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Patients' experiences of care quality and satisfaction during hospital stay: a qualitative study

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Abstract

Rationale, aim and objectives: Patients experiencing high care quality and satisfied patients are more likely to follow treatments. Patient satisfaction is an important contributor to physical and mental health-related quality of life. Research emphasises the need to further study satisfaction from the patients' perspective. The aim was to describe patients' experiences of care quality and the relation to their satisfaction during hospital stay.

Methods: A qualitative descriptive design was used. Interviews were conducted with 22 patients discharged from hospital. Data was analysed by conventional content analysis.

Results: Four categories and seven subcategories describing patients' experiences of care quality and the relation to their satisfaction emerged. *Desire to regain health* comprised *waiting for treatment, being cured, having hopes of being cured* and described the treatment and health outcome of hospitalisation. *Need to be met in a professional way as a unique person* comprised *receiving personalized knowledge, receiving healthcare by competent healthcare personnel* and described the way patients need to be met by healthcare personnel. *Need to be involved* comprised *taking responsibility for own health, leaving responsibility for own health* and concerned the patients' way of handling hospitalisation. *Need to have balance between privacy and companionship* concerned the relationship to fellow patients.

Conclusions: Health condition is of great importance to patients' experiences of quality of care and their satisfaction in relation to hospital stay. The healthcare personnel need to be aware that seriously ill patients may never be completely satisfied. Furthermore, healthcare personnel must do their utmost to provide the patients with person-centered care. Hospital managers must consider the design of wards with respect to such matters as multiple-bed *versus* single-bed rooms and heads of nursing must carefully plan each patient's accommodation.

Keywords

Conventional content analysis, emotion, inpatient, patient satisfaction, person-centered care, person-centered medicine, quality of care

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Introduction

Patient satisfaction is an important indicator of the quality of care during hospital stay [1-3] and is seen as a key concept for evaluating and improving healthcare [3,4]. A literature review showed confusion between the concepts patients' satisfaction, patient perceptions of quality of care and the actual experiences of the care received [5,6]. These concepts are often used interchangeably in the literature and it is not always clear how satisfaction, perception of quality of care and experiences are measured [6,7]. About

80 to 90% of patients rate the satisfaction with the quality of care as 'good' or 'excellent' [5].

Jenkinson *et al.* [8] suggested that scores on patient satisfaction questionnaires present a limited and optimistic picture, since questions about specific aspects of patients' experiences showed that inpatients who rated the satisfaction as 'excellent' at the same time reported several problems. Grøndahl *et al.* [9] found 3 groups of patients in hospital of which one group was less satisfied while still having good perceptions of care quality. Studies have shown that satisfaction with the quality of care is

associated with total symptom severity score at discharge and the degree of symptomatic improvement that the patients experienced during hospitalisation [10,11]. Other examples are the coexistence of high levels of satisfaction with pain management and the experiences of high levels of pain [12,13]. When questioned about this discrepancy between perceptions of care quality and satisfaction, patients said they expected to have some pain and that they did not want to be troublesome to busy personnel [14]. Merkouris *et al.* [4] found that when patients were given the opportunity to talk about their experiences, they made several negative comments even if they rated satisfaction as 'quite high' or 'very high' when responding to the questionnaire. These examples from the literature show that the concepts concerning experiences of quality of care and satisfaction are unclear. In addition, most studies had a quantitative approach. Furthermore, the concepts have been criticized for their lack of methodological and theoretical underpinning [5,15]. Therefore, in this study, perceptions of quality of care and patient satisfaction are viewed as 2 different concepts.

The model 'Quality of Care from a Patient Perspective' (Wilde *et al.*'s [15]) describes patients' perceptions of quality of care. The model states that what constitutes perceptions of quality of care is formed by the patients' norms, expectations and experiences and by their encounter with a care structure. The theoretical model includes 4 dimensions: the medical-technical competence of the caregivers, the identity-oriented approach of the caregivers, the care organisation's physical-technical conditions and the care organisation's socio-cultural atmosphere.

