report) experienced any adverse event, close call, or low risk error (ascertained by chart review). RESULTS: The 228 participants (mean age 63 years, 37% male) reported 183 service quality deficiencies. Of the 52 incidents identified on chart review, patients experienced 34 adverse events, 11 close calls, and 7 low risk errors. The presence of any service quality

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deficiency more than doubled the odds of any adverse event, close call, or low risk error (adjusted odds ratio = 2.5; 95% confidence interval = 1.2-5.4). Service quality deficiencies involving poor coordination of care (adjusted odds ratio = 4.4; 95% confidence interval = 1.4-14.0) were associated with the occurrence of adverse events and medical errors. CONCLUSIONS: Patient-reported service quality deficiencies were associated with adverse events and medical errors. Patients who report service quality incidents may help to identify patient safety hazards.

Taylor, D. M., Wolfe, R. and Cameron, P. A. (2002). "Complaints from emergency department patients largely result from treatment and communication problems." Emergency Medicine 14(1): 43-49.

Objective: Emergency department patient complaints are often justified and may lead to apology, remedial action or compensation. The aim of the present study was to analyse emergency department patient complaints in order to identify procedures or practices that require change and to make recommendations for intervention strategies aimed at decreasing complaint rates. Methods: We undertook a retrospective analysis of patient complaints from 36 Victorian emergency departments during a 61 month period. Data were obtained from the Health Complaint Information Program (Health Services Commissioner). Results: In all, 2419 emergency department patients complained about a total of 3418 separate issues (15.4% of all issues from all hospital departments). Of these, 1157 complaints (47.8%) were received by telephone and 829 (34.3%) were received by letter; 1526 (63.1%) complaints were made by a person other than the patient. Highest complaint rates were received from patients who were female, born in non-English-speaking countries and very young or very old. One thousand one hundred and forty-one issues (33.4%) related to patient treatment, including inadequate treatment (329 issues) and inadequate diagnosis (249 issues); 1079 (31.6%) issues related to communication, including poor staff attitude, discourtesy and rudeness (444 issues); 407 (11.9%) issues related to delay in treatment. Overall, 2516 issues (73.6%) were resolved satisfactorily, usually by explanation or apology. Only 59 issues (1.7%) resulted in a procedure or policy change. Remedial action was taken in 109 issues (3.2%) and compensation was paid to eight patients. Conclusions: Communication remains a significant factor in emergency department patient dissatisfaction. While patient complaints have resulted in major changes to policy and procedure, research and intervention strategies into communication problems are indicated. In the short term, focused staff training is recommended.

Tengilimoglu, D., Kisa, A. and Dziegielewski, S. F. (1999). "Patient satisfaction in Turkey: differences between public and private hospitals." Journal of Community Health 24(1): 73-91.

This article reports the results of a patient-satisfaction survey administered by interview to 2045 adults discharged from several major public and private hospitals in Turkey. The direct measurement of patient-satisfaction is a new phenomenon for this country. An instrument was designed similar to those available in the United States and administered during exit interviews. Two primary areas of analyses were determined in comparing services provided by these public and private hospitals: demographic factors with regard to accessibility and consumer perceptions of the quality of service provided. Relationships and percentages within and among the five public and two private hospitals are reported. Several statistically significant differences were found between the hospitals, with the private hospitals achieving the greatest satisfaction on most of the quality of services issues examined. Future recommendations outline the need to take into account the public's perception of these hospitals and enhancing customer satisfaction as a means of increasing service utilization.

Teno, J. M. (1999). "Putting patient and family voice back into measuring quality of care for the dying." Hospice Journal - Physical, Psychosocial, & Pastoral Care of the Dying 14(3-4): 167-76.

Quality of care and quality of life change substantially for those with a serious chronic illness and nearing the end of their lives. As one dies, life takes on new shape-values change and things once ignored become more important. Existing quality of care measures do not attend to the changes in priorities or to dimensions that acquire new significance (e.g., Spirituality and transcendence). An important impediment to addressing the inadequacies in the evidence base for palliative care, improving shortcomings of care, and holding institutions or health care systems accountable for the quality of care is the lack of valid and reliable measurement tools. In this article, an overview is presented of an ongoing research effort to develop measurement tools which will utilize the patient and family perspective to measure the quality of care. [References: 27]

Teno, J. M., Clarridge, B., Casey, V., Edgman-Levitan, S. and Fowler, J. (2001). "Validation of Toolkit After-Death Bereaved Family Member Interview." Journal of Pain & Symptom Management 22(3): 752-758.

The purpose of this study was to examine the reliability and validity of the Toolkit After-Death Bereaved Family Member Interview to measure quality of care at the end of life from the unique perspective of family members. The survey included proposed problem scores (a count of the opportunity to improve the quality of care) and scales. Data were collected through a retrospective telephone survey with a family member who was interviewed between 3 and 6 months after the death of the patient. The setting was an outpatient hospice service, a consortium of nursing homes, and a hospital in New England. One hundred fifty-six family members from across these settings participated. The 8 proposed domains of care, as represented by problem scores or scales, were based on a conceptual model of patient-focused, family-centered medical care. The survey design emphasized face validity in order to provide actionable information to health care providers. A correlational and factor analysis was undertaken of the 8 proposed problem scores or scales. Cronbach's alpha scores varied from 0.58 to 0.87, with two problem scores (each of which had only 3 survey items) having a low alpha of 0.58. The mean item-to-total correlations for the other problem scores varied from 0.36 to 0.69, and the mean item-to-item correlations were between 0.32 and 0.70. The

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proposed problem scores or scales, with the exception of closure and advance care planning, demonstrated a moderate correlation (i.e., from 0.44 to 0.52) with the overall rating of satisfaction (as measured by a five-point, "excellent" to "poor" scale). Family members of persons who died with hospice service reported fewer problems in each of the six domains of medical care, gave a higher rating of the quality of care, and reported higher self-efficacy in caring for their loved ones. These results indicate that 7 of the 8 proposed problem scores or scales demonstrated psychometric properties that warrant further testing. The domain of closure demonstrated a poor correlation with overall satisfaction and requires further work. This survey could provide information to help guide quality improvement efforts to enhance the care of the dying.

Teno, J. M., Fisher, E. S., Hamel, M. B., Coppola, K. and Dawson, N. V. (2002). "Medical care inconsistent with patients' treatment goals: association with 1-year Medicare resource use and survival." Journal of the American Geriatrics Society 50(3): 496-500.

OBJECTIVES: To describe how frequently seriously ill persons perceive that the care they receive is inconsistent with treatment preferences and the effect on 1-year resource utilization. SETTING: Five U.S. teaching hospitals. DESIGN: Secondary analysis of interview data. PARTICIPANTS: Seriously ill Medicare beneficiaries. MEASUREMENTS: Interviews about patients' preferred approaches to care and whether they perceived care was consistent with these preferences. Part A and B costs for up to 1 year, adjusted for cost differences across hospitals and over time and for 1-year survival. RESULTS: Forty percent of the 1,185 study patients expressed a preference for treatment to focus on extending life, whereas 60% expressed a preference for comfort care. Eighty-six percent of the patients who wanted aggressive treatment reported that care was consistent with their preferences, but only 41% of those who preferred comfort care reported that care was consistent with their preferences. More than one-third of those with a preference for comfort care (35%) reported that the medical care that they received was inconsistent with their goals; 24% were unsure of treatment goals. Those who preferred comfort care but believed that their care was inconsistent with their wishes had higher estimated mean 1-year costs than those who believed that their care was consistent with their wishes (92,442 US dollars vs 52,098 US dollars, P < .001). Even after adjusting for differences in disease severity, age, gender, race, functional status, income, and years of education, adjusted costs were 1.4 times (95% confidence interval = 1.2-1.6) higher. However, 1-year survival was lower in these patients who stated that care was consistent with their preference to focus on comfort care than for those who wished to receive comfort care and stated that care was not consistent with their preference (38% vs 55% 1-year survival, P < .001). CONCLUSION: More than one in three seriously ill persons who prefer comfort care believe that their medical care is at odds with their preference that treatment focus on palliation. Such discord was associated with higher 1-year healthcare costs and increased survival.

Thi, P. L. N., Briancon, S., Empereur, F. and Guillemin, F. (2002). "Factors determining inpatient satisfaction with care." Social Science & Medicine 54(4): 493-504.

The objective of the study was to identify factors associated with satisfaction among inpatients receiving medical and surgical care for cardiovascular, respiratory, urinary and locomotor system diseases. Two weeks after discharge, 533 patients completed a Patient Judgments Hospital Quality questionnaire covering seven dimensions of satisfaction (admission, nursing and daily care, medical care, information, hospital environment and ancillary staff, overall quality of care and services, recommendations/intentions). Patient satisfaction and complaints were treated as dependent variables in multivariate ordinal polychotomous and dichotomous logistic stepwise regressions, respectively. Patient sociodemographic, health and stay characteristics as well as organization/ activity of service were used as independent variables. The two strongest predictors of satisfaction for all dimensions were older age and better self-perceived health status at admission. Men tended to be more satisfied than women. Other predictors specific for certain dimensions of satisfaction were: married, Karnofsky index more than 70, critical/serious self-reported condition at admission, emergency admission, choice of hospital by her/himself, stay in a medical service, stay in a private room, length of stay less than one week, stay in a service with a mean length of stay longer than one week. The factors associated with inpatient satisfaction elucidated in this study may be helpful in interpreting patient satisfaction scores when comparing hospitals, services or time periods, in targeting patient groups at risk of worse experiences and in focusing care quality programs.

