PATIENT SATISFACTION AND TOTAL QUALITY MANAGEMENT: AN ANALYSIS OF CUSTOMER FEEDBACK

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PATIENT SATISFACTION AND TOTAL QUALITY MANAGEMENT: AN ANALYSIS OF CUSTOMER FEEDBACK

Abstract of a Thesis by
Mary J. Brown
January, 1993
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Problem: Patient satisfaction is an area of renewed interest related to quality of care and total quality management (TQM). Some patient satisfaction surveys provide narrative comments as well as empirical data about quality of care. Though numerous studies report empirical data, only one study was found which examined narrative comments related to nursing care.

Sample: This study retrospectively analyzed narrative comments from surveys at a large midwestern urban medical center. Patient surveys mailed to nearly all inpatients discharged yielded a 41% response rate. More than 50% of the returned surveys contained narrative comments, from which 600 were randomly selected.

Methodology: Content analysis was performed. Comments were categorized according to the survey sections used for empirical analysis. Content analysis was repeated according to nine attributes of quality nursing care identified in the literature.

Findings: More than 50% of the comments overall were related to nursing. Just over 50% of the nursing comments were positive. The attributes of nurse-patient interaction and personal qualities of the nurse received the greatest number of comments.

Conclusions: Perceptions and expectations of patients related to quality of nursing care were identified. The nurse and nursing care were identified as key factors in patient satisfaction. Analysis according to the attribute framework provided useful information for improving the quality of care.

Implications for Nursing: Nurse administrators are challenged to integrate these qualitative findings into their decision-making database. Policies, procedures, standards, staff development programs and patient satisfaction activities should be amended based on consumer feedback. Nurses must capitalize on each nurse-patient interaction to improve the quality care.
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CHAPTER I
INTRODUCTION

Quality of health care is being discussed more now than ever before. Escalating costs, increased expectations of accreditation agencies, stronger competition among providers, and heightened awareness of consumers have mandated changes within the health care system. Some issues related to quality include fiscal concerns, cost containment measures, standards of care and customer satisfaction. Consumers are demanding that quality service be maintained as costs continue to rise.

Total quality management (TQM) is a concept that began to appear in the literature in the 1980s. It is one of a number of methods that have been promoted in business and industry to address improvement to quality. The TQM management philosophy described by Deming (1982) involves top-down organizationwide commitment to the continuous improvement of quality and customer satisfaction. Hendricks and Triplett (1989) describe how the TQM philosophy has been applied successfully in health care organization. They identify specific improvements including increased patient satisfaction as a result of the TQM philosophy in action. There is little literature, however, about the application of the TQM approach specifically to nursing.

Increasing concentration on quality has required modifications in the focus of nurse executives in health care institutions. The role traditionally centered around internal institutional concerns such as standards of care based on
standards of nursing practice, fiscal management, and coordination of existing services. With renewed emphasis on quality, this focus has been broadened to include external perspectives as well, such as new accreditation requirements, standards of third party payors, competition among regional providers offering the same or similar services, competition among suppliers, and awareness of community economic status, to name a few. Consideration of patients as customers is an important aspect of this external perspective. Thus, investigation of customer satisfaction in a research study is an appropriate area of concern for the nurse executive.

Many authors emphasize the necessity for health care institutions to identify the wants and needs of potential customers (Auttonberry, 1988; Burda, 1991; Gillem, 1988). The development of strategies to increase the quality of care delivered and to maximize patient satisfaction requires input from patients, staff nurses and nurse executives. Nurse executives must provide leadership in identifying and analyzing this information in order to implement changes to increase customer satisfaction.

Staff nurses who provide patient care must also be involved in the overall quality process. Aucoin and Wegman (1988) point out that nursing is the professional service which all patients
require constantly throughout their hospital stay. Meisenheimer (1985) cites several reasons why staff nurses need to be involved in quality programs. Some of these reasons include: nursing responsibility for management of patient care 24 hours a day; nursing responsibility for management of family care 24 hours a day; and the fact that nurses comprise the largest percentage of health professionals. Nurses at all levels, staff or administration, need to be involved in quality management.

Confusion and inconsistencies exist in the measurement of patient satisfaction with nursing care. One method used by many health care agencies is solicitation of patient satisfaction data. A variety of instruments is being used for collection of data (McDaniel and Nash, 1990). Institutional uses of the data gathered are varied as well, seemingly dependent upon several factors. Management philosophy, the expertise of nurse executives, the perceived value of the data, and the ease with which the data can be understood and used are some of the factors determining institutional use of patient satisfaction data. In any case, institutions attempt to incorporate patient satisfaction information into the database which is available to decision-makers in developing strategies to increase patient satisfaction.

Information obtained from customers is highly valued in the TQM philosophy. Strategies designed to collect empirical
information using Likert-type scales have been very useful (Petersen, 1988; Vuori, 1987; Risser, 1975; and Press, Ganey, and Malone, 1991). Qualitative data which emerges from written or verbal narrative comments provide an additional source of customer feedback (Graham, 1990; Taylor, Hudson and Keeling, 1991). The combination of quantitative data from empirical studies of patient satisfaction together with narrative comments provided by patients may offer more useful information about customer perceptions and satisfaction than quantitative data alone.

The purpose of this study is to analyze narrative comments solicited from patients who have been hospitalized in a large urban tertiary care center. While mechanisms are currently in place to analyze the empirical data from existing patient satisfaction surveys and report findings, no formalized administrative attempt to understand the meaning of the narrative comments exists. This study will examine narrative comments and determine patterns regarding patient satisfaction. Identified patterns of response will be compared to empirical data which may aid administrative personnel in efforts to increase overall patient satisfaction with care.
CHAPTER II

REVIEW OF LITERATURE

The literature review begins with an overview of the total quality management (TQM) philosophy. A summary of TQM application in health care is given. Theoretical frameworks and background information related to quality of care are examined. The concept of patient satisfaction is discussed, and the role of nursing in patient satisfaction is discussed. Perspectives on the measurement of patient satisfaction conclude the review.

Total Quality Management

Total quality management (TQM) is one of a number of methods promoted in business and industry to address improvement in quality. This philosophy has formed the basis of management approaches in Japan since 1950 and has been used in the United States by companies such as 3M, the Ford Motor Company, and Vernay Laboratories. Deming (1982) described TQM as a top-down management philosophy in which there is a commitment to continuous quality improvement throughout the organization. Deming's (1986) management theory encompasses a broad spectrum of managerial concerns, some of which include the environment, quality of the product, managers, workers, work processes, communication, compensation, rewards, and motivation.
The Deming 14-Point System theoretically outlined the central elements of what is now known as TQM (Deming, 1986). A discussion of those elements follows. The first element offered by Deming was to "create constancy of purpose for improvement of product and service" (p. 24). Innovation, placing resources into education and research, and constantly improving the design of a product or service are statements of the organization's intent to stay in business. Customers, employees and suppliers need to be able to expect this constancy, and the consumer is viewed as the most important part of the production process.

Deming's (1986) second element recommended that American managers adopt this management philosophy in order to maintain a competitive position in the current economic era. Mistakes, ill-suited supplies, ineffective employees, and supervision that is less than optimal cannot be accepted. Another element directed toward managers emphasizes leadership. Managers need to be transformed from supervisors into leaders, and must understand the work that they supervise.

Quality comes from improvement of production processes rather than from inspection, according to Deming (1986). Reworking defective production is costly and is not a corrective action on the production process itself. Thus, ceasing dependence on inspection to achieve quality is another element of Deming's
philosophy. An additional element addressed the practice of awarding business on the basis of price tag only. This practice must end, according to Deming. The quality of what is being purchased must be considered to give meaning to price. Instead, the minimization of total cost can be achieved by working with a single supplier who is able to meet the requirements of reliability and uniformity of supplies, thereby reducing the chances of producing a defective product.

Deming (1986) included an element which advises that quality be accounted for at the design stage. Companies must "improve constantly and forever the system of production and service, to improve quality and productivity, and thus constantly decrease costs" (p. 23). Better allocation of human resources was offered as an example of a design improvement which enhances quality and decreases costs.

Teamwork is a central element in Deming's (1986) philosophy. Barriers must be broken down between staff areas. Everyone engaged in making the same product should work as a team for the company. Routine procedures for the use of customer feedback are suggested to help identify areas where teamwork is lacking and thus, losses are being incurred.

Deming (1986) recommended elimination of numerical quotas for the work force and numerical goals for managers as another
element. Production rates are an average. Unless the system is changed, there will always be workers who achieve less and others who are capable of achieving more than the average rate. According to Deming, never-ending improvement is not possible with a quota system in place. Deming also challenged management to provide leadership rather than work standards. Managers must improve processes and activities rather than trying to simply meet numerical objectives related to outcomes.

Deming (1986) also included an element which requires removal of barriers that rob people of pride of workmanship. For hourly workers, knowledge of what is acceptable workmanship is necessary to allow workers to take pride in what they do. Problems with inspection, equipment that is out of order, and poor tools are other barriers which must be removed. For salaried workers, the annual rating or merit system must be eliminated as a major barrier.

Deming (1986) also suggested elimination of slogans, posters and targets for the work force that urge increased productivity. Posters and the like are usually directed at workers, which is the wrong group of people to target. The responsibility for improvement of the system lies instead with management. Deming also believes that posters and targets lead to mistrust of management and fear in the workforce.
Another element discussed by Deming (1986) is to institute the foundations of training on the job for management and new employees. A clear standard of what is acceptable work and what is not acceptable work must be evident. A related element advised that increasing security and reducing fear are necessary for employees to perform at an optimal level. Employees need to embrace new knowledge rather than fear it in an effort to do a better job.

Deming (1986) also advocated institution of a vigorous program of education and self-improvement for everyone. This element involves each person within the company in working to accomplish the transformation to continuous quality improvement. Management must adopt the new philosophy, break tradition, explain change, coordinate the stages of work necessary to produce the product, and make plans which foster continuous improvement of quality through employee teams. TQM depends upon everyone contributing to the quality effort.

It is evident that several elements from Deming (1986) directly addressed customers and quality. The element which addressed constancy of purpose is linked to promoting customer satisfaction by considering the customer as the heart of the production process. Dobyns (1990) summarized Deming's explanation of creating constancy of purpose as "staying ahead of the
customer, not only meeting present needs, but planning for future needs, as well" (p. 77).

Two other elements directly related to quality addressed reducing dependence on inspection and seeking constant improvement of all processes. Deming (1986) stated that quality comes from improvement of production processes and he challenged managers to provide the leadership necessary for realizing these improvements. As well, Deming believed that quality needs to be built in at the stage of design, rather than later in planning or production. Deming affirmed that continuous improvement of all processes can be achieved through understanding the customer's needs.

Addressing quality is a challenge to business. It is also a challenge to nurse executives. The elements of Deming's philosophy support the need to examine patient satisfaction feedback.

The TQM philosophy is embraced by Tom Peters (Peters & Austin, 1985). Peters is a popular management consultant and author of three bestselling business books in the last decade who emphasized the constant and rapid organizational change necessary for leadership, success and excellence. Peters asserted that an adaptive organization stays in touch with the outside world in order to survive in the competitive marketplace and advocates transference of the TQM approach from its roots in business and
industry to the service sector, including health care. Determination of the customers' perceptions and expectations of the product or service are key factors in the quality improvement process, according to these authors. Peters believed that devices designed to maintain quality can be of little value if managers at all levels fail to live the message of perfection in infinite improvement every day.

Health care institutions have begun to realize the importance of alternative methods to address improvements in quality. In an effort to meet quality goals, a number of authors (Morgan and Shields, 1990; Melum and Sinioris, 1989; Summers, Naderman, Turnis, Lynn, Rechlin, Hentges & Roche, 1988; and Hendricks and Triplett, 1989) described health care institutions which have implemented the TQM philosophy. Morgan and Shields (1990) described improvements in a patient relations program as the result of TQM implementation in a military medical service setting. Additional benefits of TQM reported by various hospitals include: improvements in the quality planning process, reduction in absenteeism, and more satisfied customers (Melum & Sinioris, 1989); development of an interdisciplinary quality management program directed at improving clinical outcomes in a rehabilitation program (Summers et al., 1988); and increased patient satisfaction, improved physician relations, and increased
profit margin (Hendricks and Triplett, 1989). While health care
institutions currently in various phases of TQM implementation may
provide additional benefits not yet reported, Masters and Schmele
(1991) identified that there is a gap in nursing literature
referring to TQM.

TQM implementation in nursing administration and practice is
new. While details of TQM implementation in nursing are not yet
available, Arikian (1991) suggested strategies based on Deming's
14 points for the application of TQM to nursing service. The
strategies include: (a) identifying customers, which includes
patients, and being able to respond to them; (b) setting long-
range goals and communicating them throughout the organization;
(c) emphasizing accountability at the staff level; (d) removing
communication barriers, including the provision of clear data from
management so that nurses can see the impact of their practice on
patient outcomes; (e) providing ongoing education for all
employees to foster continuous improvement; (f) establishing
quality indicators in all areas; (g) involving staff nurses in
frequent policy and procedure updating; (h) identifying specific
expectations for nursing practice at every level through
performance standards; (i) encouraging nursing employee
participation in TQM activities and decision-making; and (j)
considering the effect of the overall corporate culture.
Arikian (1991) proposed a TQM paradigm for the restructuring of nursing service. This paradigm is centered around the patient as the customer and integrates nursing service and quality considerations such as standards established by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). Evaluation of patient outcomes and patient satisfaction were incorporated in the proposed paradigm as quality measures. Arikian anticipated that a greater demand for nursing services by future customers will result from quality patient outcomes and word of mouth expressions of patient satisfaction. Arikian speculated that the long-term cost/benefit ratio will be favorable as the result of TQM implementation. No data is yet available to support this, but it does seem reasonable that nursing and health care might expect results similar to those seen in business and industry.