Larsson and Wilde-Larsson [16] presented a tentative model of patient satisfaction in a psychological framework. The framework had its starting point in the cognitive-phenomenological tradition developed by Lazarus and Folkman [17], which states that the way a person appraises and copes with a situation causally contributes to his or her emotional reaction. In turn, the appraisal process is shaped by interacting person-related conditions and actual, external conditions. The appraisal and coping processes follow the perception of actual care received (perceived health service attribute reality) and give an emotional reaction called patient satisfaction [16,18,19].

Research emphasises the need to clarify satisfaction from the patients' perspective [20,21] by using qualitative methods [1,2,5]. The aim of this study was to describe patients' experiences of care quality and the relation to their satisfaction during hospital stay.

Methods

The study had a qualitative descriptive design. The informants were selected from a quantitative study [22] exploring and describing the relationship between patients' perceptions of the quality of care and patient satisfaction in hospital, carried out in Norway from May 2008 to April 2009. Before discharge from the hospital, the patients completed a questionnaire that contained questions about

their perception of the quality of care (Quality of Care from a Patient Perspective by Wilde *et al.* [23]) and questions about their satisfaction measured as an emotion, using the Emotional Stress Reaction Questionnaire [16]. The patients received also an enquiry asking for their consent for the first author to contact them at home for an interview and all 528 agreed. They were informed that about 20 discharged patients would be asked to participate in this qualitative study.

The inclusion criteria were that the informants had been discharged from hospital directly to their homes and that they had not been hospitalised since discharge. A strategic sample was drawn, based on the variation of the combination of the patients' ratings on their perceptions of the quality of care and their ratings of their satisfaction in the questionnaire. The purpose was to achieve as much variation as possible within the sample concerning the combination of scores on quality of care and satisfaction (e.g., lower scores on perceptions of quality of care and on patient satisfaction; higher scores on perceptions of quality of care and lower on patient satisfaction). A total of 31 patients were asked to participate. They received a letter with information about the interview and a form of consent 2 to 3 weeks after discharge from hospital. One patient of the 31 had died since discharge, 5 had been hospitalised since they completed the questionnaire and one had moved abroad for the winter. Two declined to participate because of poor health. Twenty-two informants agreed to participate (see Table 1).

Table 1 Characteristics of the informants (n=22)

Characteristics	Number	Mean (range)
Age		57.0 (24-81)
Sex		
Men	11	
Women	11	
Education level		
Compulsory school	3	
Upper secondary school	11	
University	8	
Ward type		
Medical	12	
Surgical	9	
Medical/surgical	1	
Admission type		
Emergency	9	
Scheduled	13	

The first author contacted the informants by telephone after receiving the letter of consent and booked a time and location for the interview. The informants decided where the interview should take place. The first author performed the interview, which took place in the informants' homes (6), at their work (3), in cafés (8), in a pub (1), in a meeting room at the author's workplace (1) and in meeting rooms at the hospitals (3). When public places were chosen, the informant and the first author were seated so that other

people could not hear the conversation, and the interviews were conducted during the morning when few people were visiting. The interviews took place 3-8 weeks after discharge from hospital, from January to June 2009. The interviews were recorded.

Data collection

During the interviews, 2 open-ended questions were asked: 'Can you tell me about your experiences of the care during your hospital stay?' and 'Can you tell me about your feelings in relation to these experiences?' Individually follow-up questions were based on the informants' answers. The interviews lasted from 25 to 120 minutes (average duration 50 minutes).

Ethical considerations and approval

The study was approved by the Regional Committee for Medical Research Ethics in East Norway and by the Norwegian Social Science Data Services. The study was conducted according to Ethical Guidelines for Nursing Research in the Nordic Countries [24]. Verbal and written information about the study was given to the informants. Participation was voluntary and the informants were told that they could withdraw at any time and that all data would be treated confidentially. The tapes and the transcriptions were kept safely locked away in the first author's office.