Thomas, L. H., McColl, E., Priest, J., Bond, S. and Boys, R. J. (1996). "Newcastle satisfaction with nursing scales: an instrument for quality assessments of nursing care." Quality in Health Care 5(2): 67-72.

OBJECTIVES--To test the validity and reliability of scales for measuring patients' experiences of and satisfaction with nursing care; to test the ability of the scales to detect differences between hospitals and wards; and to investigate whether place of completion, hospital, or home influences response. DESIGN--Sample survey. SETTING--20 wards in five hospitals in the north east of England. PATIENTS--2078 patients in general medical and surgical wards. MAIN MEASURES-- Experiences of and satisfaction with nursing care. RESULTS--75% of patients approached to complete the questionnaires did so. Construct validity and internal consistency were both satisfactory. Both the experience and satisfaction scales were found to detect differences between randomly selected wards and hospitals. A sample of patients (102) were sent a further questionnaire to complete at home. 73% returned this; no significant differences were found in either experience or satisfaction scores between questionnaires given in hospital or at home. CONCLUSION--Scales to measure patients' experiences of and satisfaction with nursing in acute care have been developed and found to be valid, reliable, and able to detect differences between hospitals and wards. Questionnaires can be given before patients leave hospital or at home without affecting scores, but those given at home have a lower response rate.

Thomason, J. A. and Watters, D. A. (1995). "Quality assurance in surgery. Patient perceptions of quality."

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Tropical & Geographical Medicine 47(1): 35-7.

Quality assessment and assurance should be concerned not only with technical aspects of health care but also the patient's views. This paper examines patient perceptions of the quality of care through structured interviews and focus group discussions in Port Moresby General Hospital, Papua New Guinea. The results indicated a need for more concern for patient well-being, greater attention to provision of information and improvements in living conditions in the hospital. The findings of this study will be used as a means to improve the patient's experience of surgical care. Similar studies could be performed as a measure of quality in other hospitals in the developing world.

Tokunaga, J. and Imanaka, Y. (2002). "Influence of length of stay on patient satisfaction with hospital care in Japan." International Journal for Quality in Health Care 14(6): 493-502.

OBJECTIVE: The objective of this study was to identify specific patient satisfaction items related to overall satisfaction by different length of stay (LOS) for patients in Japanese hospital settings. METHODS: This cross-sectional study involved a participant sample, drawn from 77 voluntarily participating hospitals throughout Japan, of in-patients discharged to the community. Older patients and psychiatric, pediatric, obstetric and gynecologic patients were excluded. The 1050 respondents analyzed (response rate > or = 5l.1%) were divided into three groups based on their LOS: group 1, LOS < or = 1 week; group 2, LOS < or = 1 month; and group 3, LOS > 1 month. Using stepwise multiple regression analysis, we explored for each LOS group the relationship between overall patient satisfaction and satisfaction with 33 individual items, including three regarding perceived reputation of the hospital in question. RESULTS: Some unique satisfaction items for each group (e.g. 'skill of nursing care' in group 1, 'Recovery of physical health', 'skill of nursing care', and 'respect for patients opinions and feelings' in group 2, and 'relief from pain' and 'respect for patients' opinions and feelings' in group 3) were significantly associated with overall satisfaction. In all three groups, common items (e.g. 'recovery from distress and anxiety' and 'doctor's clinical competence') also related significantly to overall satisfaction. Two items pertaining to the hospital reputation dimension (e.g. 'family member's evaluation of the hospital' and 'hospital reputation among other patients') were also significant predictors of overall satisfaction in all three groups. CONCLUSION: The findings show that according to LOS, unique items could determine significantly the achievement of overall satisfaction, while some common predictors across all three LOS groupings also seemed to be indispensable for inpatient's assessment of hospital care. It was also confirmed in this study that a positive perception of hospital reputation might have an important role in patient satisfaction in Japan.

Tokunaga, J., Imanaka, Y. and Nobutomo, K. (2000). "Effects of patient demands on satisfaction with Japanese hospital care." International Journal for Quality in Health Care 12(5): 395-401.

Objective. The objective of this study was to detect whether there was any difference among the characteristics of patient satisfaction between two patient emphasis groups: patients demanding technical elements of hospital care and patients demanding interpersonal elements. Design and setting. The sample for this study was drawn from in-patients discharged from 77 voluntarily participating hospitals throughout Japan. The relationship between overall satisfaction with hospital care and patient satisfaction, and the evaluation of a hospital's reputation, was explored by stepwise multiple regression analysis of 33 variables relevant to aspects of hospital care for each patient group. Results. In the interpersonal emphasis (IE) group, 'nurse's kindness and warmth' was associated significantly with overall satisfaction, while 'skill of nursing care' and 'nurse's explanation' were significant predictors of overall satisfaction in the technical emphasis (TE) group. On the other hand, 'doctor's clinical competence', 'recovery from distress and anxiety', and items pertaining to the hospital's reputation were significantly related to overall satisfaction in both emphasis groups. Conclusion. For overall patient satisfaction, it is essential to satisfy specific items related to the aspect of hospital Care emphasized by the patient. Specific significant predictors of overall satisfaction (e.g. 'doctor's clinical competence') were indispensable measures of professional performance in hospital care, irrespective of the patients' emphasis. A positive perception of hospital reputation items might increase overall patient satisfaction with Japanese hospitals.

Tomlinson, J. S. and Ko, C. Y. (2006). "Patient satisfaction: An increasingly important measure of quality." Annals of Surgical Oncology 13(6): 764-765.

Torres, E. J. and Guo, K. L. (2004). "Quality improvement techniques to improve patient satisfaction." International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services 17(6): 334-8.

This paper describes several approaches for implementing quality improvement initiatives to improve patient satisfaction, which enables health-care organizations to position themselves for success in today's global and increasingly competitive environment. Specifically, measuring the views of patients, improving patient satisfaction through a community-wide effort, and using a Six Sigma program are discussed. Each of these programs can be an effective mechanism for quality improvement. A key component to quality improvement techniques involves collaborative efforts by all health-care professionals and managers as they seek to increase patient satisfaction.

Torres, S. M. (2007). "Process improvements. Rapid-cycle process reduces patient call bell use, improves patient satisfaction, and anticipates patient's needs." Journal of Nursing Administration 37(11): 480-482.

Toth, K. J., Berenyi, T. and Mezofi, M. (2004). "[Assessment of patient satisfaction for the improvement of emergency medical services]." Orvosi Hetilap 145(12): 625-9.

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Quality expectations of emergency medicine are not fully formed yet. However, client satisfaction examinations proved to be a valid tool for assessment of different parts of medical care. To define process parameters turning to efficiently expand of maintenance-quality the authors developed and applied a client satisfaction questionnaire in Szent Imre Hospital Emergency Department. Answers for client satisfaction questionnaire collation of characteristics of patients' demographic data, sociological situation, and quality of life were studied by multinomial regression analysis in a prospective pilot study. The returned questionnaires were represented in 28% of the examined patient group. To achieve the greatest improvement in patients satisfaction, painkilling, patients information, and inter-relationship between patients and providers would be corrected in the emergency department. Compound client satisfaction questionnaire was proved to be a susceptible tool for identified the relevant pars of the process quality.

Triolo, P. K., Hansen, P., Kazzaz, Y., Chung, H. and Dobbs, S. (2002). "Improving patient satisfaction through multidisciplinary performance improvement teams." Journal of Nursing Administration 32(9): 448-54.

Hospitals today are challenged by high patient census, rising acuity, and workforce issues that can result in a serious decline in overall patient satisfaction. This article discusses how one hospital tackled the issue of declining patient satisfaction scores on five "troubled" patient care units through a performance improvement strategy that included MD-RN partnerships, co-mentoring, and unit staff development and involvement in the problem-solving process. The result was a steady improvement in patient satisfaction over a 6-month period.

Trumble, S. C., O'Brien, M. L., O'Brien, M. and Hartwig, B. (2006). "Communication skills training for doctors increases patient satisfaction." Clinical Governance 11(4): 299-307.

Purpose - The purpose of this paper is to examine changes in patients' satisfaction after their doctor has participated in a brief educational intervention on medicolegal risk management. Design/methodology/approach - Questionnaire completed by ambulatory patients, measuring satisfaction with their doctor's communication skills before and three months after the doctor participated in a three hour workshop on medicolegal risk management. 75 obstetrician/ gynaecologists (O&Gs) and 99 general practitioners (GPs) were each rated by 60 of their patients following a consultation in their clinical rooms. Findings - Patient satisfaction as evidenced by change to "complete satisfaction" with doctor's communication skills and overall satisfaction with the clinical encounter. Practical implications - Participants had high initial patient satisfaction ratings and these were found to have improved across all parameters three months after the educational intervention. Originality/value - The educational intervention was successful in improving doctors' communication skills as evidenced by enhanced patient satisfaction in all key areas, including those most frequently associated with patient complaint, litigation and adverse outcome.

Tsai, W. C. and Kung, P. T. (2003). "Consumers' assessment of clinic services and its affecting factors. [Chinese]." Taiwan Journal of Public Health 22(3): 181-193.