Quality of Care

In this section, theoretical frameworks and background information related to quality of care will be reviewed. The importance of the consumer's perspective of quality is identified. Support for outcome assessments of quality is given. Donabedian (1988), noted for his interest and expertise related to quality and quality assessment, asserted that health
care is the key product of the health care system, and that
knowledge of quality is necessary to effective management within
that system. He defined quality as, "the ability to achieve
desirable objectives using legitimate means" (p. 173). In health
care, the objective is almost always, "an achievable state of
health" (p. 173) with health defined either broadly or narrowly.

The framework for quality assessment which was proposed in
the 1950s by Donabedian encompassed three approaches: structure,
process, and outcome. These widely adopted approaches were
reviewed by Donabedian (1988). He identified that though the
seemingly logical flow from structure to process to outcome may
suggest causation, little was actually known about the
relationship of each to the others. In fact, he asserted that
outcome assessments may serve as a basis to understand structure
and process. Thus, one can look at patient satisfaction surveys
as one type of outcome assessment which can aid in understanding
both structure and process.

Bloch (1975) discussed in detail the structure-process-
outcome framework of Donabedian and applied it to nursing. While
process measures have been found to give clues to corrective
action, Bloch identified a gap between process and outcome. For
example, a process measure which determines errors in medication
administration can provide clues to corrective action related to
the process of administering medications; however, this type of
process measure does not necessarily provide information related
to outcomes. When considering total quality of patient care, it
is not the outcome that can be manipulated; rather, professional
practices can be changed followed by resultant changes in
outcomes. Thus, both process and outcome assessments are
warranted.

Donabedian (1988) further advocated assessment of quality at
various levels in the health care system. The assessment may be
specific to a given practitioner, a group of patients with similar
problems, or the state of health of a nation. Donabedian
suggested that, "What is important is to choose the level most
suitable to the context for assessment and to address the concerns
pertinent to each level" (p. 174). The two levels of quality
assessment that Donabedian discussed are individual and
institutional.

Judging performance at the individual level, according to
Donabedian (1988), includes two components: technical processes of
care and the management of the interpersonal or expressive
processes of care. When the level of assessment progresses to
institutional performance, Donabedian suggested consideration of
the amenities of care which include privacy, comfort, and
convenience of access and use. Both individual and institutional
considerations are important in process and outcome assessment. Patient satisfaction surveys provide both an empirical measure and narrative comments related to patient satisfaction on both levels.

Lohr (1988) examined outcome measurement as one of the central concepts of quality of care. Lohr subscribed to the Donabedian framework, and stated that, "outcome directs attention specifically to the patient's well-being; it emphasizes individuals over groups, and the interests of unique patients over those of society" (p. 37). This approach is consistent with the American Nurses' Association (ANA) Code for Nurses (ANA, 1985). Lohr considered the growing attention to the views of consumers regarding quality as an important reason for evaluating satisfaction or lack thereof and the end results of care.

The individual and institutional levels of quality assessment as described by Donabedian (1988) are evident in a framework for strategic analysis offered by Garvin (1987). Garvin, who has a business perspective, identified eight critical dimensions of quality. Each will briefly be described. Product performance is the first dimension discussed. Examples included comfort of an automobile and promptness of service in the fastfood industry. Whether performance differences are quality differences depends upon preferences or expectations of the consumer.
Features that supplement basic functioning is another dimension discussed by Garvin (1987). Special cycles on washing machines and choice of fabric and color of furniture at no extra charge are examples of supplemental features. Quality based on features is determined by consumers.

The dimension of reliability discussed by Garvin (1987) relates to the probability of product failure. The conformance dimension is the degree to which a product meets specifications. Two measures of conformance are rates of defects at the factory and defects once the product reaches the consumer.

Durability, according to Garvin (1987), is related to measurement of product life. It is closely related to reliability in that consumers must decide at which point replacement of a product is preferable to breakdowns and repairs. Another related dimension is serviceability, which refers to "the speed, courtesy, competence and ease of repair" of the product (p. 107).

Garvin's (1987) final two dimensions are more subjective than the others. Aesthetics, or how the product appeals to one's senses, reflects personal preference. The taste of food is one example. Garvin believed that it is not possible to please everyone on this dimension. Perceived quality can be determined from both reality and inferences based on the product's reputation.
The interaction of these process dimensions allows for strategic quality management. Garvin (1987) challenged managers to compete on selected dimensions to improve quality and to distinguish a company's products from those of other companies. Garvin cautioned that it is often inappropriate to continue using old quality measures when the external environment has changed. Managers need to start thinking more rigorously about quality in terms of consumers' need and preferences rather than as an effort to control the production process. Garvin concluded by stating that quality should be considered a competitive opportunity rather than a problem to be solved.

In an 1987 editorial in *Nursing Economics*, Mitchell, using Garvin's work, addressed the demand by health care consumers for information and satisfaction. Quality, according to consumers, is mandated in the competitive market of today. Mitchell discussed the eight process dimensions identified by Garvin (1987) and advocated their use by health care executives to examine quality. Mitchell suggested that perceived quality is highly subjective and is reflected by the degree of trust customers have in health care providers. According to Mitchell, each health care executive must guide the institution to invest time and energy in the selected Garvin criteria which help meet quality goals.
Provision of quality care is a goal of institutions and an expectation of patients. The literature supports solicitation of feedback from patients related to quality of care. Information gained through these outcome assessments may be beneficial in efforts to modify organizational structure and processes.

Patient Satisfaction

In this section, various authors' views regarding patient satisfaction are presented. The role of the nurse related to the outcome measure of patient satisfaction is summarized. Finally, measurement of patient satisfaction is discussed.

Donabedian (1988) viewed patient satisfaction as an outcome of care. The work of Pascoe (1983) provided a definition for patient satisfaction which primarily focused on the health care recipient's response to salient aspects of his or her service experience. In this definition, satisfaction consists of a cognitive evaluation and an emotional reaction of a patient to the structure, process and outcome of services. This is consistent with the framework offered by Donabedian and discussed by Bloch (1975).

Donabedian (1988) suggested that patient satisfaction feedback be used in assessing the quality of care so that consumers have an opportunity to influence the process of setting
standards for future care. Vuori (1987), an internationally-known researcher and advocate for quality health services, agreed with this perspective. Vuori described patient satisfaction as an attribute of quality; an indicator of how the technical, interpersonal and amenities aspect of care are perceived by the patient; and as a prerequisite for achieving the goals of health care. Vuori asserted that given the fact that patients are expected to be capable of some control over their own health, it is an ethical mandate that patients should be involved in evaluation of care.

Petersen (1988) supported Donabedian's work and agreed that patient satisfaction is very important in measuring the quality of care given to patients. Petersen believed that caregivers must come to view the subjective perceptions of patient as reality, regardless of whether the patient is right or wrong. How the patient felt should be given merit, even though perception of reality by caregivers might be quite different. This is consistent with the components of TQM.

Cleary and McNeil (1988) explored factors thought to be related to patient satisfaction and concluded that studies relating patient satisfaction to sociodemographics have been contradictory and inconsistent. According to these authors, research collectively indicated more variation in patient
satisfaction with regard to interpersonal relations than to technical skills. Also, organizations which are perceived to individualize care were usually associated with higher levels of satisfaction.

In a study designed to identify factors which contribute most to patient satisfaction, Strasen (1987) simply asked hospital patients what nurses were doing right and what they were doing wrong. Patients judged nurses mostly on courtesy, quick response time, amount of time spent with them, physical appearance, tone of voice and nonverbal communication. Patients judged the hospital on cleanliness, technology, bedside manner of the physician, response of staff in the emergency department, employees' attitudes, restful environment, food, room decor, TV's, beds, pillows and telephones. Quality according to this group of patients was equated with personal care.

Using information from this study, Strasen (1987) offered strategies for nurses to increase patient satisfaction. Included are: (a) organizing workload around patient requests or preferences; (b) developing relationships with patients; (c) treating patients as individuals rather than diseases; (d) sitting down each day to determine needs and priorities; (e) listening to patients' comments about comfort measures; (f) refraining from becoming defensive when patients make suggestions about their
care; (g) making food and drink for patients a priority; (h) providing service quickly and courteously; (i) keeping patients informed about what's happening with them; and (j) reviewing comments from patient satisfaction surveys regularly. Opportunities to implement these strategies are evident each day in nurse-patient interactions.

While the concept of patient satisfaction as an outcome has not been clearly defined, use of patient satisfaction data based on the Donabedian model is supported. The literature also supports the use of patient satisfaction data as an indicator of quality in health care. Patient satisfaction as an outcome measure is further supported by Petersen (1988) and is consistent with the TQM philosophy. The perceptions of patients as customers should be considered in efforts to improve the quality of care.

Role of Nursing in Patient Satisfaction

The views of health care consumers have changed within the last two decades to include a heightened awareness of quality of services they receive. Kanar (1988) identified that nurses are caught in the middle of the dilemma of quality, patient satisfaction and cost efficiency. Nurse executives and staff nurses are in key positions to address the challenges inherent in this dilemma.
Rapid changes in the nurse executive role related to patient satisfaction issues have occurred. Several authors encourage quality considerations consistent with the TQM philosophy. Attonberry (1988) maintained that, "Healthcare institutions must identify the wants and needs of potential consumers and develop strategies to maximize client satisfaction and quality care" (p. 42). Adams, Hockema and Wood (1988) advocated the integration of marketing into nursing service. Some nurses are beginning to recognize that utilization of marketing concepts may provide a sound basis for future directions. These authors discussed factors which impact the role of the nurse and suggested that it will be necessary to place even greater emphasis on identification of consumers' needs and wants by nurse executives to respond effectively to current trends. Thus, the nurse executive is challenged to be proactive meeting the expectations of consumers.

Staff nurses who are in direct care situations have the greatest opportunity to satisfy the needs of individuals assigned to their care. Aucoin and Wegman (1988) reminded us that, "Nurses provide the only professional services which all patients require constantly throughout their hospital stay" (p. 46). In considering the total exposure of a patient to hospital personnel, the impression of quality is heavily influenced by interactions with the nursing staff (McBrien, 1986).
Abramowitz, Cote, and Berry (1987) asserted that the nursing staff is the key to patient satisfaction. Nursing service was the only service directly related to overall satisfaction in their study of hospitalized patients. They offered strategies which might be used to increase patient satisfaction, including improvement in the recognition of nurses, educating patients about the responsibilities of staff and hospital services, developing or improving guest relations, and strengthening housekeeping services. Thus, "...effective and caring nurses who provide care in clean surroundings are the factor most likely to improve patient satisfaction and to generate patient recommendations" (p. 130).

Nurses, then, are key players in fostering quality care. It has been demonstrated that nurses have a profound influence on patient satisfaction. Any strategy which assists nursing in determining patients' need and expectations may be helpful in increasing patient satisfaction.

Measurement of Patient Satisfaction

Risser (1975) developed an instrument to measure patient satisfaction with nurses and nursing care for use in primary health care settings using a Likert-type scale. Psychometric assessment included Cronbach's coefficient alpha which was
reported as .912 for the total scale. Content validity was established using a multiple criterion approach and an unpublished taxonomy. Construct validity was not established in this study. However, positive skewing of scores as expected, based on results of similar measures, provided some evidence of construct validity.

Strengths of Risser's (1975) overall final scale as well as subscales included an ability to discriminate between persons with various levels of relative satisfaction. Risser found that respondents indicated greater satisfaction on both the professional/technical subscale and the trusting relationship subscale than on the teaching-oriented educational relationship subscale.

Bader (1988) reported on a study conducted in a 250-bed non-profit hospital. Using Risser's tool, data were collected from 50 individuals hospitalized on one of three medical/surgical units. Control for threats to internal validity such as mental alertness, orientation, ability to read and write, physical status conducive to participating in the study, and admission of 48 hours or more was achieved by reviewing the kardex on each unit and eliminating unsuitable subjects. Findings suggested that patient satisfaction with nursing care would be increased if more emphasis was placed on meeting the emotional and psychosocial needs of patients.
Petersen (1988) defined patient satisfaction as a patient's subjective perception about how their care was provided. According to Petersen, measurement of patient satisfaction should "be based on what the patient expected and then identifying the degree of satisfaction in having their expectations met" (p. 27). Petersen believed in obtaining useful data to improve patient care delivery.

Three areas of usefulness of data were outlined by Petersen (1988), including: (a) usefulness to the immediate care provider, (b) usefulness to departmental management, and (c) usefulness to the overall facility. Petersen offered suggestions for managers' use of patient satisfaction data in justifying changes in the care delivery system or facility improvements.

Consistent with Petersen (1988), Eriksen (1987) identified that professional nursing values and concerns of administration may not be congruent with the values of patients. Eriksen described a study of the relationship of patient satisfaction and the quality of nursing care in 136 randomly selected patients from eight inpatient units of a large medical center. Patient satisfaction was not defined. The Patient Satisfaction with Nursing Care Checklist instrument as formulated by Abdellah and Levine (1957) was used. Psychometric assessment included an estimate of reliability reported as a coefficient alpha of .889.
Some evidence of concurrent validity and predictive validity have been reported by Abdellah and Levine.

Eriksen's (1987) findings suggested that patient satisfaction should not be used as a sole indicator of quality. Eriksen believed that nurses could increase satisfaction by extending social courtesy and service to patients. Eriksen concluded that adherence to policies and procedures prevents individualization of care; thus, the result may be a lack of satisfaction with nursing care even though patient outcomes may have been realized. Patient evaluation of nursing care is, then, an important supplement to professional care evaluation.