The interview itself might be difficult for the informant, depending on factors such as his or her perception of hospital care and the health outcome. It was therefore important that the informant chose the location and time for the interview. The interviewer was aware of possible physical and psychological reactions from the informants during the interviews.

Data analysis

Conventional content analysis following Hsieh and Shannon [25] was used. After the interviews, notes were made to capture elements of the setting and of the informant's emotional responses. The interviews were transcribed *verbatim* by the first author on the next day. The transcripts were then read and compared with the digital recorded interviews in order to check the accuracy of the text and to capture the content related to the aim of the study. The words that appeared to capture key thoughts were highlighted. Based on the highlighted words, labels for codes emerged. The codes were compared based on similarities and differences and sorted into subcategories and categories, a process that went back and forth. The codes, the subcategories and the categories were critically investigated and discussed among the researchers until agreement was reached. Quotations were selected to support the description of the subcategories and the categories and to secure trustworthiness.

Results

Four categories and 7 subcategories describing patients' experiences of care quality and the relation to their satisfaction emerged. The category *Desire to regain health* contained 3 subcategories which comprised the treatment and health outcome of the hospitalisation. The category *Need to be met in a professional way as a unique person* contained 2 subcategories which comprised the way the informants need to be met by the healthcare personnel. The category *Need to be involved* contained 2 subcategories which comprised the patients' way of handling hospitalisation. The category *Need to have balance between privacy and companionship* comprised the relationship to fellow patients and sharing accommodation with other patients.

Desire to regain health

This category consists of the following 3 subcategories: *waiting for treatment*, *being cured* and *having hopes of being cured*. The informants described the period before being admitted to hospital and the outcome of the episode of care along a continuum from 'full recovery of disease' to 'never be able to regain health'.

Waiting for treatment

The period from when a person felt that something was wrong to receiving treatment was described as a time of concern, uncertainty and powerlessness. Some described great pain, little sleep and symptoms that had a great impact on daily life. The intensity of the symptoms could be increasing. Some patients had to wait up to 2 years before being admitted to hospital. An extra burden was described by persons who had an uncertain or unknown diagnosis. Some of the patients had to fight for the right to be treated in hospital, because the doctors would not listen:

'The fact that I had to use my fists to be admitted to hospital felt very wrong'.

Others described how they were sent from one specialist to another repeatedly before being admitted in hospital. They also longed for treatment because the symptoms affected their daily life. They had feelings of relief and happiness on finally going to be treated or diagnosed:

"I had been through a long period where I felt exhausted and did not know what was wrong with me. The ECG showed something wrong.... There was an explanation to why I had been exhausted."

Being cured

The informants described the importance of being diagnosed and having successful treatment. They had emotional reactions such as being relieved, glad or/and

pleased, when they had been 'repaired' or they had got a diagnosis that was treated:

"Yes, I do remember why I was relieved, oh yes. I was relieved because it was over. And I was relieved because the surgery had been successful, and that I was well again."

Some also described poor healthcare experiences, but they had been 'repaired' and therefore described the relief of having finished the treatment and being ready to go home. The transition from being ill to being healthy and being able to live the life they used to was also described as something that made them energetic and optimistic. Concern about recurrence of the disease, especially if the disease was considered to be a life-threatening illness such as cancer, was described.

Having hopes of being cured

The informants described having treatment as important when they were seriously ill and emphasized their desire to be cured. They had hopes for living as long as possible with the disease they knew would end their lives. Reactions to a life-threatening condition were described as anger and questions of 'Why me?' Having an incurable disease and an unsure future was associated with feelings of sadness, worry and disappointment. Family members and healthcare personnel were characterized as important supporters, but living with an incurable illness was described as something the patients had to face alone in the end:

"It is something in this situation that is completely independent of them or how can I put it; independent of how well they take care of me. I have a type of cancer that is very difficult to cure. They cannot do anything about it. What strikes me, however you see it, is that it is my cancer. It is not someone else's."

