

## A Guide to Hospital Outpatient Satisfaction Surveys. Practical Recommendations and the Satisfaction with Outpatient Services (SWOPS) Questionnaire

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**A GUIDE TO HOSPITAL OUTPATIENT  
SATISFACTION SURVEYS**  
Practical Recommendations and the Satisfaction with  
Outpatient Services (SWOPS) Questionnaire



*Research compiled by*  
Health Services Research Centre  
Department of Psychology  
Royal College of Surgeons in Ireland



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**the report and can be used and amended with appropriate references (see below) but without needing to seek permission from the authors.**

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# **A guide to hospital outpatient service satisfaction studies: practical advice and the Satisfaction with Outpatient Services (SWOPS) Questionnaire**

## **1 Introduction**

Irish health services have explicitly adopted a consumer-oriented approach to healthcare as set out in the health strategy '*Quality and fairness: a health service for you*' (Dept of Health and Children, 2001). This document and a later report identify the ideological and logistic challenges in promoting public and patient participation in healthcare (Delaney, Keegan and McGee, 2002). Both reports note that patient satisfaction surveys may be used as *one part* of an approach to including patients in the planning and delivery of healthcare. They can provide a broad picture of how patients and/or their families assess the quality of various aspects of their healthcare. Crow et al's (2002) review showed that the majority of patient satisfaction studies identified in the international literature used survey instruments specifically designed for the study in question. This is of concern with regard to establishing reliability and validity of instruments and, of course, in terms of achieving comparability across settings. In addition, most of the measurement approaches used were focused on one healthcare system (the American) and few focused on outpatient care. A number of Irish survey instruments have been designed to assess inpatient views of their hospital stay (McCarthy, et al 1998; Fallon, 2002). The current report builds on the development of the Irish Satisfaction With Outpatient Services (SWOPS) Questionnaire (McCarthy et al, 1998) by detailing approaches to the measurement of patient satisfaction in the outpatient setting. The report specifically focuses on the outpatient setting and outlines, in a step-by-step approach, areas to be considered before, during and after a patient satisfaction survey.

## **2 Features of the hospital outpatient services environment**

Outpatient or 'ambulatory' services in Ireland are usually consultant-led hospital outpatient clinics. Attendances at these clinics is monitored by the Department of Health and Children. The number of outpatients seen in acute hospitals is now approximately two million per annum. This has increased by 37% since 1980. Furthermore, hospital inpatient numbers have remained relatively stable while day

cases (excluding outpatient appointments) have also risen dramatically over the past twenty years (See Table 1, Acute Hospital Bed Capacity: a national review, 2002).

**Table 1: Number of hospital inpatient, day case and outpatient consultations in Ireland (1980 to 2000)**

<b>Year</b>	<b>Inpatient cases</b>	<b>Day appointments</b>	<b>Outpatient cases*</b>
<b>1980</b>	<b>543,698</b>	<b>8,377</b>	<b>1,460,198</b>
1981	562,633	8,796	1,452,060
1982	570,743	11,879	1,528,242
1983	565,658	18,387	NA
1984	560,969	20,486	1,552,508
1985	570,628	NA	1,574,489
1986	566,105	50,136	1,621,035
1987	512,004	85,167^	1,524,726
1988	491,474	107,352^	1,581,185
1989	507,048	119,131^	1,580,052
<b>1990</b>	<b>522,864</b>	<b>124,748^</b>	<b>1,675,529</b>
1991	520,571	142,394^	1,757,173
1992	511,586	155,326^	1,805,038
1993	522,662	187,101^	1,818,515
1994	522,803	193,018^	1,858,648
1995	529,393	207,308^	1,890,702
1996	537,557	233,908	1,901,292
1997	536,236	249,472	1,928,734
1998	537,841	270,240	1,963,504
1999	531,456	296,533	1,930,942
<b>2000</b>	<b>548,834</b>	<b>319,837</b>	<b>2,006,332</b>

\*Outpatient cases include new and return attendances

^The difference between these figures and those reported in the Annual Health Statistics Reports is that they have been adjusted for day care provided in district hospitals during those years

The implications of this changing pattern of health service use need to be considered in health services research. Appropriate assessments of the quality of day care and outpatient care from the patient's perspective are required.

The most recent breakdown of outpatient statistics available from the Department of Health and Children are for 1998. Patients are classified as 'new' or return patients. A new patient is defined as 'a patient who has not attended a clinic or the particular speciality in the year prior to this attendance'. The majority of patients (75%) are return patients with one quarter classified as new patients (Department of Health and

Children, Health Statistics Table H68B,  
<http://www.doh.ie/statistics/stats/sectionh.html>).

Outpatient appointments are generated through a number of referral routes – general practitioners, inpatient consultants, previous outpatient visits and Accident and Emergency Department referrals. The outpatient clinic is generally held in a separate part of the hospital. Non-attendance at outpatient appointments can be a particular problem with estimates recorded at between 10 and 30% of all appointments issued (Davies 1984; Cawley 1987; Jackson 1997; Potamitis et al 1994).

There has been a major expansion in the use of patient satisfaction surveys internationally and in Ireland. The goal of ensuring that the patient is at the centre in the delivery of healthcare is outlined in the most recent Irish Health Strategy (Department of Health and Children, 2001). One of the mechanisms to achieve this goal is the introduction of ‘a national standardised approach to measurement of patient satisfaction’. The Irish Society for Quality and Safety in Healthcare (previously Irish Society for Quality in Healthcare) have undertaken a programme of hospital inpatient satisfaction surveys since 1998. Similar patterns are evident in the United Kingdom where the Commission for Health Improvement in the NHS has sanctioned a rolling programme of patient satisfaction surveys.