Taylor, Hudson and Keeling (1991) performed a study to determine what constitutes quality nursing care from the perceptions and reactions of consumers. Unstructured telephone interviews of 140 consumers were conducted: 70 pairs composed of one patient and one significant other. In all 930 response items were analyzed using content analysis which yielded three major types of attributes of quality nursing care: (a) practice attributes, (b) nurse attributes and (c) practice setting attributes.

Two practice attributes were mentioned by 96% of the respondents in the Taylor et al. (1991) study. The attributes identified include holistic care and nurse-patient interaction.
Holistic care was defined by respondents to mean family involvement, total patient care, and patient and family education. Specific phrases reflective of holistic care are listed by Taylor et al. Some of these phrases include "getting all the care you need", "keep family informed of patient's condition", and "do patient and family teaching" (p. 26). In contrast, the nurse-patient interaction attribute was described as patient-centered care, effective communication and frequent contact with the nurse. Several specific phrases reflective of nurse-patient interaction are "give patient special attention", "nurses who can talk about anything", and "check on patient frequently" (p. 26).

Ninety-seven percent of the respondents in the Taylor et al. (1991) study mentioned nurse attributes. Nurse attributes described by respondents were: (a) personal qualities, (b) caring, (c) proficiency, (d) professional character, and (e) commitment to excellence. The eight personal qualities identified were: being kind; friendly and nice; flexibility; efficiency; helpfulness; gentleness; courtesy; conscientiousness; and confidence. Caring was described by the words "caring" and "compassionate". Proficiency of the nurse was conveyed by being knowledgeable and technically competent. "Being up-to-date" and "well-trained" are phrases which described proficiency. The professional character of the nurse was described by consumers as
conveying "an attitude of responsibility for their actions" (p. 27). Commitment to excellence was reflected in statements such as "the best care the nurse can give" and "going beyond that which is expected" (p. 27).

Practice setting attributes described in the Taylor et al. (1991) study focused on the hospital environment. The patient's immediate bed space and room as well as the organization and management of staff who provide direct care were addressed through phrases such as "clean bed and room" and "adequate staffing" (p. 28). Practice setting attributes were mentioned by only 16% of the respondents.

The study by Taylor et al. (1991) suggested that consumers' expectations include all three aspects of the Donabedian (1988) model. Findings also confirm that nursing care should be evaluated on structure, process and outcome aspects simultaneously as Donabedian expected. The two structural aspects of nursing care identified are: (a) organization and management of personnel and (b) a clean, quiet environment. Three processes were identified, including: (a) use of knowledge and skill, (b) continuity of care and (c) the expectation for holistic care. Consumer expectations of care may be concerned more with the factors that influence quality and focus on the psychosocial component of care. Thus, their expectations suggested that
evaluation of these factors provide outcome measures of consumer satisfaction. Taylor et al. believed that patient satisfaction with care and how it was provided is an important consideration in measurement of patient outcomes. Taylor et al. also believed that the ultimate measure of the success or failure of outcomes for patients is the distribution of quality perceptions among consumers. They further concluded that documentation of quality from the consumers' perspective is imperative for the delivery of quality nursing care in the competitive health care arena of the 90's.

The TQM philosophy, quality of care, patient satisfaction, the role of the nurse in quality of care including patient satisfaction and measurement of patient satisfaction have been reviewed. A variety of frameworks and methods have been used to assess patient satisfaction which directly relate to overall quality and the TQM philosophy: it has been repeatedly suggested that the patient's viewpoint should be given consideration by organizations. However, only one study by Taylor et al. (1991), directly assessed patient comments. The use of qualitative methods to learn more about the nature of written comments is supported.
CHAPTER III
METHODOLOGY

In this section, the patient satisfaction survey currently in use at a large urban tertiary care center (referred to in this study as "the medical center" or "the hospital") will be described. The type and purpose of the study, sampling method, a description of the data-gathering tool, data-gathering procedures, data reduction and analysis, and protection of rights of human subjects are discussed. Finally a discussion of content analysis procedures used will complete the section.

Type of Study and Purpose

This qualitative study was retrospective content analysis of narrative comments related to patient satisfaction to determine patterns of response. The information gained from this study may be used to assist administrators and nurses at the medical center improve the quality of nursing care.

Sampling Method

The target population was adult patients' narrative comments who have been hospitalized at the medical center. The accessible population sampled was comprised of approximately 4000 adult inpatients who returned patient surveys within a 12-week period
during May, June, July and August 1992. From this population, 1675 (41.89%) questionnaires were returned. Of these questionnaires, 915 (54.62%) contained narrative comments. Of the 915 questionnaires with comments, 79 were from patients discharged from nursing units excluded from this study, including Neonatal Intensive Care, Pediatrics, and the Burn Unit. This resulted in a sampling frame of 836 questionnaires with comments returned from adults. A random sample of 600 questionnaires was selected from the 836 using a table of random numbers. Each comment or series of comments related to the same or similar thought became a separate element of data.

Description of Data-Collection Tool

The data collection tool was a questionnaire (see Appendix A) which has been in use at the medical center for two years. A statement at the beginning of the tool states that the survey is confidential. A code at the bottom of the first page identifies the month of hospitalization and the nursing unit from which the patient was discharged. Respondents are informed that the code will not identify them individually.

Demographic data requested at the top of page one includes the number of days in the hospital, age, sex, whether this was the patient's first stay at the medical center, if the patient was
admitted through the emergency room or outpatient surgery, if the patient was on a special diet, if the patient had a roommate, and if the patient was in a private room.

On the first two pages of the tool, a Likert-type scale is provided for patients to indicate their feelings about services received while in the hospital. The ten sections of service include: (a) admissions; (b) your room; (c) diet and meals; (d) nursing care; (e) tests and treatments; (f) overall service and courtesy from 8 ancillary services; (g) visitors and family; (h) your physician; (i) discharge; and (j) some final ratings. Five choices ranging from "very poor" to "very good" are listed for respondents to rate items in each of the ten sections listed above. These two pages which contain demographic data and responses to the Likert-type items are forwarded to private consultants for data analysis and reporting.

Three open-ended statements appear on page three of the tool with space provided for narrative comments to be made by the respondent. These statements requested information regarding positive or negative comments about the 10 survey sections listed above, complaints or concerns which were not resolved to the patient's satisfaction, and anything else the patient would like to say. It is narrative comments made in response to these three open-ended statements that were examined in this study. An option
was provided at the end of the third page for the respondent to identify himself/herself by name.

Description of Data-Gathering Procedures

The data was gathered by mailing the tool to all inpatients excluding deaths, neonatal intensive care patients, psychiatric and chemical dependency patients. This is consistent with the recommendation of Holcomb, Adams, Ponder and Reitz (1989), who suggest that responses of patients hospitalized on psychiatric units should be excluded from the study. The tool and a postage-paid return envelope were mailed within one week after the date of the patient's discharge from the hospital.

Data Reduction and Analysis

Each narrative comment or group of comments was separated such that each written comment or series of comments related to the same or similar thought became a separate element of data. Each element of data was affixed to an index card which was prepared with codes provided in the margins to indicate nursing unit, Likert-type scale survey section headings and attributes of quality nursing care as described by Taylor et al. (1991). Nursing unit from which the respondent was discharged was indicated in the left margin of the index card. A mark in the
right margin indicated which attribute category the comments related to. An indication of which survey section the comment related to was indicated in the lower margin (see Appendix B).

Each element of data was coded to indicate whether it was a positive, negative or neutral statement. The narrative comments were coded to identify which one of the ten sections of the patient satisfaction survey instrument was being addressed. These ten sections include: (a) admissions; (b) your room; (c) diet and meals; (d) nursing care; (e) tests and treatments; (f) overall service and courtesy; (g) visitors and family; (h) your physician; (i) discharge; and (j) some final ratings. Descriptive words and phrases used as subsections provided the framework for the coding process. Comments not obviously related to one of the ten sections were placed in an additional category labelled "other". The number of positive, negative and neutral comments for each of the ten sections was tabulated.

Written comments related to nursing care were analyzed and classified into content categories according to the seven subsections of the nursing care section of the survey. These subsections include: (a) friendliness; (b) promptness in responding to the call button; (c) nurses' attitudes toward your calling them; (d) degree to which the nurses took your health problem seriously; (e) amount of attention paid to your special or
personal needs: (f) degree to which the nurses kept you adequately informed about tests, treatment and equipment; and (g) technical skill of the nurse. Comments not related to one of the above seven subsections were placed in an additional category labelled "nursing other". Comments in the category of "nursing other" were further analyzed to determine patterns of response, and additional categories were created when three to five comments or more were similar, or if in the researcher's opinion the comments were of sufficient import to require further analysis. The number of positive, negative and neutral comments in each category was reported.

All comments were analyzed a second time according to the nine specific attributes of quality nursing care identified by Taylor et al. (1991). The first type, practice attributes, are: (a) holistic care and (b) nurse-patient interaction. The second type of attributes are nurse attributes. They include: (a) personal qualities; (b) caring; (c) proficiency; (d) professional character; and (e) commitment to excellence. The third type, practice attributes, are: (a) effective organization and management and (b) patient environment. Descriptive words and phrases related to each of these categories as described by Taylor et al. were used to categorize responses. Any comment found not to conform to one of the above nine categories was placed in a
category labelled "attribute other". Comments in the "attribute other" category were further analyzed to determine patterns of response, and additional categories were created when three to five or more comments placed in the "attribute other" category were similar or if in the researcher's opinion the comments were significant enough to merit further follow-up. The number of positive, negative and neutral comments from each category was reported.

Results of the two content analyses of nursing-related comments were examined for comprehensiveness, similarities and differences. The demographic data and Likert-type portion of the survey tool were analyzed by private consultants hired by the medical center for that purpose. These results were reported by the consultants in a series of tables, graphs and charts. Identified patterns of response were compared to three empirical data reports for consistency. The empirical data reports used for comparison were the report of the overall analysis by questionnaire section (Appendix C), report of the relative contribution of each section to the overall score (Appendix D), and report of the ten questions which contribute most to patient's overall evaluation (Appendix E).

In an attempt to insure confirmability of this study, the researcher maintained an audit trail. This method to establish
trustworthiness of qualitative studies is outlined by Halpern and discussed by Lincoln and Guba (1985). The audit trail included: (a) marking raw data so that it could be replaced into its original form; (b) documentation of the meaning of coding numbers and symbols used in preparation of raw data for reduction and analysis; and (c) documentation using a journal format of personal notes and impressions of the author throughout the data analysis process.

In summary, content analysis using the survey sections, nursing subsections, and the "nursing other" category was performed. Content analysis of comments based on the attributes for quality nursing care as described by Taylor et al. (1991) was performed including the "attribute other" category. Results of these two content analyses were examined, followed by comparison of the results of these analyses to three empirical data analysis reports to determine consistency of findings.

Protection of Rights of Human Subjects

Protection of the rights of subject was accomplished by informing subjects of how their rights would be protected through two statements on the tool: one in the introductory paragraph on page one and the second a notation at the bottom of page one of the tool (Appendix A). These statements, respectively are:
"Thank you for completing this confidential survey" and "This questionnaire contains a code...which will not identify you individually". The researcher protected the rights of subjects by maintaining confidentiality. Permission to conduct the study was obtained from the Human Subjects Review Committee at Drake University as well as the Research and Innovation Committee at the medical center.
CHAPTER IV

ANALYSIS OF DATA

A description of sample characteristics begins this chapter and is followed by a discussion of data reduction procedures used in this study. Content analysis findings will be reported for survey sections which addressed: (a) admissions; (b) your room; (c) diet and meals; (d) tests and treatments; (e) overall service and courtesy; (f) visitors and family; (g) your physician; (h) discharge; and (i) some final ratings. Content analysis findings for the survey nursing care section and subsections will be reported. Content analysis findings will then be reported for each of the nine attributes of quality nursing care described by Taylor et al. (1991), which include: (a) holistic care; (b) nurse-patient interaction; (c) personal qualities; (d) caring; (e) proficiency; (f) professional character; (g) commitment to excellence; (h) effective organization and management; and (i) patient environment. The findings of the analysis according to the survey sections will be compared with the findings according to the Taylor et al. framework. Comparison of above findings to empirical patient satisfaction reports for the medical center will conclude this chapter.
Characteristics of Sample

The total number of surveys with narrative comments received during the 12 weeks sampled was 915. There were 79 surveys received from Intensive Care Nursery, Pediatric Oncology Unit, Pediatrics, Pediatric Intensive Care, and the Burn Unit which were excluded from this study. The remaining 836 surveys provided the sampling frame for this study.

