Ipsos
Social Research Institute

Development Report:

Adult Admitted Patient Survey

A report prepared for the Bureau of Health Information
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Contact details

BUREAU OF HEALTH INFORMATION
PO Box 1770
Chatswood NSW 2057
Australia
Telephone: +61 2 8644 2100
www.bhi.nsw.gov.au

IPSOS SOCIAL RESEARCH INSTITUTE
Level 13, 168 Walker St
North Sydney NSW 2060
Australia
Telephone: +61 2 9900 5100
http://ipsos.com.au/
Ipsos SRI project reference: 11-043092
Ipsos SRI project contacts: Andy Cubie, Jessica Elgood, Claire Lister and Robert McPhedran

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1. INTRODUCTION

The NSW Patient Survey Program (the Survey Program) is a suite of surveys that collects information on the experiences of patients receiving care in public hospitals and other public healthcare facilities across New South Wales (NSW). The purpose of the Survey Program, which commenced in 2007, is to report on patients' experiences and perceptions of care in NSW public hospitals and public healthcare facilities so that:

- hospital performances are readily available to the general public and
- health services and policy makers can identify their strengths and opportunities for improvement, to assist them to provide safe, quality care.

The following principles underpin the Survey Program:

- participation is voluntary
- confidentiality of patients' personal information is assured
- questionnaires are informed by evidence
- information collected is reliable, comparable and relevant
- reporting methods are open and transparent
- information reported is impartial, easily understood and useful.

The Bureau of Health Information (the Bureau) currently manages the Survey Program. The Bureau was established by the NSW Government to independently report on the performance of the public health system in NSW, including the healthcare experiences of patients. In 2012, Ipsos Social Research Institute (Ipsos SRI) was contracted by NSW Health to develop and administer a new suite of surveys for the Survey Program.

Currently, the suite of surveys is being redeveloped to ensure that the content is specifically tailored to the NSW healthcare environment (the surveys used from 2007-2011 were originally developed by NRC Picker for use in the United States). Each survey will include a set of core, common questions. These core questions will be tested in the Adult Admitted Patient Survey (the Survey), the first of the suite to be developed, on behalf of the National Health Information Standards and Statistics Committee's Patient Experience Information Development Working Group (PEIDWG). In addition to the National core patient experience questions, a wider set of questions from the Survey for potential inclusion across all surveys in the NSW Survey Program will be developed ('Development Report: Identification of the Core Survey Questions').

A program of research informed the development of the Survey. The aims and objectives of the research were to ensure that the Survey adequately captures and provides feedback on the aspects of care that:

- are relevant to the current policy context
- are important to NSW patients

- will be useful to NSW health services and policy makers.

This report describes the research process undertaken to develop the Survey. The first chapters of this report summarise the information collated at each stage of the developmental process, resulting in a list of potential question areas. The final chapter documents how these potential question areas were prioritised and translated into the final survey.

The results of the surveys will be fed back to the NSW Government and public healthcare facilities to inform service improvement, and reports will also be provided for public dissemination in the future.

2. METHODOLOGY

The development process comprised:

i) a rapid review of key literature (including policy documents and quality standards);

ii) focus groups with admitted patients;

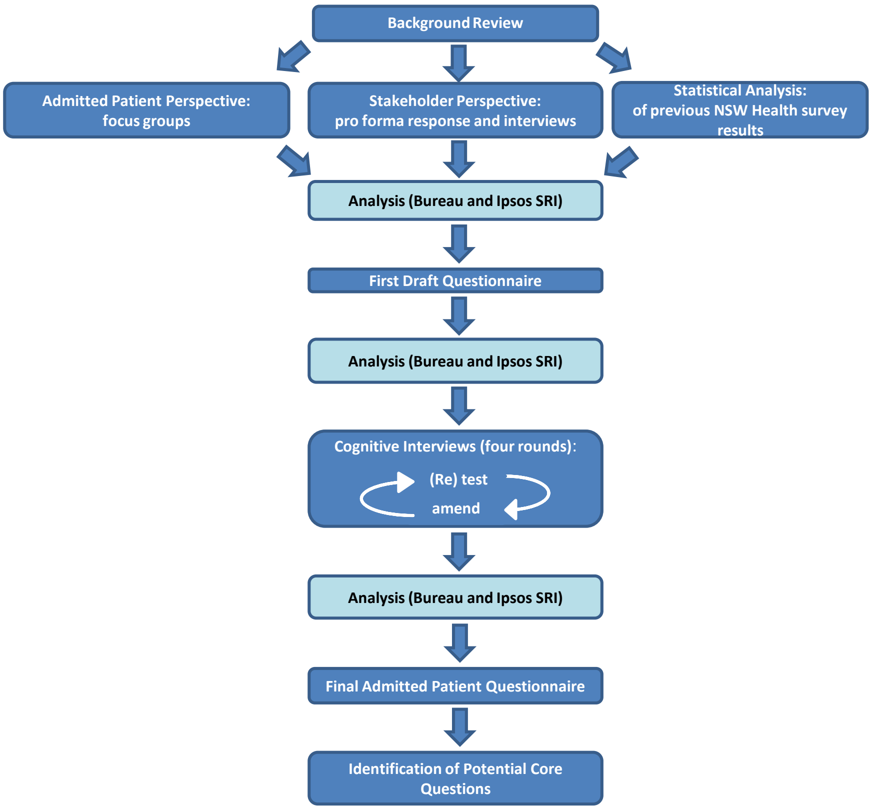
iii) stakeholder engagement;

iv) statistical analysis of the 2007-2011 NSW Health Overnight Patients Survey and Day Patient Surveys;

v) extensive discussion between the development teams at the Bureau and Ipsos Social Research Institute (Ipsos SRI) and four rounds of cognitive testing.

The following diagram illustrates the questionnaire development process (Figure 1).

Figure 1: Questionnaire development process



Rapid literature review

The rapid literature review was performed to provide context and to broadly inform the content of the Survey. The aims of the review were as follows:

- provide contextual background on patient-centred care, both internationally and in Australia
- identify prominent Australian Government and State Government policies and quality standards relevant to the Adult Admitted Patient Survey (the Survey)
- identify core domains of care for admitted patients
- briefly compare the format, content and methodology of admitted patient surveys used in other states and countries to identify best practice for use in the design of the Survey instrument.

Literature pertaining to patient surveys (the use and design of patient surveys internationally, as well as throughout Australia), Australian and State Government policies, and admitted patient questionnaires used elsewhere were initially provided by the Bureau. Additional searches for supplementary documents were performed by Ipsos SRI. Search terms included "admitted patient survey", "admitted patient questionnaire" and "admitted patient hospital satisfaction questionnaire". The abstracts of the documents returned in the search were subsequently reviewed by Ipsos SRI. The most relevant sources were synthesised with the documents provided by the Bureau to form the basis for the rapid literature review.

Patient focus groups

Patient focus groups were conducted in order to understand the range of experience of admitted patients in NSW and, in particular, the aspects that were most important in creating a positive or negative hospital experience from the patient perspective, which it was anticipated may differ in certain respects from the stakeholder perspective. These topics were then collated with the findings from the other phases of the research before being reviewed by the Bureau and Ipsos SRI for potential inclusion in the Survey.

Four focus group discussions were conducted with adults who had been admitted to a public hospital within the previous 12 months (35 participants in total), using a quota controlled sampling strategy to allow for a range of patients' views to be accounted for.

Two focus groups were conducted in metropolitan areas (one in an inner metropolitan area and the other in an outer metropolitan area) and two in non-metropolitan areas. The specific locations were selected because of their proximity to contrasting hospitals (in terms of size, staffing levels and facilities available). Two of the above groups – one metropolitan, one non-metropolitan – were conducted with patients aged 18-54 years, and two with patients aged 55 or more years, to broadly reflect the admitted patient profile and to encourage group cohesion. Each group consisted of at least three patients admitted to hospital as an emergency patient and at least three admitted as a non-emergency patient (within the previous 12 months) in order to clarify any differences in their experiences. Full profile details for each focus group can be found in Appendix A. The focus groups were conducted between 23 July and 26 July 2012.

A discussion guide was developed to ensure that key stages in the patient journey were discussed; from the initial referral (in the case of planned patients), through admission and treatment, to discharge. Following discussion around the aforementioned stages in the groups, participants were asked to arrange a set of cards, each describing an aspect of patient care, in order of importance in a group. The main purpose of this exercise was to observe the discussion and debate during and after this exercise to help understand what was important to patients, and why. Prompting was used only if key issues, as identified in the rapid literature review and by the Bureau, were not spontaneously raised. The discussion guide used in the focus groups, including the content of the pre-prepared cards used in the sorting exercise, is appended (Appendix B). Each group was audio recorded and transcribed in order to facilitate analysis and to provide verbatim comments.

An analysis session, involving all of the Ipsos SRI group moderators, was conducted to establish common themes and points of difference between the four groups. This was followed by further analysis of moderator notes and transcriptions to provide a summary of the elements of the patient experience considered most important from the patient perspective.

Stakeholder engagement

A range of key stakeholders were consulted on topics for inclusion in the Survey, for example to inform service improvement or to provide supporting evidence of compliance with quality standards and guidelines. The distribution list of key stakeholders was compiled by the Bureau and included the following groups:

- Local Health District survey leads and sponsors
- All divisions within NSW Health
- Health Consumers NSW
- The Agency for Clinical Innovation
- The Clinical Excellence Commission
- The Health Education and Training Institute
- Health Support Services
- Experts in nutrition, Aboriginal health, Culturally and Linguistically Diverse (CALD) groups, patient safety and incident reporting, obstetrics, aged care, and disability services.

These stakeholders were invited by the Bureau to suggest areas for inclusion in the admitted patient survey by submitting a pro forma response. The pro forma contained the following fields: aspect of care or question topic; reason for interest in this area; whether the question applied to a sub-set of patients; how the data would be used; question phrasing; and priority rating (see Appendix C). The pro forma was distributed on 11 July 2012 and completed by 32 contributors.

A smaller subset of stakeholders was then selected to take part in a follow-up telephone interview. These stakeholders were selected because: further detail/clarification of their responses to the pro-forma was required; a new/unexpected area was suggested; or their area of specialisation was of particular relevance. A total of 13 interviews (the discussion guide can be found in Appendix D) were conducted by Ipsos SRI, involving 27 participants (a full list can be found in Appendix C). Each interview was audio recorded and transcribed.

Ipsos SRI reviewed the transcripts and conducted an analysis session to identify common themes and points of difference. The findings from these interviews were then analysed alongside the pro forma responses. The importance rating and information on how the data would be used was taken into account during the subsequent questionnaire design and prioritisation process.

The question areas indicated by the stakeholder consultation were eventually collated with those identified from the other phases of the research to create a comprehensive list of potential question areas for the Survey, which took into account the perspective of both patients and stakeholders.

Statistical analysis of previous surveys

Survey results from the 2007-2011 NSW admitted patients surveys – the Overnight Patients Survey and Day Only Survey - were analysed using:

- ‘Key drivers’ analysis, to indicate which broad question areas were most closely related to overall satisfaction and should therefore be prioritised for inclusion in the Survey.
- Factor and reliability analysis, to identify which factors accounted for much of the variance across the patient groups, again indicating that these areas should be prioritised for inclusion in the Survey. This analysis was also used to establish whether certain factors were of more or less significance to particular groups. The reliability analysis involved the identification of highly correlated questions, to indicate where two questions were likely to be measuring the same underlying issue and could therefore be combined or removed.
- Analysis of respondent comments relating to the survey itself, to identify any issues that should be addressed in the new Survey.
- Analysis of non-response and possible ceiling and floor effects, to suggest question areas that may be less useful for informing service improvement and/or where particularly careful consideration should be given to questionnaire routing, question wording and response scales.

