



Contributors to Surgical In-patient Satisfaction— Development and Reliability of a Targeted Instrument

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OBJECTIVE: Patient satisfaction is an important indicator of healthcare system performance. High patient satisfaction is associated with greater trust in caregivers, improved compliance with treatment recommendations and a better quality of life (QOL). There are few validated instruments to measure surgical patients' satisfaction. The aim of this study was to develop a culturally-specific patient satisfaction instrument, for use as an outcome measure in evaluating surgical services.

DESIGN: Patient focus groups were convened to explore dimensions of the peri-operative hospital experience. Forums uncovered pertinent domains of interest and identified terminology understood by patients. A preliminary set of items reflecting patient satisfaction was developed. Test-retest reliability of a new surgical patient satisfaction instrument was assessed in 42 subjects at hospital discharge.

RESULTS: Domains that emerged included; admission processes and hospital environment, information provision, nursing care, doctor and nurse interaction, and ancillary staff services. Staff attitudes and human qualities were highly valued, as was prompt attention to requests for assistance. Clarity or quality of medical information did not appear to influence in-patient satisfaction. A new measure of surgical patient satisfaction, Hong Kong Index of Inpatient Happiness (HK2Happ), was developed from focus group consultation. Test-retest generated an Intra Class Correlation of 0.868–0.935, indicating a highly stable tool.

CONCLUSIONS: The initial version of HK2Happ was reliable in assessing surgical patient satisfaction. The measure is now undergoing validity testing across different surgical patient populations for generalisation and generation of a short form of discriminant items. [*Asian J Surg* 2009;32(3):143–50]

Key Words: surgery, patient satisfaction, patient report, focus group

Introduction

The patient, as an end user of the healthcare system, can provide feedback vital to the quality assurance process. Patient view of care is an important indicator of both

specific aspects of healthcare delivery and overall system performance.^{1,2} Satisfaction is also an indicator of the acceptability of new forms of intervention and is frequently employed as an outcome variable in trials.^{3,4} Where care addresses both medical and key aspects of

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patient wellbeing, higher levels of satisfaction are reported.⁵ Patient satisfaction is also predictive of intention to attend healthcare appointments and to comply with advocated treatment.^{6,7}

The satisfaction experienced by patients is a subjective experience, rising when expectations and experiences fulfil a need, desire, or want.^{2,8} Conversely, when patients perceive one or more of their expectations for care to have been unmet, satisfaction is low. Quantifying this experience is complex and multidimensional and involves cultural uniqueness.

To date, no consensus has been reached as to which aspects or dimensions adequately measure patient satisfaction.⁹ It is, however, recognised that the conceptualised framework of instruments to measure the patient perceived expectations and satisfaction are highly related to cultural background and to different health care systems.^{10,11} Thus variation will exist between cultural contexts. Patient focus groups are one option in developing an understanding of what matters to surgical patients whilst in hospital. Information-rich patients who are willing and able to air their likes and dislikes about being a patient can be approached and recruited into focus groups.¹² Such groups provide valuable feedback about what patients want and expect. Furthermore, the focus group setting communicates to patients that their voice is important and their input valuable.

The quality of measurement tools has improved markedly in recent years. A meta-analysis of existing patient satisfaction questionnaires from 1988 noted that three quarters of the instruments used were original and not standardised.¹³ Whilst numerous questionnaires have been developed to measure patient satisfaction with hospital care, psychometric properties have not always been evaluated.¹⁴ Over the last decade the trend has changed, with studies now routinely attempting to ensure the instruments selected are well grounded and validated.¹⁵⁻¹⁸

In evaluating the outcome of surgical intervention we wished to incorporate patient feedback and to use the opinion of this group to direct initiatives that would ultimately enhance quality of care.^{19,20} Scrutiny of existing patient satisfaction tools did not identify a measure suitable for use in an Asian surgical population.

The aim of this study was to identify factors important to ethnic Chinese in-patients following a surgical procedure. The secondary aim was to embed these important

domains into a formal measurement tool that could be used to quantify patient satisfaction in our surgical patient population.

Methods

Phase I: Qualitative method

Between August and October 2008, former in-patients attending for reviews at surgical outpatient clinics in our institution were invited to participate in the study. Inclusion criteria were (1) having undergone surgery and a hospital stay at least 4 days within the last 6 months, (2) Chinese speaking, and (3) cognitively able. Potential subjects who were mentally ill, deaf or unable to speak were excluded from the study. Subjects were informed that focus groups would explore and conceptualise issues and perceptions arising from each individual's recent hospital stay experiences.