Objectives: In order to decrease the utilization of hospital outpatient services by patients with minor illnesses and to increase the willingness to visit primary care clinics, this study investigated the consumers' assessment of the types and quality of services delivered by clinics. The study also examined the factors determining the low preference for clinic-based services compared to hospital outpatient care. Based on the results, a number of policy interventions are proposed to improve the utilization of clinic-based care. Method: Structured questionnaires were used to interview patients selected randomly from four levels of the health service delivery system. A total of 1148 patients were interviewed. Descriptive statistics provide the basic information about patient's opinion and assessment of services received from clinics and the stepwise regression method was used to identify the factors affecting the assessment scores of clinics. Results: Factors affecting the patient's preference include the educational status of individuals, perception about physician's referral pattern, satisfaction with physician's competence, attitudes of nurses and pharmacists, time needed to diagnose illnesses, and the patient satisfaction with physician's explanation about the illness. From the patient's point of view, the three most important factors determining the quality of clinic care were the explanations given by physicians about the illnesses, cleanliness of the clinic and perceived knowledge and competence of the physician. The top three factors affecting patients' satisfaction with clinics were the physician's manner and attitude, rapport between physicians and patients, and the physician's knowledge and competence. Conclusion: The results indicate that the utilization of clinics will improve if the physicians perform patient-oriented promotional activities, improve service quality, establish group medical practice, and enhance physician's competence. The health policy decision makers may also consider increasing the out-of-pocket payment for patients at the hospital level if not referred by a primary care physician. The health care delivery system can also promote the adoption of a well-defined protocol for patient referrals from primary to secondary and tertiary levels. Finally, continuing educational programs to update the knowledge and skills of clinic physicians will help to improve the confidence of patients in physicians in the primary care clinics.

Tucker, J. L. (2002). "The moderators of patient satisfaction." Journal of Management in Medicine 16(1): 48-66.

The purpose of this study was to determine which Department of Defense (DOD) active duty patient sociodemographic, health status, geographic location, and utilization factors, predict overall patient satisfaction with health care in military facilities. A theoretical framework developed from patient satisfaction and social identity theories and from previous empirical findings was used to develop a model to predict patient satisfaction and delineate moderating variables. The major finding indicated in this study was the

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significance of patients' characteristics in moderating their satisfaction. Principal components factor analysis and hierarchical linear regression revealed that patient specific factors predicted patients' satisfaction after controlling for factors depicting patients' evaluations of health system characteristics. Patient specific factors provided added, although very minimal, explanatory value to the determination of patients' satisfaction. The study findings can aid in the development of targeted, objectively prioritized programs of improvement and marketing by ranking variables using patients' passively derived importance schema.

Turnbull, J. E. and Luther, K. M. (1996). "Patient satisfaction report paves way to improved care." QRC Advisor 13(1): 1-7.

In this article, the second in a two-part series, we show how a data-driven clinical model was implemented to improve care using patient satisfaction reports. Last month, we outlined the essential components of a data-driven clinical model and summarized two research paradigms that provide the theoretical foundation for such a model.

Turner, J. T. and Matthews, K. A. (1991). "Measuring adolescent satisfaction with nursing care in an ambulatory setting." ABNF Journal 2(3): 48-52.

This descriptive study addresses the topic of patient satisfaction with nursing care. A convenience sample of adolescent females who attended health department family planning clinics in a southeastern city was surveyed to determine the level of satisfaction with care provided by clinic nurses. Data were collected using the Risser Patient Satisfaction with Nursing Care instrument (Risser, 1975) which had been used exclusively with adults. A primary purpose, therefore, was to test the instrument with a teenage population. Data analysis yielded descriptive statistics, frequency distributions, correlations and alpha reliability coefficients. Findings indicated that the teenagers were most satisfied with the technical-professional aspect of nursing care and least satisfied with the interpersonal-educational aspect. The Risser instrument was found to be highly reliable with this adolescent cohort.

Turris, S. A. (2005). "Unpacking the concept of patient satisfaction: a feminist analysis." Journal of Advanced Nursing 50(3): 293-298.

AIM: The aim of this paper is to present a feminist critique of the concept of patient satisfaction. BACKGROUND: Fiscal restraint, health care restructuring, shifting demographics, biomedical technological advances, and a significant shortage of health care professionals are stretching health care systems across North America to the breaking point. A simultaneous focus on consumerism and health service accountability is placing additional pressure on the system. The concept of patient satisfaction, with roots in the consumer movement of the 1960s, has both practical and political relevance in the current health care system and is commonly used to guide research related to consumer experiences of health care. Because the quality of health care encounters may lead to treatment-seeking delays, patient satisfaction research may be an effective vehicle for addressing this public health issue. However, there is wide agreement that patient satisfaction is an under-theorized concept. Using current conceptualizations of patient satisfaction, we end up all too often producing a checklist approach to 'achieving' patient satisfaction, rather than developing an understanding of the larger issues underlying individual experiences of health care. We focus on the symptoms rather than the problems. DISCUSSION: Without further theoretical refinement, the results of research into patient satisfaction are of limited use. To push forward theoretical development we might apply a variety of theoretical lenses to the analysis of both the concept and the results of patient satisfaction research. Feminism, in particular, offers a perspective that may provoke further refinement of patient satisfaction as a concept. CONCLUSIONS: Without a deeper understanding of the values and beliefs (or the worldview) that informs our approaches to researching patient satisfaction, researchers will be reacting to the most obvious indicators and failing to address the underlying issues related to individual experiences of health care.

Twardon, C. A. and Gartner, M. B. (1991). "Empowering nurses: patient satisfaction with primary nursing in home health." Journal of Nursing Administration 21(11): 39-43.

Responsibility, accountability, and authority are the tools of primary nursing that enable nurses to impact patient care. It is important to determine if nurses empowered by a primary care delivery system can positively influence patient outcomes. The authors describe an outcome audit conducted to study patient satisfaction with nursing care, one indicator of quality patient care.

VanderVeen, L. and Ritz, M. (1996). "Customer satisfaction: a practical approach for hospitals." Journal for Healthcare Quality 18(2): 10-5.

A California hospital developed a program to better serve and satisfy its customers. This article details the hospital's plan to implement the program with the collection and use of data to measure success, promote staff accountability, and, ultimately, demonstrate improved customer satisfaction as measured by fewer complaints. The various activities initiated to promote staff education and recognize employees also are briefly addressed.

Verbeek, J., van Dijk, F., RÃ¤sÃ¤nen, K., Piirainen, H., KankaanpÃ¤Ã¤, E. and Hulshof, C. (2001). "Consumer satisfaction with occupational health services: should it be measured?" Occupational & Environmental Medicine 58(4): 272-278.

OBJECTIVES: To find answers in the literature to the questions if, why, and how consumer satisfaction with occupational health services (OHSs) should be measured. METHODS: Publications about the concept of consumer satisfaction with health care and surveys of consumer satisfaction with occupational health care

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were reviewed. RESULTS: For care providers, surveys of consumer satisfaction can be useful to improve quality or as indicators of non-compliant behaviour among patients. For clients, satisfaction surveys can be helpful for choosing between healthcare providers. Satisfaction is made up of an affective component of evaluation and a cognitive component of expectations. Also, in occupational health care, patient satisfaction is measured by dimensions such as the humanness and competence of the care provider similar to health care in general. However, there are dimensions that are specific to occupational health-such as the perceived independence of the physician, unclear reasons for visiting an OHS, and the perceived extent of knowledge of OHS professionals about the patient's working conditions. Dimensions of client satisfaction are mostly similar to patient satisfaction but include more businesslike aspects. They are different for the two groups of client, employers and employees. To measure consumer satisfaction in occupational healthcare specific questionnaires must be constructed. To achieve the highest possible reader satisfaction guidelines are provided for construction of a questionnaire. CONCLUSIONS: Consumer satisfaction is a complex theoretical concept, but it is relatively easy to measure in practice and can be a valuable tool for quality improvement. Consumers' evaluations of occupational health services will become increasingly important due to changes in the organisation of occupational health care. Occupational healthcare providers are encouraged to measure the consumer satisfaction of their services.

Verdessi, B. D., Jara, G., Fuentes, R., Gonzalez, J. C., Espejo, F. and de Azevedo, A. C. (2000). "The role of discriminant analysis in the refinement of customer satisfaction assessment." Revista de Saude Publica 34(6): 623-30.

OBJECTIVE: To test discriminant analysis as a method of turning the information of a routine customer satisfaction survey (CSS) into a more accurate decision-making tool. METHODS: A 7-question, 10-multiple choice, self-applied questionnaire was used to study a sample of patients seen in two outpatient care units in Valparaiso, Chile, one of primary care (n=100) and the other of secondary care (n=249). Two cutting points were considered in the dependent variable (final satisfaction score): satisfied versus unsatisfied, and very satisfied versus all others. Results were compared with empirical measures (proportion of satisfied individuals, proportion of unsatisfied individuals and size of the median). RESULTS: The response rate was very high, over 97.0% in both units. A new variable, medical attention, was revealed, as explaining satisfaction at the primary care unit. The proportion of the total variability explained by the model was very high (over 99.4%) in both units, when comparing satisfied with unsatisfied customers. In the analysis of very satisfied versus all other customers, significant relationship was identified only in the case of the primary care unit, which explained a small proportion of the variability (41.9%). CONCLUSIONS: Discriminant analysis identified relationships not revealed by the previous analysis. It provided information about the proportion of the variability explained by the model. It identified non-significant relationships suggested by empirical analysis (e.g. the case of the relation very satisfied versus others in the secondary care unit). It measured the contribution of each independent variable to the explanation of the variation of the dependent one.