Further details are provided below and full technical details can be found Appendix E.

Factor and reliability analysis

Filters were created for each patient group of each of the two previous admitted patient surveys - the 2007-2011 Overnight Patient Survey and the 2007-2011 Day Patient Survey – to ensure the stability in the number of participants responding to questions required for analysis. Patient groups for the two surveys comprised:

1) Overnight Patient Survey
    a. Planned patients
    b. Emergency patients
    c. Patients who experienced pain
    d. Obstetrics patients
    e. Surgical patients
2) Day Only Patient Survey
    a. Planned patients
    b. Emergency patients
    c. Patients who experienced pain

Missing values were identified and populated for each of the patient groups using either modes (for scales with few response options) or means (for scales with more response options, or for scales where variance in responses was greater). Question scales were then standardised by allocating each response option a value between naught and 100 in equal increments, where nought represented poor performance and 100 represented outstanding performance. For example, in the Overnight Patient Survey, the scale for the question 'was your admission date changed by the hospital?' was allocated the following values:

- 'No' was allocated a value of 100
- 'Yes, once' was allocated a value of 66
- 'Yes, 2 or 3 times' was allocated a value of 33
- 'Yes, 4 or times or more' was allocated a value of 0.

Principal Components Analyses were performed for each of the filtered participant groups using Varimax rotation to maximise the differences between factors. Questions that contributed to the variance of several factors were removed from the analyses to ensure meaningful factors. Factors were then analysed and named to represent the range of questions that they encompassed.

Following the identification of factors, the reliability and the pattern of inter-item association of their components were examined using Cronbach's alpha and correlation matrices.

Non-response analysis

The survey results from the 2007-2011 Overnight Patients Survey and Day Survey were analysed to identify patterns of non-response in the data. These data were analysed using the filters for particular patient groups to identify the correct rates of non-response.

Ceiling and floor effects

The 2007-2011 Overnight Patients Survey and the 2011 Day Survey were also analysed to identify questions that exhibited possible ceiling or floor effects.

A ceiling effect is present for a measurement variable when the majority of scores are at or close to the highest possible score, indicating a loss of sensitivity in the upper register. Conversely, a floor effect is present when the majority of scores are at or close to the lowest possible score.

The analysis was performed using a criterion of a skewness statistic value falling between -1 and 1 to indicate the absence of a ceiling or floor effect.[A] There was an abundance of questions with a skewness value below -1. Therefore, in order to determine the occurrence of true ceiling or floor effects, several additional criteria were used. These criteria comprised: a sufficiently small standard deviation relative to the number of points on the scale (25 or less for a three point scale), a skewness statistic exceeding 1.5 or below -1.5, and a mean greater than 85. Dichotomous variables were excluded from the analysis because of the inherent response constraints of these questions.

Patient comment analysis

The NSW Health Overnight Patient and Day Patient surveys included a final question - "if you could change one thing about the hospital, what would it be?" - that allowed for free text comments.

Comments made by survey respondents in 2010 (the most recently available results) were entered into a data file and coded into categories. This analysis was used as an additional indicator of the aspects of the admitted patient experience that were most important to patients. More importantly, all comments coded as 'other mentions' and/or containing the keyword 'survey' were manually reviewed for content relating to the conduct of the survey.

Cognitive interviews

Four rounds of cognitive interviews were conducted with NSW patients in order to investigate how patients interpreted and responded to the survey questions. This was performed to: ensure questionnaire validity (i.e. that questions were understood, consistently interpreted and measured what they were intended to measure); that patients were able to follow the questionnaire routing instructions; that they understood the accompanying information; and as a final opportunity to confirm that individual questions were relevant to patients and that no crucial question areas were missing (from the patient perspective).

The first three rounds of interviews were conducted to test the questionnaire content. Questions identified as problematic in these interviews were redrafted and presented to patients in the subsequent rounds of the cognitive interviews, or removed altogether. The final round of cognitive

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[A] Bartman B. Floor and Ceiling Effects. *The Health Science*. Accessed 09/08/2012 from http://thehealthscience.com/wiki/Health-Status-Measurement-Floor-and-Ceiling-Effects interviews was conducted primarily to test the layout of the printed survey and the other materials to be sent with the survey (accompanying letter and information sheet).

The interviews were conducted among a wide range of admitted patients from the North Shore, East and West of Sydney. Quotas were set to ensure representation of a range of participants in terms of age, level of educational attainment, admission route (emergency or non-emergency) and background (including culturally and linguistically diverse and Aboriginal patients).

A total of 30 cognitive interviews were conducted between 27 August and 26 October 2012. The profile of participants in each round can be found in Appendix E.

Each interview was audio recorded and cover notes were prepared by Ipsos SRI consultants to facilitate analysis. The discussion guides used in the cognitive interviews can be found in Appendix F.

Analysis sessions involving Ipsos SRI and the Bureau

Throughout the development process, the Bureau and Ipsos SRI teams were in regular contact. This involved ad-hoc discussions, as well as a series of meetings held at the key stages of the development, including:

- following completion of the patient focus groups and stakeholder interviews
- following each round of cognitive testing
- following each substantial redraft of the Survey.

At each meeting, survey inclusions and exclusions were discussed, with decisions made in light of the results of the development components, the Bureau's expert knowledge of the NSW Healthcare system, data analysis and reporting needs and Ipsos SRI's research expertise. Further, upon the drafting of the penultimate version of the Survey, the Survey was presented to the Strategic Advisory Committee (SAC) for final review. Feedback from the SAC was subsequently incorporated into the final version of the Survey.

3. FINDINGS

3.1 Rapid review of key literature

The following review provides a broad overview of the use of patient-centred care and patient experience survey programs, both internationally and throughout Australia. As mentioned in the Methodology section, the aims of this review were as follows:

- provide contextual background on patient-centred care, both internationally and in Australia
- identify prominent Australian Government and State Government policies and quality standards relevant to the Adult Admitted Patient Survey (the Survey)
- identify core domains of care for admitted patients
- briefly compare the format, content and methodology of admitted patient surveys used in other states and countries to identify best practice for use in the design of the Survey.

Aims of patient-centred care and the role of research

In 1993, the Picker Institute and the Harvard School of Medicine collaborated to perform the formative research into patient-centred care.[1] Since then, medical systems' use of patient-centred care based approaches has proliferated, both internationally and in Australia.[2,3]

In the same period, there has been a commensurate increase in the amount of research seeking to investigate the effects of the use of patient-centred frameworks in health systems worldwide. This research has yielded findings that demonstrate that the use of patient-centred approaches often results in positive outcomes for both patients and healthcare providers.[4] Benefits identified include decreases in: the length of patients' stay in hospitals, rate of readmission to hospital and mortality (both in the short and medium term); in addition to increases in: patients' compliance with treatment recommendations and satisfaction with treatment.[5]

A key component of most patient-centred frameworks is the use of patient experience surveys.[6] These surveys are primarily used in order to measure hospital quality; gauge patients' level of satisfaction with their hospital care; provide feedback to clinicians and facilities on the quality of care from the patient's perspective; and clarify areas in which healthcare can be improved both in a given facility or within a greater region. [7,8,9]

For the reasons above, patient-centred frameworks – often incorporating patient experience surveys - have become a key component in the evaluation of performance and in the generation of best-practice approaches to care in healthcare systems worldwide. Specifically, the Institute of Medicine (IOM) in the United States, the National Health Service (NHS) in the United Kingdom, and Health Canada have sought to embed the notion of patient-centred care as a key dimension in strategy documents and policies.[10]

Australian patient-centred care documents

Patient-centred care frameworks are also entrenched in health strategies and initiatives at an Australian and State Government level. One of the most eminent methods aimed at ensuring a more patient-centred approach to healthcare in Australia is the recent development and dissemination of quality framework and medical guideline documents. These documents strive to improve both patient safety and standards of care.

The Australian Safety and Quality Framework for Healthcare (the Framework), endorsed by Australian Health Ministers in 2010, outlines: three standards for the provision of high-quality healthcare (that healthcare is consumer-centred, driven by information and organised for safety); what these standards mean for patients; and actionable plans for healthcare providers to uphold these standards.[11] The Survey will contribute to the 'driven by information' standard outlined in the Framework by providing supplementary safety and quality data to improve care.[12]

The Australian Charter of Healthcare Rights (the Charter) is another guideline relevant to the patient survey. Contained in the Charter are seven basic principles that aim to provide a shared understanding of the rights of people receiving healthcare among those seeking, receiving or providing care.[13] These seven principles include the right to: access healthcare; access safe, high-quality care; be shown dignity and respect; be informed about available services and treatment options; participate in one's care; privacy and confidentiality of information; and comment on one's care.[14]

The National Safety and Quality Health Service Standards (NSQHS Standards) is a document which outlines ten standards that, if complied with, should ensure safe and high-quality healthcare. These standards include: governance for safety and quality in health service organisations; partnering with consumers; preventing and controlling healthcare-associated infections; medication safety; patient identification and procedure matching; clinical handover; blood and blood products; preventing and managing pressure injuries; recognising and responding to clinical deterioration in acute healthcare; and preventing falls and harm from falls. [15] The NSQHS Standards differ from the Charter and the Framework in that they are to be used in the accreditation of organisations - as of January 2013 compliance with the NSQHS Standards will be compulsory for most private and public healthcare providers. Providers will be rated on a three point rating scale (not met, satisfactorily met and met with merit) in order to ensure quality of care is maintained.[16]

The standards outlined in the documents listed above should be taken into account during the questionnaire design process. In particular, the draft questionnaire should be cross-checked against the NSQHS Standards, to ensure that the Survey contributes towards evidence required for accreditation purposes. However, only those standards that patients themselves are able to observe in the provision of care will be suitable for inclusion; for example, standards relating hygiene and cleanliness, as opposed to those relating to blood and blood products.

The use of patient experience of care surveys

Australia

In NSW, the 2007 State Health Plan, *A New Direction for NSW,* emphasised the importance of improved customer satisfaction and specified that patient satisfaction surveys should be conducted and reported on annually.[17] In response to this imperative, NSW Health implemented the NSW Health Patient Survey, run annually since 2007.[18] More recently, in the NSW Government's **NSW 2021** report, increasing timely access to quality healthcare was listed as a key point of action. In order to gauge the success of hospitals in achieving this goal, the document mentions the aim of improving on the results of the previous year's level of patient satisfaction, as measured by the Program surveys.[19]

Most other jurisdictions - including Victoria, Queensland, the ACT, South Australia and Western Australia – also distribute patient experience surveys annually.[20] These surveys are used to quantify patient experience in a variety of medical environments, to verify if patient-centred care strategies and initiatives have been effective, and to formulate or refine future policy.

One example of another state's survey is the Victorian Patient Satisfaction Monitor (VPSM), an admitted patient's survey that is currently administered by post to public hospital patients in Victoria and the ACT. [21] State-wide results are reported on an annual basis, with additional bi-annual reports available for each hospital. The VPSM has similar aims to the NSW Survey in that it seeks to illustrate the entire patient journey, encompassing questions dealing with access and admission as well as discharge and follow-up. There are 28 questions comprising six sub-indices of care – access and admission, general patient information, treatment and related information, complaints management, physical environment and discharge and follow-up – in the VPSM, all of which are used to calculate the global indicator of participants' satisfaction with their patient journey, the Overall Care Index.[22]

Both South Australia[23] (SA) and Queensland[24] operate patient survey programs using the English National Patient Survey Programme (NHS) questionnaires. Questionnaires utilised in these programs were designed and tested by the Picker Institute Europe and have many similarities to the Picker NRC surveys used by NSW until 2012.