In all, 21 subjects were recruited and allocated to one of three focus groups. Each group consisted of between six and eight participants, with a equal gender mix. All group sessions were held at times of greatest convenience for participants and in a neutral, confidential environment away from the surgical outpatient clinics. To optimise interaction participants were seated in a circle. Refreshment was provided during each group discussion. As a token of appreciation each participant received a gift certificate redeemable at a local grocery store. Approval for the study was granted by the Survey and Behavioural Research Ethics Committee, The Chinese University of Hong Kong.

The focus group methods, introduction, ground rules, guidelines, questions and prompts for the topic of interest were developed beforehand based on guidelines by Kreuger.²¹ Introductory remarks by the moderator included study objectives and a confidentiality statement. Written and verbal consent was obtained to tape record the session, take notes and to use direct quotes in the report of findings. Throughout each of the discussions the moderator maintained neutrality. Each focus group lasted approximately 1.5 hours.

Following each session important themes, noteworthy quotes, and unexpected disclosures were documented. Verbatim transcripts were prepared and cross validated then coded as themes to allow comparison of similarities and differences and the development of concepts to include in the measurement tool.²²

Phase II: Construction and reliability testing of in-patient satisfaction instrument

The pertinent domains of interest and suggested terminology, as understood by patients, underpinned development of the new patient satisfaction instrument. An electronic literature search was performed to identify the pool of existing items related to satisfaction with inpatient care.^{15-18,23-25} The keywords or subject headings (from the MeSH database) used included; patient satisfaction, in-patient satisfaction, patient satisfaction, inpatient satisfaction, patient experience; quality of life (QOL), tool or instrument; surgical or surgery. Under each identified aspect, all the existing items were reviewed. Potential items were selected and added to those generated from focus group transcripts.

Test-retest reliability of this new patient satisfaction instrument (HK2Happ) was assessed in 42 patients on discharge from surgical wards. Patients who had undergone general surgery, orthopharyngeal, cardiothoracic, neurosurgery, dental, and eye surgeries were invited to participate. Consenting participants completed the new instrument (HK2Happ) twice, once on being informed of their discharge date and then again immediately prior to discharge from hospital. The intra-class correlation coefficient (ICC) was utilised to describe the stability of the instrument over time. Acceptable internal reliability is associated with a coefficient of 0.7 or above.

Results

Table 1 describes the socio-demographic characteristics of focus group participants. Mean age and length of hospital stay (LOS) were 55.7 years and 12.1 days respectively. Eleven (52.4%) patients were recruited from the cardiothoracic outpatients clinic, whereas ten (47.6%) came from the colorectal rectal review clinic. None of the participants were illiterate, 33.3% had received primary education only, 57.2% completed secondary education and almost 10% attended tertiary education. The proportion of employed to non-working participants was 1:3. All of the subjects were either living with a spouse (9.5%) or with other family members (90.5%).

Thematic analysis revealed the emergence of six themes from focus groups discussions. These were summarised as; admission processes and environment, information provision, nursing care, nurse interaction, doctor interaction, and ancillary staff services (Figure). The admission

process and hospital environment represented the patients' first encounter with the hospital and profoundly influenced satisfaction with the hospital experience.

The attitude and human quality of nurses and hospital health assistants, such as care, sensitivity and support, were important indicators of patient satisfaction. Kindness and sensitivity when patients were sick and required immediate assistance were highly regarded. Staff availability and promptness when in need of help and assistance were highly valued. Doctors received respect and praise from patients in the focus groups and generated relatively few complaints. Almost all of the informants expressed their satisfaction with doctors' care of them, particularly in terms of their helpfulness, empathy and friendliness.

Perception of disrespect by hospital staff when support was most needed negatively impacted patient satisfaction. Requests that did not receive immediate attention engendered feelings of helplessness. Most informants expressed the observation that the ward did not have enough nursing staff to look after them, thus making the nursing care service substandard. Physical comfort or discomfort when receiving nursing care was also critical to the evaluation of quality of care.

The amount of information directly communicated to patients and their relatives is an important medico-legal issue for doctors. Patients in western countries are concerned about technical information such as illness details, necessity for medical tests and treatment options.^{10,26} In contrast, patients in this study seldom asked doctors for clarification or explanation as to why a certain examination was needed. The majority of informants expressed contentment and felt well informed of the surgical processes.