Vinagre, M. H. and Neves, J. (2008). "The influence of service quality and patients' emotions on satisfaction." International Journal of Health Care Quality Assurance 21(1): 87-103.

PURPOSE: The purpose of this research is to develop and empirically test a model to examine the major factors affecting patients' satisfaction that depict and estimate the relationships between service quality, patient's emotions, expectations and involvement. DESIGN/METHODOLOGY/APPROACH: The approach was tested using structural equation modeling, with a sample of 317 patients from six Portuguese public healthcare centres, using a revised SERVQUAL scale for service quality evaluation and an adapted DESII scale for assessing patient emotions. FINDINGS: The scales used to evaluate service quality and emotional experience appears valid. The results support process complexity that leads to health service satisfaction, which involves diverse phenomena within the cognitive and emotional domain, revealing that all the predictors have a significant effect on satisfaction. RESEARCH LIMITATIONS/IMPLICATIONS: The emotions inventory, although showing good internal consistency, might be enlarged to other typologies in further research--needed to confirm these findings. PRACTICAL IMPLICATIONS: Patient's satisfaction mechanisms are important for improving service quality. ORIGINALITY/VALUE: The research shows empirical evidence about the effect of both patient's emotions and service quality on satisfaction with healthcare services. Findings also provide a model that includes valid and reliable measures.

Vingerhoets, E., Wensing, M. and Grol, R. (2001). "Feedback of patients' evaluations of general practice care: a randomised trial." Quality in Health Care 10(4): 224-8.

OBJECTIVE: To assess the effects of feedback of patients' evaluations of care to general practitioners. DESIGN: Randomised trial. SETTING: General practice in the Netherlands. SUBJECTS: 55 GPs and samples of 3691 and 3595 adult patients before and after the intervention, respectively. INTERVENTIONS: GPs in the intervention group were given an individualised structured feedback report concerning evaluations of care provided by their own patients. Reference figures referring to other GPs were added as well as suggestions for interpretation of this feedback, an evidence-based overview of factors determining patients' evaluations of care, and methods to discuss and plan improvements. MAIN OUTCOME MEASURES: Patients' evaluations of nine dimensions of general practice measured with the CEP, a previously validated questionnaire consisting of 64 questions, using a six point answering scale (1= poor, 6 = very good). RESULTS: Mean scores per CEP dimension varied from 3.88 to 4.77. Multilevel regression analysis showed that, after correction for baseline scores, patients' evaluations of continuity and medical care were less positive after the intervention in the intervention group (4.60 v 4.77, $p < 0.05$ and 4.68 v 4.71, $p < 0.05$, respectively). No differences were found in the remaining seven CEP dimensions. CONCLUSIONS: Providing feedback on patients' evaluations of care to GPs did not result in changes in their evaluation of the care received. This conclusion challenges the relevance of feedback on patients'

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evaluations of care for quality improvement.

Vista, A. A. (2000). An exploratory study of the relationship between home health patient satisfaction and patient outcomes, Walden University: 222 p.

The purpose of this nonexperimental, descriptive study was to investigate the relationship between the health outcomes of patients in a home health care agency, the patients' satisfaction with the care received, and the RN case managers' perceptions of quality outcomes. The data were collected from closed files of 115 patients and 27 Registered Nurse case managers from one home health agency.

A significant relationship did not exist between quality outcomes and patient satisfaction. Whereas the patients registered a high degree of satisfaction on the Patient Satisfaction Survey, the RN case managers' report of patient outcomes on the OASIS (Outcome and Assessment Information Set) was not positively correlated with patient satisfaction; however, the patients' status did stabilize.

Some personal and professional characteristics of the RN case managers were positively correlated with patient outcomes. Other nurse characteristics may have contributed to the high degree of patient satisfaction, irrespective of health outcomes. While the length of the OASIS presented a challenge for case managers, its usefulness as an assessment and quality improvement tool was demonstrated by this study.

Volpintesta, E. (2002). "Patient complaints and risk of being sued.[comment]." JAMA 288(13): 1585; author reply 1585-6.

Vukmir, R. B. (2006). "Customer satisfaction." International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services 19(1): 8-31.

PURPOSE: This paper seeks to present an analysis of the literature examining objective information concerning the subject of customer service, as it applies to the current medical practice. Hopefully, this information will be synthesized to generate a cogent approach to correlate customer service with quality. DESIGN/METHODOLOGY/APPROACH: Articles were obtained by an English language search of MEDLINE from January 1976 to July 2005. This computerized search was supplemented with literature from the author's personal collection of peer-reviewed articles on customer service in a medical setting. This information was presented in a qualitative fashion. FINDINGS: There is a significant lack of objective data correlating customer service objectives, patient satisfaction and quality of care. Patients present predominantly for the convenience of emergency department care. Specifics of satisfaction are directed to the timing, and amount of "caring". Demographic correlates including symptom presentation, practice style, location and physician issues directly impact on satisfaction. It is most helpful to develop a productive plan for the "difficult patient", emphasizing communication and empathy. Profiling of the customer satisfaction experience is best accomplished by examining the specifics of satisfaction, nature of the ED patient, demographic profile, symptom presentation and physician interventions emphasizing communication--especially with the difficult patient. ORIGINALITY/VALUE: The current emergency medicine customer service dilemmas are a complex interaction of both patient and physician factors specifically targeting both efficiency and patient satisfaction. Awareness of these issues particular to the emergency patient can help to maximize efficiency, minimize subsequent medicolegal risk and improve patient care if a tailored management plan is formulated. [References: 79]

Vukmir, R. B. (2006). "Customer satisfaction with patient care: "Where's the Beef?"." Journal of Hospital Marketing & Public Relations 17(1): 79-107.

STUDY OBJECTIVE: This was an attempt to present an analysis of the literature examining objective information concerning the subject of customer service, as it applies to the current medical practice. Hopefully this information will be synthesized to generate a cogent approach to correlate customer service with quality. METHODS: Articles were obtained by an English language search of MEDLINE from January 1976 to July 2005. This computerized search was supplemented with literature from the author's personal collection of peer reviewed articles on customer service in a medical setting. This information was presented in a qualitative fashion. RESULTS: There is a significant lack of objective data correlating customer service objectives, patient satisfaction, and quality of care. Patients present predominantly for the convenience of emergency department care. Specifics of satisfaction are directed to the timing, and amount of "caring." Demographic correlates including symptom presentation, practice style, location, and physician issues directly impact on satisfaction. It is most helpful to develop a productive plan for the "difficult patient" emphasizing communication and empathy. CONCLUSION: The current emergency medicine customer service dilemmas are a complex interaction of both patient and physician factors specifically targeting both efficiency and patient satisfaction. Awareness of these issues can help to maximize efficiency, minimize subsequent medicolegal risk and improve patient care. [References: 79]

Vuori, H. (1987). "Patient satisfaction -- an attribute or indicator of the quality of care?" QRB: Quality Review Bulletin 13(3): 106-108.

Vuori, H. (1991). "Patient satisfaction--does it matter?" Quality Assurance in Health Care 3(3): 183-9.

The paper aims at answering the question: Has the measurement of patient satisfaction improved the quality of care? After concluding that there is no evidence in the literature, the paper proceeds to look at why the evidence is lacking. Four factors seem to explain it: the objectives, the focus and the originator of the patients satisfaction studies and measurements and difficulties related to the interpretation of the findings. The last part of the paper analyses why patient satisfaction should be taken seriously although we do not know whether its measurement improves the quality of care. They include the fact that the patients

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are partners in health care; they literally feel in their skin whether care is good or bad. They are also the best judges of certain aspects of care, such as amenities and interpersonal relations. The second reason is the transformation of health care from a sellers' market to a consumers' market where the satisfaction of the patients' needs is part of the definition of quality. Finally, there is the ideological reason that, in a democratic society, the patients should have the right to influence decisions and activities influencing them. Measurement of patient satisfaction realizes the principle of community participation in health care.

Wadhwa, S. S. (2003). "Customer satisfaction and health care delivery systems: commentary with Australian bias." Internet Journal of Health 3(1): 9p.

As the health care industry strains the nation's financial resources it has come under increased pressure to provide evidence of quality controls and quality improvements. Increasing evidence that the service aspects of health care are closely linked to health care outcomes has caught the attention of industry leaders. The current health care consumer is better educated and the best informed it has ever been. Health care organizations must address those aspects of service that consumers most readily appreciate: access to care; relationships between physicians, meaningful and understandable information; and participation in their own health care and treatment decision making processes. One aspect of health care quality that is being increasingly recognized for its importance is the influence of patient perception. Even though the patient's perception of quality relies more on the service aspects of health care, it correlates well with objective measures of health care quality. A health care organization's ability to satisfy consumer demand for convenience and information can significantly influence the quality of health care it ultimately delivers. The health care service industry is complex with multiple facets and levels of organization. Health care system management has previously been relatively inefficient, incoherent and supply driven, keeping customers on the outside of the product design, development and the delivery process. Today there is a shift to an organization model in which the customer influences every function and managers must adapt and be instrumental in establishing a cultural change within the system to meet the new quality focus. Many physicians doubt that the current emphasis on quality is really aimed at improving patient's health. There is paucity of evidence that, as a whole quality initiatives actually do anything to improve outcomes for patients. Physicians however are in the best position to make a case for improving quality. Showing leadership in assessing and improving the quality of care can not only improve outcomes for patients, but also give physicians renewed autonomy over the practice of medicine. There are a number of ways in which the community and consumers may participate in the development of health care policy. These can range from passive consultations to structural participation is an engaged and developmental process in which community control predominates. Unfortunately entrenched biases of researchers and practitioners can limit community involvement. Reform of bureaucratic structures, curriculum and research methodology are all required to effectively involve the health care consumer. Although there is strong evidence in favor of consumer participation care and due diligence however needs to be exercised to ensure that consumer rights are not over emphasized at the expense of health care quality.