A random sample of 600 surveys with narrative comments was selected using the table of random numbers. The sample was analyzed to determine nursing units from which respondents were discharged. Table 1 lists the type of patients cared for on each nursing unit represented in the sample.
<table>
<thead>
<tr>
<th>Nursing unit</th>
<th>Type of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>N3</td>
<td>Urology/Gynecology</td>
</tr>
<tr>
<td>N4</td>
<td>Obstetrics/Newborn Nursery</td>
</tr>
<tr>
<td>N5</td>
<td>Neurology</td>
</tr>
<tr>
<td>N6/ONC</td>
<td>Oncology</td>
</tr>
<tr>
<td>P4</td>
<td>Medical</td>
</tr>
<tr>
<td>P5</td>
<td>Orthopedics</td>
</tr>
<tr>
<td>S2</td>
<td>Surgical</td>
</tr>
<tr>
<td>S3</td>
<td>Surgical</td>
</tr>
<tr>
<td>S4</td>
<td>Predelivery/Labor and Delivery</td>
</tr>
<tr>
<td>Y4</td>
<td>Stroke Rehabilitation</td>
</tr>
<tr>
<td>Y5</td>
<td>Orthopedics</td>
</tr>
<tr>
<td>Y6</td>
<td>Head/Spinal Cord Injury Rehabilitation</td>
</tr>
<tr>
<td>Y7</td>
<td>Cardiac Telemetry</td>
</tr>
<tr>
<td>Y8</td>
<td>Medical</td>
</tr>
<tr>
<td>CCU</td>
<td>Cardiac Intensive Care</td>
</tr>
</tbody>
</table>
Identification and enumeration of respondents discharged from each nursing unit was done to demonstrate the relative weight of each nursing units' impact on overall patient satisfaction and to sensitize nurses to unit-specific issues which may have affected patient satisfaction. The number of surveys in the sample from each nursing unit was representative of the patient population based on the average number of patients discharged from each nursing unit during a 12-week period. Inclusion of the respondent's signature on the narrative comment sheet of the tool was optional, so the number of narrative comment sheets which included a signature was determined. Approximately 70% of the comment sheets in the sample included the signature of the respondent. A description of the sample is outlined in Table 2.
Table 2

Description of Sample (n=600)

<table>
<thead>
<tr>
<th>Nursing unit</th>
<th># of surveys</th>
<th>% of total</th>
<th># with signature</th>
<th>% with signatures</th>
</tr>
</thead>
<tbody>
<tr>
<td>N1</td>
<td>82</td>
<td>13.67</td>
<td>61</td>
<td>74.39</td>
</tr>
<tr>
<td>N4</td>
<td>109</td>
<td>18.17</td>
<td>58</td>
<td>53.21</td>
</tr>
<tr>
<td>N5</td>
<td>40</td>
<td>6.67</td>
<td>33</td>
<td>82.50</td>
</tr>
<tr>
<td>N6/Onc</td>
<td>26</td>
<td>4.33</td>
<td>21</td>
<td>80.77</td>
</tr>
<tr>
<td>P1</td>
<td>26</td>
<td>4.33</td>
<td>15</td>
<td>57.69</td>
</tr>
<tr>
<td>P5</td>
<td>35</td>
<td>5.83</td>
<td>25</td>
<td>71.43</td>
</tr>
<tr>
<td>S2</td>
<td>53</td>
<td>8.83</td>
<td>38</td>
<td>71.70</td>
</tr>
<tr>
<td>S3</td>
<td>37</td>
<td>6.17</td>
<td>29</td>
<td>78.38</td>
</tr>
<tr>
<td>S4</td>
<td>7</td>
<td>1.17</td>
<td>6</td>
<td>85.71</td>
</tr>
<tr>
<td>Y4</td>
<td>7</td>
<td>1.17</td>
<td>3</td>
<td>42.86</td>
</tr>
<tr>
<td>Y5</td>
<td>46</td>
<td>7.67</td>
<td>34</td>
<td>73.91</td>
</tr>
<tr>
<td>Y6</td>
<td>8</td>
<td>1.33</td>
<td>6</td>
<td>75.00</td>
</tr>
<tr>
<td>Y7</td>
<td>88</td>
<td>14.67</td>
<td>58</td>
<td>65.91</td>
</tr>
<tr>
<td>Y8</td>
<td>35</td>
<td>5.83</td>
<td>26</td>
<td>74.29</td>
</tr>
<tr>
<td>CCU</td>
<td>1</td>
<td>0.17</td>
<td>1</td>
<td>100.00</td>
</tr>
<tr>
<td>Total</td>
<td>600</td>
<td>100.00%</td>
<td>414</td>
<td>av. 70%</td>
</tr>
</tbody>
</table>

Note. # = number.
Data Reduction

The sample of narrative comment sheets from 600 respondents was marked for separation into individual elements of data. Each element of data consisted of one comment or series of comments related to the same or similar thought. Each element of data was coded with date received by the medical center, nursing unit at time of discharge, and the number assigned to that comment sheet for purposes of sample selection. After the coding procedures were completed, each element of data was separated and each was mounted on an index card which was prepared for content analysis coding (see Appendix B).

A total of 1378 elements of data were derived from the sample. From this point on in this study, "element of data" and "comment" are used interchangeable. The number of comments from each nursing unit was determined and summarized in Table 3.
Table 3

Number and Percentage of Comments (n=1378) by Nursing Unit

<table>
<thead>
<tr>
<th>Nursing unit</th>
<th># of comments</th>
<th>% of total comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>N3</td>
<td>184</td>
<td>13.35</td>
</tr>
<tr>
<td>N4</td>
<td>258</td>
<td>18.72</td>
</tr>
<tr>
<td>N5</td>
<td>97</td>
<td>7.04</td>
</tr>
<tr>
<td>N6/ONC</td>
<td>55</td>
<td>3.99</td>
</tr>
<tr>
<td>P4</td>
<td>45</td>
<td>3.26</td>
</tr>
<tr>
<td>P5</td>
<td>93</td>
<td>6.75</td>
</tr>
<tr>
<td>S2</td>
<td>116</td>
<td>8.42</td>
</tr>
<tr>
<td>S3</td>
<td>76</td>
<td>5.52</td>
</tr>
<tr>
<td>S4</td>
<td>15</td>
<td>1.09</td>
</tr>
<tr>
<td>Y4</td>
<td>13</td>
<td>0.94</td>
</tr>
<tr>
<td>Y5</td>
<td>121</td>
<td>8.78</td>
</tr>
<tr>
<td>Y6</td>
<td>18</td>
<td>1.31</td>
</tr>
<tr>
<td>Y7</td>
<td>201</td>
<td>14.59</td>
</tr>
<tr>
<td>Y8</td>
<td>81</td>
<td>5.88</td>
</tr>
<tr>
<td>CCU</td>
<td>5</td>
<td>0.36</td>
</tr>
<tr>
<td>Total</td>
<td>1378</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Note.  # = number.
Survey Sections

Coding of the comments as positive (+), negative (-), and/or neutral was performed. This was followed by coding of the comments according to the pre-determined sections of the survey: (a) admissions; (b) your room; (c) diet and meals; (d) tests and treatments; (e) overall service and courtesy; (f) visitors and family; (g) your physician; (h) discharge; and (i) some final ratings.

Comments found not to relate to any of the predetermined sections were placed in the categories of "other" and "nursing other". The number of comments related to each section of the survey and the category "other" were tabulated. Some comments pertained to more than one survey section or subsection. Thus, the total number of comments (n=1588) reported here is greater than the number of comments derived from the sample (n=1378) as reported in Table 3. Table 4 summarizes this information.
Table 4

Number and Percentage of Comments Related to Each Survey Section

<table>
<thead>
<tr>
<th>Survey section</th>
<th>Total # of comments</th>
<th>% of total</th>
<th># +</th>
<th>% of section</th>
<th># -</th>
<th>% of section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>4</td>
<td>0.25</td>
<td>1</td>
<td>25.00</td>
<td>3</td>
<td>75.00</td>
</tr>
<tr>
<td>Your Room</td>
<td>184</td>
<td>11.59</td>
<td>33</td>
<td>17.93</td>
<td>149</td>
<td>80.98</td>
</tr>
<tr>
<td>Diet and Meals</td>
<td>66</td>
<td>4.16</td>
<td>26</td>
<td>39.39</td>
<td>38</td>
<td>57.57</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>795</td>
<td>50.06</td>
<td>483</td>
<td>60.75</td>
<td>307</td>
<td>38.61</td>
</tr>
<tr>
<td>Tests and Treatments</td>
<td>20</td>
<td>1.26</td>
<td>7</td>
<td>35.00</td>
<td>12</td>
<td>60.00</td>
</tr>
<tr>
<td>Overall Service/Courtesy</td>
<td>44</td>
<td>2.77</td>
<td>33</td>
<td>75.00</td>
<td>11</td>
<td>25.00</td>
</tr>
<tr>
<td>Visitors/Family</td>
<td>46</td>
<td>2.90</td>
<td>13</td>
<td>28.26</td>
<td>33</td>
<td>71.74</td>
</tr>
<tr>
<td>Your Physician</td>
<td>102</td>
<td>6.42</td>
<td>60</td>
<td>58.82</td>
<td>41</td>
<td>40.20</td>
</tr>
<tr>
<td>Discharge</td>
<td>15</td>
<td>0.94</td>
<td>1</td>
<td>6.67</td>
<td>14</td>
<td>93.33</td>
</tr>
<tr>
<td>Final Ratings</td>
<td>32</td>
<td>2.02</td>
<td>31</td>
<td>96.88</td>
<td>1</td>
<td>3.12</td>
</tr>
<tr>
<td>Other</td>
<td>280</td>
<td>17.63</td>
<td>112</td>
<td>40.00</td>
<td>93</td>
<td>33.21</td>
</tr>
<tr>
<td>Total</td>
<td>1588</td>
<td>100.00%</td>
<td>800</td>
<td>50.38%</td>
<td>702</td>
<td>44.21%</td>
</tr>
</tbody>
</table>

Note. # = number. # + = number positive. # - = number negative.

Total # of responses includes 86 neutral responses; 75 relate to "other" section.
As the enumeration of individual comments in Table 4 reflects, nursing care was addressed in more than 50\% of the comments. The section "your room" was frequently commented upon, as was "your physician". The section on diet and meals received a generous number of comments. The following sections received considerably fewer comments: (a) visitors/family; (b) overall service and courtesy; (c) final ratings; (d) tests and treatments; (e) discharge; and (f) admissions. Overall, the number of positive comments was greater than the number of negative comments.

A narrative summary of content analysis findings follows. While nursing is the emphasis of this study, the comments from the other survey sections will be addressed first. Analysis of data related to nursing begins on page 56. Data are presented by section according to frequency of response, beginning with the section which received the most responses, followed by sections which received progressively fewer comments, and ending with the findings from the section labelled "other".

**Your Room**

The survey section "your room" received 184 comments (11.59\%), 149 (80.98\%) of which were negative. Cheerfulness of the room was commented on 19 times; other positive comments
included having a nice view from the window. Negative comments suggested a complete "redo" of a nursing unit and changing the color of the curtains. One respondent stated that occupying the bed which is not by the window is "like being in jail". Daily cleaning of rooms was addressed in 22 comments, 19 of which were negative. Temperature of the room was commented on 19 times; 18 of the comments were negative. Noise level received 70 responses, 68 of which were negative. Roommate noise contributed to 19 of the negative responses; visitor noise was mentioned 16 times; and nurses were identified as the cause for noise 10 times. A variety of other factors contributing to noise was identified including other staff members, construction, elevators, and room placement near a high-traffic area of the nursing unit. Few comments were received regarding the working order of equipment in the room such as the TV, call light and bed. Courtesy of the person cleaning rooms was commented on 6 times, 5 of which were positive. One respondent indicated that a patient information guide was not provided.

Additional comments related to this survey section received from multiple respondents include 6 comments expressing concern that the room size is too small. These comments addressed single as well as double rooms. Eighteen comments were received which dealt solely with preference for a private room. Of these 18
comments, 6 statements indicated enjoyment of a private room; 1 respondent would have preferred a private room if one was available but reported having had a satisfactory stay in a double room; 11 comments suggested that privacy and/or rest were compromised as the result of a private room not being available.

Your Physician

The survey section "your physician" received 102 (6.42%) comments. Of the 60 (58.82%) positive responses related to physician care, 16 comments indicated a rating of excellence. Personal qualities such as "friendly", "nice" and "kind" were identified in 38 positive comments. Additionally, 11 comments indicated that the physician was "considerate", "concerned", "accommodating" or "comforting". Five positive comments indicated that the physician was "professional". Of the 41 (40.2%) negative responses related to physicians, 20 addressed a lack friendliness, kindness or sensitivity; 11 indicated a problem with communication; 6 were related to anesthesia services; and six respondents indicated doubt or uncertainty about medical care decisions.
Diet and Meals

The number of responses related to the survey section "diet and meals" was 66 (4.16%). There were 38 (57.57%) negative comments and 26 (39.39%) positive comments. The temperature of the food received 10 negative comments. Quality of the food received 22 positive comments and 16 negative comments. Eight comments suggested that the food checked on the menu form was not received. There were no other comments related to diet and meals which occurred more than 3 times; however, three respondents indicated that they were not given explanations regarding a special diet which was prescribed for them.

Visitors and Family

The survey section "visitors and family" received 46 (2.90%) comments. Of these, 33 (71.74%) were negative. The nurses' attitudes toward visitors was favorable in 11 comments. Adequacy and accuracy of information given to family members about condition or treatment of the patient was commented on sixteen times; ten of these responses were negative. One respondent indicated that a family member was informed over the phone that he had died when, indeed, this was not true. Respondents indicated in 6 responses that visitors rated cafeteria services negatively,
including reasons such as "too expensive" and "too far to walk if family member is hospitalized on the other end of the building". Visitors were identified as interfering with privacy and rest in 10 comments. Several respondents indicated the desire for the nurse to be more assertive in explaining to family members and visitors the rest and sleep needs or desires of the patient.

Overall Service and Courtesy

The "overall service and courtesy" section of the survey received 44 (2.77%) of the comments, with 33 (75%) positive. Four positive comments were related to overall courtesy. Twenty-five positive comments were related to service and courtesy of selected personnel, including social services, physical therapy, chaplains, transporters, volunteers and nuclear medicine personnel. Of these 25 positive comments, 11 were related to physical therapy and 7 were related to chaplains. Of the 14 negative responses to services and courtesy of selected personnel, 9 relate to physical therapy and 3 to x-ray personnel.

Some Final Ratings

In the section "some final ratings", 32 (2.02%) comments were found, of which 31 (96.88%) were positive. Overall cheerfulness of the hospital was positively commented on by 5 respondents.
Twenty-five comments stated that the respondent would recommend this hospital to others. One negative comment indicated that the respondent would not recommend the medical center to others.