Much of the activity in patient satisfaction research has focused on the experience of inpatient care. As already outlined, outpatient services account for many more patient-professional encounters than other services (e.g., approximately four times that of inpatient cases). Thus there is a need to develop systems and instruments to measure patient views of this area. In the UK, outpatient and emergency services in acute trusts were surveyed during 2003 ([http://www.nhssurveys.org/docs/programme\\_2002-3.pdf](http://www.nhssurveys.org/docs/programme_2002-3.pdf)). In Ireland, postal and telephone versions of questionnaires have been developed to evaluate outpatient attender and non-attender views of outpatient services (McCarthy et al, 1999; McCarthy et al 2000, Doyle et al 2002).

### 3 Patient satisfaction: general overview

Patient satisfaction has been variously defined as '*an individual's positive evaluations of distinct dimensions of health care*' (Linder-Pelz, 1982) and as '*an evaluation by the patient of a received service where the evaluation contains both cognitive and emotional reactions*' (Fitzpatrick, 1997).

The research literature focusing on patient satisfaction is diverse. As Hall and Dornan (1988) noted in their review of the satisfaction literature, the aspects of the medical setting chosen for study vary such that some areas (e.g., humaneness of health professionals, information about health care) are studied extensively and others (e.g. outcomes) are assessed to a much lesser degree. Satisfaction is a multi-factorial construct - patients experience different facets and dimensions of a health service episode and they make multiple evaluations about the process of care as well as the outcome. The dimensions identified in the review were:

- Access
- Overall quality
- Competence
- Bureaucracy
- Attention to psychosocial problems
- Outcome of care
- Cost
- Humaneness
- Information supplied
- Physical facilities
- Continuity of care

A meta-analysis (i.e. a statistical analysis combining a number of satisfaction studies) showed some aspects of healthcare were consistently rated as more satisfactory than others (Hall and Doran, 1988). Scores in the analysis ranged from 0 to 1 where 1 represented the maximum satisfaction rating. There were generally high quotients for humaneness (.66), competence (.63) and outcome (.60) but a lack of satisfaction with informativeness (.42), cost (.28), bureaucracy (.24) and attention to psycho-social problems (.15).

Surprisingly, little had changed by 2002 when Crow et al. conducted their systematic review of the measurement of patient satisfaction. These authors noted a diversity of approaches to measurement and showed that a range of dimensions of the healthcare

situation were being assessed. Their review also showed that interpersonal aspects of care and patient-practitioner relationships were the major determinants for overall satisfaction.

An overarching debate in the patient satisfaction literature is the extent to which satisfaction is a subjective state (i.e. mainly influenced by the patient, his/her experiences, life outlook, personality) or a reflection of objective features of the healthcare process and its outcomes. Ware (1983) made the distinction between *reporting* on an aspect of hospital care (objective) and *rating* an aspect of hospital care (subjective). For instance, the length of time spent waiting for a service can be objectively recorded and is *reported* in hours and/or minutes, while the evaluation of whether this is too long to wait is a subjective evaluation or *a rating* of an aspect of care. The World Health Organisation (2000) observed that the responsiveness of a health system is influenced by features of the system (waiting time, attitude of professionals) as well as by features of the individual patients (expectations). In general, a highly consistent relationship has been established between the objective features of a service as reported by patients and levels of satisfaction. In other words, patients are seen as fair and just in their assessments. Observable features such as shorter waiting times, availability of information and successful treatment outcomes relate to higher satisfaction and vice versa.

Just as there are many definitions of patient satisfaction, there is also a range of approaches to measuring it. Ideally, patient satisfaction should comprise a global statement of satisfaction with overall healthcare which is supplemented with separate assessments of individual dimensions of satisfaction.

Among the reasons for assessing patient satisfaction are an increasing emphasis on consulting patients in the planning of healthcare delivery and an organisational environment for health services which focuses on audit and accountability. In addition, patient satisfaction has been shown to relate to a person's health behaviour – for example satisfied patients are more likely to adhere to treatment recommendations and physician advice (Hall, Roter & Katz, 1988).

#### **4 The context of patient satisfaction surveys**

The decision to undertake a patient satisfaction survey may have its origins in a number of diverse sources – internal departmental audit, hospital-wide audit or external review by a commissioning authority or accreditation body. A hospital, like any organisation, is an interdependent or ‘organic’ system and as such careful attention should be paid to the implications of the process and outcomes of a patient satisfaction survey for staff, for management and most particularly for patients. Among the issues to consider are the legislative environment (freedom of information, data protection) and organisational structures and processes. These are outlined next.

##### ***Legislative environment***

The uses to which information will be put need to be clearly stated to all those involved in the survey, from hospital personnel granting permission for such activities through to patients being asked to participate. The implications of freedom of information and data protection legislation may need to be clarified in order to assure that confidentiality will be maintained and that identifying information is recorded or stored only in accordance with good practice. The Irish Freedom of Information Act (1997) confers certain rights on individuals with respect to information held, as follows:

- a legal right of an individual to access information held about them
- a legal right of an individual to have official information relating to them amended where it is incomplete, incorrect or misleading
- a legal right of an individual to see reasons for decisions affecting them.

In practice, the Act refers to information which is held about identifiable individuals. Consequently, the ways in which confidentiality and anonymity are preserved in patient satisfaction studies merit specific attention (for example, data should be stored anonymously and only group information should be reported). A guide to the Act is available from the Office of the Information Commissioner (<http://www.oic.gov.ie/guide.htm>).

The Data Protection Act (1988 and 2003) refers to personal information held in a form which can be 'processed', i.e. computerised. Personal data is information which is capable of being processed automatically and which relates to a living individual who is identifiable from that information or from other information held by the organisation. (Murray and Kelleher, <http://www.ictlaw.com/dp.htm>). The objective of the Act is to ensure personal privacy. Once again the manner in which information is both collected and stored is crucial as the Act refers only to identifiable information. A 1996 article outlining the scope of the Act may be obtained at the following website: <http://elj.warwick.ac.uk/jilt/dp/1eire/default.htm> Finally, there is a data protection commissioner for Ireland and further information can be accessed at the commissioner's website - <http://www.dataprivacy.ie/index.htm>.