Western Australia (WA) has a long-standing survey program – known as the Patient Evaluation of Health Services - with methods and questionnaires built from first principles (constructed based on theories of best practice).[25] These instruments were built using consumer feedback derived from a variety of focus groups that elucidated seven dimensions of patient experience. At present, there are 13 different survey instruments aimed at different patient groups (including overnight patients, emergency patients and maternity patients).[26]

The Survey will draw on some of the approaches used in other Australian states. The Survey will use a similar framework to WA in constructing the questionnaire: focus groups will be used to inform Survey content, along with stakeholder interviews, a rapid literature review, cognitive interviews and data analysis. Further, as in SA and Queensland, the NHS questionnaires will be used as a key reference point for Survey materials. Lastly, as in the VPSM, the Survey will seek to illustrate the entirety of the journey of admitted patients, from access and admission to follow-up.

In contrast to the VPSM approach, the Survey should predominantly measure patient experience (for example, 'Did you **see** nurses wash their hands, use hand gel to clean their hands, or put on clean gloves before touching you?') rather than patient satisfaction (for example, 'how satisfied were you with the hygiene practices of the nurses?'). The rationale for this approach is that patient experience is less subjective and reliant upon patient preferences in care than patient satisfaction, and is therefore able to more accurately capture characteristics of patients' treatment and care. Further, results derived from a survey of patient experience are more actionable than those from patient satisfaction because they more clearly elucidate deficiencies in care.[27]

International

Internationally, there are two survey programs held up as 'gold standards' for use in jurisdiction-administered patient survey programs, primarily due to the robust methodologies used in their development.[28] One of these, the Hospital Consumer Assessment of Health Providers and Systems Hospital Survey (HCAHPS) is a standardised survey that measures patient perspectives on hospital care. It was developed by the Center for Medicare and Medicaid Services and the Agency for Healthcare Research and Quality and is currently used in hospitals throughout the United States.[29] The HCAHPS has been psychometrically tested and validated across various demographic groups of patients, hospital services and types of hospitals.[30,31] The 2011 questionnaire has 27 items comprising two global ratings (overall rating of hospital and willingness to recommend the hospital) and six composites of care (communication with nurses, communication with doctors, responsiveness of hospital staff, pain management, communication about medicines and discharge information).[32] Confirmatory factor analysis has demonstrated that an abridged version of 16 questions established excellent fit of the data for performance reporting.[33]

The other well-recognised, standardised survey programme is conducted by the NHS[34], and consists of surveys for seventeen distinct patient groups. The NHS Adult Inpatients Survey is implemented annually. Surveys of emergency department care, outpatients and maternity cycle over a three year period, while other surveys are implemented to co-ordinate with service reviews. In 2011, the Adult Inpatient survey comprised 85 questions which spanned admission to hospital (either planned or non-planned), characteristics of the hospital and the ward, performance of doctors and nurses, patient care and treatment, operations and procedures, discharge, measures of overall performance and demographic characteristics.[35] Hospitals taking part in the inpatient survey also have the option to add additional questions that are of local relevance from the inpatient question bank, a reserve of 121 tested questions designed from patient and stakeholder suggestions throughout the history of the inpatient survey.[36]

Topics to be covered in a NSW Adult Admitted Patients Survey

Based on our review of the literature, a number of the aforementioned survey programs have been identified as potential sources of information for the Survey. Specifically, topics (or domains) to be encompassed in the Survey will be informed by the HCAHPS, the NHS Programme surveys and the VPSM.

This section outlines questions and question areas that are commonly mentioned in VPSM, HCAHPS and NHS literature as having the most impact upon the level of patients' satisfaction with their care. Such questions are often referred to as 'key drivers' of admitted patient satisfaction and dissatisfaction. Questions pertaining to all of these priorities will be included in the Survey.

In Victoria, the factors that had the greatest impact upon the overall satisfaction of patients in the VPSM primarily pertained to characteristics of the treatment provided by doctors and nurses. Specifically, helpfulness of staff, staff's responses to healthcare problems, staff's willingness to listen, patients' involvement in decisions and responsiveness of nurses all correlated the most highly with overall patient satisfaction.[37]

In the United States, the key drivers of patients overall ratings of hospitals in the HCAHPS were similar to that found from the VPSM and included: communication with nurses and doctors; responsiveness of hospital staff; pain medication; and communications about medication.[38] Similarly, questions in the NHS Inpatients Survey that had the highest level of association between patients' overall satisfaction and their care included: the level of collaboration between doctors and nurses; the extent to which patients' felt that they were treated with dignity and respect; confidence and trust in their nurses and doctors; and perceived degree of pain control.[39]

Therefore, questions included in the Survey will address the recurring themes from the NHS Inpatient Questionnaire, the HCAHPS and the VPSM, and will seek to answer gaps not addressed in these surveys (see Figure 2). Themes to be addressed include: patients' perceptions of the efficacy of administration (including admission and discharge); functioning of doctors and nurses (in terms of factors like communication, information provided and provision of services); quality and cleanliness of facilities; privacy; pain control; and attention to psychosocial problems.[40,41]

Figure 2: Domains of prominent admitted patient surveys

Survey domains	NHS 2011 Inpatient Questionnaire	HCAHPS	VPSM	2011 NSW Day Patient Survey	2011 NSW Health Overnight Survey
Waiting list/Pre-admission	✓✓		✓✓	✓✓	✓✓
Admission	✓✓		✓✓	✓✓	✓✓
Emergency room	✓✓				✓✓
Doctors	✓✓	✓✓	✓	✓✓	✓✓
Nurses	✓✓	✓✓	✓	✓✓	✓✓
The ward	✓✓		✓		✓
Obstetrics					✓✓
Surgery/Procedures	✓✓			✓✓	✓✓
Pain management	✓	✓		✓✓	✓✓
Hygiene	✓	✓		✓✓	✓✓
Hospital amenities	✓		✓✓	✓✓	✓✓
Discharge	✓✓	✓✓	✓✓	✓✓	✓✓

✓✓	✓
Addressed in a domain	Addressed partially

More specifically, the Survey is anticipated to incorporate questions relating to the following general areas of public hospital care. These question areas are derived from the content of the NHS 2011 Inpatient Questionnaire, HCAHPS and the VPSM, as well as from the research literature included in this review.

Referral, arrival and admission

- The process of referral
- Arrival at the hospital
- The admission procedure[42]
- Whether admission was planned or unplanned[43]
- The point of referral[44]
- Wait times (including the wait between referral and admission, as well as the wait time at the hospital)[45,46,47]
- The perceived efficiency of the admission[48]
- Informing patients of their rights as a patient[49]
- Reassessment of patients during waits (particularly during non-planned admissions)[50]

- Communication of prognosis[51]

The Hospital and ward facilities

- The type of room that the participant stayed in[52]
- Cleanliness and hygiene[53]
- The use of unisex accommodation[54]
- Availability of facilities or services[55]
- Privacy[56]
- Disturbances[57]
- Use of up-to-date technology and/or equipment[58]
- Provision of and quality of food[59]
- Variety and choice of dishes[60]

Communication and care

- Patients’ confidence and trust in practitioners (both nurses and doctors)[61]
- Continuity of care from the same members of staff[62]
- Level of collaboration between doctors and nurses[63]
- Provision of information (particularly with regard to treatment and medication)[64]
- Treatment with dignity and respect[65]
- Performance and explanation of requisite tests[66]
- Performance and explanation of procedures[67]
- Availability of staff for assistance (with eating or the bedpan) and staff responsiveness[68]
- Communication with doctors and nurses[69]
- Staff hygiene[70]
- Pain relief[71]
- Privacy of examination[72]
- Adverse experiences in care (such as infections)[73]
- Availability of an avenue through which to make a complaint[74]
- Staff courtesy and helpfulness[75,76]
- Support, and staff’s willingness to listen[77]
- Patients’ involvement in decisions[78,79]

Discharge

- Delays in discharge[80]
- Collaboration between patients and staff in the formulation of health goals/healthcare needs following discharge[81]
- Information regarding subsequent appointments[82]
- Provision of information necessary for a smooth discharge[83]
- Provision of information necessary for ongoing self-management outside of hospital[84]
- Health outcomes (including readmission)[85]

Implications of patient’ demographic characteristics for survey design

Recent research has demonstrated that patients’ responses to surveys about their experience as a patient differ significantly according to their demographic characteristics.[86,87] Demographics that have been shown to be related to certain patterns of responses – for example, older respondents tend to be more positive about their care experiences than younger respondents[88] - include:

- Age[89]
- Gender[90]
- Level of education[91]
- Type of patient (surgical or medical)[92]
- Health status[93] and
- Whether a proxy was used to fill in the survey in place of the patient.[94,95]

With these results in mind, it is imperative that the design of the Adult Admitted Patient Survey includes such questions so that they can be used to profile the responses of admitted patients and be used for the retrospective standardisation of patients’ responses.

Summary - Implications for the design of the Adult Admitted Patient Survey

- The draft questionnaire should be cross-checked against the NSQHS Standard, to ensure that the Survey contributes towards evidence for accreditation purposes where appropriate (i.e. where actions relevant to the Standard are able to be observed by patients and/or where robust evidence is not available from other sources).
- The Survey should utilise some of the approaches used in the patient surveys from other Australian states, including:
    - building from first principles – i.e. using theories of best practice, as well as stakeholder and focus group consultations (Western Australia)
    - be informed by the NHS surveys (SA and Queensland) and
    - aim to cover the entirety of the patient journey (Victoria).
- The Survey should ask about patients’ experiences of care rather than their level of satisfaction. However, as with the HCAHPS, the NHS and the VPSM, the Survey should also include at least one question that aims to quantify patients’ global (or overall) satisfaction with their journey.
- Key drivers from the NHS, HCAHPS and VPSM should be included in the Survey. Other question areas from these surveys should also be considered for inclusion (as outlined above).
- Demographic characteristics shown to affect patients’ patterns of responses should be included in the Survey for purposes of standardisation.

3.2 Admitted patient focus groups

This section summarises the aspects of the admitted patient experience that were most important to the patients who took part in the focus groups and therefore potential areas for inclusion in the Survey. Often, the importance of a particular area of the experience was exposed because there was a failing in that area. However, the analysis also highlights areas that were most important in creating a positive experience.

Waiting times

One of the key issues for participants in the patient focus groups was waiting times at various points in the patient journey. This issue was spontaneously mentioned by those who had experienced short wait times as a positive element of their experience, as well as a significant problem by those who had to wait for longer periods.

Waiting times were a particular issue for those who had been admitted through the **Emergency Department** (ED) – both to be triaged and to be admitted or treated. Some participants reported waiting for five or six hours. A wait in the ED was made more difficult by what were described as uncomfortable surroundings and, in some cases, a lack of information about the likely wait time and reasons for long waiting times as well as a perceived lack of empathy by staff in the ED.

Although there was some awareness that patients were prioritised according to the seriousness of their health issue (and an understanding that this was necessary) some felt that they were overlooked because they did not have obvious external symptoms, even though their condition was actually very serious. A long wait for triage was particularly concerning for those who did not know what was causing their problem or how serious it might be. Some who had waited a long time felt as though they had been forgotten and therefore began to lose faith in the level of care they would receive.

> *"You start to question whether you're going to be seen by a doctor who knows what's wrong with you and be really looked after".*

Two patients who participated in the focus groups believed that infections they acquired resulted from waiting a long time in the ED for wounds to be treated, suggesting the potential need for a survey question about adverse events as a result of the hospital visit.

Some participants who had been admitted for a non-emergency procedure were happy with the **referral process**, but others complained about waiting lists.

A number of the non-emergency patients from one of the groups had attended a **pre-admission day**, which was described as 'tedious' because they had various tests, with long waits in between, over a number of hours. However, this seemed to be primarily an annoyance, or inconvenience, especially when compared to the more traumatic experience of waiting a long time in the ED.