**Tests and Treatments**

The survey section "tests and treatments" received 20 (1.26%) of the comments; 12 (60%) were negative. Proficiency of lab personnel was addressed by 10 respondents. Of these responses, 9 negative comments were received and included phrases such as "not skilled", "stuck 4 (or more) times", "did not wear gloves", and "no concern for my pain while jabbing around".

**Discharge**

Fifteen (0.94%) comments were received regarding discharge, fourteen (93.33%) of which were negative. Six comments indicated that discharge was "too slow" or "delayed"; 10 (66.67%) comments indicated a need for more information about diagnosis, care at home, or knowledge of what to expect after discharge.

**Admissions**

Four (0.25%) comments were received regarding this survey section. No patterns of responses were identified.
Other

Many comments were found not to relate to any of the above sections and were placed in a section labelled "other". Of these 615 "other" comments, 372 (60.48%) were positive, 161 (26.17%) were negative and 82 (13.33%) were neutral. To gain a comprehensive perspective, all 615 comments will be discussed here. Two hundred-eighty (45.52%) have no relation to nursing. The remaining 335 (54.47%) comments which have some link to nursing will also be addressed in the "nursing other" section.

Approximately 150 of these comments addressed personal qualities of staff in general and were positive. More than 50 positive comments simply expressed thanks to staff or for care received. Twenty-two positive comments described the medical center overall, including comments such as "a very good hospital", "impressive facility" and "first class operation". Many additional positive and neutral comments in this section described care in general, with descriptors such as "excellent care", "good care", "everything was O.K."., and "everything fine".

Some comments in the section labelled "other" were negative. Twenty-one respondents described a problem identifying personnel. Thirteen comments indicated that it appeared that there was a shortage of help. Ten comments related to cost, seven of which were negative. At least 12 comments indicated that a private room
was preferred but not available. Waiting for a bed was identified as taking too long for more than 10 respondents; 7 referred to the Emergency Department and 3 to Post-Anesthesia Care Unit. Six respondents stated that they "waited too long" for tests or a transporter. Four comments indicated that parking was "a problem" or "inconvenient". Four comments indicated that items were lost or stolen during hospitalization. Nine comments addressed billing, including requests for itemized statements and displeasure with receiving a bill while still hospitalized. Five comments were requests for 2 TV's per double room.

Twenty-one comments specifically addressed nursing assistants. Of these 21 comments, 13 were positive, with descriptors such as "nice", "gave good care", and "helpful". The remaining 8 comments indicated that some nursing assistants "appear somewhat limited", "never did give me a bath", "rude and didn't seem to care if you needed help or not", "noisy, banter and joke", and "didn't like the unkind language or way of saying things". Other comments of interest were that the "survey is good" and "no problem with the survey". One comment suggested that patients and visitors be informed when fire warnings are over so they may leave their room.
Nursing

This portion of the paper reports findings related to the survey section on nursing as well as the 7 subsections under nursing. An overview of findings is presented, followed by a discussion of each subsection beginning with the subsection with the greatest number of responses and progressing to the subsection with the fewest responses. Findings from the category "nursing other" conclude this section.

The nursing section received the largest number of responses overall (795 or 50.06%). Each nursing subsection received comments as well. The number of positive (# +), negative (# -) and neutral comments related to each nursing subsection of the survey and the category "nursing other" was determined. This information is summarized in Table 5.
Table 5

Number and Percentage of Comments Related to Nursing Subsections

<table>
<thead>
<tr>
<th>Subsection</th>
<th># of comments</th>
<th>% of total</th>
<th>% of subsection</th>
<th>#</th>
<th>% of subsection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendliness</td>
<td>42</td>
<td>5.28</td>
<td>37</td>
<td>88.09</td>
<td>5</td>
</tr>
<tr>
<td>Promptness</td>
<td>31</td>
<td>3.90</td>
<td>13</td>
<td>41.94</td>
<td>18</td>
</tr>
<tr>
<td>Nurses' Attitudes</td>
<td>5</td>
<td>0.63</td>
<td>1</td>
<td>20.00</td>
<td>4</td>
</tr>
<tr>
<td>Took Health Problem Seriously</td>
<td>18</td>
<td>2.26</td>
<td>9</td>
<td>50.00</td>
<td>9</td>
</tr>
<tr>
<td>Attention Paid to Special/Personal Needs</td>
<td>112</td>
<td>14.09</td>
<td>60</td>
<td>53.57</td>
<td>52</td>
</tr>
<tr>
<td>Adequately Informed</td>
<td>32</td>
<td>4.03</td>
<td>19</td>
<td>59.37</td>
<td>13</td>
</tr>
<tr>
<td>Technical Skill</td>
<td>30</td>
<td>3.77</td>
<td>10</td>
<td>33.33</td>
<td>20</td>
</tr>
<tr>
<td>Nursing Other</td>
<td>525</td>
<td>66.04</td>
<td>334</td>
<td>63.62</td>
<td>186</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>795</strong></td>
<td><strong>100.00%</strong></td>
<td><strong>483</strong></td>
<td><strong>60.75%</strong></td>
<td><strong>307</strong></td>
</tr>
</tbody>
</table>

**Note.** # = number. #+ = number positive. #− = number negative.

# of comments for nursing other includes 5 neutral comments.
Of the subsections related to nursing, the greatest number of responses (112 or 14.09%) was related to the amount of attention paid by the nurse to special or personal needs of patients. The remaining subsections on friendliness of the nurse, prompt response to patient's call buttons, keeping patients informed, and technical skill of the nurse each received numerous comments. The subsection on nurses' attitudes toward calling them received the fewest number (5 or 0.63%) of comments.

Attention Paid by the Nurse

One hundred twelve (14.09%) comments were received related to the amount of attention paid to your special or personal needs. Of these 112 comments, 60 (53.57%) were positive and 52 (46.43%) were negative. Of the positive responses, multiple comments were received for each of the following: "sensitivity", "attentive", "accommodating", "concerned", "comforting", "understanding", "did their best", "moved me to a private room as soon as possible", "went out of their way to be helpful", "showed concern for you as an individual", "personal touch in care", "took care of all my needs", "really cared for how I felt", "supportive", "made me feel welcome", and "made it possible for my husband to stay with me". Many comments were found which indicate that special needs were
met. Some of these include: "I felt like I was the most important
guy in the hospital", "did what I needed and then asked if there
was anything else I needed before she left the room", and "bend
over to help emotional well-being as well as physical well-being".

Of the 52 negative comments, assistance with meeting basic
needs was frequently addressed, including back and feet washed
with stockings removed only after 3 days; no opportunity to wash
hands before meals; meals/supplies left out of reach; and no offer
to help with bath or shower. Four comments indicated that
respondents expected to see the nurse more frequently than they
did. Other comments of interest included: "nurse didn't seem
interested in my care", "felt as if I was in my own", and "all
care appeared to be casual and without planning".

Friendliness

The survey subsection on friendliness of the nurses received
42 (5.28%) comments. Thirty-seven (88.09%) described the nurse or
nurses as friendly; 5 (11.09%) responses stated that the nurse was
unfriendly or rude.

Degree to Which Nurses Kept You Adequately Informed

The degree to which nurses kept you adequately informed about
tests, treatment and equipment received 32 (4.03%) of the
comments. Of the 19 (59.37%) positive comments, 12 indicated that nurses either explained things or were very informative. Other comments stated that nurses were "willing to talk to me" and "answered my questions". The 13 (40.62%) negative responses indicated that a variety of things were not explained, including medications, equipment, instructions related to care and information about patient condition or progress.

Promptness to Call Button

Regarding promptness in responding to the call button, 31 (3.90%) comments were received. There were 13 (41.94%) positive comments which addressed this specific item. Of the 18 (58.06%) negative responses, 5 responses were related to waiting for pain medication; one respondent reported waiting 3 hours in the bathroom for assistance to take a shower; and one respondent reported initially calling for a nurse at 8:30 PM and actually seeing a nurse at 10:15 PM.

Technical Skill

The subsection on technical skill of the nurses received 30 (3.77%) comments. There were 10 (33.33%) positive responses to this item. A variety of descriptive phrases was used, including "competent", "skilled", and "had no problems getting IV's in". Of
the 20 (66.67%) negative responses, 10 were related to difficulty inserting IV's. Twelve of the negative responses suggested that a variety of procedures was not performed correctly.

Degree to Which the Nurses Took Your Health Problems Seriously

The degree to which the nurses took your health problem seriously received 18 (2.26%) responses. There were 9 (50%) positive and 9 (50%) negative responses. Five comments indicated that the nurse showed concern. Seven of the nine negative comments indicated that there was difficulty convincing the nurse that respondents were truly suffering from a reported physical complaint, including 4 responses related to pain.

Nurses' Attitudes Toward Your Calling Them

The subsection on nurses' attitudes toward your calling them received only 5 (0.63%) responses, 1 which was positive and 4 which were negative. No patterns of response were able to be identified.

Nursing Other

Five hundred twenty-five (66.04%) remaining comments related to nursing, nurses, and nursing care were placed in a section labelled "nursing other" and categorized. Of these comments, 334
(63.62%) were positive and 186 (35.43%) were negative. It is interesting to note that of the 186 negative comments in this section, 94 (50.54%) are from respondents who were discharged from one nursing unit. Five negative comments were related to handwashing, all suggesting that handwashing by staff and opportunities for handwashing by patients was lacking. Twenty-two comments addressed comfort. Of these, 16 were positive and 6 were negative. Waiting long periods of time for pain medication was described by at least 5 respondents. Twenty comments addressed being kept informed, including 6 negative comments suggesting that not enough information or vague information was given.

Qualities of the nurse. Qualities of the nurse was addressed in nearly 250 (47.61%) comments. The most frequently observed positive descriptors include "helpful", "kind", "nice", "wonderful", "courteous", "cheerful", "friendly", "pleasant", and "great". Negative descriptors related to qualities of the nurse include 6 comments stating that the nurse was "rude", 2 comments stating that the nurse was "abrupt", and one comment stating that the nurse was "unfriendly".

Descriptions of the nurse. Other descriptors relating to the nurse were seen repeatedly. Positive descriptors include
"caring", "considerate", "understanding", "prompt", "sensitive", "patient", "supportive", "considerate", "concerned", "attentive", "thoughtful", "knowledgeable", "competent", "well-trained", and "professional". Many positive descriptors of nursing care were also found, including "great care", "good care", "very good care", "well taken care of", "excellent care", "went beyond that which was expected", "got the best care possible", and "first class care".

Several negative descriptors relating to the nurse and/or nursing care were also observed, including "insensitive", "lacked experience", "lacked knowledge", "bitched because the sheets were coming off", "borderline negligent", "wearing too much perfume", "didn't do things properly", "unconcerned", "short with me", "unprofessional", "problem with communication", "didn't check on me", "no one excited about getting up to help me", "appalled at what passes for care", and "care could be improved".

Efficiency of unit. Additional comments of interest include 16 comments indicating that the nursing unit was short of help, 2 comments that a nursing unit was run efficiently, 2 respondents requesting that the same nurse care for them each day, 1 respondent indicating that a nurse manager in the patient care area "never acknowledged anyone", and 1 respondent reporting
overhearing staff complaining about assignments and staffing patterns.

Attributes of Quality Nursing Care

The narrative comments have been analyzed according to the survey sections. The next step performed was content analysis of the 1378 comments according to the nine attributes of quality nursing care described by Taylor et al. (1991) which include: (a) holistic care; (b) nurse-patient interaction; (c) personal qualities; (d) caring; (e) proficiency; (f) professional character; (g) commitment to excellence; (h) effective organization and management; and (i) patient environment. The number of respondents addressing at least one attribute will be reported followed by presentation of specific findings in the order of Taylor's framework.

The number of respondents who submitted at least one comment related to the attribute categories was determined for each attribute. This was done in an effort to estimate the number of medical center customers who consider each attribute significant enough to warrant writing a narrative comment. Table 6 demonstrates the number of respondents (n=600) in the sample who submitted at least one comment related to the nine attribute categories.
### Table 6

**Number and Percentage of Respondents (n=600) for Attribute Categories**

<table>
<thead>
<tr>
<th>Attribute</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic Care</td>
<td>109</td>
<td>18.27</td>
</tr>
<tr>
<td>Nurse-Patient Interaction</td>
<td>176</td>
<td>29.33</td>
</tr>
<tr>
<td>Personal Qualities</td>
<td>189</td>
<td>31.50</td>
</tr>
<tr>
<td>Caring</td>
<td>33</td>
<td>5.50</td>
</tr>
<tr>
<td>Proficiency</td>
<td>55</td>
<td>9.17</td>
</tr>
<tr>
<td>Professional Character</td>
<td>40</td>
<td>6.70</td>
</tr>
<tr>
<td>Commitment to Excellence</td>
<td>122</td>
<td>20.33</td>
</tr>
<tr>
<td>Effective Organization/Management</td>
<td>29</td>
<td>4.83</td>
</tr>
<tr>
<td>Patient Environment</td>
<td>64</td>
<td>10.67</td>
</tr>
<tr>
<td>Attribute Other</td>
<td>63</td>
<td>10.50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>880</strong>*</td>
<td></td>
</tr>
</tbody>
</table>

*280 respondents addressed more than one attribute category.*

**Note:** # = number.
Two hundred eighty respondents (46.7%) in this sample addressed more than one attribute category in their narrative comments. A measurable percentage of respondents in this sample wrote narrative comments related to each of the nine attributes.