### ***Organisational structures and communication processes***

Some hospitals require research ethics committee approval for patient satisfaction studies, although in practice this is more likely to be the case when external bodies are conducting the surveys. Other hospitals classify patient satisfaction studies as 'audit' and hence do not require research ethics committee approval. There is currently no national consensus about obtaining ethical approval for these types of studies.

The purpose of a patient satisfaction survey should be clearly delineated and communicated across the hospital. Staff may have concerns regarding motives for and possible uses of findings – e.g. that results may be considered in isolation from key contextual factors such as staff or facility shortages. Satisfaction research needs to incorporate consultation with key stakeholders (e.g. staff) to clarify what is being done, why it is being done and what will happen following the study. In planning the study, staff should have access to the survey forms which will be used in the survey and should be encouraged to comment. This process allows staff to provide feedback on topic coverage in the questionnaire. Patient satisfaction questionnaires often need to be amended to include assessment of 'local' conditions at a particular location – this may be to assess areas which are expected to function either particularly well or particularly badly. Staff participation at this point can be important in reducing their

(staff) anxieties about ‘being evaluated’ and in creating an interest in, and sense of ownership of, the findings of the survey.

Information sheets about patient satisfaction surveys should be developed for each of the staff groups. Information need to be short and written in a clearly understood style. Other aspects of the content of information sheets are outlined in Box 1 below.

As a general rule, questionnaires should be designed to be completed anonymously (i.e. without patient name, patient number or other identifier) unless a name or identifier is specifically needed, e.g. where a follow-up survey is planned or a link to hospital outcomes. Follow-up studies need some way of connecting the responses of the same patients at two time points. However, these are not usual in patient satisfaction studies.

**Box 1: Points to include in a satisfaction survey information sheet to patients and other stakeholders**

- *purpose of the study*
- *who is conducting the study* (i.e. health board, hospital, university)
- *uses to which information will be put*
- *how the person was selected to be surveyed* (e.g. are all patients being surveyed?)
- *voluntary and confidential* (or anonymous) nature of the study and the fact that participating (or not) will have no impact on their healthcare
- *methods of maintaining confidentiality*
- *what participation will involve* (amount of time, type of questions)
- *name of a responsible contact person who can provide more information.*
- *choice to discontinue involvement in the study at any time even if individual decides to take part at the outset*

**5 Choice of a survey instrument**

There are a wide range of patient satisfaction questionnaires of varying sizes, detail and focus. A review of the measures of patient satisfaction currently available and

their theoretical and empirical properties was published by the NHS Health Technology Assessment Group (Crow et al, 2002). The following are important criteria for choosing a patient satisfaction survey instrument – whether it is a generic or specific measure, question focus and its psychometric properties (Bisset and Chesson, 2000; McColl et al 2001).

### ***Generic or specific measures***

Satisfaction or dissatisfaction can be expressed by rating a number of specific aspects of healthcare or by rating in a generic or global sense satisfaction with the overall health services encounter. If generic measures of satisfaction are to be useful, there needs to be a clear understanding of which specific aspects of a service influence that rating. For example, it is of little practical value to know that the majority of patients are satisfied in an overall sense with their outpatient experience - this finding maintains a *status quo* and gives no indication of priorities for change/improvement. However, an overall satisfaction score supplemented by information on more specific aspects of a service, e.g. staff explanations of treatments, or the hospital waiting area, provides service evaluators with much more useful feedback (Williams and Calnan, 1991).

### ***Question focus***

Questions may focus on different aspects of the outpatient experience. Furthermore, they may ask patients about their *actual* experience (e.g. Did the doctor give you written information on the test? How long did you wait to see a doctor?) or about their *evaluation* of events (e.g. How satisfied were you with the information you received about tests? How would you rate the time you had to wait at the clinic appointment?). Objective questions are useful to establish the patient's experience of the visit to the outpatient department relative to established standards – for example time spent in waiting area or seeing the same doctor as on previous visits. Evaluation questions allow for a measure of the impact of aspects of services on the patient. In answering these questions, patients respond relative to their own expectations and standards.

This is an important distinction to make from the quality point of view as how a question is asked reflects whether the focus is on aspects of the service (waiting time,

treatments) or on aspects of the patient (expectations, values). The logical way to decide which question is important is to consider which will be the focus of an intervention – the service or the person/ patient (Cartwright et al 1973; Addington-Hall et al 1995; Bruster et al 1994; Cleary et al 1992).

A further categorisation for describing survey questions was defined by Dillman (1978). He identified the following types of information which may be collected through survey processes:

*Attributes* – characteristics/ demographic characteristics of the respondent

*Behaviour/ events* – behaviours (e.g. does clinician ask questions during consultation, does respondent drive to the outpatient appointment) and events (e.g. appointment allocation, test procedure)

*Beliefs/ knowledge* – respondents' information and views about aspects of experience (e.g. beliefs and knowledge about their own illness; beliefs about appropriate healthcare provision)

*Attitudes/opinions* – respondents' value judgements, appraisals of their experiences as good or bad.

Particular attention should be paid to the wording of questions in surveys administered as either interviews or self-completion questionnaires. Short, clear questions are best. Questions should not use more than one reference point – so for example the question ‘Did you have a quiet and relaxing place to wait?’ – “Yes or No”, asks the respondent to focus on two aspects of experience – was it quiet? *and* was it relaxing? The response categories of ‘yes’ and ‘no’ however assumed a single question.

Some guidelines for designing question formats for questionnaires or interviews are illustrated in Box 2.