Delays to procedures or surgery also occurred once admitted. This was frustrating and inconvenient, and led to increased anxiety levels for some people.

> *"They told me a specialist was going to speak to me between 10 and 11 in the morning and he didn't show up. I had to ask and the nurse acted like I was annoying her. Then she told me I had to come back tomorrow. It was just really unprofessional and a waste of time."*

Participants frequently described delays in the **discharge process** caused by having to wait to be seen by a doctor, or for prescription medications, which was particularly frustrating when relatives had arrived at the allotted time to take them home.

Attitude of staff

The attitude of staff was crucial to the overall experience for patients who took part in the focus groups. Descriptions tended to be polarized with participants either very complementary in this respect or very negative. The attitude of nurses was mentioned most often, but this issue also applied to doctors, allied health professionals, paramedics, receptionists and, to a lesser extent, other staff such as porters and cleaners. Words used to describe the positive attitude of staff included: 'caring, pleasant, friendly, cheerful, efficient, polite, reassuring, concerned and empathetic.

> *"I got the sense that a lot of them [the nurses] really love what they do."*

This compared to negative traits such as: insensitive, disinterested, grumpy, 'bitchy', dismissive, uncaring, blasé, rough, and impatient.

The attitude of staff made a strong impression on the focus group participants at all stages of their patient journey, but it was perhaps particularly important in the ED, where they were most likely to be in pain and sometimes fearful or distressed. Some felt that staff, including those on the reception desk, displayed a lack of empathy with how they were feeling, failed to update them on the likely wait time, or the reasons for long wait periods, and, in some cases, gave the impression that they doubted the seriousness of their condition. Paramedics on the other hand were complemented for being quick, caring and calm.

Once admitted, some participants recounted how the nurses had introduced themselves upon arrival (and at handovers/before treatment) and shown them to their bed, which helped them to feel at ease, especially for those who had come from the 'chaos' of the ED. Staff who recognised and acknowledged patient needs, even if they were unable to meet them immediately, were praised. When participants felt staff had displayed **genuine concern** for them this had a very positive impact on their overall experience.

Some participants noticed that staff members **worked well together** as a team, while others had observed disagreements, described 'cliqueyness' and 'bitchyness' between staff, as well as junior staff being reprimanded in front of them, which had a negative impact on their perception. There was also criticism of instances where doctors had talked about patients, rather than to them.

> *"They were talking to each other and I felt like I wasn't there."*

It was important to that staff were **physically careful and as gentle as possible** when attending to them. Some participants reported being roughly handled or staff being too cavalier when they made mistakes and had to repeat uncomfortable procedures.

> *"I had an epidural from a doctor who yelled out that he missed it, and then on the fifth one he asked whether I had a crooked spine. The fact was that he just couldn't get it. It was the language and the way they react."*

Responsiveness of staff

Staff responsiveness to patient needs was another important facet of the experience for focus group participants. Some reported that **basic care was not provided, or recalled having to ask a number of times for their requests to be met**, for example the provision of a blanket while waiting to be taken to theatre (while wearing only a hospital gown). Others reported that staff responded promptly to their requests and use of the call button.

There was general agreement that public hospitals were understaffed, although some reported that 'good' nurses were still able to ensure that patient needs were met, so this issue was seen as being closely linked to the attitude of staff. There were a range of experiences in relation to this aspect of care – from those who said they were very well looked after to those who felt basic care had not been delivered.

> *"[Main impression of their hospital experience:] I'd say neglect. Nobody came anywhere near me in terms of washing, caring, or physically with anything."*

One group participant felt that his **pre-existing medical condition** was not taken into account by staff. He reported that none of the doctors or nurses asked him about other conditions, even though he was still wearing bandages as a result of previous surgery. The participant felt that this omission was irresponsible, and resulted in a reduction in the levels of trust and confidence in the abilities of the medical staff at this facility.

Patients who participated in the focus groups wanted to see a **regular presence of doctors** on the ward, both to oversee their treatment and to respond to their questions. Some felt that doctors spent too little time with them personally or on the ward in general; this impacted on their trust and confidence in the treatment they were receiving.

Participants in one of the groups spontaneously expressed a strong preference for staff to be employed by the hospital rather than by an agency because they wanted staff to be familiar to them and with the hospital. There was also a perception that agency staff were less caring, at least partly because they did not develop a relationship with the patients. When prompted on this issue, other participants also expressed this preference, as they felt issues or complaints would be addressed more readily if staff were employed directly, though this was not a crucial issue. However, patients may not know whether they were cared for by staff employed by an agency or directly by the hospital. Plus, some of the problems outlined above may be caused by factors other than this, so it is likely to be more important to include questions about staff attitude and familiarity with patient care plans and hospital processes.

Communication and information provision

Participants wanted to be well informed about **what to expect** when visiting hospital and provided with **understandable explanations** of issues related to their care/condition throughout their hospital visit.

Participants who had been admitted for a planned procedure generally received information in writing outlining where they need to go and at what time, which they found useful. The level of verbal explanation and discussion about what to expect varied. Some felt they were not given an adequate description and therefore went on the internet to find out more. There was also a suggestion that hospital visits would be less stressful for emergency patients if they were better informed about what would happen and how the admission procedure worked.

There was a sense that **sufficient information was provided at discharge** (regardless of whether they had been admitted via the ED or for a planned procedure). This included written information about medication, a letter for their GP and what to do/who to contact if their condition deteriorated. However, some felt they were not ready to go home when they were discharged (for example because they were still drowsy) or that they were simply handed medication and sent home without sufficient advice or discussion about after care, in order to free up beds.

Participants in the focus groups did not seem to be particularly concerned about being offered the **opportunity to ask questions**, as they generally felt that it was up to them as patients to make a point of doing so – although, as noted, this was sometimes problematic where doctors were unavailable. Also, very frail or particularly vulnerable patients were unlikely to be represented by the focus group discussions, and these patients may be less able to assert themselves in this way.

Participants were more concerned about the **quality of the response**, in terms of being given an understandable explanation and correct advice.

There was agreement that doctors and nurses should be open and honest with patients. However, while some were keen to know as much as possible about their condition and what would happen during procedures, others preferred not to know every detail, so medical staff need to be sensitive to this.

Beyond being provided with explanation and information, participants made it clear that they wanted to be **listened to, and actively involved in decisions around their care**. Some gave examples where this had not taken place, for example where they had explained to staff that they could not or did not want to take particular medications, but they had to push for their concerns to be taken seriously.

As noted above, being given regular updates about likely waiting times and the reason for delays was very important to patients.

Organisation and communication between staff

Experiences in relation to organisation and communication between staff and departments were mixed. Some focus group participants reported that the hospital was well prepared for their arrival and that they progressed efficiently through the various processes involved in their care, but others had lengthy waits to be seen by doctors and specialists, or found that they were unavailable at the allotted time.

Effective **handovers** between staff were seen as particularly important for ensuring high quality care and preventing mistakes – participants were reassured when they observed a thorough verbal hand-over and staff reading their notes. While they understood the need for each person involved in their care to confirm their identity and key details through asking questions, some felt that they had to unnecessarily repeat information because of lack of communication between staff and/or a lack of thorough paperwork or reading of paperwork. The safety aspect of this repetition was not necessarily recognised by all of those who took part in the focus groups.

Perceived competence of staff and quality of treatment

Trust and confidence in the staff treating them was extremely important and generally based on perceived level of competency. The competency of staff was assumed by some participants, while the perceptions of others seemed to be based primarily on factors such as personality, whether staff appeared confident in their own abilities, and the type of language used, by doctors in particular. For others, their trust and confidence in staff was undermined because of **mistakes** (in carrying out procedures, diagnosis etc.), because staff treating them displayed a **lack of certainty** about what to do or what was wrong with them, or because they were given **contradictory information**. Where this had happened it was very stressful as they had become concerned about their safety and felt that they had to be vigilant to make sure mistakes were not made.

> *"The explanation they gave me wasn't very convincing and that's why they kept doing more tests, because they weren't sure themselves. After a doctor finishes the shift another one comes in and has another opinion."*

Some reported examples of being given incorrect information relating to medication and how they should deal with dressings upon discharge, which only came to light when they queried what they had been told.

Participants mentioned being pleased to observe that **medical students or interns** were well supervised. For example, one recounted a senior staff member asking her questions to make sure procedures had been correctly followed by a student doctor. Others expressed concern that students did not do what the doctors advised, or that they were not adequately monitored.

Patients may not know the final **outcome of treatment** until sometime after discharge. However, whether they felt better on leaving hospital than when they arrived was very important to participants in these discussions, particularly to those admitted via the ED.

Comfort and facilities

Levels of comfort while in hospital left a significant impression on those who took part in the focus groups.

The issue of **pain management** was particularly important for those who had been admitted via the ED, primarily because they had often experienced significant pain when they first arrived at hospital. It tended to be rated as less important by planned admission patients during the prioritisation exercise, but it became apparent that this was because they were generally not in pain on arrival and/or because their pain was well managed during their stay, so this factor was less pressing. It was clear from the discussion that if their pain had not been managed it would have been a key issue and a few participants did report that the pain control medication they were given was insufficient (e.g. being given Panadeine after major heart surgery).

Beyond pain management, patients also wanted to feel **comfortable and comforted** while in hospital. A few participants mentioned being cold at various stages in their care, which made for an unpleasant experience - one explained that this had made a nervous wait for a planned operation pass even more slowly.

The ED was widely criticized during the discussions for being uncomfortable. Descriptions of EDs included references to cold, hard chairs, fluorescent lighting, a lack of beds and nowhere to get food (other than ‘junk food’ vending machines) - essentially not a comforting environment for someone who is feeling very unwell.

Expectations about the public healthcare system influenced views on what was important when it came to levels of comfort and issues around **privacy** once admitted. While having a separate room may have been preferred, it was felt that this could not be expected as a public patient. When prompted on the issue of mixed gender wards some (especially females) felt this was inappropriate, particularly for more personal or sensitive procedures, while others were unconcerned by this or felt this was to be expected in the public system.

The issue of privacy was not paramount among participants. However, when prompted, the amount of privacy afforded by curtains around a bed was discussed, in one group in particular. It was seen as important that curtains were always drawn when examinations were taking place, and this generally occurred. However, some were concerned that curtains did not prevent conversations with staff from being overheard and felt that discussion around particularly sensitive subjects (e.g. in relation to very personal issues or bad news) should take place in a separate room. Similarly participants described being disturbed by noises from other patients or large groups of visitors.

> *“I had a mixed room and there were people crying, but it’s to be expected of a public hospital.”*

While some participants mentioned being offered a choice of meals and the option to state special dietary requirements, there was broad consensus the **quality of food** was poor in public hospitals and this was spontaneously raised as a problem early on in the discussion by participants, suggesting it had left a significant impression on them. It was pointed out that good quality food was important for recovery and some reported that their relatives had brought food in for them. However, others explained that they had little interest in food when they were feeling unwell and the quality of food was generally placed towards the bottom of the list when rated against other aspects of patient care.

A number of participants argued that the private healthcare option was available if people wanted better food, more comfort, greater privacy and single-sex wards, and that it was unrealistic to expect this level of service from the public system.

Cleanliness and hygiene

Cleanliness was not spontaneously suggested as an important issue by most participants in the focus groups, mainly because it was assumed minimum standards of hygiene would be met. Participants seemed satisfied with the level of cleanliness they had observed in hospital. With some exceptions, the focus seemed to be on visible cleanliness, as opposed to the transmission of germs.

When asked to prioritise the various elements that might be important to the patient experience a **clean room or ward and clean bathrooms** tended to be placed towards the bottom of the list. Staff **washing their hands** between treating patients was placed slightly higher up the list of priorities by some, but again it was generally assumed that this would take place, and participants reported seeing this happen. Had there been an obvious lack of hygiene or cleanliness then this issue would likely have been deemed more important.

