THE USE OF PATIENT SATISFACTION SURVEYS ON OBSTETRICAL INPATIENT UNITS IN OKLAHOMA CITY HOSPITALS

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CHAPTER I

INTRODUCTION

The 1970's witnessed drastic changes within our health care system from external forces. One of the more obvious changes was the gradual shift in power from the physician/medical system to the patient/consumer. Two events, the consumer movement and sustained technological advances were major catalysts in effecting the shift towards tailoring health care to the needs of individuals.

The actions of health care consumer groups in the 1960's laid the ground work for health care institutions to reexamine their patient care policies and philosphies. By the 1970's many health care institutions and health care providers' professional organizations had chartered a number of "patient bills of rights." Although the majority of these bills were little more than a recognition of basic human rights, they helped shift the direction of health care from a physician to a consumer orientation.

Interest in patient/consumer rights seems to have awakened the corresponding interest of providing quality care. Since the 1960's a growing portion of patient/consumer research has been devoted to measuring patient satisfaction as an indicator of quality care.

Past research has indicated patient satisfaction is enhanced when interpersonal relationships and open communication patterns between the patient/consumer and the health care provider are developed. Today, an increasing number of institutions and health care providers are using patient satisfaction surveys and questionnaires as assessment and evaluation tools to make changes in their health care delivery.

Maternal (obstetrical) health care is an excellent example of a health care area which has received growing public scrutiny and criticism. In the past ten to fifteen years consumers have intensified their demands for our health care system to personalize their childbirthing experiences (Willson, 1984).

A 1982 study by Sullivan and Beeman (1982) surveyed a population of recently delivered mothers to correlate factors promoting higher levels of patient satisfaction with the childbirthing experience. Their study suggested the level of satisfaction a patient derived from her labor and delivery experience was closely related to two factors. These factors were communication patterns and choice of specific clinical procedures. Both of these factors are dependent upon developing an interpersonal relationship between the consumer and the health care team which fosters the exchange of information.

An extensive literature review has convinced this researcher our health care system is changing. A part of

this change has been influenced by growing consumer activism prompted by technological advances. These advances have impacted health care positively and negatively. The negative impact of these advances focuses around two issues, money and use of machines. Consumers are concerned, to them advanced technology represents higher health care costs and increased depersonalization. In many instances, their concern is placing our health care system under greater scrutiny. As a result, the health care industry is becoming increasingly interested in keeping consumers happy since they are the primary source of the industry's income. The advent of the patient/consumer satisfaction survey is an excellent example of how the industry is trying to monitor and evaluate the consumer climate.

More than ever, the health care industry appears to be soliciting consumer input by developing tools to measure patient/consumer satisfaction. Current literature suggests this is particularly true of hospitals providing obstetrical care. The purpose of this study is to establish whether Oklahoma City hospitals with inpatient obstetrical services are utilizing consumer/patient satisfaction surveys or questionnaires.

Statement of Problem

Concern about consumers' level of satisfaction with health care services has become an increasingly important issue over the past twenty years. As medical costs have

escalated and available medical alternatives multiplied, the consumer has started to demand more from the medical community. Evidence of consumer awareness and involvement in their medical care can be traced back to the consumer/patient rights movement.

According to Trandel-Korenchuk (1982), the patient rights movement is an off shoot of the welfare rights movement in the 1960's. The patient rights movement is a reflection of the conflict between professional judgement and consumers' demands for individualized care. Over the past thirty years scientific and technological advances have contributed to impressive improvements within the health care system (Rivin, 1982). However, these improvements have come with a price tag, many consumers feel health care has become too technological and too expensive. Traditionally, the patient-doctor relationship was based on trust, but "as the cost of health care has increased and the range of alternatives widened, patients have come to expect more than an unexplained treatment or prescription" (Annas, v. 3, p. 1201). Similarly, Naisbitt (1984) reports in "Megatrends" an observed trend towards "high touch," a more personal approach, as a direct consumer response to technological advances. It stands to reason, then, that hospitals as the primary institution representing both modern medicine and technological advances have become the focus of the patient/consumer rights movement.