## Box 2: Pointers for designing question formats

### *Questions for either a self-completion or interview based survey should AVOID:*

- Multiple foci (e.g. were you satisfied with the nursing and technical staff?)
- Jargon (e.g. MRI, GUM)
- Complicated/ exaggerated response categories (e.g. 'extremely delighted' or numerous choices of response)
- Excessive length

### *Questions SHOULD be:*

- Clearly numbered or sequenced
- Arranged in chronological order – e.g. receiving outpatient appointment, arrival at clinic, consultation, follow-up
- Logical and capable of being understood by patients
- As short as possible

### *Psychometric properties*

Measures of patient satisfaction (whether interview based or self-completion) should adhere to basic principles of psychometric measurement (Roberts 1999, Sitzia 1999). Sitzia (1999) analysed 195 studies of patient satisfaction and concluded that authors demonstrated a poor understanding of the importance of core measurement properties required if a measure is to measure satisfaction with confidence. The following characteristics should be demonstrated:

**Validity:** the measure should be a 'true' measure of patient satisfaction and not, for example, be a measure of general life satisfaction. To be valid the measure should have :

*Construct validity* – it should correlate with other measures of patient satisfaction, and with other correlates of patient satisfaction (e.g. age)

*Divergent validity* – the measure should be distinguished from measures or features which are not associated with high levels of patient satisfaction

*Face validity* - it should be clear to the patient that what is being asked about is their experience of the service.

**Reliability:** the measure should be reliable in a number of ways. It should be consistent, such that given similar experiences patients would return similar ratings on the scales (*test-retest reliability*). Secondly, the questions should form discrete groupings or dimensions (e.g. relating to interpersonal attitude, physical environment). While the questions may ostensibly seem to group together this needs to be tested and demonstrated – for example by showing the correlation between the questions. Cronbach’s co-efficient statistic yields a *consistency* indicator (the alpha co-efficient) with ranges between 0 and 1. This indicates the average correlation of items on a particular dimension. To be reliable a dimension or scale should have a high coefficient, preferably above 0.7. A reliable set of items or questions may be used independently of the total questionnaire to assess satisfaction relative to only one dimension of healthcare.

*Example of an outpatient satisfaction questionnaire: Satisfaction with Outpatient Services (SWOPS) Questionnaire*

A multi-dimensional outpatient instrument – the Satisfaction with Outpatient Services (SWOPS) Questionnaire has been developed for use in Irish hospitals by the Health Services Research Centre at the Department of Psychology, Royal College of Surgeons in Ireland (RCSI). These questionnaires have been developed in both self-completion and telephone administration forms<sup>1</sup>. Appendix One summarises the content of the questionnaires, the dimensions of satisfaction tested and the reliability scores (alpha co-efficients for each). An acceptable alpha co-efficient is over 0.7. This means that the satisfaction dimension has relevant questions focused clearly on one aspect of satisfaction. Alpha co-efficient scores for this instrument, based on outpatient clinic data from a large sample (N=364) based at two adult general hospitals (McCarthy and McGee, 1999), are very high (see table 2) – all above .88 and averaging .89 over the five subscales. The generic items make up an overall dimension with an alpha co-efficient of .84. The high reliability co-efficient of each

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<sup>1</sup> Electronic versions of the questionnaires are available from the Health Services Research Centre, RCSI by contacting the secretary at Dept of Psychology psychology@rcsi.ie.

of these dimensions means that dimension's questions can be used as discrete subscales outside of the context of the total questionnaire. For example, if the scope of interest for a study was confined to the registration process, it is legitimate to use only the registration process questions.

**Table 2: Subscales, number of items and alpha co-efficients for the SWOPS (Satisfaction with Outpatient Services) questionnaire**

<b>Dimension title</b>	<b>No. of items</b>	<b>Alpha Score*</b>
Registration process	6	.84
Nursing care	6	.92
Physician care	12	.95
Information	3	.88
Testing services	6	.88
Overall satisfaction	4	.84

\*Psychometric properties based on N=364

The questionnaire is organised chronologically to reflect patient encounters with the outpatient department – from receiving an appointment to post-visit follow-up from the clinic. The questionnaire uses both objective and subjective questions and collects verifiable objective data as well as rating or opinion data.

Telephone administration of the survey allows for the collection of more in-depth qualitative data or comment than the postal and self-completion version.

## **6 Choice of method of administration of survey**

A recent review of administering questionnaires/ surveys found more or less equivalent responses for self-completion questionnaires and those administered by interviewers face-to-face or by telephone (McColl, et al 2002). However, telephone and face-to-face interviews had higher response rates than self-completion questionnaires. No reliable evidence could be found to imply that social desirability (i.e. participants responding in a manner they feel is expected or socially acceptable), answers on sensitive topics, or the quality (e.g. legibility) of responses were affected by the mode of administration of questionnaires. A summary of the advantages and disadvantages of the three modes of questionnaire administration examined is illustrated in table 3.

**Table 3: Summary of advantages and disadvantages of various modes of survey administration – (McColl, et al, 2001)**

	<b>Face-to-face interviews</b>	<b>Telephone interviews</b>	<b>Postal questionnaires</b>
<b>Response rates:</b> General populations Special populations	Usually best Usually good	Usually lower than face-to-face Satisfactory to best	Poor to good Satisfactory to good
<b>Representative samples:</b> Avoidance of refusal bias  Control over who completes questionnaire Gaining access to a named selected person	Requires good interview technique Good Good	Requires good interview technique  Moderate Good for those with telephone	Poor  Poor to good Poor to good
<b>Ability to handle:</b> Long questionnaires  Complex questions  Boring questions Item non-response Filter questions  Question sequence control Open-ended questions	Good Good Good Good Good Good	Moderate Moderate Moderate Good Good Good Good Good	Satisfactory to poor Moderate to poor poor Moderate Moderate to poor Poor Poor
<b>Quality of answers:</b> Minimise social desirability responses	Poor	Moderate	Satisfactory
<b>Avoid distortion due to:</b> Interviewer characteristics Interviewer opinions Influence of other people Allows opportunity to consult	Poor Moderate Moderate Moderate	Moderate Moderate Good Poor	Good Good Poor Good
<b>Implementing the survey</b> Ease of finding suitable staff Speed Cost	Poor Poor Poor	Moderate Good Moderate	Good Poor Good