> *"It's important, but you assume it happens [washing hands]. You see them wear gloves and that. It's a given."*

Out of pocket costs

Concerns about out of pocket costs were mentioned by some participants – these generally related to seeing a specialist in order to get a referral. It was noted by one group that the rebate available from Medicare did not cover the full cost of these and that appointments were often very short given the fee charged. In another group, one participant recounted that he had been required to pay a significant amount of money upfront for a procedure in a public hospital that was not covered by Medicare and another had felt under duress from a nurse to rent adaptive equipment upon discharge that she did not want or require.

There was also some discussion around the high cost (and difficulty) of parking and paying to watch TV. However, out of pocket costs were not rated as a particularly important issue in comparison to other aspects of the patient experience and some expressed surprise that this was even included in the prioritisation exercise as they had not experienced any out-of-pocket expenses during their hospital visit.

Overall rating of experience

Some participants recounted their experience as predominantly positive or predominantly negative; others had experienced both extremes within the one hospital admission. This made it difficult to decide on an overall rating of their experience using a five-point scale.[B]

[B] This quantitative exercise was included primarily so it could be followed-up with a discussion around why this was the case.

To deal with this some ticked two response options (e.g. very good and very bad), others ticked the neutral option. This issue should be taken into account as far as possible in the questionnaire design and examined in the cognitive testing phase.

Summary - Implications for the design of the Adult Admitted Patient Survey

Based on the findings outlined above, the following areas were identified for inclusion in the list of potential areas for inclusion in the admitted patient survey, alongside those indicated from analysis of the stakeholder engagement exercise.

Emergency Department

- Length of time spent waiting – for triage and for treatment
- Patients kept informed of likely wait time and the reasons for delays
- Comfort of ED waiting room
- Attitude of staff in the ED (doctors, nurses, receptionists) - politeness, empathy, concern, taking patients' conditions seriously
- Attitude of paramedics – efficient, caring, calm
- Effective pain management

Waiting times

- Waiting lists – prior to admission
- Waiting involved in the admission procedure (inc. pre-admission days)
- Delays to scheduled surgery/procedures
- Delays in the discharge process
- Patients kept informed of likely wait times and the reasons for delays

Attitude of staff (inc. doctors, nurses, paramedics, receptionists and other staff)

- Caring, friendly, cheerful, polite, empathetic and exhibited genuine concern for patients
- Introduce self before treatment/examination
- Talk to, rather than about, patients
- Being careful when examining/treating patients

Responsiveness and availability of doctors and nurses

- Patient needs attended to/basic care needs met/sufficient nurses to meet care needs
- Patients assisted in a timely manner
- Regular presence of doctors on the ward to oversee patient care and respond to questions
- Pre-existing conditions acknowledged and taken into account
- Familiarity of staff with patients' treatment/care and hospital processes/layout

Information provision and communication

- Sufficient information provided pre-admission (inc. logistical information and what to expect)
- Sufficient information provided throughout hospital visit (inc. about their condition, test results/diagnosis, next steps, medication, reasons for delays etc.)
- Sufficient information provided at discharge (medication, managing condition at home/after care, what to do if condition deteriorates, letter for GP)
- Understandable explanations provided throughout their stay
- Staff open and honest with patients
- Patients felt listened to and actively involved in decisions about treatment, care and medication

Organisation and communication between staff

- Effectiveness of handovers and use of patient notes (including. staff reading notes and not having to repeat information unnecessarily)
- Efficient progress through each stage in the patient journey
- Staff worked together as a team

Comfort

- Adequate pain management
- Comfortable facilities (including temperature)
- Disturbance from patients or visitors
- Privacy (curtain drawn for examinations, sensitive topics discussed in a separate room)
- Quality of food
- Cleanliness

Competency of staff and quality of treatment

- Overall trust and confidence in doctors , nurses and other staff
- Perceived level of ability/understanding of condition
- Incidence of receiving contradictory or incorrect information
- Incidence of mistakes / adverse events (including hospital acquired infection)
- Supervision of students/interns
- Outcome of treatment (felt better)
- Felt well enough/ready to be discharged

Financial issues

- Fee charged for seeing a specialist (to obtain a referral to hospital)
- Fees charged for equipment/treatment not covered by Medicare

3.3 Stakeholder engagement

To ensure the Survey meets the needs of stakeholders who will ultimately use the results to monitor and improve patient services, a full range of stakeholders were invited by the Bureau to suggest areas for inclusion in the questionnaire by completing a pro forma and/or participating in a telephone interview.

While the value of an overall satisfaction measure was recognised by stakeholders, they were primarily interested in questions that went beyond this, to provide information that could help them improve services. There was therefore a preference for questions that asked about actual experience, rather than satisfaction, where possible.

Broad reasons given for the recommendation of particular question areas included: monitoring improvements in care (especially where new processes or courses had been implemented or trialled); monitoring or providing evidence of implementation of policy and compliance with standards/for accreditation; providing evidence to support calls for change; updating guidelines; to identify gaps in patient knowledge and understanding; because certain procedures or processes had implications for patient safety; or because an aspect of care had been shown to be important for patient satisfaction or a common factor in complaints and errors.

Waiting times

Waiting times at various points in the admitted patient experience were identified as a key issue for patients during the focus groups and these were also of interest to stakeholders. Records are kept of actual patient waiting times at a number of stages of in the patient journey – for example, the length of time between arrival in the ED and being admitted/treated. Where records are not available, it was suggested that an indication of waiting times from the patient survey would be useful. Stakeholders suggested that this includes, the time elapsed from referral (for example by a GP) to consultation with a specialist/surgeon; sometimes referred to as a **'hidden waiting list'**. As patient views on the appropriateness of any delay might not correlate with clinical assessment, the actual time waited was seen as more useful than satisfaction with the length of wait. It was also suggested that an indication of the **efficiency of the pre-admission process** would be useful, as well as the incidence of **delays to planned procedures**.

There was a request for data on whether emergency surgery patients in particular were given times or dates for surgery that did not eventuate, or had surgery in the middle of the night, as new guidelines specify that some planning allowance should be made for emergencies (and a number of hospitals have been funded for redesign in this area).

Also reflecting the views of patients, stakeholders recommended that question areas should include whether patients were **kept informed** of expected wait times or delays, and reasons for delays and cancellations.

Attitude of staff

Various aspects of the attitude of staff were mentioned as issues that are often raised by patients, and therefore relevant for inclusion in the questionnaire. This included staff displaying **sensitivity to the needs and preferences of patients** (including cultural and religious preferences), their ability to break bad news sensitively, anticipating and **addressing patients' anxiety**, treating patients with **dignity and respect** (which, it was suggested, may be a particular issue for groups who often have to deal with prejudice or assumptions being made about them), and being friendly and helpful.

Responsiveness of staff

An important area related to the attitude of staff, at least in part, was whether staff were attentive to the needs of patients and **responded to calls for assistance in a timely manner**. Stakeholders noted that it was especially important that feedback (from patients or their families) relating to new symptoms, lack of improvement, or deterioration, was listened to and taken seriously.

Staff awareness and understanding of dementia and early recognition of delirium was also suggested as an important issue. Although it may be difficult for patients to comment on whether staff recognised particular conditions, patients and/or carers and family members may be able to provide feedback on the extent to which they felt staff understood and responded appropriately to the needs of people with conditions such as dementia.

The extent to which patients felt that they received the care they needed, including existing conditions being taken into account and the provision of emotional support was also seen as important.

Communication and information provision

Information provision and effective communication was recommended by many stakeholders as key areas for inclusion in the Survey because of the necessity for patients to make **informed decisions about their care** and provide **informed consent**, as well as for patient safety and patient satisfaction.

It was suggested that questions relating to communication should ideally each be asked in relation to doctors, nurses and allied health professionals separately, although it was acknowledged that limited space may not allow this.

It was seen as crucial to establish not only if patients were given (sufficient) information at specific stages, but also whether the information provided was understood. Approaching this issue from another perspective, some stakeholders requested questions that asked about the **incidence and quality of explanation by staff**, overall and at key stages in the patient journey.

Measures to deal with language barriers were relevant here. A number of stakeholders wanted the questionnaire to capture the incidence of **awareness and use of interpreters and translated information** among patients from Non-English Speaking Backgrounds (NESB). Where a translator was not provided one stakeholder wanted to know whether someone else (friends, family, other staff etc.) helped with interpretation. However, the patient survey may not be the appropriate vehicle for accurately monitoring the extend of the need for, or use of, language services because the questionnaire will be in English; even though an interpreter service will be offered (via a multi-language information sheet), it is reasonable to assume that the extra effort involved might result in a lower incidence of completion among non-English speaking patients.

Stakeholders were interested in whether patients (and their family or carers) were kept up-to-date throughout their hospital stay about their **care pathway, next steps**, and when they were likely to be discharged and whether they received sufficient information and explanation at a number of key points during the admitted patient journey, including pre-admission, admission, when receiving test results or diagnosis, before and after treatments or procedures, when prescribing medication, and at discharge. Types of information and explanation that stakeholders suggested should be asked about in relation to **pre-admission**, included:

- logistical information, such as where to park, arrival time, anticipated length of stay, arrangements for discharge and what to bring (e.g. X-rays, insurance details, personal belongings)
- instructions on preparation for admission (stopping medication, fasting etc.)
- information on pain management and the likely course of recovery.

Information provided pre-admission was viewed as particularly important because surgical procedures are often cancelled as a result of patients not being properly prepared.

Question areas relating to the provision of information on **patient rights and responsibilities** were suggested by a number of stakeholders, including whether written information was provided, read, understood by patients and explained by staff.

Communication and information provision at **discharge** was also a key focus for stakeholders, as this is crucial for ensuring correct aftercare, and therefore preventing infection and readmissions. One stakeholder noted that a greater focus on health promotion by staff in hospitals was required (to prevent readmission) and that this may be particularly relevant to patients who are elderly, Aboriginal or Torres Straight Islanders, people with mental health issues and people with cancer or terminal conditions.

Suggestions for question areas relating to discharge included:

- whether concerns about going home where discussed
- how well patients understood how to care for themselves at home (including the correct administration of medication, wound care, nutrition etc.)
- whether patients were given sufficient information about how to cope with changes that may occur as a result of their condition or treatment (e.g. to their appearance, energy levels, emotional needs, relationships/sexual activity, work capacity etc.)
- whether written information was provided (instructions, aftercare appointments, letter for GP)
- who to contact to ask questions or for help if needed after discharge.

It was recommended that feedback on communications around **medication**, during a hospital visit and at discharge, should be included in the questionnaire, as this plays a crucial role in ensuring patient' safety, as well as in helping to instill trust and confidence in decisions made by staff. This should cover whether staff obtained information about medication being taken by patients and explained the reasons for the use, benefits and risks or side effects of medication, as well as alternative options. Similarly, stakeholders wanted to find out whether patients were given information and explanation about the purpose of procedures, what they involved, any **risks or side effects and potential alternatives**, as well as the opportunity to ask questions. One stakeholder wanted to find out whether staff discussed the option of using complementary, alternative or non-traditional therapies with patients.

Linked to the provision of information about risk, side effects etc., there were a number of requests for data on the extent to which patients felt able to provide fully **informed consent** for invasive procedures such as blood transfusion, surgery etc. This also included whether they were asked about who should give consent on their behalf if they were unable to do so.

Beyond the provision of consent, stakeholders were keen to find out the degree to which patients (and their families or carers) felt they were **listened to, involved in decisions, and supported in making decisions** about their care. This included involvement in handovers, and whether staff enquired as to whether patients had recorded their treatment preferences in writing (advance care plans). There was an interest in investigating whether patients were offered the option to go home early, with an acute health team providing care in-home and, if not, whether patients would have considered or chosen this option and why, although this option would only be relevant to a sub-group of patients.