Phase II: Reliability

The draft version of the instrument consisted of 51 items before revision and removal of ten redundant, irrelevant and impractical items. Item wording was modified before instrument testing to identify ambiguous terms or difficulties in understanding. The resulting 41-item instrument named Hong Kong Index of Inpatient Happiness (HK2Happ) formed the basic index to evaluate patient satisfaction in surgical patients. Each of the multi-item subscales includes a unique set of items. Subscales included in the new instrument were: admission process and environment (items 1-5), information provision

Table 1. Demographic characteristics of non-participants and participants in focus groups

	Non-participants <i>n</i> (%)	Participants <i>n</i> (%)	<i>p</i> value
No. of patients	27	21	
Male	19 (70.4%)	13 (61.9%)	0.537 ^b
Female	8 (29.6%)	8 (37.9%)	
Mean age (yrs)	63.6 ± 8.5 (range, 51.6–76.1)	56.1 ± 14.9 (range, 20.1–79.7)	0.047 ^a
Age group			
≤ 40 yrs	0 (0%)	3 (14.3%)	0.099 ^b
40–59 yrs	12 (44.4%)	10 (47.6%)	
≥ 60 yrs	15 (55.6%)	8 (38.1%)	
Education level			
Primary school	—	7 (33.3%)	—
Secondary school	—	12 (57.2%)	
University or above	—	2 (9.5%)	
Living with family			
Living alone	—	0 (0%)	—
Living with spouse only	—	2 (9.5%)	
Living with family	—	19 (90.5%)	
Distance of living place to focus group venue*			
Close to venue	15 (55.6%)	15 (71.4%)	0.260 ^b
Far away from venue	12 (44.4%)	6 (28.6%)	
Working status			
Working/student	—	5 (23.8%)	—
Not working/retired/housewife	—	16 (76.2%)	
Mean length of stay (d)	11.3 ± 6.3 (range, 4–36 days)	12.1 ± 4.8 (range, 4–23 days)	0.597 ^a
Length of stay (d)			
< 1 wk	3 (11.1%)	1 (4.7%)	0.572 ^b
1–2 wks	19 (70.3%)	14 (66.7%)	
> 2 wks	5 (18.5%)	6 (28.6%)	
Types of procedure			
Cardiac or thoracic	19 (70.4%)	11 (52.4%)	0.202 ^b
Colorectal	8 (29.6%)	10 (47.6%)	

*Living place close to hospital is defined as on average it takes ≤ 30 minutes to travel from living place to hospital; living place far away from hospital is defined as on average it takes > 30 minutes to travel from living place to hospital. ^aStudent *t* test; ^bChi-square test.

(items 6–12), nursing care (items 13–16), nurse interaction (items 17–23), doctor interaction (items 24–33), ancillary staff services (items 34–40) and a global satisfaction visual analog scale (VAS).

The question response options utilised a 5-point Likert scale (disagree strongly, disagree, neutral, agree and strongly agree). A raw score of each subscale/item was linearly transformed into a percentage of the maximum score of the subscale/item (each score ranged from

0 to 100). A high scale score represents a higher response level. Thus a high score for a multi-item scale represents a high satisfaction level in that subscale; a high score for the global satisfaction represents a high patient satisfaction during their hospitalisation.

A total of 42 completed questionnaires were collected from surgical patients across the different types of surgical procedures. As can be seen in Table 2 there was no floor effect and a very mild ceiling effect (< 10% for each