## 7 Planning

A review of survey methods focusing on the implications of aspects such as question wording, question sequencing, the administration of the survey instrument and response rates concluded that a contingency approach is the most important aspect of survey design in the health services (McCull et al, 2002). In other words, no one approach has been established as universally most effective. The authors recommend consideration of the particular circumstances and a focus key questions (See Box 3):

### Box 3: Key questions when planning a survey

***Study population*** - Who is being surveyed?

***Where?***

***When?***

***Survey topic*** - What information needs to be collected?

***Volume of data*** - In what detail?

***What is the desired accuracy if factual observations are being collected?*** are estimates acceptable?)

***What level of accuracy is reasonably attainable?***

***Resources available*** - What resources (time, money, personnel, skills) are available?

## 8 Sampling strategy

Sampling strategy addresses the first three questions listed in the previous box – namely who is being surveyed, where and when. For outpatient satisfaction surveys, a number of patient groups are likely to be of interest, and different procedures may be required for each:

- **New patients:** Those who have attended a recent appointment and are attending the clinic for the first time in a twelve-month period. New patients are currently likely to account for about 25% of appointments in Irish outpatient settings although there will be local variations.
- **Return patients:** Those who have attended a recent appointment and have attended the clinic more than once during the preceding twelve month

period. Return patients typically account for about 75% of patients in the Irish system at present.

- Non-attenders: Those who were scheduled to attend an outpatient appointment but who did not attend at the scheduled time (termed 'did not attend' or 'DNA').

Depending on the number of patients and on the resources available to the survey, all patients may be invited to participate or a sample of all patients may be chosen as representative.

The requirements of sub-groups of the population or those deemed to be 'vulnerable' should be taken into account during the planning stages of a satisfaction study. For example, How will children's views be incorporated? What about patients who are seriously or terminally ill? Or patients using psychiatric services? If these groups of patients are to be included survey forms and materials may need to be adapted. Another option is that of 'proxy' respondents. An example is a survey of hospital services for those who have died in the past year, – Keegan et al (1999) interviewed next of kin of 155 patients who died in the care of a large adult general hospital in the 7 to 18 month period following the death. Some evidence shows that family members' can provide useful proxy and retrospective ratings for service related issues (Higginson, Priest and McCarthy, 1994).

It is important to balance potential disruption or distress with the need to have some information on how these groups experience services. It may be justifiable and indeed appropriate to exclude a small group of 'vulnerable' patients in a large survey of outpatient clinic attenders in a general hospital. However, wide scale exclusion of certain services should not be avoided if a system-wide approach to satisfaction evaluation is being considered.

### ***Random sampling***

Where all patients are not included. studies should employ a random sample of patients attending a clinic in order to ensure 'representativeness', e.g., that the correct proportions of new and return, male and female patients are sampled. Checking the sample characteristics against the profile of *all* patients at a clinic is a way of

validating the sampling process. This may not always be possible. Those inexperienced in conducting surveys should obtain statistical advice to determine sample sizes necessary before embarking on a survey. Samples which are too small mainly risk underestimating differences across services or aspects of services. On the other hand, samples which are unnecessarily large take up staff and patient time and effort and are equally to be avoided. The 'population' may be those patients scheduled to attend a clinic during a specified period of time. For example McCarthy et al (2000) sampled patients across two hospitals in 30 outpatient clinics who had been scheduled to attend during a one-week period. A sub-set of clinics may be targeted. The purpose of the survey, and the uses to which results will be put, should shape the decision about which clinics to sample and over what length of time. For example, a study may review the general outpatient experience across all clinics in a hospital, or may focus on the outpatient experience in one speciality (e.g. paediatric surgery).

## **9 Timing of survey and completion of interview or questionnaire**

For outpatient surveys a number of factors will influence the decision about when the survey should be conducted. For example, patients should be able to remember clearly the hospital appointment to which the questionnaire refers. Ideally other outpatient appointments should not have occurred in the meantime. Consequently, not too much time should elapse between the appointment of interest and the collection of patient information.

Data may be collected during the actual clinic (e.g. in the waiting room or after consultation). The main advantage to this approach is the chance to obtain a high response rate. There are however, disadvantages to collecting data at the time of attending the clinic. Patients may complete the survey at a point in time when they are unable to comment on the whole process (e.g. while waiting to be seen by health professionals as they have not been treated). Some patients may feel that their confidentiality is compromised by responding to questions in the clinic setting. Furthermore, patients may be anxious, worried or rushed at the time of appointment and therefore be unwilling or unable to participate. Patients, for instance, are sometimes concerned that they will miss their turn in the queue if they become engaged in a research study.

The optimum timing for patient satisfaction surveys has not yet been determined. Crow et al (2003) identify the need for further methodological research aimed at examining 'the effect of timing of surveys on people's evaluations of their healthcare'. Of importance here are issues of recall and the influence that clinical and health-related quality of life outcomes may have on perceptions.

## **10 Response rates**

Survey data need to reflect the attitudes of the overall population of patients. Consequently a high response rate from those invited is required if participants are to reflect the overall patient profile – e.g. in terms of sex, age, and service used. Concern has been expressed that conclusions drawn from surveys with low response rates (e.g. 30% response) may be qualitatively different to those from a larger group of patients (Carr-Hill, 1992). Barkley and Furse (1996) have highlighted the issue and proposed that in order to make policy decisions based on patient views, response rates of at least 50% are needed. No significant demographic or satisfaction differences have been found between patients who responded to a questionnaire and non-responders who were subsequently followed-up by telephone (Lasek, 1997). Overall, attempts to achieve a high response rate should be a priority for planning any patient satisfaction survey (Crow et al, 2002). A smaller sample size with a higher response rate (e.g. 75% of 200=150) is more valid for planning purposes than a larger sample with a poorer response rate (e.g. 40% of 1000=400).