In response to increasing consumer/patient pressure hospitals and many professional organizations have authored numerous statements known as "patient bill of rights." Probably the best known and most widely accepted statement is the "Patient's Bill of Rights" adopted by the American Hospital Association in 1972. By 1975 more than 30% of all hospitals had adopted this bill of rights. Two of this document's greatest drawbacks are: (1) it perpetuates the traditional paternalistic approach of the professional medical community, and (2) it reiterates basic, god given human rights (Trandel-Korenchuk, 1982). While the bill is not perfect, it is an indication of consumers' growing influence in the health care industry.

The impact of consumer-influenced changes is particularly prevalent in the maternity care segment of the health care system. Historically, maternity care and childbearing were considered "women's business," with midwives as the primary caregivers and most childbirthing occurring in the home setting. However, by the late 1800's, an accumulation of specialized knowledge and teachings in maternal care helped spur the creation of a new medical specialty, obstetrics.

> The conquest of puerperal fever, the inclusion of obstetrics in medical practice, the emergence of modern nursing, pioneering efforts in obstetric anesthesia, the use and refinement of forceps, the development of infant isolettes, along with evolution of the male midwife (physician), and the development of "lying-in" wards for the urban poor....(Burst, 1983, p. 43)

contributed to changes in maternal health care. At the

end of the nineteenth century, social and economic factors such as the industrial revolution, immigration influxes, economic competition and the low status of women converged and by the beginning of the twentieth century childbirthing moved out of the home and into the hospital setting (Burst, 1983). In 1900, fewer than 5% of all deliveries occurred in a hospital setting. However, by 1960 hospitals were being credited with more than 70% (Burst, 1983).

Recognition of obstetrics as a medical specialty changed the focus of childbearing from a normal function to a disease process and helped the public to accept hospitals as places of hope, care and cure, instead of places of pests and death (Willson, 1984).

These drastic changes did not occur without repercussions. Although the move to institutional settings and improved medical technology decreased mother and infant mortality, it imposed heavy social and psychological burdens on childbearing women (Norr, Block, Charles, Meyering & Meyers, 1977). In hospital settings, women were encouraged to adopt passive behaviors, delivered among strangers in an alien environment and were subjected to accepted obstetrical practices such as twilight sleep, centralized nurseries, and family separation.

Consumers started expressing dissatisfaction and unhappiness with hospitals' childbearing practices and routines as early as the 1940's. The first agency to successfully reverse a hospital practice was the Maternity

Center Association of New York City. They protested the practice of mother-infant separation, and today's "rooming-in" is a direct result of their efforts (Burst, 1983). This organization and the work of two physicians, Read and Lamaze can be credited with the growth of the "natural childbirth movement" in the 1940's (Norr et al., 1977). Read's book "Childbirth without Fear" published in 1944 and Lamaze's theory of psychoprophylaxis did much to make childbirth a more satisfying and natural experience for women and their spouses (Burst, 1983). By the 1950's and 60's the natural childbirth movement was alive and well.

Growing consumer involvement in childbirth practices was influenced by several external factors. According to Burst (1983) these included: (1) increased visibility of the women's movement and feminism, (2) using journals and magazines to depict and discuss childbearing practices, (3) federal employment of nurse midwives in family planning and maternal-infant care projects, (4) the endorsement of nurse-midwifery practice by professional organizations, and (5) movement of nurse midwives into the hospital environment. All these factors culminated into the conceptualization of family centered maternal care. Family centered maternal care involves significant others in the mother's care throughout the pregnancy and childbirth experience. In family centered maternal care "the father or significant other takes part in prenatal classes and in the actual labor and delivery, visiting privileges are extended to siblings, and the mother

and father take an active role in caring for the newborn during hospitalization" (Willson, 1982, p. 15-6).