Wagner, D. and Bear, M. (2009). "Patient satisfaction with nursing care: a concept analysis within a nursing framework." Journal of Advanced Nursing 65(3): 692-701.

AIM: This paper is a report of a concept analysis of patient satisfaction with nursing care. BACKGROUND: Patient satisfaction is an important indicator of quality of care, and healthcare facilities are interested in maintaining high levels of satisfaction in order to stay competitive in the healthcare market. Nursing care has a prominent role in patient satisfaction. Using a nursing model to measure patient satisfaction with nursing care helps define and clarify this concept. DATA SOURces: Rodgers' evolutionary method of concept analysis provided the framework for this analysis. Data were retrieved from the Cumulative Index of Nursing and Allied Health Literature and MEDLINE databases and the ABI/INFORM global business database. The literature search used the keywords patient satisfaction, nursing care and hospital. The sample included 44 papers published in English, between 1998 and 2007. RESULTS: Cox's Interaction Model of Client Health Behavior was used to analyse the concept of patient satisfaction with nursing care. The attributes leading to the health outcome of patient satisfaction with nursing care were categorized as affective support, health information, decisional control and professional/technical competencies. Antecedents embodied the uniqueness of the patient in terms of demographic data, social influence, previous healthcare experiences, environmental resources, intrinsic motivation, cognitive appraisal and affective response. Consequences of achieving patient satisfaction with nursing care included greater market share of healthcare finances, compliance with healthcare regimens and better health outcomes. CONCLUSION: The meaning of patient satisfaction continues to evolve. Using a nursing model to measure patient satisfaction with nursing care delineates the concept from other measures of patient satisfaction.

Waldrop, R. D., Harper, D. E. and Mandry, C. (1997). "Prospective assessment of triage in an urban emergency department." Southern Medical Journal 90(12): 1208-12.

BACKGROUND: This study examined the effectiveness of a triage system based on patient complaints, medical history, vital signs, and triage nurse impression. Measurements included recognizing patients needing admission, in correlating with disposition, and its effectiveness in all age groups. METHODS: Data were collected prospectively on all patients coming to a general emergency department (ED) of an urban teaching hospital from October 1, 1992, through November 30, 1992. Data included assigned triage acuity, disposition waiting time to physician examination, and disposition, as well as return to the ED within 2 weeks. The patients were divided into age groups: 0 to 16 years, 17 years to 25 years, 25 years to 50 years, 50 years to 65 years, and >65 years of age. RESULTS: There were five patients (n = 4,993, 0.4%) who were triaged nonemergently and subsequently admitted. The sensitivity and specificity of an assigned triage 3 acuity assignment in correlating with lack of admission were 99% and 56%, respectively. Mean waiting time to physician examination was 61 +/- 14 minutes for triage 1, 129 +/- 19 for triage 2, and 182 +/- 22 for

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triage 3. Mean time to admission from sign-in was 246 +/- 10 minutes for triage 1 and 372 +/- 16 minutes for triage 2. CONCLUSIONS: This triage system accurately correlated with disposition and determined waiting time to examination.

Walsh, M. and Walsh, A. (1999). "Measuring patient satisfaction with nursing care: experience of using the Newcastle Satisfaction with Nursing Scale." Journal of Advanced Nursing 29(2): 307-15.

Patient satisfaction with care has frequently been used as a measurement of quality, especially in attempts to demonstrate the benefits of changes in nursing practice. Unfortunately such attempts have frequently failed as patient satisfaction ratings have lacked sensitivity, consistently achieving very high scores. They have also failed to isolate the nursing component from the whole health care experience. The Newcastle Satisfaction with Nursing Scale (NSNS) has been developed after extensive research work as an attempt to establish reliable and valid measures of patients' experiences of and satisfaction with nursing care. This study evaluated the use of the NSNS in practice and found that it was readily understood by patients and easily administered by clinical staff. However, several lessons were learnt which could help its administration. The results demonstrated a very high degree of satisfaction with nursing care which left the discriminatory ability of the scale open to question, although its potential benefits in standard setting were demonstrated. Further evaluative studies are needed if the potential benefits of the NSNS are to be fully realised.

Ward, K. F., Rolland, E. and Patterson, R. A. (2005). "Improving outpatient health care quality: understanding the quality dimensions." Health Care Management Review 30(4): 361-71.

Based on literature review, we derive a set of dimensions that influence patient-perceived health care quality. Utilizing outpatient survey data from 222 different physicians, we identified six underlying quality factors and classified them according to the derived dimensions. These quality factors explain approximately 51 percent of the variation in overall patient-perceived health care quality. [References: 40]

Watrous, J. and Hobson, A. (1994). "A systems approach to gathering and analyzing patient and family complaints and suggestions." Journal for Healthcare Quality 16(6): 14-6.

Most medical facilities' leaders are concerned with satisfying the patients who use their healthcare organization. Whereas many facilities have identified specific individuals whose job it is to hear patient complaints, the authors promote the view that all staff members play important roles in patient advocacy. Management's role is to determine how to collect and analyze the complaints and suggestions voiced by patients throughout their healthcare experience. This article presents one method.

Webb, B. (1995). "A study of complaints by patients of different age groups in an NHS trust." Nursing Standard 9(42): 34-7.

A study was undertaken in an NHS trust general hospital to determine if older or younger patients submitted more complaints, and if differences existed in the topics of complaint, and the subsequent handling of the complaints. The patient administration system, the complaints register and a questionnaire were used to collect the data from the complaint files. The study found that older patients were twice as likely to complain to the unit as younger patients. The majority of complaints from both age groups specified poor attitudes and communication of staff, and inadequate care. The recommendations include the need to improve the documentation and filing of the complaints, to use the Patient's Charter (1) as a resource for planning the service and to examine why complaints specified doctors more than other staff.

Weingarten, S. R., Stone, E., Green, A., Pelter, M., Nessim, S., Huang, H. and Kristopaitis, R. (1995). "A study of patient satisfaction and adherence to preventive care practice guidelines.[see comment]." American Journal of Medicine 99(6): 590-6.

PURPOSE: Patient satisfaction ratings are being used to judge physicians' quality of care and to determine physician reimbursement. We therefore studied the association between patient satisfaction and the quality of medical care received by patients in physicians' offices. PATIENTS AND METHODS: Patient satisfaction was measured in a survey of patients cared for by 48 primary care physicians in a health maintenance organization in Southern California. Evidence that patients were offered or received preventive care services was determined by patient survey and medical record abstraction, respectively. The medical records of 3,249 randomly selected elderly patients (65 to 75 years old) were studied. Of these patients, 2,799 completed a patient satisfaction and preventive care services survey (response rate 86.1%), 2,654 completed a patient satisfaction survey (response rate 81.7%), and 2,258 completed a quality-of-life survey (response rate 69.5%). RESULTS: Patients were generally satisfied with their physicians' care (median satisfaction score 4.2; scale 1 to 5, 5 being most satisfied). Patients who received or were offered mammography, clinical breast examination, influenza vaccine, pneumococcal vaccine, tetanus vaccine, exercise counseling, and smoking cessation counseling were more satisfied with their medical care than those patients who did not ($P < 0.001$ for all tests). After controlling for the physician who was providing the medical care, there was still a statistically significant relationship between these factors and patient satisfaction. CONCLUSIONS: We found a significant association between patient satisfaction and the performance of some but not all preventive care services. However, we cannot be certain whether there is a relationship between patient satisfaction and quality of patient care.

Wennberg, J. E., Bronner, K., Skinner, J. S., Fisher, E. S. and Goodman, D. C. (2009). "Inpatient care intensity and patients' ratings of their hospital experiences." Health Affairs 28(1): 103-112.

The intensity of hospital care provided to chronically ill Medicare patients varies greatly among regions,

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independent of illness. We examined the associations among hospital care intensity, the technical quality of hospital care, and patients' ratings of their hospital experiences. Greater inpatient care intensity was associated with lower quality scores and lower patient ratings; lower quality scores were associated with lower patient ratings. The common thread linking greater care intensity with lower quality and less favorable patient experiences may be poorly coordinated care.

Wensing, M. and Elwyn, G. (2002). "Research on patients' views in the evaluation and improvement of quality of care." Quality & Safety in Health Care 11(2): 153-7.