Various response rate maximisation strategies have been used. Meredith and Wood (1995) found that when staff personally handed questionnaires to patients and requested them to mail back the completed version, response rates were higher (89%) than through a mailed version of the same questionnaire (78%). However, the additional workload for staff means it may not be a viable option in many surveys. In an effort to maximise inclusiveness and to take account of variable literacy rates, Harris et al (1997) tested two methods of questionnaire administration - telephone versus postal survey. The former had a response rate of 73% compared to 50% by mail. It is important to note however that the current telephone number of patients was specifically obtained by a research assistant before each patient's discharge from

hospital. In that study, telephone administration of the satisfaction questionnaire both increased the response rate and reduced costs over a mailed administration.

Resources and effort are required to expand follow-up of non-responders. In Ireland, McCarthy and McGee (1999) increased response rates by 18% through a three-phase follow-up procedure (ask patients before discharge if they were willing to be contacted by post after discharge; send one postal reminder 2-3 weeks after the first postal survey; and make follow-up phone calls to those who had not replied to postal questionnaires. Interestingly, in this instance at least, the demographic profiles and overall satisfaction scores were similar for initial responders and late responders.

## **11 Managing patient satisfaction data**

Once patient satisfaction data has been collected, it needs to be collated and analysed into group data. Where large numbers of patients have been consulted it is usual to enter the data to a computerised database. A number of specialised statistical databases exist, for example the Statistical Package for the Social Sciences (SPSS). Mainstream packages such as Microsoft Excel may also be used however to obtain descriptive statistics such as percentages. The advantages of the latter approach include the fact that computer support and advice is more often available for these widely used computer tools.

## **12 Reporting patient satisfaction survey data**

The information obtained through the data collection phase should be prepared in an anonymised report. Data should be presented in concise and clear language. Tables and graphics should be used appropriately, e.g. to summarise demographic data or to highlight contrasts or comparisons. The report should include explicit reference to the factors detailed in Box 4.

Patient satisfaction surveys are generally conducted in the context of quality initiatives. The main implication of this is that the emphasis is on description of the findings, acknowledgement of those aspects which are rated well and identification of the areas requiring most improvement. Survey findings should be communicated clearly to staff. Firstly, it is very important that clear acknowledgement be given to what is seen to work well from the patients' perspectives. The identification of less

positive aspects of services is the first diagnostic step in a change process and allows targets for improvement to be identified.

**Box 4: Items to consider when reporting patient satisfaction surveys**

**Background to survey** (Reason survey was conducted, Who conducted survey, When was survey conducted)

**Details of measurement instrument used** (Was existing questionnaire adapted? Was new questionnaire developed? Describe the process. Is validity and reliability information available for the measure?)

**Details of clinic and patient population** (Describe outpatient clinic(s), patient profiles, proportions of new and return patients, proportions of non-attenders)

**Description of sampling method** (Were all patients /all clinics selected? If not how were participants selected?)

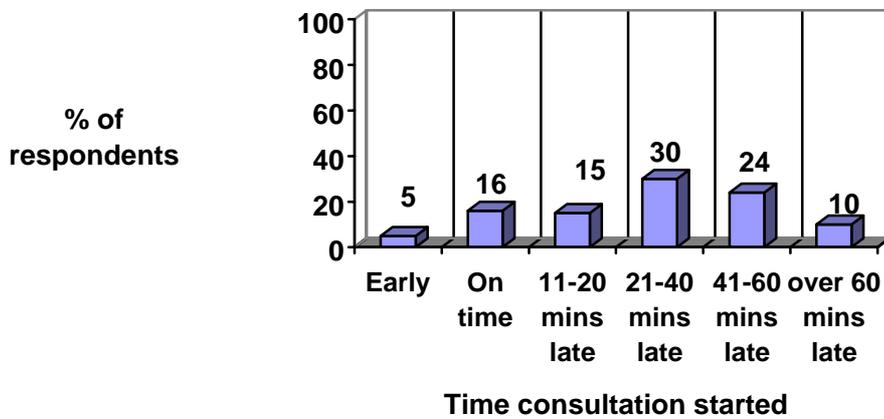
**Description of how survey was administered** (By post, telephone or face-to-face interview? At the time of clinic appointment or afterwards?)

**Report the response rate** (The number of patients invited to participate, the number agreeing to participate, the number of follow-up rounds engaged in)

**Results** (Demographic results. Satisfaction results)

**Conclusions and recommendations** Clear outcomes and practical strategies to improve services based on evidence

Data may take different forms –objective data as well as evaluations, ratings or subjective data. The example to follow shows how data may be categorised for interpretation. It considers the issue of waiting time and time spent in the waiting area of the outpatient department. Figure 1 displays (using fictional data) the percentage of patients whose outpatient consultations were early, on time or late. Figure 2 displays the questions used to generate this data. The responses to questions in figure 2 may be reported in many different ways. Asking these questions is important since it allows researchers to estimate if patients attended early and to distinguish delay (i.e. waiting time after scheduled appointment time) from time spent in the waiting area.