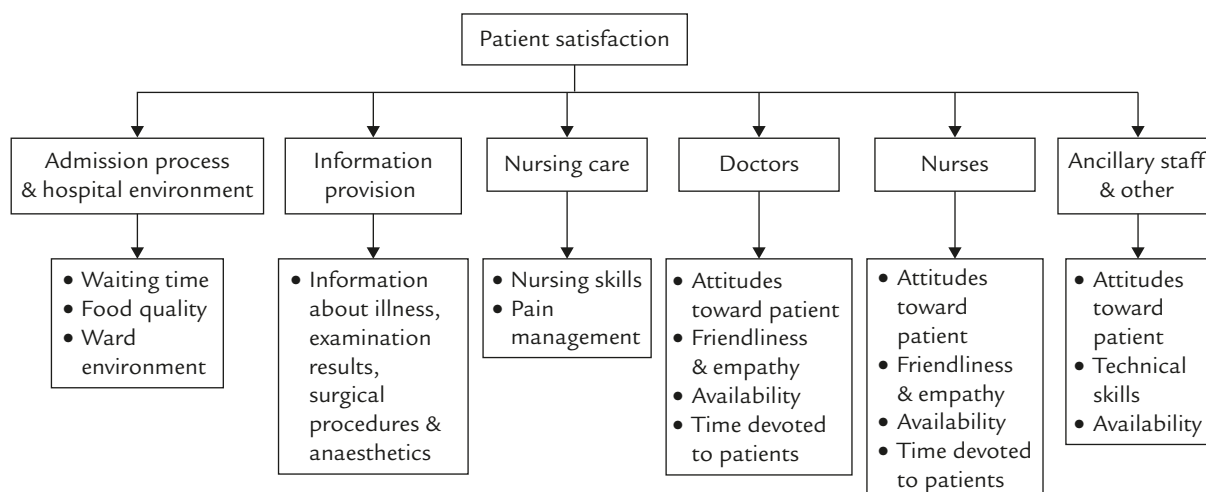


Figure. A Venn diagram to illustrate the relationship of concepts within patient satisfaction.

Table 2. Descriptive statistics for each scale of the initial version of HK2Happ instrument (*n* = 42)

Multi-item scale	Item no.	Median	Mean (SD)	Min-Max	% floor effect	% ceiling effect
Admission process & hospital environment	1-5	67.5	64.6 (13.5)	25.0-90.0	0.0	0
Information provision	6-12	75.0	77.5 (14.1)	28.6-100.0	0.0	7.1
Nursing care	13-16	75.0	74.1 (14.2)	25.0-100.0	0.0	9.5
Nurses	17-23	75.0	74.5 (14.6)	25.0-100.0	0.0	9.5
Doctors	24-33	72.5	72.9 (10.3)	42.5-100.0	0.0	2.4
Ancillary staff & other	34-40	75.0	74.6 (12.9)	30.0-100.0	0.0	4.8

subscale) in our instrument. The test-retest reliability results showed the ICC ranged from 0.868 to 0.935, indicating the new instrument was stable over time (Table 3). Two items were excluded, care by a physiotherapist and advice of a dietetic consultant, since less than half the sample used these services.

Discussion

Illness is a destabilising experience that frequently strips an individual of personal control, privacy, dignity and the ability to make choices. Whilst it is not always so, many patients feel disempowered and at the mercy of strangers for their most basic requirements. Facing a surgical procedure can be frightening, whilst the aftermath of pain, limited mobility, and the need for assistance with personal care is confronting. As healthcare staff we have a theoretic understanding of the patients' experience which may be discrepant from the lived reality. Genuine commitment to quality assurance in provision of care

demands that services obtain feedback from end-users and draw on this when evaluating clinical care and factors contributing to the hospital experience.

The present study aimed to both hear patients' voices from a service perspective and to include patient self-report as a potent outcome measure of the efficacy of surgical intervention. In the focus groups informants were encouraged to discuss the issues that were important to them whilst a patient in hospital. Interestingly, the human quality of medical and nursing staff and health-care assistants was shown to be a disproportionately important contributor to perceived patient satisfaction. Whilst nurses provide routine daily care and attend to surgical wounds they also impact patients' psychological state. Patients also commented on the positive aspects of being cared for with genuine feeling and how receiving emotional support during their hospitalisation impacted on their sense of satisfaction.

Although there are many general definitions of patient satisfaction, there is widespread agreement that the

Table 3. Test-retest reliability of the HK2Happ instrument (*n* = 42)

	ICC
Overall score	0.925
Admission process & hospital environment	0.929
1. Waiting time to get to a bed on a ward when admitted was acceptable	
2. Noise at night was a bother*	
3. Quality of hospital food was acceptable	
4. The ward was clean	
5. The ward was comfortable	
Information provision	0.868
6. The information given about my illness was adequate	
7. The information given about my treatment was adequate	
8. The information given about my medical test results was adequate	
9. The information about the risks and benefits of the operation was clear	
10. What would be done during the operation was clearly explained	
11. How the anaesthetic would be administered was clearly explained	
12. The schedule for taking medicines once I was at home was clearly explained	
Nursing care	0.933
13. Routine care (e.g. took my temperature, felt my pulse) was good	
14. Injections were skilfully performed	
15. Wound care was adequate	
16. Pain after surgical operations was adequately controlled	
Nurse interaction	0.935
17. Nurses attended to my physical problems (e.g. pain) adequately	
18. Nurses were sensitive to my physical comfort	
19. Nurses were kind toward me	
20. Nurses were helpful when I had a request	
21. Nurses were empathetic	
22. Nurses answered my buzzer calls promptly	
23. The time nurses devoted to me was adequate	
Doctor interaction	0.893
24. I had confidence and trust in the doctors treating me	
25. The way the doctors treated and examined me was professional	
26. Doctors were friendly toward me	
27. Some of the doctors appeared to lack experience with my medical problems*	
28. Doctors sometimes ignored what I told them about my concerns*	
29. When I had a medical question, I was able to speak to a doctor without any problem	
30. Doctors attended to things that bothered me	
31. Doctors were willing to listen to all of my concerns	
32. Doctors were empathetic	
33. The time doctors devoted to me during visits/consultations was adequate	
Ancillary staff services	0.875**
34. Blood taking skill was good	
35. Hospital assistant respected me as a patient	
36. Hospital assistants were helpful toward me	
37. Hospital assistant staff answered my requests promptly	
38. Waiting time to take me to examination (e.g. X-ray department) was acceptable	
39. Care provided by physiotherapist was adequate	
40. Dietetic consultation provided by dietitian was helpful	