The total number of individual comments related to the attributes was 718 (52%). Some of the 718 comments addressed more than one attribute resulting in 1035 attribute categorization markings. The category of "attribute other" was developed to accommodate 67 nursing-related comments which were not found to be related to one of the nine attributes.

The sample which included 1035 attribute categorization markings provided numerous responses to each of the nine attributes of quality nursing care. Comments primarily addressed two types of attributes: nurse attributes (48%) and practice attributes (34%). Fewer comments addressed the third type of attributes: practice setting attributes (10%). The two attributes which received the greatest number of comments were nurse-patient interaction and personal qualities of the nurse. Table 7 summarizes the number of positive (# +), negative (# -), and neutral responses for each attribute of quality nursing care.
Table 7

Number and Percentage of Markings (n=1035) for Attributes

<table>
<thead>
<tr>
<th>Attribute</th>
<th>total # of markings</th>
<th>% of total</th>
<th># +</th>
<th>+ % by attribute</th>
<th># -</th>
<th>- % by attribute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic Care</td>
<td>122</td>
<td>11.79</td>
<td>63</td>
<td>51.64</td>
<td>57</td>
<td>46.72</td>
</tr>
<tr>
<td>Nurse-Patient Interaction</td>
<td>231</td>
<td>22.32</td>
<td>125</td>
<td>54.11</td>
<td>101</td>
<td>43.72</td>
</tr>
<tr>
<td>Personal Qualities</td>
<td>220</td>
<td>21.25</td>
<td>197</td>
<td>89.55</td>
<td>15</td>
<td>6.82</td>
</tr>
<tr>
<td>Caring</td>
<td>33</td>
<td>3.19</td>
<td>32</td>
<td>96.97</td>
<td>1</td>
<td>3.03</td>
</tr>
<tr>
<td>Proficiency</td>
<td>68</td>
<td>6.57</td>
<td>28</td>
<td>41.18</td>
<td>38</td>
<td>55.88</td>
</tr>
<tr>
<td>Professional Character</td>
<td>42</td>
<td>4.06</td>
<td>31</td>
<td>73.81</td>
<td>11</td>
<td>26.19</td>
</tr>
<tr>
<td>Commitment to Excellence</td>
<td>142</td>
<td>13.72</td>
<td>141</td>
<td>99.30</td>
<td>1</td>
<td>0.70</td>
</tr>
<tr>
<td>Effective Organization</td>
<td>33</td>
<td>3.19</td>
<td>7</td>
<td>21.21</td>
<td>25</td>
<td>75.76</td>
</tr>
<tr>
<td>Patient Environment</td>
<td>77</td>
<td>7.44</td>
<td>4</td>
<td>5.19</td>
<td>73</td>
<td>94.81</td>
</tr>
<tr>
<td>Attribute Other</td>
<td>67</td>
<td>6.47</td>
<td>55</td>
<td>82.09</td>
<td>7</td>
<td>10.4</td>
</tr>
<tr>
<td>Total</td>
<td>1035</td>
<td>100.00%</td>
<td>683</td>
<td>82.09</td>
<td>329</td>
<td></td>
</tr>
</tbody>
</table>

Note. # + = number positive. # - = number negative. Total number of markings column includes 23 neutral responses.
Practice Attributes

Practice attributes were identified in 34% of the comments. Both practice attributes are discussed below.

Holistic Care

One of the practice attributes is holistic care. The descriptors outlined by Taylor et al. (1991) which describe holistic care were used, and involve ideas related to total patient care, family involvement, and patient/family education. Included are statements such as: "took care of all needs", "do everything possible to make me comfortable", "attentive to all needs", "involve spouse in discussions regarding care", "answered all of my questions and my wife's questions", "kept family informed of what is going on", "kept family informed of my condition", "provided patient education classes as needed", "do patient and family teaching", "explain things", and "instruct patient regarding condition". Holistic care was described in nearly 12% of the comments; however, only about 50% of these comments were positive. Some negative responses include: "waited for medications", "not informed" and "vague information was given".
Nurse-Patient Interaction

Nurse-patient interaction, the second practice attribute, was described in more than 22% of the comments related to the attributes. Just over half (54.11%) of the comments were positive. The descriptors identified by Taylor et al. (1991) relate to patient-centered care, frequent contact with the nurse, and effective communication. According to Taylor et al., statements such as "made me feel like a person", "remembers that patient is a person and a family member", "pay attention to patient requests", and "gave patient special attention" describe patient-centered care. Several additional phrases related to patient-centered care were found, including: "sympathetic", "maintained privacy", "empathetic", "considerate", "took me seriously", "sensitivity", "accommodating", "concern", "respect", "felt important", "understanding", "patient", "thoughtful", "supportive", "sincerity", and "interest". Some negative responses related to the nurse-patient interaction include: "didn't seem concerned", "problems with communication", and "made me wait too long".

Frequent contact with the nurse was described by Taylor et al. (1991) in statements such as "be there when needed", "answered call light right away", "checked on patient frequently", and "just
pop in to see if everything is O.K." No additional descriptors were found which address frequent contact with the nurse.

Effective communication was described by Taylor et al. (1991) as "answering questions the best they can", "nurses could talk about anything", "responsive", "good listener", "communicated with others about care", and "kept track of all aspects of care". Additional phrases identified by this study related to effective communication included: "introduced themselves", "insured that everything went smoothly", and "welcomed me".

**Nurse Attributes**

Nurse attributes identified by Taylor et al. (1991) include personal qualities, caring, proficiency, professional character and commitment to excellence. These attributes were identified in more than 48% of comments related to the attributes of quality nursing care. Each nurse attribute is discussed below.

**Personal Qualities**

Personal qualities of the nurse were addressed in more than 21% of the comments, with nearly 90% of them being positive comments. Specific words used by Taylor et al. (1991) to reflect the attitude that the nurse brings to the nurse-patient interaction include: "nice, kind and friendly; flexibility;
efficiency; helpfulness; gentleness; courtesy; conscientious; and confidence". Other descriptors identified by this study which address personal qualities of the nurse included: "pleasant", "cheerful", "exceptional", "outstanding attitude", "wonderful", "super", "polite", "tops", "great", "terrific", "a gem", and "made me smile". Several negative descriptors relating to nurse-patient interaction were seen in the remaining 15 negative comments, including: "rude", "abrupt", and "rough".

Caring

Caring was described by Taylor et al. (1991) in these terms: "caring", "compassionate", and "nurses show they care". More than 3% of the comments related to the Taylor framework addressed caring. Nearly all (96.97%) of the comments related to caring were positive. An additional phrase found in this study which suggests caring was "loving care".

Proficiency

The third nurse attribute is proficiency. Taylor et al. (1991) described proficiency using these words and phrases: "knowledgeable"; "technically competent"; "qualified through education"; "know exactly what to do"; "competent"; "well-trained"; and "know what to do, how to do it, and when to do it".
More than 6% of the comments contained a statement related to proficiency. However, only 41.18% of the comments related to proficiency were positive. Other descriptors identified in this study related to proficiency include: "capable", "clumsy", "medications missed", "very skilled", and "lacked experience".

**Professional Character**

Professional character of the nurse as described by Taylor et al. (1991) includes comments such as "professional manner", "professional dress", "professional attitude", and "act like they enjoy what they're doing". Forty-two comments, which is more than 4%, addressed professional character of the nurse. Of these 42 comments, 73.81% were positive. Another descriptive phrase identified in this study related to professional character was "enthusiasm for work".

**Commitment to Excellence**

The final nurse attribute addressed by Taylor et al. (1991) is commitment to excellence. The following phrases were used by Taylor et al. to describe this commitment: "best possible care", "goes beyond what is expected", "doing what's best", "the best care the nurse can give", and "excellence in all areas". More than 13% of the comments related to the attributes of quality
nursing care suggested excellence. In addition to the above descriptors, the following words and phrases were identified in this study which suggest a commitment to excellence: "A-one", "A+", "first-class", "top notch care", "great care", "exceptional care", "fantastic", "#1", "superb", "outstanding", "perfect", and "extraordinary care".

Practice Setting Attributes

The third type of attributes described by Taylor et al. (1991) is practice setting attributes. Over 10% of comments received which address the Taylor et al. framework relate to practice setting attributes.

Effective Organization and Management

The first of these two attributes addresses effective organization and management. Taylor et al. (1991) described this attribute with phrases such as "enough nurses", "adequate staffing", "weekend staff same as during the week", and "same nurse to care for me for most of my stay". Just over 3% of the comments related to the attributes addressed effective organization and management using these phrases. Of these comments, 75.76% were negative, however. Most of the negative
comments indicated a perception that the nursing unit was "short-staffed" or "short of help".

**Patient Environment**

The second practice setting attribute described by Taylor et al. (1991) addresses patient environment. Phrases Taylor et al. used to describe this attribute include: "clean room", "clean bed", "clean bathroom", and "sensitivity to the need for less noise at night". Of the comments related to the attributes, more than 7% addressed the patient environment, 94.81% of which were negative. Some negative comments related to this attribute indicated that daily cleaning of rooms was inadequate and that the environment was "too noisy".

**Attribute Other**

Of the comments having some relationship to nursing, only 67 (6.4%) were found not to relate to the nine attribute categories. These 67 (6.47%) comments were placed in a separate category labelled "attribute other". Over 80% of these comments were positive. Of these comments, 4 (5.9%) simply thanked staff for the care received; 12 comments (17.9%) indicated that "very good" care was received; 11 (16.4%) stated that care was good; 10 comments (nearly 15%) indicated that respondents were "happy with
care", "pleased with care", or "well cared for"; and 11 comments (16.4%) indicated that nurses were "good" or "positive". The remaining comments in the category of "attribute other" addressed a variety of things involving nursing, some of which include: "care being better than it was during a prior hospitalization"; "being appalled by what passes for care"; "female patients should have only female nurses to care for them and male nurses should care only for male patients"; and an observation that "staff tried very hard to keep health costs at a minimum".

Comparison of Content Analyses

It can be seen from these analyses that comments from each of the survey sections except "admissions" were included in the analysis for the nine attributes of quality nursing care described by Taylor et al. (1991). This finding suggests that satisfaction with nursing care extends beyond those comments which appear to be directly related to nursing. Table 8 lists the number of comments from each of the survey sections found to be related to at least one attribute category.
Table 8
Number and Percentage of Comments from Survey Sections Related to Attributes

<table>
<thead>
<tr>
<th>Survey section</th>
<th># of comments related to attributes</th>
<th>% of section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Your Room</td>
<td>73</td>
<td>39.67</td>
</tr>
<tr>
<td>Diet and Meals</td>
<td>5</td>
<td>7.57</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>see below</td>
<td>-</td>
</tr>
<tr>
<td>Tests and Treatments</td>
<td>2</td>
<td>10.00</td>
</tr>
<tr>
<td>Overall Service/Courtesy</td>
<td>4</td>
<td>9.09</td>
</tr>
<tr>
<td>Visitors/Family</td>
<td>19</td>
<td>41.30</td>
</tr>
<tr>
<td>Your Physician</td>
<td>10</td>
<td>9.80</td>
</tr>
<tr>
<td>Discharge</td>
<td>5</td>
<td>33.33</td>
</tr>
<tr>
<td>Final Ratings</td>
<td>5</td>
<td>15.62</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>2.86</td>
</tr>
<tr>
<td>Total</td>
<td>131</td>
<td></td>
</tr>
</tbody>
</table>

Note. # = number.
Since the attribute analysis according to the framework of Taylor et al. (1991) focuses on satisfaction with nursing care in a more comprehensive fashion than does the analysis by medical center survey section, it is apparent that related services may contribute more to patient satisfaction with nursing care than was initially thought to be the case. Responses from the visitors/family section of the survey accounted for 41.30% of the non-nursing comments in the attribute analysis; 39.67% came from the section regarding your room; and 33.33% were related to discharge. The section of the survey on nursing care was considered for comparison to the attributes for quality nursing care. The number of comments in each survey subsection on nursing care which related exclusively to one of the nine categories used by Taylor (1991) was tabulated. This information is summarized in Table 9.
Table 9

Number and Percentage of Comments in Nursing Survey Subsections

Related Exclusively to One Attribute

<table>
<thead>
<tr>
<th>Survey subsections: Nursing</th>
<th># of comments</th>
<th>% of total comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendliness</td>
<td>5</td>
<td>0.85</td>
</tr>
<tr>
<td>Promptness/Call Light</td>
<td>23</td>
<td>3.92</td>
</tr>
<tr>
<td>Nurses' Attitude Toward You Calling Them</td>
<td>3</td>
<td>0.51</td>
</tr>
<tr>
<td>Degree to Which Nurses Took Your Health Problem Seriously</td>
<td>11</td>
<td>1.87</td>
</tr>
<tr>
<td>Amount of Attention Paid to Your Special or Personal Needs</td>
<td>63</td>
<td>10.73</td>
</tr>
<tr>
<td>Degree to Which Nurses Kept You Adequately Informed About Tests, Treatment and Equipment</td>
<td>18</td>
<td>3.07</td>
</tr>
<tr>
<td>Technical Skill of the Nurse</td>
<td>23</td>
<td>3.92</td>
</tr>
<tr>
<td>Nursing Other Only</td>
<td>441</td>
<td>75.13</td>
</tr>
<tr>
<td>Total</td>
<td>587</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Note. # = number.
Upon comparison of Table 9 to Table 5, it is apparent that of the 795 comments from the nursing section of the survey, 587 comments addressed 1 attribute category exclusively; 208 comments addressed more than one of the nine attribute categories. The comments which addressed more than one attribute category were counted in the "nursing other" section of Table 5.

The two content analyses for nursing-related comments were examined for comprehensiveness, similarities and differences. Both analyses indicated that the nurse or situations over which the nurse may exert some control are important determinants in patient satisfaction. This is validated with more than 50% of the comments received having some direct relationship to nursing.