Need to be met in a professional way as a unique person

This category consists of 2 subcategories; *receiving personalized knowledge* and *receiving healthcare by competent healthcare personnel*. Descriptions of person-centered care characterized this category.

Receiving personalized knowledge

Informants described the importance of obtaining enough information to have knowledge of their own health situation and treatment and also information about ward routines. The information was useful when it was connected to the individual patient's disease, symptoms, treatment and possible consequences of treatment. The way information was given was also important. The patients felt relieved and hopeful when healthcare personnel were honest about the patients' situation, spoke clearly and did not try to hide anything.

"So she tried very hard to tell me how bad this could be. I never had it so bad, so therefore I have been positive. Everything has been fine, all the time. I actually liked the way she informed me, being honest and clear."

Continual information about the patient's health situation was important when the informants had been admitted as an emergency. Becoming a patient was a new and unknown situation and explanation and information about ward routines were important for the patients to feel safe. Feelings of uncertainty and being a bit 'stupid' arose when they were unsure of how to behave in hospital. The patients who changed wards and also hospitals, described feelings of insecurity, fear and irritation when they lacked knowledge about the differences regarding routines between the wards in different hospitals. Some of the patients experienced that no one took care of them for hours after being transported from special units to ordinary wards. Continuity of the doctor was a positive factor, because they did not have to repeat themselves, and they described the doctor as someone who knew them, their disease and treatment. To be given conflicting information regarding treatment or time for discharge was irritating and to hear doctors argue was an experience that made the patients worried, uncertain, powerless and sad. Reactions to lack of personalized information before discharge about how to behave at home were described as worry, uncertainty and tension.

Receiving care by competent healthcare personnel

Descriptions of being listened to and treated individually and not as one among many gave the patients experiences of being met by healthcare personnel with knowledge. The opposite can be illustrated with the following example:

'They were not in a way accommodating. They did not see me and that was not good.'

Irritation occurred when the healthcare personnel only said that everything will be fine and gave general explanations that were not adapted to the patient. The personnel were also described as being those who knew best and made the patient feel foolish. Experiences of being treated like a child were described and also how some personnel made the informant feel stupid and disappointed. When the personnel made mistakes, but admitted it and expressed regret, the patients expressed an understanding that this was a safe place to be. Denial of mistakes made the patients feel afraid and worried. They expected healthcare personnel to be competent and have knowledge of their health status, the consequences and treatment:

"The lack of knowledge among some healthcare personnel shocked me. It creates a sort of, well not aggression, but it creates a lot of feelings. I strongly dislike lack of knowledge."

Need to be involved

This category consists of 2 subcategories. These were *taking responsibility for own health* and *leaving responsibility for own health*. Descriptions of how informants were able to influence hospitalization by making their own decisions characterized this category.

Taking responsibility for own health

Being aware of what was going on when an inpatient, such as checking that the right medication is received and asking for information, was described as important. Patients described the need for knowledge required to be able to choose among procedures and treatment. It was difficult to be given the opportunity to choose and at the same time not having enough knowledge to make a proper choice. The informants described family members as resources and important when patients were making decisions concerning treatment. Feelings of frustration, anger and sadness were described when family members were not included in the patient's care.

There were also descriptions of the need to be involved, to be in charge and express personal wishes. To express a personal opinion was seen as a way of being in charge. Further descriptions concerned the right to choose hospital and some patients had chosen hospitals far away, because those had good care quality. To be able to actually do that, gave feelings of energy and happiness:

"I had heard that the quality of the healthcare was good, so I called and asked if I could have the surgery done there and they said yes. I did not have to wait at all. And I will go there again if I need to even if it is far away from home. I was so pleased that I could choose were to go."