The identification of methods for assessing the views of patients on health care has only developed over the last decade or so. The use of patients' views to improve healthcare delivery requires valid and reliable measurement methods. Four approaches are recognised: inclusion of patients' views in the information to those seeking health care, identification of patient preferences in episodes of care, patient feedback on delivery of health care, and patients' views in decision making on healthcare systems. Outcome measures for the evaluation of the use of patients' views should reflect the aims in terms of processes or outcomes of care, including possible negative consequences. Rigorous methodologies for the evaluation of methods have yet to be implemented.

Wensing, M., Grol, R., van Montfort, P. and Smits, A. (1996). "Indicators of the quality of general practice care of patients with chronic illness: a step towards the real involvement of patients in the assessment of the quality of care." Quality in Health Care 5(2): 73-80.

OBJECTIVE--To develop a list of indicators of the general practice care of people with chronic illnesses considered important by both patients and practitioners and to identify the indicators that are considered relevant for patient assessment of health care quality. DESIGN--Qualitative study with focus group interviews and a written consensus procedure. SETTING--General practice in the Netherlands in 1993. SUBJECTS--34 patients with chronic illness, mostly members of patient organisations, and 19 general practitioners with expertise in either chronic disease management or experience with patient surveys. MAIN MEASURES--Aspects of general practice care considered important for the delivery of good quality care that emerged from focus group interviews; the relevance of evaluations of 41 aspects of care for patients explored through the written consensus procedure. Those aspects of general practice care agreed to be both important and relevant by patients and general practitioners were considered to be suitable indicators for patient assessment of the quality of care. RESULTS--Patients and general practitioners differed to some extent in their assessment of the aspects of care that they considered important for quality. They agreed that most indicators of care that related to the inverted-?doctor-patient relationinverted-? and to inverted-?information and supportinverted-? were relevant and therefore suitable as indicators for patient assessment of health care quality. There was less agreement about the relevance of indicators of inverted-?medical and technical care,inverted-? inverted-?availability and accessibility,inverted-? and inverted-?organisation of services.inverted-? CONCLUSIONS--Several indicators of the quality of general practice care of patients with chronic illness were thought to be suitable for the patient assessment of healthcare quality, but other indicators were not, mainly because of reservations by general practitioners. IMPLICATIONS-- Qualitative methods can contribute to the selection of indicators for assessment of the quality of health care in areas where scientific evidence is limited or where patients' and providers' preferences are particularly important.

Wensing, M., Vingerhoets, E. and Grol, R. (2003). "Feedback based on patient evaluations: a tool for quality improvement?" Patient Education & Counseling 51(2): 149-53.

Feedback regarding patient evaluations of health care is expected to be a tool for quality improvement. This study examined the response of general practitioners to such feedback in a randomised trial. Practitioners in the intervention group read and discussed the feedback report and then reported on a range of actions that can be undertaken to improve the quality of care. Their communication behaviour was not found to change. All of the practitioners were highly motivated to learn from patient views, both at baseline and after the intervention period. Compared to the control group, the practitioners in the intervention group had less favourable views of the relevance of patient feedback for their practice after the receipt of such feedback. Furthermore, these practitioners felt that a patient survey required considerable time and energy and saw little reason for change. Although patient feedback can help identify areas for improvement, specific barriers must be addressed before such feedback can be put to more widespread use.

Westaway, M. S., Rheeder, P., Van Zyl, D. G. and Seager, J. R. (2003). "Interpersonal and organizational dimensions of patient satisfaction: the moderating effects of health status." International Journal for Quality in Health Care 15(4): 337-44.

OBJECTIVES: Based on Donabedian's structure, process, and outcome model, this study was conducted to identify the underlying dimensions of patient satisfaction for diabetic patients and determine the effects of demographic characteristics and health status on these dimensions. DESIGN: A cross-sectional analytical research design was used with a questionnaire, comprising demographic characteristics, the general and mental health items from the SF-20, and a 25-item patient satisfaction scale. SETTING AND STUDY PARTICIPANTS: The questionnaire was administered to 263 South African black diabetic outpatients from the diabetic clinics at two hospitals. There were 174 females and 89 males, aged between 16 and 89 years (mean = 53.5, sd = 13.9). The average number of years of schooling was 6.3 (sd = 4.1). Main outcome measure. A reliable and valid patient satisfaction scale. RESULTS: Factor analysis was conducted on the patient satisfaction scale and two factors, accounting for 71.6% of the variance, were extracted. The major items on Factor I were support, consideration, friendliness, and encouragement, labelled the interpersonal

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dimension. Factor II emphasized availability of a seat and toilet in the waiting area and cleanliness, labelled the organizational dimension. The two factors had very good reliability coefficients: 0.85 (organizational) and 0.98 (interpersonal). Multi-trait scaling showed that all items exceeded the item convergent (r > 0.40) and discriminant (Z > 1.96) validity criteria. Patients in poor general health were significantly less satisfied (P = 0.007) with the organizational quality of their care than patients in good health; patients in poor mental health were significantly less satisfied (P = 0.04) with the interpersonal quality of their care than patients in good mental health. CONCLUSIONS: The findings provided support for Donabedian's model. They demonstrated that attributes of providers and settings are major components of patient satisfaction, and showed that the scale is a reliable and valid measure of patient satisfaction for this South African population.

Westbrook, J. I. (1993). "Patient satisfaction: methodological issues and research findings." Australian Health Review 16(1): 75-88.

Patient satisfaction plays a significant role in the health care process. It influences the health care seeking behaviour of patients, compliance with treatment and the health outcomes of patients. The use of ill-conceived and limited patient satisfaction questionnaires, in conjunction with inadequate methods of administration, have contributed to the poor reputation of patient satisfaction as an indicator of the quality of health care services. This paper addresses some of the methodological issues related to the measurement of patient satisfaction and describes validated and reliable tools which are available for use by hospitals in Australia. Research findings discussed demonstrate that patients are able to evaluate validly and reliably the quality of both clinical and non-clinical aspects of health care services. Australian health care organisations should implement patient satisfaction as a quality indicator and thereby actively seek to improve the health outcomes of their patients. [References: 57]

Wilcock, P. M., Brown, G. C. S., Bateson, J., Carver, J. and Machin, S. (2003). "Using patient stories to inspire quality improvement within the NHS Modernization Agency collaborative programmes." Journal of Clinical Nursing 12(3): 422-30.

The importance of obtaining the opinions of service users has long been recognized and, traditionally, most contact has focused on measuring their satisfaction with the services they receive. However, there is little evidence that this has had much impact on improving care. The Discovery Interview Process, a technique for listening to patients and carers and using their narratives to improve care, is discussed in this article. This approach has been used in the pilot phases of the UK Coronary Heart Disease Collaborative and Critical Care Collaborative. These narratives develop understanding grounded in experience. Those delivering care can interpret the narratives using their own clinical and professional knowledge and experience to create better or new ways of meeting patients' and carers' needs. Using their own expert knowledge they can identify needs within the narratives, including those that patients and carers did not know they had. The principal techniques for gathering these narratives are outlined, and ways of using such data to inform patient-focused service improvements are discussed. Various locally sensitive methods for presenting the narratives to expert interprofessional teams are also described along with emerging experience of this feedback. We consider the Discovery Interview technique for gathering patient and carer narratives to be a potentially powerful method for informing quality improvements, discovering what really matters to patients and their carers. This pragmatic approach could prove manageable within local quality improvement projects.

Williams, B. (1994). "Patient satisfaction: a valid concept?" Social Science & Medicine 38(4): 509-16.

Over the past 10 yr consumer satisfaction has gained widespread recognition as a measure of quality in many public sector services. This has become manifest in the NHS in the call by the 1983 NHS Management inquiry to ascertain how well the service is being delivered at local level by obtaining the experience and perceptions of patients and the community. Patient satisfaction is now deemed an important outcome measure for health services; however, this professed utility rests on a number of implicit assumptions about the nature and meaning of expressions of 'satisfaction'. Through a review of past research findings this paper suggests that patients may have a complex set of important and relevant beliefs which cannot be embodied in terms of expressions of satisfaction. Consequently, many satisfaction surveys provide only an illusion of consumerism producing results which tend only to endorse the status quo. For service providers to meaningfully ascertain the experience and perceptions of patients and the community then research must first be conducted to identify the ways and terms in which those patients perceive and evaluate that service.

Williams, S. J. and Calnan, M. (1991). "Convergence and divergence: assessing criteria of consumer satisfaction across general practice, dental and hospital care settings." Social Science & Medicine 33(6): 707-16.

This paper describes the results of the first-stage of a study carried out in the spring of 1988 in the South East of England. The study looked at general and specific aspects of consumer satisfaction with general practitioner services, general dental care services and hospital in-patients care. It also examined which specific consumer criteria were the key predictors of overall satisfaction within each of these particular medical care settings. A related aim was to assess the degree of congruence or divergence of consumer criteria across these differing medical care settings. The evidence suggests that whilst general levels of consumer satisfaction are high (i.e. 83-97%), questions of a more detailed and specific nature revealed greater levels of expressed dissatisfaction (e.g. 38% of the sample felt that they could not discuss personal problems with their GP, 51% felt their dentist was not easy to reach at weekends/holidays, whilst 35% felt hospital doctors did not give sufficient information). Whilst different areas of dissatisfaction were found in

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each specific medical care setting examined, what was particularly striking was the degree of convergence of the key predictors of overall consumer satisfaction across the medical care settings. That is to say, our findings clearly suggest that issues concerning 'professional competence', together with the nature and quality of the patient-professional relationship, are the key predictors of overall consumer satisfaction with general practice, dental and hospital care [e.g. GP giving sufficient information correlated 0.64 (P less than 0.001) with overall GP satisfaction scores; competent dentist 0.52 (P less than 0.001) with overall dental satisfaction scores; and full confidence in hospital doctors 0.49 (P less than 0.001) with overall hospital satisfaction scores]. The theoretical importance and policy implications of these findings, particularly in the light of the recent NHS reforms, are discussed.