Both analyses were extensive. Analysis according to survey sections provided a more comprehensive view of the institution but left many comments in the category labelled "nursing other" from which patterns of response were identified. The analysis according to the attributes for quality nursing care left a relatively small number of comments in the "attribute other" category but provided limited, if any, information about some of the institutional dimensions covered in the analysis by survey sections. Thus, the Taylor framework provided a much more comprehensive and less laborious means for analysis of nursing care than analysis by survey section. This is supported by the
observation that the attribute categories are mutually exclusive and that attribute categories accommodated most of the comments from the "nursing other" survey subsection. In addition, the results of the attribute analysis provided much more organized and useful data from a nursing theoretical viewpoint.

Both analyses yielded similar results in that the qualities of the nurse were outlined. The nurse-patient interaction was more easily identified using the attribute categories and descriptors. The content analysis by attributes provided more specificity for nursing when attempting to identify nursing actions which enhance patient satisfaction and quality of care. Thus, the analysis by attributes may provide better direction for nursing in using the results of this study.

Comparison of Findings to Empirical Data

The results of the content analyses were compared to three empirical data reports which were generated by the same survey from which these data were derived: overall hospital ratings, relative contribution of each survey section to overall patient satisfaction score, and ten survey questions which contribute most to the patient's overall evaluation. In reference to overall ratings (Appendix C), overall room rating and diet/meals rating have the lowest rating according to the empirical data. The
number of negative comments was significantly greater than the number of positive comments in both of these content analysis categories, thus offering qualitative support for the empirical evidence. The overall nursing rating was the highest section rating in the empirical data. Content analysis according to the survey sections supports this, yielding 795 comments related to nursing with 483 (60.75%) positive comments and 307 (38.61%) negative comments. Findings from the attribute analysis is consistent with these findings. The overall visitor/family rating is fairly high (87) in the empirical data report; however, content analysis for this survey revealed only 46 (2.90%) comments related to visitors/family. In the attribute analysis, however, further evidence consistent with the empirical finding is seen with 109 respondents commenting on the attribute of holistic care which includes family. The discharge rating empirically was also fairly high (86); however, content analysis found 1 positive and 14 negative comments related to discharge. This may be due to the fact that the empirical rating is based only on the speed of the discharge process and advice given about care after discharge.

Comments related to the survey sections on nursing and your room were greatest in number. These two sections contributed a great deal to the overall empirical patient satisfaction score as indicated by the empirical report which details the relative
contribution of each section to the overall score (Appendix D). Visitors/family received fewer comments but contributed relatively more to the overall empirical score; however, the attribute analysis indicated that 109 (18.27%) respondents addressed holistic care which includes family. One hundred two comments were received regarding physicians; this survey section contributed relatively less than nursing, your room, and visitors/family to the overall empirical score.

Another of the empirical data reports identified the 10 survey questions which contribute most to the patient’s overall evaluation (Appendix E). Of these 10 questions, all were addressed in the narrative comments by respondents. Overall cheerfulness of the hospital was commented upon by many respondents. Specifically, nursing attitude toward visitors was addressed favorably in 11 comments; likelihood of recommending the hospital was found to be positive in 25 comments and negative in only one comment; the degree to which nurses kept the respondent adequately informed about tests, treatments and equipment was addressed in 19 positive and 13 negative responses. Adequacy of information given to family received 16 comments, 10 of which were negative. The degree to which nurses took health problem seriously received 9 positive and 9 negative responses. Adequacy of advice for home care was addressed in 10 comments, all of which
indicated a need for more information about diagnosis, home care or expectations following discharge. The likelihood of recommending the medical center to others was found to be of high relative importance in the empirical report. Consistent with this, over 20% of respondents in this study commented on commitment to excellence in the attribute analysis.

The content analysis according to the survey sections facilitated comparison of qualitative data to empirical data. However, it is evident that the content analysis according to the Taylor et al. (1991) framework provided more specific information regarding nursing care delivery and the institution's commitment to excellence.

Summary

The findings of the study have been presented. Clearly, patient satisfaction for this sample was influenced by a wide variety of factors. Both content analyses provided valuable information related to patient satisfaction to supplement the empirical data analysis. These findings may be used to determine ways patients at the medical center could be cared for in order to more closely meet their expectations and increase patient satisfaction.
CHAPTER V
DISCUSSION AND RECOMMENDATIONS

In this section, findings of the study will be discussed. A discussion of overall findings related to patient satisfaction will be presented, including comparison of findings with the literature. This will be followed by discussion of findings specific to nursing as a profession, nursing at the medical center, nursing administration, nursing research and nursing education. Discussion of findings as they relate to implementation of the TQM philosophy at the medical center will be presented, followed by limitations of this study. This section will conclude with recommendations for further research and a summary statement.

Discussion of Findings

Traditionally, quality of care measures have most frequently been made using quantitative means. Until recently, studies on quality have focused on the structural and process aspect of care discussed by Donabedian (1988). Outcomes of care, in contrast, are being considered with greater intensity now than in the past. Patient satisfaction as one outcome of care is more frequently studied. This study demonstrated that much can be
learned about patient satisfaction as an outcome of care using a qualitative approach. A considerable number of customers at this medical center provided narrative feedback about this outcome when given the opportunity.

**Overall Findings**

The narrative comments analyzed in this study appeared to be sincere. Nearly 70% of the respondents included their signature with their comments which was optional. This aids in establishing the perceived significance of their comments.

No prior studies reviewed describe determinants of patient satisfaction in terms of positive versus negative responses. This study provides specific positive as well as negative comments related to content analysis categories. In addition to validating the important determinants or attributes of patient satisfaction at the medical center, this study gives examples of situations which are perceived to be negative by the customer. Areas for follow-up due to negative perceptions identified in this study include visitors/family (71.74% negative responses), discharge (93.33% negative responses), and multiple negative comments regarding nursing assistants. This information may provide staff and administration some direction in setting priorities for quality improvement activities.
Many respondents commented about their room. It has been demonstrated in the past that patient environment contributes significantly to patients' perceptions of quality and satisfaction (Vuori, 1987; Strasen, 1987; Abramowitz et al., 1987; and Taylor et al., 1991). In this study, the survey section "your room" received 11% of the total comments. It is significant that more than 80% of these comments were negative. The Taylor et al. attribute "patient environment" was commented upon by 10.67% of respondents with 7.44% of the overall attribute analysis comments related to this attribute. In addition, 94% of the comments related to "patient environment" were negative. These findings are consistent with the literature. However, the high degree of negativity in these comments warrants follow-up for factors contributing to this perception.

Significance of Study for Nursing

This study provides substantial information for consideration by nurses. The high frequency with which comments pertained to nursing care was anticipated based on findings of past patient satisfaction studies (Aucoin and Wegman, 1988; Abramowitz et al., 1987; and McBrien, 1986). Evidence of the importance to patients of the nurse-patient interaction and the interpersonal aspects of care was also identified. This is consistent with prior studies
on patient satisfaction (Donabedian, 1988; Risser, 1975; Bloch, 1975; Eriksen, 1987; Vuori, 1987; Cleary and McNeil, 1988; and Taylor et al., 1991) which identify the interpersonal and psychosocial aspects of care as major determinants of patient satisfaction with nursing care.

In this sample of patients, respondents addressed all survey sections and all attributes of quality nursing care established by Taylor et al. (1991). The attributes of quality nursing care most frequently described in this sample were holistic care, nurse-patient interaction, personal qualities of the nurse and commitment to excellence. These findings are consistent with the findings of Taylor et al. with the exception of the commitment to excellence attribute. In this study, comments containing numerous words and phrases suggesting excellence were placed in this category resulting in a higher percentage of respondents commenting on this attribute. In the Taylor et al. study, the methodology using phone interviews may have discouraged general descriptions related to excellence as seen in this sample.

Patients most frequently commented on the nurse attributes with slightly fewer comments on practice attributes. Practice setting attributes received considerably fewer comments. These
findings are consistent with the results of the Taylor et al. (1991) study.

Nursing as a Profession

The findings of this study reaffirm that nursing involves many aspects of patient care management. Nurses functioning as a friendly coordinator of care, teacher, technical expert, listener, and more is the expectation of the patients in this study. Caring and demonstration of a commitment to excellence are important factors in the profession's responsibility to the patients it serves.

Personal qualities of the nurse in both content analyses were a major factor in shaping the perception of satisfaction and quality of care. Nurses need to consider the powerful impact they have on patient satisfaction during every interaction with patients, their families and visitors. Therefore, active listening and actively discussing patients' perceptions of their care may allow the nurse to capitalize on opportunities to improve care and thus, increase patient satisfaction.

Nursing at the Medical Center

The three nursing units with the greatest number of respondents (N3, N4 and Y7) provided 46.5% of the respondents and
46.66% of the comments evaluated in this study. As stated earlier, over 50% of the negative comments in the category "nursing other" were reported by patients discharged from one of these units. The impact of these nursing units on overall patient satisfaction with care should be emphasized.

Both content analyses were consistent in identifying that positive comments outweighed negative comments related to nursing by a margin of approximately 2 to 1. This is consistent with the empirical data which revealed that the nursing section of the survey received the highest (89%) empirical rating of the ten survey sections (see Appendix C). However, the percentile rank of the nursing section when compared to similar hospitals indicates a margin for potential improvement of nursing care.

Regardless of which content analysis is examined, positive comments related to nursing outweighed negative comments. The challenge to nursing at the medical center is to seek methods to increase the potential for future patient situations to be perceived as positive. Several areas in which concentration should be focused are patient environment, taking patients' health problems seriously, and proficiency/technical skill.

Nurse-patient interactions provide the most frequent opportunity to increase patient satisfaction. The quality nurse-patient interactions was described in negative terms over 40% of
the time. Many comments suggested that some nurses need to be better listeners. It would seem that improved listening would allow nurses to better identify patient needs and, thus, could foster increased patient satisfaction. Through listening and actively seeking out the patient's perceptions about the quality of care being given, one may also have the opportunity to discover what their expectations for quality care are and make plans to either meet these expectations or seek additional resources to more fully meet their expectations if possible.

Nursing Administration

At the institutional level, the results may be reviewed by a variety of staff members and administrators to gain a more thorough understanding of patient's needs, perceptions and expectations. The findings of this study may be used to define consumer wants, needs, expectations and perceptions consistent with the TQM approach at the medical center. As a result, institutional standards regarding the structure, processes and outcomes of care may be considered for change. Dissemination of the information gained in this study to all involved employees and development of appropriate education to implement the changes indicated to achieve quality is essential.
Institutional and nursing administrators may choose to examine the orientation program and ongoing educational programs for employees. Incorporation of information from this study may serve to identify learning needs of employees in areas which patients have identified as important to them. For example, nurse administrators may involve staff in discussions on model units to identify the types of nursing activities which promote high quality care in a given group of patients. Sharing that information with other nursing units could improve the quality of care delivered, and thus, patient satisfaction as well.

Many comments specifically related to effective organization and management were negative. Inadequate staffing was addressed most frequently. This is an area where attempts can be made to alter the perception of patients by altering the behavior of the staff. Many strategies to maximize the function of human resources could be employed in this instance, including staff training on skills such as time management, organization of tasks, stress management, and delegation. In addition, administrators and managers staffing should review and revise resource allocation systematically to keep pace with changing patient care needs.

Nurse executives may be mindful of the results of this study and consider the impact they may have on the overall institutional vision and philosophy. It is the responsibility of administration
to assess performance at the institutional level. This performance review would not be complete without consideration of patient/customer satisfaction as an important aspect of the external environment. Review of the vision and philosophy for nursing departments and related services must also be examined and revised, if necessary, to remain consistent with the overall institutional vision and philosophy.

As this study and other authors (Aucoin and Wegman, 1988, and Meisenheimer, 1985) suggest, the manner in which direct care and service is delivered to patients has the greatest impact on their satisfaction with care. However, increased patient satisfaction depends upon the nurse executive giving direction in analysis and use of available data to effect change in direct care delivery. Changes in professional practices or the processes of care must occur before changes can be appreciated in the outcomes of care, including patient satisfaction.

Nursing Research

This study demonstrates the wealth of information that is available to better meet the needs of patients. It also demonstrates how a qualitative study can be used to more fully appreciate empirical data. Nursing can take a proactive role in shaping the future of health care by studies such as this which
are related to a major shift in management philosophy to TQM.
This study capitalizes on the opportunity to integrate the
principles of TQM into nursing and nursing literature.

Nursing education

Information gained from this study may also be useful to
nurse educators. Patient needs, expectations, and perceptions
presented from the perspective of actual patients may have a
significant impact in demonstrating the importance of inclusion of
patients in planning care to basic nursing students. In addition,
overall results may assist basic nursing students in appreciating
the importance of the interpersonal aspects and psychosocial
aspects of care to patients as well as technical skill performance
and proficiency.

Findings of this study may also be considered at higher
levels of nursing education. Nurses aspiring to become nurse
executives could gain a comprehensive understanding of patient
satisfaction and related topics through examination of findings of
this study. The value of qualitative studies in a research
environment which is primarily empirical may also be appreciated.
Significance of Study Related to TQM

The quality improvement program based on TQM principles may be influenced in a number of ways by the results of this study. Information gained through this study may assist quality experts in making recommendations or decisions about continuation or revision of current quantitative measurement of patient satisfaction and quality of care. It is possible to consider using qualitative data categories to develop or critique quantitative survey tools which may be used in the future to gather specific nursing data. Consideration may be given to conducting additional surveys on an intermittent basis which could focus on one or more of the attributes described by Taylor et al. (1991). Use of the descriptors and categories from this study to develop or revise quantitative tools may be considered. Disciplines and departments other than nursing, some of which may include social work, physicians, and marketing, may find this data useful in facilitating patient satisfaction and assessment of such. Other qualitative means for gathering information may also be improved through the use of the results of this study.