*Scoring was reversed before analysis, **Item nos 39 and 40 were excluded in final analysis (42.9% answered N/A for item 39 and 57.1% for item 40). ICC = intra class correlation coefficient.

construct remains inadequately conceptualised. A key reason is that people vary both in their perception of a health condition worthy of care and in their health literacy.^{27,28} Variation also exists in expectations associated with any particular encounter with health care providers.²⁹ Such differences at both the individual and societal level may render what is important in one context relatively unimportant in another. As such it cannot be assumed that a patient satisfaction scale developed in one country is directly transferable to another cultural context.^{30,31}

A search for patient satisfaction questionnaires, revealed few measures specific to in-patients.^{15,17,23-25,32} In addition, surveys reviewed use the “yes/no” response format which does not allow for the dispersion of responses at the positive end of the scale.³³ Some questionnaires were devised to monitor and evaluate quality of care throughout the whole hospital journey, seeking to identify problems rather than to assess satisfaction with particular services/aspect of care.³⁴

Available instruments evaluated patient satisfaction based on service delivery dimensions such as information and medical care, nursing care, comfort, visiting, privacy and cleanliness. Other tools investigated admission procedures, other disciplines, patient autonomy, emotional support, “hotel” aspects of care, recreation facilities, miscellaneous aspects, ease of access to the hospital, and discharge and aftercare.^{15,25} Clearly specific encounters might not be weighted equally in different cultural contexts.^{35,36}

To both maximise usefulness and avoid irrelevance, this study developed a measure based substantially on local perceptions and grounded concept of patient satisfaction. The qualitative approach used encounters in the local language to gather rich and in-depth information not otherwise available from quantitative surveys.^{37,38} Assessments incorporated personal standards which could not be predicted without direct interaction.

Focus groups convened for this study allowed us to define a conceptual framework for patient satisfaction following a surgical procedure and associated hospitalisation. Six themes emerged from the local focus group consultation that have the potential to enrich our understanding of patients’ assessment of health service performance. The derived information formed the basis for developing the patient satisfaction measurement tool, HK2Happ.

When subject to test re-test reliability, the new measure proved robust, with minimal variation in responses.

In order to ensure generalisation of the target population of surgical in-patients the tool is now undergoing validity testing across a wider geographical area in multiple clinical settings. Information derived from the application of HK2Happ will be used to target resources, especially staff supply, and to monitor highlighted aspects of management of healthcare. Non-clinical interventions, resulting from patient feedback, whilst not necessarily directly related to clinical care can be evaluated by scrutinising differences in domain or total HK2Happ scores. The new measure will be incorporated into the suite of outcome measures routinely applied to evaluate efficacy of surgical intervention.

Participants in this study were limited to surgical patients interested in expressing their views in a group context; thus introducing a self-selection bias. Inferences from patients disinterested in joining a focus group, those too sick, unable to arrange transportation or with employment restrictions, were missed. However, in qualitative research case sampling is commonly adopted in order to maximise rich information and insight into perceptions and experiences.¹²

The final number of focus groups used in this study was selected using a process called information saturation. This is determined by concurrent data analysis to identify the point at which no new information or understanding is generated.³⁹ Whilst this study achieved information saturation with the population selected, patients who received other types of surgery may have contributed different material. Likewise, subjects with lower educational achievements who were less willing participate in group discussion may have had a different perspective. Further investigation warrants inclusion of strategies to hear the voices of a wider range of subjects.

In conclusion, the study generated a culturally-specific surgical in-patient satisfaction measure that was demonstrated to be reliable and robust. This unique measure has the potential to be completed by ethnic Chinese patients across Asia, thus giving surgeons an opportunity to identify and address issues that matter to their patients.

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