Leaving responsibility for own health

The informants described that sometimes they want the healthcare personnel to decide what further action to take, because they perceive that they do not have enough knowledge, even if they have been given sufficient information. It was the healthcare personnel's responsibility to make competent decisions on behalf of the patients. Some of the patients left the responsibility to God:

"Well, it might sound a bit strange. I felt that everything was prepared, all the time. And I think that I have a God who takes care of me. And that gives me a feeling of being safe."

Need to have balance between privacy and companionship

The informants described sharing a room as both a strength and a source of distress. The patients having the same diagnosis described how they learned from each other. The

strengths were described as receiving more information, because the other patients also had questions for the doctor. On the other hand, violations of doctor-patient confidentiality were irritating and frustration arose:

"The only positive was having single room. One patient was there in the evening when I arrived and he left in the morning. And then the doctor had been there and told me that I had a lung disease. And of course he overheard. And I thought that only I should receive that news, that it was information between me and the doctor, because the whole hospital is not supposed to know my disease."

There were also descriptions of having good times with the fellow patients and that it made the hospital stay better. However, sharing a room with a seriously ill patient was a burden. They felt responsible and tried to help their fellow patient as much as possible. Informants felt sadness when they watched the negative progress of a disease in a fellow patient.

Toilets and baths were described as private and intimate rooms. Sharing those facilities was an extra burden, because of poor hygienic conditions. Having to wait because of occupied toilets was not always easy, because of the consequences of their diseases.

Discussion

Conventional content analysis approach was used to describe patients' experiences of care quality and the relation to their satisfaction. The method is suitable because it reflects human communication and preserves information from the data. Credibility, transferability, dependability and confirmability are important aspects of trustworthiness in qualitative studies [26]. In this study, *credibility* was achieved by describing the data collection and the analysis of the data in detail. The interviews were carried out in places and at times chosen by the informants. The word 'feelings' was used instead of 'emotions' during the interview, because it is more common in everyday speech in Norway. An atmosphere of trust between the informant and the interviewer was sought. Clarifying questions were asked to avoid misunderstanding and the interviewer tried to be sensitive to possible discomfort the informants might feel. The authors were aware that the analysis could be influenced by the model of quality of care [15] and the model of patient satisfaction [16] used and did their utmost to let the informant's statements govern the analysis, in addition to reflecting on and discussing this possible influence in the research group. Thorough descriptions of the informants and of the subcategories and categories were given. The informants had been patients on medical wards, surgical wards or a medical/surgical ward. Patients with severe physical or mental health symptoms were not included in the study. The categories identified, however, might still be *transferable* to similar groups and contexts. A digital recorder was used and interviews were transcribed *verbatim*. In addition, the steps of the content analysis were

followed to ensure *dependability*. Finally, *confirmability* was achieved by the use of systematic data collection and systematic conventional content analysis. The researchers read the interviews separately and the first author analysed the interviews. The codes, sub-categories and categories were discussed in the research group until agreement was reached.

Four categories emerged to describe patients' experiences of care quality and the relation to their satisfaction. The emotions connected to the categories include descriptions of both positive emotions (such as gladness, happiness, relief) and negative emotions (such as anger, irritation, sadness). The categories and examples of the emotions will be discussed in relation to the theoretical model of quality of care [15] and the tentative model of patient satisfaction [16].

Desire to regain health focused on patients' illnesses and their hopes of being diagnosed and treated. These results are in line with the 'medical-technical competence' dimension in the model of the quality of care from a patient's perspective [15]. When the self-rated health was considered good, positive emotions such as being relieved, glad and pleased emerged, which means that high satisfaction was achieved. The opposite occurred when the self-rated health was considered poor; negative emotions such as sadness and worry emerged, which means that the satisfaction was low. In the study by Larsson and Wilde-Larsson [16], in which a theoretical model of the relationship between quality of care from a patient perspective and patient satisfaction was explored, self-rated health was found to contribute to patient satisfaction. In the current study, the informants expressed the importance of physical health for high levels of satisfaction. Previous studies have found that medical outcomes [27] and the degree of symptomatic improvement from admission to discharge [10] are important predictors of satisfaction with hospital stay. Patients who are satisfied with their nursing care are more likely to follow treatment and thus more likely to have better health outcomes [28]. Patient satisfaction is also an important contributor to both physical and mental health-related quality of life [29].