Only recently have health care providers really looked to consumers for their input. Although patient satisfaction with care has been of some interest to health care professionals, during the past ten years this interest has escalated into a position of importance. No longer are care providers concerned with whether or not to consider patient perceptions, but how much credence to give to those perceptions (Stamps & Finklestein, 1981). Patient satisfaction has become increasingly important as a criterion by which the quality of care can be measured (Hulka, Zyzanski, Cassel & Thompson, 1970; Hulka & Zyzanski, 1982; Linn, Dimatteo, Chang & Cope, 1984). Probably the most significant result of all this activity is the agreement among physicians and researchers that patient satisfaction is an important outcome of health care services and in it's use "as a potential determinant of patient utilization and compliance behavior" (Hulka & Zyzanski, 1982). This and other studies have confirmed patient satisfaction is a significant factor to consider when evaluating the quality of care and a predictor of consumers' use of health care services.

Although a number of studies have explored the relationships between patient satisfaction and other variables such as care provider's professional competence, personal qualities and cost/convenience, consumer studies

conducted among the childbearing population, particularly the labor and delivery experience are limited. This is somewhat surprising in an area where recent advances in technology and greater consumer awareness have joined forces to produce a growing demand for information and a positive birthing experience. There is little doubt that the labor and delivery experience for most childbearing couples is of utmost importance. While the duration of the labor and delivery experience is short when compared to nine months of pregnancy, the events surrounding birthing experiences are unique and will be remembered a lifetime (Richards, 1982). The value placed upon patient satisfaction combined with the limited number of accomplished studies makes continued research imperative if health care providers want to improve the labor and delivery experience for the consumer population.

This brief overview of the consumer movement, patient rights, changes in childbearing practices, and patient satisfaction research is a honest attempt to examine changes in our health care system. The literature indicates advances in our health care technology are affording the health care consumer more options to choose from, and consumers are becoming increasingly active in making their choices. Furthermore, the literature observes that as health institutions and professionals have recognized the value of maintaining consumer satisfaction, there has been a growing use of mechanisms to measure consumer satisfaction. Patient

surveys and questionnaires are the most common form of these mechanisms seeking to gain consumer information.

As a component of the health care system, maternal health care is an excellent example of a specialty which has witnessed numerous changes over the last fifteen years. Many of these changes were consumer/patient induced, some as direct results of patient dissatisfaction with health care services. This study an attempt to apply what is reported in the literature to what was is being practiced in the community. Therefore, the primary focus of the study is to establish whether or not the obstetrical units of hospitals located in the Oklahoma City area are following the suggested trend of soliciting consumer input. The study's question is: "Are Oklahoma City hospitals with inpatient obstetrical services utilizing patient satisfaction surveys?"

Purpose of Study

The purpose of this study is to establish whether Oklahoma City hospitals with inpatient obstetrical units are using patient satisfaction surveys. The objectives of this study are:

(1) To determine if Oklahoma City hospitals with inpatient obstetrical units are using a tool to survey consumer/patient satisfaction.

(2) To assess whether obstetrical nurse managers perceive a need to survey their consumer population if they

do not have/use a tool designed to solicit consumer/patient satisfaction.

(3) To determine if a tool is being used, whether it is designed to solicit information specific to consumers'/ patients' satisfaction with their labor and delivery experience.

Significance of Study

As primary care providers, nurses are in an ideal position to assess and evaluate consumer/patient care practices. In the past, consumer criticism was given little or no notice from the medical staff, now the health care system is taking notice. If this study indicates consumer/patient satisfaction surveys are being utilized in Oklahoma City area hospitals, it will be to the nursing profession's benefit to help design surveys which solicit both positive and negative criticism. This is particularly true if nurses are going to effect positive and mutually advantageous changes in the health care delivery system.

On the other hand if this study shows consumer/ patient satisfaction surveys are not being used, then the nursing profession may be neglecting one, if not the most important source of information. Nonuse of patient satisfaction surveys might suggest the nursing profession in Oklahoma City area hospitals is not (1) fulfilling it's role as patient advocate and (2) practicing current consumer/patient centered care.

Assumptions and Limitations

In this proposed study there are a number of assumptions and limitations to consider. The following assumptions and limitations are not an all inclusive list, but are an honest effort to delineate major restrictions affecting this study.

It is assumed:

(1) Each obstetrical nurse manager surveyed will be the charge or assistant charge nurse of the hospital's inpatient obstetrical unit.