The term **'patient empowerment'** was mentioned and, as part of this, some stakeholders requested questions pertaining to the incidence of patients questioning staff about their medication or prompting staff about hand washing. However, this type of question could provide ambiguous results as patients prompting staff could be interpreted as either a positive indication that messages aimed at increasing patient empowerment were getting through, or that staff were failing to implement guidelines.

Communication and co-ordination among staff

While patients may be less able to provide feedback on staff co-ordination and communication with each other, stakeholders did make suggestions for a number of areas where it would be relevant for patients to comment. As noted, patients who took part in the focus groups were certainly left with an impression on this issue, which had an impact on their trust and confidence in their treatment.

Suggestions in this area included whether **handovers** always took place in front of patients, whether staff understood patients' whole condition or history and the extent to which staff appeared to work as a team, as well as after care services being organised in advance.

The issue of **communication with GPs and other medical practitioners** was also raised. One stakeholder wanted to ask patients about their GP's awareness of their hospital visit and after care arrangements and another about consultation with GP's or other medical professionals during admission. However, patients may not be able to answer these last two questions with certainty.

Patient safety, accidents and adverse events

One stakeholder indicated that the Adult Admitted Patient Survey could be an opportunity to obtain the **incidence of adverse events** during their stay, as there is no measure of this currently. A number of suggestions also related to **preventative measures**. For example, in relation to falls, conducting risk assessments, providing timely assistance to patients when mobilising, explaining how to use the call bell and making sure it is in reach, and discussion with patients of strategies for reducing the risk of falls. Similar suggestions were made in relation to preventing pressure injuries (incidence of staff explanation of the causes of pressure injuries, helping patients to change positions regularly etc).

A number of stakeholders wanted to confirm that **patient identity** (name, date-of-birth etc.) was checked before procedures and at handovers.

Complaints

Stakeholders explained the importance of patients being **aware of the process for raising concerns and feeling that feedback and complaints were dealt with appropriately**.

It was recommended by stakeholders that the questionnaire covers patient awareness of how to provide feedback and how to complain. A couple of stakeholders made specific reference to the introduction of the Nurse Unit Manager (NUM), who would usually be the first point of contact.

Following on from this, it was suggested that questions should be asked of those who had made complaints, to find out what happened as a result – i.e. whether staff were open and honest about the mistake and whether they received: a satisfactory apology; explanation for the error; and reassurance steps were being taken to avoid a repeat of the error in future.

Comfort (including pain management)

Participants in the patient focus groups explained that adequate **pain management** was important to them, especially for those admitted as an emergency patient. Stakeholders also felt that this area should be included in the survey – they wanted to know whether patients were regularly offered pain relief and whether their pain was effectively controlled.

Also reflecting the focus groups, stakeholders indicated that the questionnaire should cover **general comfort** (for example the temperature of wards), **privacy** (particularly during examinations, conversations with staff and handovers) and the provision of **age-appropriate facilities**, particularly for young adults (e.g. aged 16-25) with chronic illnesses who have made the transition to adult hospitals.

It was suggested that additional questions should be asked to establish **whether the special needs of various patient groups were met**. For example, whether staff enquired about any special equipment or additional assistance required for disabled people to manage their personal care, and provided appropriate assistance as a result. Similarly, whether patients with cognitive impairments such as dementia were able to easily and safely locate and reach toilets and other facilities (adequate signage, minimal clutter etc.) and whether transfers to different beds/locations minimised for these patients (to avoid disorientation). Finally, whether staff and facilities met the cultural/religious needs of patients, in terms of privacy space for prayer, special diets, and respect.

Cleanliness/hygiene

Stakeholders raised a number of areas for inclusion that related to hygiene and infection control. This included patient observation of **staff hand washing**, or using hand cleansing solution, prior to and after touching them. One stakeholder explained that while this may be a crude measure of whether the correct procedure was followed, it is still important because of its relationship to patient confidence and empowerment. There was a similar suggestion about the cleansing of equipment, but this is perhaps less likely to be conducted in sight of patients and therefore harder to assess via the Survey. Patient rating of **cleanliness of wards and bathrooms** was also suggested as a topic for inclusion, although of course patients can only comment on whether facilities appear to be clean (as opposed to whether they are free of germs).

One other hygiene related issue was whether patients were able to wash or cleanse their own hands (in-line with their own preferences). This was particularly relevant for immobile patients, where this might involve the provision of hand wipes or hand gel within easy reach and assistance with hand washing when required (to prevent falls).

Food/diet

In relation to food and diet, stakeholders recommended a number of question areas which were considered important because of the role of nutrition in positive health outcomes. This included:

- whether help with eating and drinking and choosing from the menu was provided, if needed (especially important for people with cognitive disability)
- how staff responded to concerns about lack of appetite or nutrition
- the quality and quantity of food (ability to satisfy hunger, taste, temperature, etc.)
- whether patients were able to eat without interruptions
- incidence of patients missing meals because of being away from the room or ward
- whether special dietary requirements were accommodated
- whether written information about meal services and the importance of nutrition was provided.

Outcomes

Although patients in the focus groups explained the importance of a positive outcome and the competence of staff, few of the suggestions made by stakeholders related to this, perhaps because it is perceived that patients are not in a position to fairly judge this, especially during the first few months after discharge.

Where suggestions were made in this respect, they tended to require a number of questions relating to a specific condition or type of treatment, which the Survey is unlikely to be able to accommodate.

Discharge arrangements and care transition

Suggestions were made for question areas relating specifically to discharge and care transition (beyond the provision of information noted previously).

It was recommended that patients are asked about the practical arrangements made for discharge, including the provision of transportation and consideration of their living situation or access to community care. One stakeholder suggested that the survey could be an opportunity to monitor staff engagement in anticipatory care, by asking patients whether staff discussed how well they had been able to understand and manage any chronic health problems at home.

For those being transferred to other services, such as community health services or specialist rehab services, the provision of appropriate transportation was again important, along with timely transfer, and explanation of why transfers were taking place.

There was interest in the incidence of care being provided via electronic means (telephone, video-conferencing etc.), as well as satisfaction with outpatient therapy and in-home care, although this is likely to be outside of the scope of this survey.

Out of pocket costs and insurance

Issues related to out of pocket costs and insurance were mentioned by a couple of stakeholders. One wanted to know how well people understood the financial implications of treatment and their health insurance cover (e.g. that they would not necessarily be given a private room). Another was interested in patient concerns about their future, resulting from the financial implications of their treatment, but felt that the questionnaire may be distributed too soon after discharge to adequately measure this.

Overall rating of experience/improvements

As noted, stakeholders acknowledged the value of an **overall satisfaction measure** – suggestions for questions included ratings of how well hospitals met patient needs and the overall quality of care.

Willingness to recommend the hospital was also suggested, partly because public perceptions of care services are often based on the experience of family and friends. One stakeholder also reported that this type of question can produce quite different findings to questions around satisfaction, so it should not be assumed that they are interchangeable.

Finally there was a request for an open-ended question asking what could have been improved from the patient perspective.

Patient classification and demographics

Various classification and demographic questions were requested, either because an indication of the number of patients in that category was of interest or, more commonly, to allow analysis of results by particular sub-sets of the population. It may be possible for some of this information to be provided in the sample or made available by linking survey results to patient records (if this is found to be technically possible and desirable, a question requesting permission would need to be asked). Suggestions included:

- Age
- Presence of a chronic health condition, disability (including type) or cognitive impairment
- Whether the patient has a carer
- Who completed the survey – i.e. the patient or a carer/family member (and, if so, the reason for this)
- Whether the patient is also a carer for someone else
- CALD/NESB/preferred language (for analysis and to establish whether the profile of respondents reflects the profile of patients)
- Aboriginal or Torres Strait Islander descent
- Country of birth
- Religion
- Ward/unit of care
- Reason for admission
- Whether a pre-admission assessment was conducted by person/in a clinic or by phone
- Date of admission and length of stay.

Summary - Implications for the design of the Adult Admitted Patient Survey

Based on analysis of the stakeholder feedback, the following areas were identified for inclusion in the list of potential question areas for the Survey (in addition to the demographics):

Waiting times

- Hidden waiting lists – time from referral from GP to consultation with a specialist
- Pre-admission process

- Delays to planned procedures and to scheduled emergency surgery
- Patients kept informed of likely wait times and the reasons for delays/cancellations

Attitude of staff

- Sensitivity to the needs and preferences of patients (including cultural and religious)
- Sensitivity when breaking bad news
- Anticipating and addressing patient anxiety
- Treating patients with dignity and respect
- Friendly and helpful staff

Responsiveness of staff

- Attentive to the needs of patients and respond to calls for assistance in a timely manner
- Patient/family reports of deterioration or lack of improvement taken seriously
- Awareness and understanding of dementia and early recognition of delirium
- Pre-existing conditions acknowledged and taken into account
- Emotional support provided

Information provision and communication with patients

(Ideally asked in relation to doctors, nurses and allied health professionals separately)

- Sufficient information and understandable explanation provided at key stages, including:
    - pre-admission (including logistics, preparation, pain management and likely course of recovery)
    - admission
    - test results or diagnosis
    - before and after treatments or procedures (including benefits, risks, side effects, alternative options explained, opportunity to ask questions)
    - when prescribing medication (information about existing medication requested, purpose of medication, benefits, risks, side effects and alternative options explained)
    - at discharge (care at home, coping with changes resulting from condition, written instructions, aftercare appointment times, letter for GP, and discussion of concerns)
- Information on patient rights and responsibilities (provided, read, understood and explained by staff)
- Patient awareness and use of interpreters and translated information

- Patients and family/carers kept informed (of care pathway, next steps and likely discharge date)
- Patients sufficiently informed to give consent and to make decisions about their care (and asked who could give consent on their behalf if required)
- Patients felt listened to and involved in decisions and handovers
- Staff enquired about advance care plans
- Complementary and alternative therapies discussed

Organisation and communication between staff

- Effective handovers (took place in front of patients, staff understood patients whole condition/history)
- Teamwork
- After care services (organised in advance)

Patient safety, accidents, adverse events and complaints

- Incidence of adverse events
- Steps taken by staff to reduce the risk of falls, pressure injuries or other injury in hospital
- Patient identity checked at handovers and before procedures
- Patient awareness of how to provide feedback/complain
- Feedback/complaints dealt with appropriately (staff open and honest, apology and explanation provided, preventative steps taken)

Comfort

- Effective pain relief provided
- Comfortable facilities (e.g. temperature of wards)
- Privacy
- Age appropriate facilities
- Special requirements accommodated (relating to disability, cognitive impairment and cultural/religious beliefs)

Cleanliness/hygiene

- Observation of staff hand washing before and after touching patients
- Cleanliness of wards and bathrooms
- Patient ability to wash/cleanse their hands as and when desired (provision of hand gel in easy reach / assistance when required)

Food/diet

- Help with eating and drinking provided
- Staff response to patient concerns about lack of appetite or nutrition
- Quality and quantity of food
- Patients able to eat without interruptions
- Incidence of missed meals
- Accommodation of special dietary requirements
- Provision of written information about meal services and the importance of nutrition

Discharge/care transition

- Provision of (timely) transportation where required
- Reason for transfers to other facilities explained
- Adequate consideration of home situation
- Access to community care considered/arranged
- Patients management of chronic health conditions at home discussed

Overall rating

- Overall satisfaction rating
- Willingness to recommend
- Patients felt they received the care they needed
- Suggested improvements (open)

Finances

- Patient understanding of the financial implications of treatment

3.4 Statistical analysis of previous surveys

Survey results from the 2007-2011 NSW admitted patients surveys – the Overnight Patients Survey and Day Only Survey - were analysed using 'key drivers' analysis, factor and reliability analysis, analysis of respondent comments relating to the survey itself, and analysis of non-response and possible ceiling and floor effects. Although a new survey is being developed, this analysis is useful to provide an additional indication of the question areas likely to be most important for inclusion, questions areas where particularly careful consideration should be given to the wording/response scales and question areas that could potentially be removed. The results of these analyses are as follows. For further technical detail, please see Appendix D.