Wofford, M. M., Wofford, J. L., Bothra, J., Kendrick, S. B., Smith, A. and Lichstein, P. R. (2004). "Patient complaints about physician behaviors: a qualitative study." Academic Medicine 79(2): 134-8.

PURPOSE: Health care institutions are required to routinely collect and address formal patient complaints. Despite the availability of this feedback, no published efforts explore such data to improve physician behavior. The authors sought to determine the usefulness of patient complaints by establishing meaningful categories and exploring their epidemiology. METHOD: A register of formal, unsolicited patient complaints collected routinely at the Wake Forest University Baptist Medical Center in Winston-Salem, North Carolina was used to categorize complaints using qualitative research strategies. After eliminating complaints unrelated to physician behavior, complaints from March 1999 were analyzed (60) to identify complaint categories that were then validated using complaints from January 2000 (122). Subsequently, all 1,746 complaints for the year 2000 were examined. Those unrelated to physician behavior (1,342) and with inadequate detail (182) were excluded, leaving 222 complaints further analysis. RESULTS: Complaints were most commonly lodged by patient (111), followed by a patient's spouse (33), (52), parent (50), relative/friend (15), or health professional (2). The most commonly identified category was disrespect (36%), followed by disagreement about expectations of care (23%), inadequate information (20%), distrust (18%), perceived unavailability (15%), interdisciplinary miscommunication (4%), and misinformation (4%). Multiple categories were identified in (19%) complaints. Examples from each category provide adequate detail to develop instructional modules. CONCLUSION: The seven complaint categories of physician behaviors should be useful in developing curricula related to professionalism, communication skills, practice-based learning.

Wolf, D. M., Lehman, L., Quinlin, R., Zullo, T. and Hoffman, L. (2008). "Effect of patient-centered care on patient satisfaction and quality of care." Journal of Nursing Care Quality 23(4): 316-321.

A clinical randomized study (posttest design) was conducted to examine whether patient-centered care (PCC) impacts patient satisfaction, perception of nursing care, and quality of care. Differences were seen in 2 of 3 subscales within the Baker and Taylor Measurement Scale. The PCC group rated satisfaction (P = .04) and quality of services (P = .03) higher than controls. PCC may impact patients' perception of the level of satisfaction and quality of care received.

Woods, S. E., Bivins, R., Oteng, K. and Engel, A. (2005). "The influence of ethnicity on patient satisfaction." Ethnicity and Health 10(3): 235-242.

Objective. To investigate the influence of ethnicity on patient satisfaction with hospitalization care. Methods. We conducted a random selection, cross-sectional study. Data were collected by telephone interviews over a three-year period utilizing a 16-question survey. Patients were excluded from the study if they were admitted for an obstetric visit, physical rehabilitation, or psychiatric illness or if we were unable to reach them by telephone. We used logistic regression to compare ethnicity with the responses for each of the 16 questions while controlling for three confounders (age, gender, and insurance status). For each question, patient responses of excellent and very good were considered satisfied. Patient responses of good, fair, and poor were considered not satisfied. Results. We surveyed 7,795 patients. Compared to African-Americans, non-Hispanic white Americans were significantly older, included more males, and were insured by Medicaid less often ($p < 0.05$). Using multivariate analysis, we found that seven of the 16 questions exhibited significant satisfaction differences. African-Americans expressed significantly less satisfaction for two of six questions related to nursing care, two of three questions related to entire staff care, one of two question related to physician care, and one of three questions related to overall satisfaction ($p < 0.05$). However, African-Americans expressed significantly more satisfaction for one question related to nursing care. There was no difference between the two groups for nine of the 16 questions, including both questions regarding communication and coordination. Conclusion. African-Americans reported significantly lower rates of satisfaction compared to non-Hispanic white Americans for six of 16 questions regarding satisfaction during hospitalization care. copyright 2005 Taylor & Francis Group Ltd.

Woodside, A. G. (1991). "What is quality and how much does it really matter?" Journal of Health Care Marketing 11(4): 61-7.

Perhaps no single word has appeared more often in health care literature during the last 12 months than "quality." Designing and marketing high quality health care services is likely to be a strategic issue through the 1990s. The purpose of this commentary is to describe why the adoption of a three-component definition of quality may be useful for designing strategies for continual quality improvements, as well as to suggest the principal ways quality should be assessed. Answers to the question, "How much does quality really matter?" are examined. The commentary is based on the keynote address presented at the 1991 Health Care Consumer Buying Guides Conference in Cleveland, Ohio, sponsored by the Academy for Health Services Marketing.

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Woodward, C. A., Ostbye, T., Craighead, J., Gold, G. and Wenghofer, E. F. (2000). "Patient satisfaction as an indicator of quality care in independent health facilities: developing and assessing a tool to enhance public accountability." American Journal of Medical Quality 15(3): 94-105.

The objective of this research was to examine the performance of a brief patient survey about quality of care received in community-based diagnostic and therapeutic facilities. The survey was administered to patients in 44 facilities that were also scheduled for a formal external assessment. The response rate was 53%. Patients generally rated their care positively; 18.5% of patients rated at least 1 item as fair or poor. The amount of information received about risks and complications was rated least favorably; concern and caring shown by staff was rated most favorably. The 10 items which patients rated regarding aspects of quality formed an internally consistent scale (alpha = .93). Patients' ratings were not useful predictors of assessor ratings. Although patients' ratings cannot substitute for expert on-site assessments, they are an important part of a quality management program. The patient survey provides additional, complementary information about components of quality care that are important to them.

Worthington, K. (2004). "Customer satisfaction in the emergency department." Emergency Medicine Clinics of North America 22(1): 87-102.

Patient satisfaction is not merely a "smile and be nice" set of behaviors. It is a philosophy that is founded in the concept that the patient's experience of care is important and ultimately translates into their actual response to care. The improved response to care that patients exhibit makes patient satisfaction important from a clinical vantage point. That point alone is enough to justify implementation of and commitment to a customer satisfaction program. There are, however, other compelling reasons also. Customer satisfaction has profound ramifications for the financial status of the institution and for its professional reputation in the community. The caregivers who participate in a system of good customer satisfaction experience fewer malpractice suits than their counterparts. And they enjoy a work environment that is more stable and pleasant than other institutions. The implementation of a meaningful customer service program is a huge task. It is a fundamental culture change that requires vision, long-term commitment, and constant surveillance. The single most critical factor in the successful implementation of a program that produces all the gains that it promises is leadership. Leadership must set the stage, create the atmosphere, demand that staff meet expectations, reward success, provide an example, and shape the new culture. Without strong, clear leadership, any customer service initiative will be simply a hospital-wide exercise, and those staff members who harbor a cynical viewpoint will be proved right in the end. One major difference between a successful customer service initiative and an unsuccessful one is the level of sincerity the hospital and its staff have about the care they express for their patients. If the whole process is merely an exercise to improve scores, the success will be limited and without deep roots. If the push is to establish an atmosphere of genuine care and interest for patients, however, the results are more meaningful, longer lasting, and more appreciated by patients and staff. Copyright Â© 2004 by Elsevier Science (USA).

Yarnold, P. R., Michelson, E. A., Thompson, D. A. and Adams, S. L. (1998). "Predicting patient satisfaction: a study of two emergency departments." Journal of Behavioral Medicine 21(6): 545-63.

To identify perceptions that predict overall patient (dis)satisfaction with Emergency Department (ED) care, we studied responses to a survey mailed to all discharged patients over a 6-month period (Academic Hospital), and to a telephone interview of a random sample of discharged patients over a 1-year period (Community Hospital). The survey and interview both assessed overall satisfaction, as well as satisfaction with perceived waiting times, information delivery, and expressive quality of physicians, nurses, and staff. Data for 1176 patients (training sample) and 1101 patients (holdout sample) who rated overall satisfaction as either "very good" or "very poor" (Academic Hospital), and for 856 patients (training sample) and 431 patients (holdout sample) who rated overall satisfaction as either "excellent" or "poor" (Community Hospital), were retained for analysis. For both hospitals, nonlinear tree models efficiently achieved overall classification accuracy exceeding 98% in training analysis and 95% in holdout analysis (all $p < .0001$). The findings suggest that overall patient (dis)satisfaction with care received in the ED is nearly perfectly predictable on the basis of patient-rated expressive qualities of ED staff, particularly physicians and nurses. Interventions designed to reinforce positive (and extinguish negative) expressive health-care provider behaviors may cut the number of extremely dissatisfied patients in half.

Yellen, E. and Davis, G. C. "Patient satisfaction in ambulatory surgery." AORN Journal 74(4): 483-6.