Need to be met in a professional way as a unique person concerned the informants' need for personalized care by competent healthcare personnel. The findings are related to the 2 dimensions identity-oriented approach and medical-technical condition of the model of quality of care [15]. The identity-oriented approach dimension describes the patients' desire for humanity in care with qualified caregivers with the knowledge and empathic skills required to meet each patient as a unique person [15]. The dimension of the medical-technical condition concerns the patients' desire to receive examination, diagnosis, treatment and symptom alleviation by qualified personnel with knowledge and proficiency [15]. Furthermore, emotions such as hope, optimism, being powerless and irritation were connected to the informants' preferences for the relationship to healthcare personnel and of the personnel's competence. When the relationship was considered good and the informants' preferences were met, high satisfaction was achieved. Low satisfaction was

expressed when these conditions were considered poor. This category can also be related to the person-related condition 'commitment', in the model of patient satisfaction [16]. 'Commitment' or 'preferences' describes how important patients consider various aspect of healthcare. Empirical testing of the model of patient satisfaction showed that the patients' preferences did not contribute significantly to satisfaction, which might be due to different forms of analysis or it may be due to differences in the items and numbers of items included [16]. Previous work, however, has shown that patients expect the personnel to be competent and professional in their relationship with patients [27,30,31].

Need to be involved concerned how the patients were able to influence their hospitalization by making their own decisions. The findings are related to the dimension 'identity-oriented approach' in the model of quality of care [15] which emphasises the relationship between patients and healthcare personnel and also the patients' possibility for participation in care. Further, the category can be related to the person-related condition 'personality' which is included in the person-related conditions in the model of patient satisfaction [16]. Previous studies have been inconclusive regarding the effect of personality on satisfaction. Hendriks *et al.* [32] did not find any relationship, while Larsson and Wilde-Larsson [16] found that patients who were extraverted and emotionally stable reported higher satisfaction. Frank *et al.* [33] found that when patients participated in their care they experienced greater satisfaction. This agrees with findings in the current study, in which being involved was important for patient satisfaction.

Need for balance between privacy and companionship showed that fellow patients can be both a source of feelings such as joy and fun, that is, high satisfaction and a source of feelings such as stress, worry and irritation, that is, emotions that characterize low satisfaction. The dimension 'socio-cultural atmosphere' in the model of quality of care from a patient perspective [15] emphasises the patients' opportunity for self-chosen seclusion and/or self-chosen socialising. This dimension emphasises also that the healthcare personnel and the ward design should provide patients with these opportunities. Another study revealed that patients who became more ill or whose behaviour was disturbing, had a negative impact on a fellow patient [34]. Confidentiality is difficult to maintain when patients are sharing a room [35]. One review found that single rooms had a moderate effect on patient satisfaction regarding aspects such as care, noise and privacy [36].

Conclusion

Health outcome is of great importance to patients' experiences of quality of care and their satisfaction in relation to hospital stay. If the patient is seriously ill, their satisfaction may never be complete and healthcare personnel must be aware of this. Healthcare personnel must do their utmost to provide the patients with person-

centered care. The personnel must also be aware that the patients might want to leave responsibility for their health to the RNs and doctors from time to time. Hospital managers need to consider the design of wards with respect to such matters as multiple-bed or single-bed rooms. When a patient is admitted to hospital, head nurses must consider the patient's diagnosis before deciding on accommodation.

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