Key drivers

NSW Health performed key driver analyses on the admitted patient surveys from 2007-2011 in order to clarify the aspects most closely related to the overall satisfaction rating.

The following aspects of care were consistently identified as key drivers in each of the surveys across these years. For overnight patients, the most important aspects of care were related to staff attitude and collaboration, specifically, the extent to which doctors and nurses work well together; the degree to which patients felt that they had been treated with dignity and respect; nurse courtesy and availability; and confidence and trust in nurses.[96,97,98] The cleanliness of rooms and courtesy of admission staff were also key drivers, although the strength of association was not as strong.[99]

For day only patients, in addition to the drivers mentioned above, well-organised hospitals or departments; availability of staff with which they could discuss their concerns; and effective pain and/or nausea control were vital.[100,101,102]

The majority of these areas were identified as important in the stakeholder consultation and/or patient focus groups. This analysis reinforces the need to include them in the revised admitted patient survey.

Factor and reliability analysis

The majority of factors were consistent across the range of **overnight patient groups** (planned, emergency, obstetrics, pain experiencing and surgical patients). For all but the surgical patients, the 'Doctors' factor accounted for the most variance. This factor also demonstrated high levels of reliability (internal consistency) for all patient groups, although it comprised different questions for each. Other factors that explained much of the variance across the patient groups included 'Discharge', 'Facilities' and 'Nurses' (communication and responsiveness). The 'Hygiene' factor routinely accounted for the least variance across groups, suggesting it may be less important from the patient perspective, but there may be other reasons for its inclusion in the survey (e.g. its importance to stakeholders because of its impact on patient safety).

An important finding from the factor analysis was that while a number of factors were common across each patient group, there were others that were unique to particular groups. In particular, aspects of obstetrics patients' experiences were different to those of the other patient groups (encompassing factors pertaining to 'Delivery' and 'Medication'), suggesting that a separate obstetrics survey should be developed.

Analysis of **day only patients'** surveys yielded similar results to those of the overnight patients. 'Doctors' accounted for a great deal of variance across day only patient groups, surpassed only by 'Facilities'. Both of these factors exhibited good to excellent levels of reliability. 'Discharge', 'Admission' and 'Nurses' were other factors that explained a lot of variance across patient groups. As for the overnight patients, the 'Hygiene' factor accounted for the least variance across groups and, in contrast to overnight patients, for day only patients the factor also exhibited poor levels of reliability.

High correlations between variables

As part of the reliability analysis, inter-item correlation matrices were produced for each factor. These matrices were examined to identify redundancy of questions within factors, and follow-up Pearson correlations were conducted to check the correlation across patient groups. It is important to note that high correlations between variables can be an artefact of participants' response patterns. Therefore, the questions mentioned below are questions that possess high correlations with each other as well as semantic or syntactic similarity in question structure.

In the 2007-2011 **Overnight Patient Surveys**, two pairs of questions fulfilled the aforementioned criteria:

- Q51. Did your healthcare providers wash or clean their hands before providing care before providing care for you? and Q52. Did your healthcare providers wash or clean their hands after providing care for you?
- Q82. Cleanliness of the facility and Q83. Cleanliness of the room.

In the 2007-2011 **Day Patient Surveys**, three pairs of questions fulfilled the aforementioned criteria:

- Q48. Did your healthcare providers wash or clean their hands before providing care before providing care for you? and Q49. Did your healthcare providers wash or clean their hands after providing care for you?
- Q70. Cleanliness of the facility and Q71. Cleanliness of the room.
- Q30. Did the doctor who did your procedure explain the risks and benefits of the procedure in a way you could understand? and Q34. Were the results of the procedure explained in a way you could understand?

This analysis suggests that these question pairs could potentially be redeveloped as a single question, without reducing the insight provided.

Missing responses analysis

A missing response analysis was performed on the 2007-2011 Day Patient and Overnight Patient Surveys to determine whether certain questions were particularly prone to non-response.

For both patient groups, Q7. 'While you were in the emergency room, did you get enough information about your medical condition' had unusually high rates of non-response (around 20%). It may be that these specific details were not salient and/or particularly hard to recall, particularly after a stressful hospital experience such as treatment in an Emergency Room.

Further, questions that addressed hygiene issues in the 2007-2011 Day Patient Surveys also exhibited high levels of non-response (around 16%). A possible reason for this non-response may be that hygiene was simply not a priority of 2007-2011 day patients, so they were liable to *not notice* hospital cleanliness practices, or that they were *unable* to comment, for example because they could not or did not see whether staff washed their hands. This result would be congruent with findings from the qualitative research performed for the current research, in which cleanliness was not spontaneously raised by most participants in focus groups. However, if questions on hygiene are included (because of the importance placed on these by stakeholders and the Bureau), cognitive testing will be crucial to ensure that patients can understand and respond to them.

Finally, in the 2007-2011 Day Patient Surveys, rates of non-response were unusually high for the questions that pertained to food and food service (between 10% and 20%). The most probable explanation for these rates is that patients who had only stayed at hospital for a day were more likely to have not eaten or ordered food during their short stay. Therefore, a 'screener' question should precede questions related to hospital food.

One key point surrounding the patterns of non-response is that levels of non-response did not increase over the course of the survey, indicating that systematic attrition based on survey length is not an issue for this survey.

Ceiling and floor effects

The questions from the 2007-2011 **Overnight Patient Surveys** with a ceiling effect (i.e. indicating that the majority of patients gave a positive rating), according to the ceiling and floor effect criteria (see Appendix D), were as follows (no floor effects were identified):

- Q5. Was your admission date changed by the hospital? (date not changed by the hospital)
- Q55. Did the surgeon explain the risks and benefits of the surgery in a way you could understand?
- Q37. Did you feel like you were treated with respect and dignity while you were in the hospital?
- Q56. Did the surgeon or any of your other doctors answer questions about surgery in a way you could understand?
- Q51. Did your healthcare providers wash or clean their hands before providing care for you?
  Q15. Did you have trust in the doctors treating you?
- Q21. Did you have confidence and trust in the nurses treating you?

The questions from the 2007-2011 **Day Patient Surveys** with a ceiling effect according to the criteria were as follows (no floor effects were identified):

- Q48. Did your healthcare providers/staff wash or clean their hands before providing care for you?
- Q10. Were you told everything you needed to know about how to prepare for your tests?
- Q37. Did you feel like you were treated with dignity and respect while you were in hospital?
- Q5. Was your admission date changed by the hospital? (date not changed by the hospital)
- Q20. Did you have confidence and trust in the doctors treating you?
- Q49. Did your healthcare providers/staff wash or clean their hands after providing care for you?
- Q9. Did your doctor explain why you needed tests in a way that you could understand?
- Q54. Did someone explain when you would be allowed to go home?
- Q31. Did the doctor who did your procedure answer your questions about the procedure in a way you could understand?

- Q24. When you had important questions to ask a nurse, did you get answers you could understand?
- Q6. How organised was the care you received in the emergency department?
- Q18. When you had important questions to ask a doctor, did you get questions you could understand?
- Q62. How well organised was the hospital or department where you had your procedure?

The identification of ceiling effects for these questions indicates that they might be less useful in terms of informing service improvement, which should be one consideration when prioritising potential question areas. However, they should not be automatically excluded from the questionnaire because: while the overall picture is positive, there may be problems with some of these aspects of care at the individual hospital level; patients should feel the questionnaire covers areas of importance to them; positive feedback is likely to be important for staff moral; and the survey is one avenue for facilities to provide evidence of compliance with standards and for accreditation.

Patient comments analysis

The Overnight and Day Patient surveys included an open question, which asked 'If you could change one thing about the hospital what would it be?'. Comments made by survey respondents in 2010 were coded into categories. All comments coded as 'other mentions' and/or containing the keyword 'survey' were manually reviewed for content relating to the actual conduct of the survey. Examples of these comments can be found in Appendix D.

Recommendations based on this analysis include:

- the questionnaire should include a question to establish whether or not the survey was completed by the patient (as a number of comments indicated the survey had been completed on behalf of someone else)
- the information accompanying the questionnaire should clearly explain which visit survey responses should be based on (as a number of comments suggested that the survey was completed in relation to a different hospital admission than the one sampled)
- consideration should be given to removing patients who visited hospital for a very short period of time or for a routine visit (as a number of these patients commented that the survey was not as applicable to them).

There were also requests to reduce the number of surveys sent out. However, sending reminders and replacement questionnaires is important for achieving a good response rate.

Summary of implications for the design of the Adult Admitted Patient Survey

- The number of questions relating to hygiene should be limited, and questions on this issue thoroughly tested, due to the lack of variance the 'Hygiene' factor accounted for, its poor internal consistency, and high level of non-response in the 2007-2011 Day Patient Surveys.
- Question areas identified as correlating highly with each other should be combined into a single question (i.e. healthcare providers washing or cleaning their hands before/after providing care, cleanliness of the facility/room and doctors explaining the risks and benefits/results of procedures in a way patients can understand).
- The presence of ceiling effects should be one of the issues taken into account when prioritising question areas for inclusion in the Survey.
- The Survey should include a question to establish whether it was completed by the patient of by someone else.
- When the inclusion/exclusion criterion for the admitted patient sample is revised consideration should be given to excluding patients admitted for a very short time, or for a routine visit, and obstetrics patients.
- Key factors (question areas) to be included in the Survey should include: doctors, nurses, admission, discharge, facilities, food, tests, pain management and pre-admission and
- Question areas consistently identified as key drivers of overall patient satisfaction should certainly be included in the Survey, as follows:
    - the extent to which doctors and nurses work well together
    - the degree to which patients felt that they were treated with dignity and respect
    - nurse courtesy and availability
    - confidence and trust in nurses
    - cleanliness of rooms
    - courtesy of admission staff
    - well-organised hospitals or departments
    - availability of staff with which patients could discuss their concerns
    - effective pain and/or nausea control.

4. SUMMARY OF RESULTS AND IMPLICATIONS

This section summarises how the key findings from the rapid literature review, statistical analysis, stakeholder consultation and patient focus groups were brought together to inform the final questionnaire design. This included creating a list of potential areas for inclusion in the Survey, consideration of other implications arising from each stage of the research, developing parameters/rules to guide the questionnaire development, prioritising question areas and refining the questionnaire, via extensive consultation between Ipsos SRI and the Bureau, as well as cognitive testing.

Potential question areas

The potential question areas indicated by each stage of the developmental research were brought together to create a full list of possible question areas.

This included a range of issues relating to:

- the emergency department
- waiting times/delays
- attitude of staff
- responsiveness of staff
- information provision and communication with patients
- organisation and communication between staff
- patient safety/the prevention of accidents and adverse events
- complaints
- comfort (including pain relief)
- cleanliness/hygiene
- food/diet
- competency of staff and quality of treatment
- discharge/care transition
- out of pocket costs and insurance
- overall ratings of care and patient suggestions for improvements
- demographics and classification information (including questions required for standardisation purposes).

The full list of potential question areas can be found in Appendix G.

Development of rules/design parameters for the questionnaire design

The identification and review of 'gold standard' patient surveys supported the planned approach for the development of the Survey (i.e. consulting with patients and other stakeholders to build the questionnaire from first principles) and also provided a source of tried and tested questions as starting point for the design of individual survey questions, where appropriate.