(2) Each obstetrical nurse manager contacted will participate in this survey.

(3) Each respondent will answer all questions presented in the survey honestly.

(4) Each respondent will interpret the survey's questions and statements as intended.

(5) The instrument will measure what it was designed to measure.

It is anticipated several limitations will impact upon this study. To begin, the population studied will be relatively small, limited to hospitals located in the greater Oklahoma City area. Furthermore, only hospitals with inpatient obstetrical units will be asked to participate. Time for data collection will be restricted to two weeks. The method of data collection by telephone survey is yet another limitation to this study.

Operational Definitions

This study will strive to establish whether inpatient obstetrical units in Oklahoma City hospitals are using consumer/patient satisfaction surveys. Terms used to describe the problem and the study's question are defined as follows:

Consumer/patient: For the purpose of this study these words are used interchangeably.

Patient satisfaction survey: A written instrument developed to elicit opinions and attitudes regarding patients' likes, dislikes, desires, and/or needs.

Obstetrical nurse managers: The individual who is ultimately responsible for the nursing management of the inpatient unit, also known as the unit supervisor, coordinator, charge nurse or head nurse.

Inpatient obstetrical units: The unit(s) within the hospital setting which are designed and tasked to care for the ante, intra and postpartum patient and her infant.

Labor and delivery experience: The experience related to the time spent in the labor and delivery suite, from the time of admission through the time of discharge from the labor and delivery suite.

Family-centered maternity care: "Can be defined as the delivery of safe, quality health care while recognizing, focusing on, and adapting to both the physical and psychological needs of the client-patient, the family, and the newly born" (Family-Centered Maternity/Newborn Care, 1981).

CHAPTER II

REVIEW OF LITERATURE

In the past, health care research focused on medical indicators of wellbeing instead of the consumer's attitudes and/or experiences (Norr et al., 1977). Hulka et al. (1970) were among the first to examine patient attitudes toward physician's in the primary care setting. Since then a number of researchers have studied patient attitudes toward different groups of care providers in a variety of health care settings in an effort to describe and improve the quality of care. Results of these studies have impacted our present health care system by providing strong empirical evidence that "patient attitudes toward their care providers are crucial components of the evaluation of health services" (Linn et al., 1984, p. 804). Social scientists as well as physicians are now convinced physician behavior and patients' perceptions relate directly to patients' level of satisfaction with health care services (Dimatteo & Hays, 1980).

Early Research

The subjects studied in early research were primarily physicians. At least six studies identified physician

behaviors as a variable associated with patient satisfaction (Hulka et al., 1970; Stewart & Wanklin, 1978; Dimatteo & Hays, 1980; Stamps, Finklestein, 1981; .Fletcher, O'Malley, Earp, Littleton, Fletcher, Greganti, Davidson & Taylor, 1983; Linn et al., 1984). Linn et al. (1984) designed a study to measure patients' values on: (1) technical quality, (2) psychosocial concern, (3) courtesy, and (4) mutual participation. Consumers in this study valued physician's concern and mutual participation the most, technical skill and courtesy the least. In a study done by Fletcher et al. (1983) patients were asked to evaluate eight physician attributes. This study's results indicate patients considered continuity of care as the number one priority with compassion, expertise and coordination following as close seconds. Dimatteo and Hay's (1980) study examined the relationship between patients' perception of physicians' communication ability, affective behavior and technical competence. Their research concluded patient satisfaction was closely related to the patients' perception of the physician's technical competence, but this perception was influenced by how well patients thought physicians communicated with them. From these studies it can be surmised that consumer attitudes and perceptions vary and professional competence is usually allied with interpersonal qualities.

Research and the Obstetrical Consumer

Although physicians were the primary subjects studied in early patient satisfaction research, today this research is being extended to other care providers. A review of the literature reveals at least six studies reporting patient satisfaction with care providers in the maternal health care setting (Nunnally & Aguiar, 1974; Norr et al., 1977; Danzinger, 1979; Sullivan & Beeman, 1982; Pridham & Schultz, 1983; Burst 1983). In this setting, especially the labor and delivery suite, nursing personnel are often the care providers giving the "hands on care."