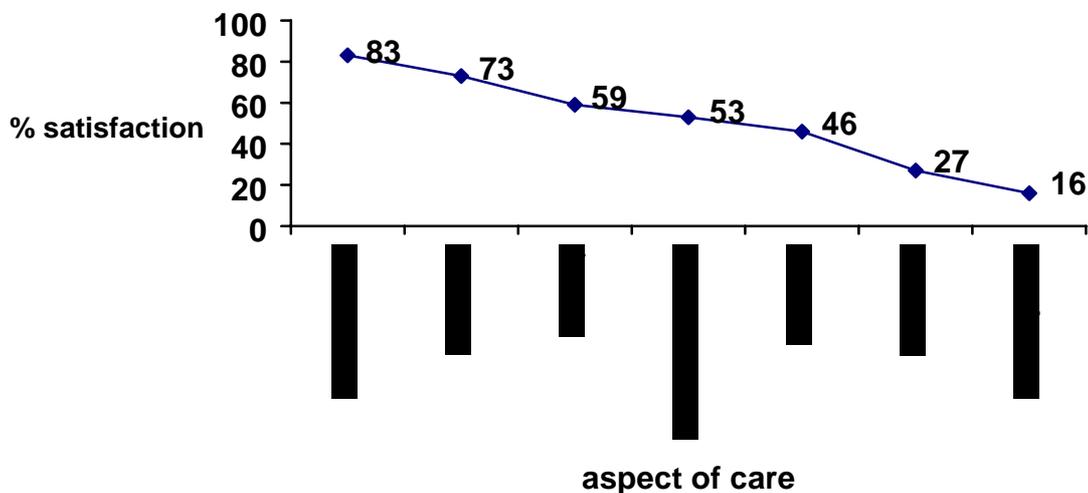


**Figure 1: Profile of consultation waiting times for patients attending an outpatient clinic.**

a) What was your appointment time?	_____
b) At what time did you arrive at the clinic?	_____
c) At what time were you seen by the doctor?	_____

**Figure 2: Questions relating to waiting time at hospital**

Figures are also useful to show the relative level of satisfaction with various aspects of a service as expressed in subjective ratings. For example, figure 3 shows that patients discriminate across different aspects of a service. This data, based on a survey of Accident and Emergency services (N=176 patients in one adult general hospital setting; Keegan et al, 2000) illustrates that patients' subjective experience of waiting time was the poorest aspect of the A&E service.



**Figure 3: Patient satisfaction with various aspects of an A&E service (N=176)**

### **13 Non-attenders and satisfaction with outpatient services**

The discussion to date has focussed on surveying patients who attended for an outpatient consultation. It is a documented feature of outpatients however, that a significant minority of people may not attend for their scheduled appointment (referred to as 'DNA's'). The majority of outpatient appointments are for repeat or return visits. Similarly, the highest proportion of non-attendance is for repeat rather than first appointments at outpatients clinics (Doyle et al, 2002). The reasons for non-attendance vary and include preventable reasons due to clerical error (e.g. appointment not received, hospital transport problems, cancellation of appointment not recorded). Some DNAs have forgotten their appointments - up to 18% of missed appointments in one study (Potamis et al 1984). An Irish study identified a range of explanations for DNAs which included service variables such as waiting time to see the doctor (Cawley and Stevens, 1987). A comprehensive evaluation of an outpatients service should include the views of patients who were scheduled with appointments but who did not attend (DNA).

Planning a survey of non-attenders demands a separate methodology (McCarthy et al, 2000; Doyle et al 2002). The objectives to this type of survey should be clearly defined and focus on a limited number of pertinent areas. A suggested framework used in the non-attenders version of the SWOPS questionnaire focused on:

- Reasons for non-attendance (questions probing the reasons ranging from not having received notification of appointment through to not wanting to attend)
- Background to and purpose of appointment
- Previous outpatient experience and evaluation of care
- Demographic profile of non-attenders (including distance from hospital, travel arrangements, cost of attending)

The explanation of the study – its purpose, the use to which the information will be put and the confidentiality of survey information - needs to be addressed in a particularly sensitive manner for non-attenders. They should be assured that their future care at the hospital will not be affected, either by their decision to participate (or not), or by their responses to the survey. Information sheets and a letter of invitation to non-attenders should be carefully constructed. These should be sent in advance of telephone surveys where possible.

## **14 Conclusion**

Patient satisfaction surveys are one means of gathering patient perspectives on healthcare experiences. To date, there has been little emphasis on collecting the views of those using outpatient hospital services even though this constitutes a major aspect of healthcare delivery

This report examined the context for patient satisfaction surveys in the outpatient setting and provided the empirical details of a satisfaction instrument which has been satisfactorily used in the Irish setting (Satisfaction with Outpatient Services Questionnaire – SWOPS).

A clear purpose and rationale for using a patient satisfaction study, preferably as part of a broader approach to encouraging a person-centred approach, is important. Identifying reliable and valid tools which meet this purpose is also recommended. Devising a methodology which clarifies, both for staff and for patients, the importance, purposes and uses to which these data will be put will increase the usefulness and acceptability of the approach. Finally, in order to be useful and credible as quality assurance tools, patient satisfaction surveys should be used to plan, effect and subsequently evaluate change in the healthcare settings where they are employed.

## Web resources

- Information & Communication Technology Law in Ireland  
<http://www.ictlaw.com/dp.htm>
- Clark, R. (1996) 'Data Protection in Ireland', *The Journal of Information, Law and Technology (JILT)*.  
<http://elj.warwick.ac.uk/jilt/dp/1eire/default.htm>
- Office of the Information Commissioner (Freedom of Information Act)  
<http://www.oic.gov.ie/guide.htm>
- Guidance on conducting surveys and links to relevant bodies, including NHS approved contractors for conducting patient satisfaction surveys in the UK.  
<http://www.nhssurveys.org/>
- NHS Health Technology Assessment Website – including reports on design and use of questionnaires and a systematic review of patient satisfaction measurement.  
<http://www.hta.nhsweb.nhs.uk/>
- Crow R et al (2003) The measurement of satisfaction with healthcare: implications for practice from a systematic review of the literature  
<http://www.hta.nhsweb.nhs.uk/fullmono/mon632.pdf>
- Department of Health and Children annual statistics Table H68B,  
<http://www.doh.ie/statistics/stats/sectionh.html>

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**Appendix One – Satisfaction with Outpatient Services (SWOPS) Questionnaire –  
reliability data**

**Dimensions of questionnaire based on Seibert et al, 1996.  
Data bank used for reliability analysis was 364 responses to a self-completion  
form of the questionnaire.**