Potential question areas were developed into a draft survey questions through extensive discussion between the Bureau and Ipsos SRI, and with reference to these standardised surveys. A number of key design parameters were developed during this process (and finalised as a result of cognitive testing).

A key decision was that survey questions should primarily focus on patients' experiences of care (i.e. factual questions about what happened or did not happen), rather than on their level of satisfaction, as this is less subjective and more useful for informing service improvement. An overall satisfaction question would be included, in-line with best practice, to establish how patients felt about their experience as a whole, and to allow analysis of the factors that have the most influence on this. It was also decided that an overall rating of doctors and nurses should be incorporated because of their importance to the overall patient experience and the potential to conduct key drivers analysis to investigate why patients were left with a particular impression of doctors and nurses.

It was agreed that key questions should be asked separately for doctors and nurses, as the patient focus groups indicated that expectations of each were different and stakeholders suggested that this separation would be more useful for informing service improvement. Stakeholders also indicated that they would ideally like key survey questions to be asked specifically in relation to allied health professionals and, potentially, administration and other hospital staff, to recognise the importance of each role and to inform service improvement. However, they acknowledged that this may not be possible given the need to keep the questionnaire length within reasonable parameters. The final questionnaire therefore included a small number of key questions about allied health professionals and 'staff' in the ED/on arrival, as well as doctors and nurses.

Other general design parameters included:

- ensuring response scales were balanced
- avoiding double barrelled questions wherever possible (except where this was required for clarification, e.g. '...were nurses polite and courteous..?')
- avoiding leading leading/biased question wording

- using a small suite of question formats and response options facilitate ease of completion
- using filter questions (where space allowed) or clarifying the difference between a negative and 'not applicable' response by reflecting the question wording in these options (to avoid missing responses)
- using plain English throughout
- providing 'don't know' and/or 'not applicable' options only where essential, to encourage respondents to provide an answer or their 'best estimate'.

A potential set of national core, common patient experience questions are being tested in the Survey, on behalf of PEIDWG. This meant that these questions could only be amended if agreed by PEIDWG, resulting in some inconsistency in relation to the design parameters outlined above. Full details are contained in Appendix H.

Cognitive testing

Cognitive testing was conducted to ensure the validity of the questionnaire, by confirming that participants were able to understand and answer the survey questions and that they were consistently interpreted in the way intended. The cognitive interviews also acted as a final opportunity assess relative importance of the question areas from the patient perspective and to confirm that the Survey adequately captured the key aspects of their experience.

A summary of the most common changes made as a result of the cognitive testing phase, and subsequent discussion between the Bureau and Ipsos SRI, follows below:

- Simplifying the level of information requested where participants were unable to recall the level of detail originally required. For example, replacing a question asking for precise waiting times with one asking about the acceptability of waiting times (Q2).
- Replacing, or clarifying a word that was unfamiliar to some participants. For example, replacing 'courtesy' with 'politeness and courtesy' (Q5).
- Ensuring the question was sufficiently comprehensive. For example, including 'putting on clean gloves' in the question relating to staff hand washing (Q11).
- Amending the question wording to reduce ambiguity, where respondent interpretation differed from that intended. For example, a question asking '…did the doctors who treated you know enough about your condition or treatment' was interpreted by some as being about a doctor's general knowledge of a condition, rather than their familiarity with a patient's individual history. It was therefore changed to '…did the doctors who treated you know enough about your medical history' - subsequent testing confirmed that 'medical history' was better understood (Q24).

- Simplifying question response scales. For example, in a question about the opportunity for family to talk to staff there were effectively a number of not applicable options that were amalgamated into ‘this was not applicable to my situation’ (Q46).
- Where a question required both a ‘not applicable’ and a ‘no’ response option, making the distinction between two clear, by reflecting the question wording in the response. For example, in a question about staff respect for religious beliefs, ‘No’ was amended to ‘No, my beliefs were not respected’ (Q53).
- Amending response scales to achieve balance and a true mid-point. For example, in a question adapted from the NHS Inpatient question bank the scale was amended from ‘Excellent, very good, good, fair, poor’ to ‘very good, good, neither good nor poor, poor, very poor’ (Q26).
- Removing questions that were too complex to define in a self-completion quantitative questionnaire and/or ambiguous (see below).

The fourth and final round of cognitive interviewing focused on the layout of the questionnaire and the accompanying information, rather than the content. Few significant problems were encountered, but there was a tendency of participants to overlook the routing instructions (the ‘skips’ are denoted by arrows from one questions to the next). For this reason, the arrows were made bolder in the final version.

Prioritisation of question areas

A key task in the latter stages of survey development was to reduce the number of potential questions in order to produce a questionnaire that was within budget and would not place undue burden on respondents (an important consideration for facilitating a high response rate), while still meeting the needs of the Bureau, its stakeholders, and the expectations of patients.

Although there was some overlap between the potential question areas suggested by stakeholders and those identified as important from analysis of the patient focus groups, the underlying rationale often differed. Patients tended to focus on the aspects of the hospital experience that were memorable because they were very positive or very negative; these were often aspects that helped to reassure them or make their hospital visit more comfortable (or vice versa).

Stakeholders were often interested in obtaining more detailed information (generally relating to their area of specialisation) that would be of practical use for informing service improvements. They were particularly concerned about areas that related to patient safety. They also wanted the survey to provide evidence of compliance with standards/for accreditation purposes. A number of issues were also suggested by stakeholders because they were aware that they were a common factor in patient’ complaints. Because of these differences, the prioritisation exercise was not as simple as retaining the potential question areas indicated by all or most of the research stages (stakeholders, patients, rapid literature review, and analysis) and removing those suggested by only one or two. Rather, decisions were made as a result of in-depth discussion, utilising the Bureau's expert knowledge of the NSW healthcare system and Ipsos SRI's research expertise, as well as revisiting the results of each stage of the research to evaluate the *relative* importance of each question area.

Results of the statistical analysis (key drivers, correlation, reliability and identification of ceiling effects) were also taken into account when prioritising questions for inclusion in the final survey (as outlined below), although results from the patient focus groups and stakeholder consultation were given more weight in this process, as the questionnaire was being redesigned from first principles.

The prioritisation process was iterative; a number of question areas were removed prior to production of a first draft questionnaire, others were removed prior to cognitive testing and others were removed following each stage of cognitive testing. A small number of questions were also suggested by the Bureau for inclusion in the draft questionnaire during the cognitive testing phase, as a result of additional discussions with stakeholders.

The most common reasons why potential questions were eventually excluded from the final questionnaire are summarised below (often, a question area was excluded for more than one of these reasons):

- **Where a separate questionnaire may be required to adequately capture the experience of specific patient groups.** For this reason a number of questions relating to the Emergency Department (ED) were removed. Two areas; courtesy of staff and waiting times, were retained because the focus group results indicated that these issues were particularly important to patients who had been admitted via the Emergency Department (ED) and that these patients were likely to feel a key part of their experience had been missed from the survey if there were no questions relating to the ED.
- **Where a question applied to a relatively small sub-section of patients or situations**. This included a number of questions relevant only to; Culturally and Linguistically Diverse (CALD) patients; patients who were transferred to another hospital or service; patients with symptoms of dementia or delirium; and patients who may have been eligible to be discharged early, with care provided at home.
- **Where a patient experience survey is not an appropriate vehicle for assessing the issue, because patients are unlikely to be able to provide the information, level of accuracy or detail required for the resulting data to be useful**. For, example because of issues related to recall, potentially high levels of distress at particular points in the patient journey, or because they were unlikely to have heard or observed the relevant

process/event. Removals for this reason included questions to assess: break-down of actual wait times in the ED before and after triage; wait times between using the call button and receiving assistance; whether there were enough doctors to oversee patient care; whether students and interns were adequately supervised; whether respondents were treated as a public or private patient; whether effective handovers took place; whether staff reacted appropriately to family or patient reports of deterioration or lack of improvement; whether patients gave informed consent for invasive procedures (as they may not know when this is required); whether information about existing medication was collected (as this information may have been provided by an accompanying family member).

- **Where a particular question was effectively measuring the same aspect of care as another question and/or adequately covered by another question**. This included: whether nurses were gentle and careful (similar to a question assessing whether nurses were caring and kind); whether staff talked to, rather than about, patients (covered by questions around courtesy and dignity and respect); whether patients were informed about potential 'danger signals' at discharge and possible side effects of medication (covered by a question asking whether patients were given sufficient information at discharge); whether questions before surgery were answered in a way patients could understand (covered by a question asking whether staff explained what would be done in a way patients could understand); whether patients were informed of the 'next steps' in their care (similar to a question on information provided about their condition or treatment); whether written information was provided at discharge (covered by whether enough information was provided about how to manage care at home); whether effective handovers took place (indicated by questions about doctors' knowledge of patients' medical history and nurses' knowledge of their care and treatment); whether there was sufficient explanation of the benefits, risks, side effects, alternative options in relation to both medication and procedures (covered by a question on whether enough information about condition/treatment was provided and whether patients were involved as much as they wanted to be in decisions about care and treatment). Also, whether staff washed their hands *after* touching patients (in this case statistical analysis of past NSW Health surveys indicated that there was high correlation between response to this and questions about staff hand washing *before* touching patients).
- **Where it was felt that a question related to an area outside of the role/ responsibility of hospital staff.** This included the provision of emotional support and some aspects of staff attitude that were, arguably, personality traits (questions relating to staff attitude that were included in the final version were carefully designed to ensure a focus on behaviour rather than personality).

- **Where a question area was too complex to define in a self-completion quantitative questionnaire and/or ambiguous, meaning that results would be difficult to interpret.** This included: whether ward facilities were suitable to meet patient needs; two questions that attempted to assess clinical outcome by asking how patients expected feel as a result of their hospital stay and how they felt after leaving hospital; and questions attempting to find evidence of patient empowerment as indicated by patients prompting staff to follow best practice for example.
- **Where a large number of question areas were suggested by stakeholders on a relatively specific topic and/or an aspect of the patient journey that would not be relevant to all admitted patients**. This included a number of questions relating to food and nutrition (questions on this topic that were retained were deemed most important with respect to ensuring adequate nutrition); complaints; and surgery.
- **Re evaluation of the *relative* importance of question areas to patients/stakeholders and/or for informing service improvement, given finite space within the questionnaire**. This included whether: written information was provided in hospital; patients were given contradictory information or information/advice that turned out to be incorrect; there were delays/waiting periods during the pre-admission process and planned procedures/surgery; staff were able to break bad news sensitively; pre-existing conditions were taken into account; staff were employed by an agency or by the hospital; there was continuity of care; written appointments times were provided on discharge; patients were provided with advice on how to cope with changes resulting from condition/treatment; patients were given sufficient opportunity to discuss concerns on discharge; complementary or alternative therapies were discussed; staff enquired about advance care plans; patients were readmitted following deterioration or lack of improvement at home; patients understood the financial implications of the treatment they received; patients stayed on mixed-sex wards; patients were able to cleanse/wash their own hands as and when desired; and questions relating to out of pocket costs and insurance.
- **Demographic/classification information that was not seen as essential for analysis purposes and/or has potential to be obtained as part of a data-linkage exercise, subject to appropriate agreements** – country of birth, religion, ward/unit of care, reason for admission, how the pre-admission assessment was conducted (by phone/in person/clinic), date/length of admission, point of referral and type of room.

Appendix H details the development process for every individual question in the final survey, including the primary reason for inclusion, the source question (where applicable) and changes made to the question during the development process (as a result of cognitive testing and discussion between the bureau and Ipsos SRI). Appendix I outlines which questions in the final

Survey are relevant to the National Safety and Quality Health Service Standards and the Australian Charter of Healthcare Rights. The final questionnaire is contained in Appendix J.

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