The purpose of this study was to explore the relationships between patient satisfaction and selected variables that were identified as important in ambulatory surgery. The study addressed whether the selected variables are associated with the satisfaction of patients admitted to the hospital for ambulatory surgery. A descriptive correlational study was conducted in two hospital settings with 130 ambulatory surgical patients. Nurses (n = 16) in the ambulatory surgery departments completed a nurse demographic data form. The patient sample differed between settings in age, diagnosis, and use of computers. The nurse sample differed in the number of nurses with computers in their homes and their satisfaction with nursing. Results showed that patients' higher ratings of postoperative pain correlated with higher patient satisfaction. Patients with high postoperative pain rated satisfaction with pain management lower. A point biserial correlation (rpb = .22) indicated a significant correlation between patient satisfaction and nurses' use of computers to collect and record patient information (P = .01). The patient sample in the setting where computers were used showed a higher mean patient satisfaction.

Yellen, E., Davis, G. C. and Ricard, R. (2002). "The measurement of patient satisfaction." Journal of Nursing Care Quality 16(4): 23-9.

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Patient satisfaction is an important quality outcome indicator of health care in the hospital setting. The measurement of patients' satisfaction with nursing is particularly important since nursing service is often a primary determinant of overall satisfaction during a hospital stay. This article reports on a study designed to update and revise the definition of patient satisfaction for application with ambulatory surgical patients and to develop a questionnaire that captures this definition. The Patient Satisfaction Scale, which specifically focuses on patient satisfaction with nursing care and is used extensively by nursing researchers, was selected for factor analytical examination. Psychometric testing resulted in a 15-item scale with three underlying dimensions.

Ygge, B. and Arnetz, J. E. (2004). "A study of non-response in a questionnaire survey of parents' views of paediatric care." Journal of Nursing Management 12(1): 5-12.

The aim of this study was to examine whether there were differences in quality ratings between respondents and non-respondents to a questionnaire concerning parents' views of paediatric care. This study also examined whether quality ratings differed when questionnaire respondents were asked to reassess certain aspects of hospital care in a follow-up questionnaire. A total of 1094 questionnaires were distributed to parents at the hospital. Three weeks later, follow-up questionnaires were sent home to a random sample of 140 parents who had visited the hospital during the 2 weeks when the main questionnaire was distributed. Forty-six per cent of respondents to the follow-up questionnaire had never received the original questionnaire in hospital, while only seven individuals in the follow-up sample were active non-respondents. Analysis of variance revealed that respondents to the follow-up questionnaire who had never received the main questionnaire did not differ significantly from respondents to the main questionnaire in their ratings of key quality domains. There were no statistically significant differences in quality ratings between parents who responded to both questionnaires and parents who responded to the main questionnaire. For hospital management, it is important to be able to trust questionnaire results. Non-response bias can jeopardize the validity of questionnaire results, which is why studies of non-response are important. The current study pinpoints a number of difficulties that need to be considered when conducting investigations of non-response.

Ygge, B. M. and Arnetz, J. E. (2001). "Quality of paediatric care: application and validation of an instrument for measuring parent satisfaction with hospital care." International Journal for Quality in Health Care 13(1): 33-43.

OBJECTIVE: To apply and validate an adapted version of an existing adult patient questionnaire in a study of parental satisfaction with paediatric care in a university hospital. DESIGN: A cross-sectional, anonymous questionnaire study. A total of 912 questionnaires were distributed to parents by hospital staff during a 2-week period. SETTING: A university children's hospital in Stockholm, Sweden. STUDY PARTICIPANTS: Six hundred and twenty-four parents whose children were receiving care at the hospital during a 2-week period in April of 1999. MAIN OUTCOME MEASURES: The 63-item questionnaire uses eight main measurement indices and an overall quality rating to define parental satisfaction with paediatric care. Measures of the instrument's reliability and validity were established by comparison with results of a pilot study conducted 1 year earlier on the paediatric departments of two regional Swedish hospitals. All measures were compared to reliability and validity estimates in the original patient questionnaire. RESULTS: A total of 624 questionnaires were returned, a response rate of 68%. The instrument demonstrated good reliability and validity. Reliability estimates for all eight indices were greater than 0.70 and consistent over time. Inter-index correlations were generally lower than 0.60, indicating index independence. Of the nine parameters measured, parents were most satisfied with staff attitudes, care processes and medical treatment. Parents' ratings were lowest for accessibility and staff work environment. CONCLUSION: This study presents a valid and reliable questionnaire instrument for measuring parental views of paediatric hospital care. The instrument measures the quality of paediatric care from a broader perspective than previously existing parent questionnaires.

Young, G. J., Meterko, M. and Desai, K. R. (2000). "Patient satisfaction with hospital care: effects of demographic and institutional characteristics." Medical Care 38(3): 325-34.

BACKGROUND: There are a growing number of efforts to compare the service quality of health care organizations on the basis of patient satisfaction data. Such efforts inevitably raise questions about the fairness of the comparisons. Fair comparisons presumably should not penalize (or reward) health care organizations for factors that influence satisfaction scores but are not within the control of managers or clinicians. On the basis of previous research, these factors might include the demographic characteristics of patients (eg, age) and the institutional characteristics (eg, size) of the health care organizations where care was received. OBJECTIVES: The goal of this study was to examine the extent to which a patient's satisfaction scores are related to both his/her demographic characteristics and the institutional characteristics of the health care organization where care was received. METHODS: We conducted an analysis of secondary data from the Veterans Health Administration (VHA), US Department of Veterans Affairs. The database contained patient responses to self-administered satisfaction questionnaires and information about demographic characteristics. Additional data from VHA were obtained regarding the institutional characteristics of the hospitals where patients received their care. RESULTS: Among demographic characteristics, age, health status, and race consistently had a statistically significant effect on satisfaction scores. Among the institutional characteristics, hospital size consistently had a significant effect on patient satisfaction scores. CONCLUSIONS: Study results can be interpreted as justifying the need to adjust patient satisfaction scores for differences in patient population among health care organizations. However, from a policy perspective, such adjustments may ultimately create a disincentive for health care organizations to customize their care.

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Zemencuk, J. K., Hayward, R. A., Skarupski, K. A. and Katz, S. J. (1999). "Patients' desires and expectations for medical care: a challenge to improving patient satisfaction." American Journal of Medical Quality 14(1): 21-7.

Patients' desires and expectations for medical care warrant scrutiny because of their potential influence on health care use and patient satisfaction and their effects on patients' perceptions of quality of care. To determine if desires and expectations for selected elements of medical care and specialty referral differ between VA outpatients and non-VA outpatients, we conducted a cross-sectional survey of patients at a VA medical center site and 2 primary care sites of its university affiliate. Of 390 eligible patients at the VA medical center site, 270 (69%) consented to participate and returned completed self-administered questionnaires. At its university affiliate sites, 119 (73%) of the 162 eligible patients completed questionnaires. Overall, patient desire and expectation for elements of medical care and specialty referral were similar and high at all study sites. Desire ranged from 33% for a blood test to check for anemia to 80% for heart auscultation. Desire for specialty referral for hypothetical scenarios averaged 71% and 61% among VA Medical Center patients and university affiliate patients, respectively. Patient demographics and socioeconomic status were poor predictors of desire for care. These results suggest (a) that VA medical center outpatients' desires and expectations for preventive medical care are not significantly different from those of non-VA outpatients, (b) that desire is often high for both highly recommended care and care that is not generally recommended or is controversial, and (c) that high levels of desire are not limited to patients of higher levels of socioeconomic status. In an effort to improve satisfaction, it is important to examine ways in which to address patients' desires and expectations for medical care, even while faced with competing health care spending priorities.

Ziegenfuss, J. T., Jr. and O'Rourke, P. (1995). "Ombudsmen, patient complaints, and total quality management: an examination of fit." Joint Commission Journal on Quality Improvement 21(3): 133-42.

BACKGROUND: In response to mounting health care costs in the United States and Canada, there is considerable national discussion of health care quality, including the importance of assessing and monitoring patient satisfaction and of responding to complaints. Many physicians and health care administrators cringe at the mention of using patient complaints and satisfaction levels as quality measures; others perceive the need to develop multiple source indicators of patient care. At the same time, leaders are seeking programs and methods that contribute to the continuous improvement of all aspects of health care organizations. DISCUSSION: The use of patient ombudsmen and patient complaints in quality management programs is reviewed and the relation between the two functions--ombudsmen/complaint handling and total quality management--is discussed. Purposes, objectives, problem-solving processes, program operations, data use, and the outcomes of ombudsmen efforts are reviewed. Since ombudsmen programs value patient feedback, empower customers, and help contribute to the diagnosis of organizational areas for improvement, they are consistent with the intent and workings of quality teams. The activities of ombudsmen can contribute to the broader effort to manage the whole organization toward the continuous improvement of quality.

Zifko-Baliga, G. M. and Krampf, R. F. (1997). "Managing perceptions of hospital quality. Negative emotional evaluations can undermine even the best clinical quality." Marketing Health Services 17(1): 28-35.

Patients use more than 500 criteria to evaluate a hospital's quality. The authors synthesized these criteria into 14 dimensions to provide the foundation of a new instrument for measuring service quality in health care. Patients use emotional criteria to evaluate technical quality. Therefore, hospitals must not neglect the emotional aspects of cure. Developed around three theoretical components--structure, process, and outcome--the quality dimensions should help hospital marketers pinpoint what is important to patients and how they perceive the service encounter.

Zimcosky, L. K., Brown, M. and Zapalski, D. M. (1997). "Points of view. Patient satisfaction is an indicator of quality of care." Respiratory Care 42(5): 511-516.

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