Actual use of consumer input into the quality improvement process may be accomplished through institutional use of this data. Consistent with the principles of TQM, staff need to see
that these findings are perceived as important to administrators. Administrators and managers must collaborate in using this information to improve the institutional processes and increase teamwork. Thus, the potential exists to sharpen the focus of quality improvement projects in various departments throughout the medical center. It is expected that these projects would serve as models for the institutional change.

Limitations of the Study

There were several limitations in this study. First of all, the questions to which narrative responses were given on the tool did not specifically ask about patient satisfaction or quality determinants. However, the intent of the survey as stated on the first page of the survey requests that respondents "tell us what we're doing right and what needs improvement" (Appendix A).

There was some risk of subjectivity in view of the fact that one researcher completed the data analysis independently. Morse (1991) suggests that when the primary investigator is the coder that the material be allowed to sit and be recoded. This was done in this study. In addition, two separate frameworks for content analysis of the same data were used.

The amount of tedious and costly work involved in content analysis may be considered by some to be a limitation. Though
many hours are needed to prepare the data for analysis and actually perform the content analysis, the insight gained in doing this type of study provides consumer feedback in an organized fashion for the organization and for nursing.

Coding categories were not mutually exclusive based on the predetermined medical center survey sections. This compels the reader to carefully consider narrative explanations of study results in addition to enumeration of recorded occurrences in each section. The categories outlined by Taylor are mutually exclusive; therefore, much less narrative explanation of category inclusions and exclusions was necessary. With data that is freely written by respondents, it was anticipated that it would not be possible to break down the individual comments into units of data which would be mutually exclusive in completing either of the two content analyses.

The data were collected using a single data collection instrument only once on single individuals. However, in this study, content analysis was used in conjunction with empirical data collection and analysis. Content analyses provided information regarding expectations and perceptions that could not be captured using empirical means. Additionally, the sample size provided a large volume of data for analysis.
While it is not possible to generalize the specific findings of this study beyond the institutional level, comparison of the overall findings with other studies related to patient satisfaction and the previous study by Taylor (1991) was possible. The methodology used in this study may be reviewed by future researchers to determine if institutional frameworks or the nursing-oriented framework offered by Taylor best meets their information needs.

**Recommendations for Further Study**

It is evident that there is much which can be learned from a qualitative study related to patient satisfaction with care. Quality of care issues as well as meeting consumer needs and expectations will continue to be an important aspect of healthcare. Additional qualitative studies on an intermittent basis may be helpful in determining the effects of institutional changes and to identify changes in expectations of the patient population being served. Similar studies in comparable institutions may be useful in performing organizational analyses and systematic program analyses.

Additional studies which describe specific nursing actions which foster each of the attributes of quality nursing care as outlined by Taylor (1991) would be helpful to improve overall
patient satisfaction with care. This would provide nurses with an additional quality improvement resource which could assist them in selection and implementation of nursing actions to promote quality. Descriptions of the specific actions related to the attributes of quality nursing care may also provide a guide for role delineation when caregivers with multiple skill levels work together to meet the needs of patients. Similar studies on patient satisfaction with nursing in settings other than an acute care hospital would be interesting as well to improve quality in other settings. Nurses functioning in expanded roles and diverse practice settings may be better served by setting-specific quality of care and patient satisfaction data.

Studies which describe integration of qualitative data into the database for institutional decision-making and the quality improvement process would be of interest as well. The degree to which this is accomplished would serve as one indication of the perceived value of the data.

Findings of this study specifically related to one or several nursing units could be investigated and compared with other outcome measures. For example, repeated comments related to lack of handwashing by staff and lack of opportunity for patients to wash their hands might be compared to incidence of infection on a given unit or units. Thus, the qualitative data may provide clues
about factors influencing patient complications, cost, and extended hospital stays.
Summary

The analysis of written comments from this sample of patients/customers reaffirms that the structure, process, and outcomes of care as discussed by Donabedian (1988) are factors in quality of care. These comments provide a crucial piece of the "real" picture that patients have of their experience with the health care system as many authors, including Deming (1982), Garvin (1987) and Mitchell (1987), have suggested. Members of healthcare institutions, especially nurses, must continue to bravethe challenge of providing high quality, patient-centered care. Health care administrators, nurse administrators, staff nurses and all other health care providers must maximize the resources of facilities, supplies, personnel and time to meet the stated needs, perceptions and expectations of customers we serve in the 1990s and beyond.
REFERENCES


Patient Survey

Iowa Methodist Medical Center is committed to constantly improving the care we provide to our patients. To do so, we must depend on you to keep us informed. Please assist us by telling us what we're doing right and what needs improvement. Thank you for completing this confidential survey.

INSTRUCTIONS: Please rate the following services you received while in our hospital. Circle the number that best represents your feeling. We welcome your comments on the attached page. When you have completed the survey, please mail it in the enclosed envelope. Thank you!

GENERAL QUESTIONS (fill in)
1. Number of days in hospital? ____________
2. Your age? ________
3. Your sex? □ Male □ Female
4. Your first stay here? □ Yes □ No
5. Admitted through Emergency Room? □ Yes □ No
6. Admitted through Outpatient Surgery? □ Yes □ No
7. On a special diet here? □ Yes □ No
8. Have a roommate? □ Yes □ No
9. Were you in a private room? □ Yes □ No

IF YOU HAD NO EXPERIENCE WITH A PARTICULAR ITEM, SKIP TO THE NEXT QUESTION.

A. ADMISSIONS
1. Speed of the admissions process ..................................... 1
2. Courtesy of admissions personnel ...................................... 1

B. YOUR ROOM
1. Cheerfulness ................................................................. 1
2. Daily cleaning ............................................................. 1
3. Room temperature ......................................................... 1
4. Noise level in and around room ........................................ 1
5. How well things worked (TV, call button, lights, bed, etc.) .... 1
6. Courtesy of the person who cleaned your room ................. 1
7. Helpfulness of the patient information guide .................... 1

C. DIET AND MEALS
1. Explanations given about your diet (if on a special diet) ....... 1
2. Temperature of the food (cold foods cold, hot foods hot) .... 1
3. Quality of the food ....................................................... 1
4. Likelihood of getting the food you checked on the menu .... 1

D. NURSING CARE
1. Friendliness of the nurses ................................................ 1
2. Promptness in responding to the call button .................... 1
3. Nurses' attitudes toward your calling them ...................... 1
4. Degree to which the nurses took your health problem seriously 1
5. Amount of attention paid to your special or personal needs . 1
6. Degree to which nurses kept you adequately informed about tests, treatment and equipment .... 1
7. Technical skill of the nurses .............................................. 1

This questionnaire contains a code which is used to identify the month you were here and the floor you were on. It will not identify you individually.
E. TESTS AND TREATMENTS

<table>
<thead>
<tr>
<th></th>
<th>VERY GOOD</th>
<th>POOR</th>
<th>FAIR</th>
<th>GOOD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How well your blood was taken</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2. Courtesy of the person who took your</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3. How well IVs were started</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4. Length of time you had to wait in the</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5. X-ray technician's concern for your</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>6. Adequacy of explanations of tests</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

F. PLEASE RATE THE OVERALL SERVICE AND COURTESY YOU RECEIVED FROM THE FOLLOWING (If Applicable):

<table>
<thead>
<tr>
<th></th>
<th>VERY GOOD</th>
<th>POOR</th>
<th>FAIR</th>
<th>GOOD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Social Services</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2. Physical Therapy</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3. Occupational Therapy</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4. Electrocardiogram (EKG)</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5. Respiratory Therapy</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<tr>
<td>6. Chaplains</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>7. Staff who transported you to and from</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>8. Volunteers</td>
<td>5</td>
<td>4</td>
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G. VISITORS AND FAMILY

<table>
<thead>
<tr>
<th></th>
<th>VERY GOOD</th>
<th>POOR</th>
<th>FAIR</th>
<th>GOOD</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. Courtesy of the people at the</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<tr>
<td>2. Adequacy of visiting hours</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3. Accommodations and comfort for</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4. Nurses' attitudes toward your visitors</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5. Information given your family about</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<tr>
<td>6. Visitors' rating of the hospital</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<tr>
<td>7. Visitors' rating of the convenience</td>
<td>5</td>
<td>4</td>
<td>3</td>
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H. YOUR PHYSICIAN

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<th></th>
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</thead>
<tbody>
<tr>
<td>1. Amount of time your physician spent</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2. Physician's concern for your</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3. How well your physician kept you</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4. How informative physician was in</td>
<td>5</td>
<td>4</td>
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I. DISCHARGE

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<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td>1. Speed of the discharge process, after</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<tr>
<td>2. Advice you were given about caring</td>
<td>5</td>
<td>4</td>
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J. SOME FINAL RATINGS

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</thead>
<tbody>
<tr>
<td>1. Overall cheerfulness of the hospital</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2. Staff concern for your privacy</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3. Staff sensitivity to the inconvenience</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4. Likelihood of your recommending this</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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</tbody>
</table>
Please comment below on any positive or negative experiences regarding the previous survey sections:

If you had any complaints/concerns during your hospital stay which were not resolved to your satisfaction, please explain:

Is there anything else you would like to say?

Name (Optional) ________________________________

If you would like to speak with us directly, please call the Guest Relations Office at 515-283-5000.

Please return your completed forms in the postage paid envelope provided.

Your time in completing this questionnaire is sincerely appreciated.
Iowa Methodist Medical Center
Overall Analysis By Questionnaire Section


<table>
<thead>
<tr>
<th></th>
<th>THIS PERIOD</th>
<th>LAST PERIOD</th>
<th>ALL HOSP</th>
<th>% TIE RANK</th>
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<td>N=2012</td>
<td>N=1974</td>
<td>N=255</td>
<td>N=255</td>
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<tr>
<td>Overall Hospital Rating</td>
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<td>85</td>
<td>85</td>
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<td>Overall Admissions Rating</td>
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<td>87</td>
<td>87</td>
<td>54</td>
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<tr>
<td>Overall Room/Accommodations Rating</td>
<td>80</td>
<td>80</td>
<td>80</td>
<td>43</td>
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<tr>
<td>Overall Diet and Meals Rating</td>
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<td>79</td>
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<td>Overall Nursing Rating</td>
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<td>88</td>
<td>58</td>
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<td>Overall Tests &amp; Treatments Rating</td>
<td>83</td>
<td>83</td>
<td>85</td>
<td>22</td>
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<tr>
<td>Overall Services Rating</td>
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<td>88</td>
<td>88</td>
<td>57</td>
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<tr>
<td>Overall Discharge Rating</td>
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<td>87</td>
<td>85</td>
<td>72</td>
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<tr>
<td>Overall Physician Rating</td>
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<td>84</td>
<td>86</td>
<td>19</td>
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<tr>
<td>Overall Visitors &amp; Family Rating</td>
<td>87</td>
<td>87</td>
<td>86</td>
<td>63</td>
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<tr>
<td>Overall Finals Rating</td>
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<td>86</td>
<td>87</td>
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Distribution of Responses

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<th>GOOD</th>
<th>VERY</th>
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<tbody>
<tr>
<td></td>
<td>4%</td>
<td>2%</td>
<td>8%</td>
<td>35%</td>
<td>55%</td>
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Overall Trend Analysis
RELATIVE CONTRIBUTION OF EACH SECTION TO OVERALL SCORE

<table>
<thead>
<tr>
<th>Section</th>
<th>Score</th>
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<tbody>
<tr>
<td>Finals</td>
<td>13.0%</td>
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<tr>
<td>Visitors &amp; Family</td>
<td>12.3%</td>
</tr>
<tr>
<td>Nursing</td>
<td>10.9%</td>
</tr>
<tr>
<td>Room/Accommodations</td>
<td>10.4%</td>
</tr>
<tr>
<td>Tests &amp; Treatments</td>
<td>10.4%</td>
</tr>
<tr>
<td>Services</td>
<td>10.1%</td>
</tr>
<tr>
<td>Discharge</td>
<td>9.1%</td>
</tr>
<tr>
<td>Diet and Meals</td>
<td>8.1%</td>
</tr>
<tr>
<td>Physician</td>
<td>7.9%</td>
</tr>
<tr>
<td>Admissions</td>
<td>7.8%</td>
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</table>
Iowa Methodist Medical Center
Ten Questions Which Contribute Most to Patient's Overall Evaluation


<table>
<thead>
<tr>
<th>Question</th>
<th>Relative Importance (Correlation)</th>
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<tbody>
<tr>
<td>Staff sensitivity to inconv.</td>
<td>0.78</td>
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<tr>
<td>Overall cheerfulness of hosp.</td>
<td>0.77</td>
</tr>
<tr>
<td>Staff concern for your privacy</td>
<td>0.76</td>
</tr>
<tr>
<td>Nursing attitude toward visitors</td>
<td>0.72</td>
</tr>
<tr>
<td>Likelihood of recommending hosp.</td>
<td>0.72</td>
</tr>
<tr>
<td>Courtesy of info. desk pers.</td>
<td>0.71</td>
</tr>
<tr>
<td>Nurses' informative re. tests</td>
<td>0.71</td>
</tr>
<tr>
<td>Adequacy of info given family</td>
<td>0.70</td>
</tr>
<tr>
<td>Nurses' took problem seriously</td>
<td>0.70</td>
</tr>
<tr>
<td>Adequacy of advice for home care</td>
<td>0.70</td>
</tr>
</tbody>
</table>

Range of Correlations for all questions (0.78 to 0.49)