**Registration process (Alpha .84)**

	<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>
	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>
The registration process (simplicity, speed, etc.)	38 (11)	72 (21)	101 (30)	84 (25)	44 (13)
Attitude of the clerical staff	125 (35)	108 (30)	96 (27)	23 (6)	9 (2)
Privacy of the registration process	49 (14)	63 (18)	92 (27)	88 (25)	54 (16)
Quality of the waiting area	21 (6)	45 (12)	87 (24)	119 (33)	92 (25)
Waiting time at the clinic	19 (5)	34 (10)	75 (21)	110 (31)	114 (32)
Canteen or refreshment facilities	20 (7)	23 (8)	69 (25)	76 (28)	86 (31)

**\*Nursing care (Alpha .92)**

<b>Nurse's attitude towards you</b>	<b>Extremely</b>	<b>Very</b>	<b>Quite</b>	<b>A Little</b>	<b>Not at all</b>
	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>
	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>
Helpful	181 (53)	108 (32)	40 (12)	9 (3)	3 (1)
Polite	170 (51)	127 (38)	32 (9)	6 (2)	-
Caring	167 (50)	108 (33)	41 (12)	11 (3)	4 (1)
Professional	182 (55)	100 (30)	40 (12)	7 (2)	4 (1)
	<b>Very sat</b>	<b>Sat</b>	<b>Neither</b>	<b>Diss</b>	<b>Very diss</b>
How satisfied were you with the information given to you by the nurse?*	128 (42)	116 (38)	54 (17)	6 (2)	4 (1)
	<b>Very Good</b>	<b>Good</b>	<b>Average</b>	<b>Poor</b>	<b>Very poor</b>
Overall, how good do you think the nursing care is at the outpatient clinic?*	209 (60)	102 (29)	33 (9)	3 (1)	1 (1)

**Physician care (Alpha .95)**

	<b>Excellent</b> N %	<b>Very Good</b> N %	<b>Good</b> N %	<b>Fair</b> N %	<b>Poor</b> N %
The amount of time spent with the doctor	83 (23)	118 (33)	83 (23)	45 (13)	27 (8)
The thoroughness of care you received from the doctor	119 (33)	125 (35)	68 (19)	28 (8)	17 (5)
The doctor's instructions regarding medications and follow-up care	129 (37)	111 (32)	69 (20)	23 (7)	16 (5)
The doctor's advice about ways to avoid illness and stay healthy (diet, exercise)	80 (29)	81 (29)	54 (20)	39 (14)	21 (8)
	<b>Very Satisfied</b>	<b>Satisfied</b>	<b>Neither satisfied nor dissatisfied</b>	<b>Dissatisfied</b>	<b>Very Dissatisfied</b>
How satisfied were you with the doctor's explanation of what was done for you (tests, diagnosis, treatment)?	160 (46)	122 (35)	36 (10)	20 (6)	9 (3)
	<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
The outcome of your medical care (that is given your problem, were you helped as much as you expected)	106 (33)	92 (29)	78 (24)	33 (10)	13 (4)
The chance to have questions answered after your visit	70 (24)	70 (24)	69 (24)	39 (14)	39 (14)
	<b>Very Good</b>	<b>Good</b>	<b>Average</b>	<b>Poor</b>	<b>Very Poor</b>
Overall, how good do you think the medical care is at the outpatient clinic?	171 (48)	130 (37)	43 (12)	6 (2)	2 (1)
Doctor's attitude towards you	<b>Extremely</b>	<b>Very</b>	<b>Quite</b>	<b>A Little</b>	<b>Not at all</b>
Helpful	159 (48)	98 (30)	50 (15)	15 (4)	8 (2)
Polite	147 (45)	126 (38)	35 (11)	14 (4)	6 (2)
Caring	143 (44)	104 (32)	47 (15)	20 (6)	9 (3)
Professional	185 (55)	101 (30)	34 (10)	11 (3)	7 (2)

**Information (Alpha .88)**

	<b>Very Satisfied</b>	<b>Satisfied</b>	<b>Neither</b>	<b>Dissatisfied</b>	<b>Very Dissatisfied</b>
How satisfied were you with the information given to you by the nurse?	128 (42)	116 (38)	54 (17)	6 (2)	4 (1)
How satisfied were you with the doctor's explanation of what was done for you (tests, diagnosis, treatment)?	160 (46)	122 (35)	36 (10)	20 (6)	9 (3)
Overall how satisfied were you with the information you received about your condition and treatment in the outpatient clinic?	141 (40)	142 (40)	32 (9)	28 (8)	8 (2)

**Testing services (Alpha .88)**

	<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
The x-ray technician's personal manner	101 (43)	76 (32)	39 (17)	10 (4)	9 (4)
The lab technician's personal manner	99 (46)	73 (34)	32 (15)	9 (4)	4 (2)
The physiotherapist's personal manner	70 (49)	39 (27)	20 (14)	8 (6)	6 (4)
The ease of getting lab tests or x-ray's done	77 (30)	78 (31)	64 (25)	21 (8)	15 (6)
Signposting to the testing facility	60 (23)	70 (27)	80 (30)	35 (13)	18 (7)
The cleanliness of the testing area	79 (30)	84 (32)	63 (24)	33 (12)	5 (2)

**Overall satisfaction (items also included in other dimensions)  
(Alpha .84)**

	<b>Very Satisfied</b>	<b>Satisfied</b>	<b>Neither</b>	<b>Dissatisfied</b>	<b>Very Dissatisfied</b>
Overall, how satisfied are you with your treatment at the outpatient clinic?	142 (40)	159 (45)	36 (10)	11 (3)	3 (1)
	<b>Very Good</b>	<b>Good</b>	<b>Average</b>	<b>Poor</b>	<b>Very Poor</b>
Overall, how good do you think the medical care is at the outpatient clinic?	171 (49)	130 (37)	43 (12)	6 (2)	2 (1)
Overall, how good do you think the nursing care is at the outpatient clinic?	209 (60)	102 (29)	33 (9)	3 (1)	1 (1)
Overall, how good do you think the running of the outpatient clinic is?	138 (39)	105 (3)	75 (21)	27 (8)	4 (1)