Pridham's (1983) study explored women's attitudes towards their labor and delivery and postpartum experiences. Overall, the study's findings indicated a high level of patient satisfaction with their experiences and care. However, respondents expressed a desire: (1) for more maternal-infant contact after delivery, (2) to remain unmedicated through labor and delivery, (3) for greater eye to eye contact with their infant, and (4) to deliver in the same room they labored in. Also, at least 50% of these patients indicated they would have liked the opportunity to keep their infants for a longer time while they were recovering.

Another approach to researching labor and delivery experiences was taken by Danzinger (1979). Her research was designed to study the onset and style of interactions between staff members and patients. The hypothesis she set out to

prove was the quality of staff-patient interaction during labor and delivery impacts on how patient's transition into parenthood. Results of the study supported her hypothesis, "that staff communication may serve as a mediating influence upon the woman's assessment of childbirth and thereby her initial parent experience...." (Danzinger, 1979. p. 900).

A study conducted by Nunnally and Aguiar (1974) focused on differences among patients who attended prenatal classes versus those who did not, and their perceived level of satisfaction with their labor and delivery experience. Generally patients who attended prenatal classes had more positive birthing experiences. In another study, Walsh, Lewis, Leroux and Kerlin (1984) tried to correlate patients level of satisfaction with their labor and delivery experience when they received continuous care by the same nurse. Three dimensions of nursing care were measured: (1) interpersonal-emotional, (2) information-giving, and (3) physical-technical activity. Results of this research suggested that although continuity of care is important to patient satisfaction, satisfaction was enhanced when continuity of care was provided whether or not it was provided by one or more caregivers.

Of all these studies, Sullivan and Beeman's (1982) is probably the most interesting. Their study proposed patient satisfaction could be evaluated by measuring two variables. These were: (1) communication patterns between care

providers and patients and (2) patient choice of clinical procedures used in labor and delivery. The outcome of their study implied "more personal, more satisfactory course of care depends on more attention to the interpersonal relationships between caretakers and patients and greater flexibility in clinical procedures" (Sullivan & Beeman, 1982, p. 330).

Even though the focus in each of these studies differed, they were all geared to measure patient satisfaction in the maternal care setting. Common findings included a general satisfaction with care and recommendations from consumers for improving the birthing experience.

Today childbearing in the hospital setting is becoming more family oriented. Slowly the role of demi-god assumed by physicians and nurses is being replaced with the new role of adviser and supporter. In the past, many confrontations between obstetricians and consumers occurred because of differences in their orientation on how labor should be managed (Willson, 1984). Now, with more professionals recognizing childbearing as a social process, requiring interaction between the caregivers and consumers, physicians and nurses are starting to modify their orientation towards the obstetrical consumer.

Sullivan and Beeman's (1982) and Danzinger's (1979) studies concluded communication and interaction between care providers and patients were essential to fostering mutual understanding and cooperation in the inpatient obstetrical

health care setting. Furthermore, Danzinger's research revealed "the rules of proper birth conduct are often dictated by the staff instead of being negotiated with individual patients" (Danzinger, 1979, p. 898). A failure to provide an atmosphere conducive to an exchange of concern and expectations for their labor and delivery experience reduced the chances patients would communicate their needs to providers. When patients and staff do not learn of the others concerns and expectations, then care is more likely to be prescribed for the patient.

Danzinger's (1979) and Richard's (1982) research unearthed other barriers to communication. Both researchers found the form of address staff members used when talking to labor patients is often patronizing. Language and tone of voice staff members used were similar to the form of address usually reserved for children. One other communication barrier these studies surfaced was what caregivers have interpreted as a "failure to communicate on the patient's part." Frequently, this seemed to occur when the caregiver was unable to or had difficulty in persuading the patient and/or family members that the caregiver's plan of care was in the patient's best interests (Danzinger, 1979; Richards, 1982).

Summary

It appears in an analysis of Danzinger's, Richard's and Sullivan and Beeman's research, communication and interaction

between caregivers and consumer without sharing eachothers' wants and needs promotes a less than optimal birthing experience for the consumer. Closely related to communication and interpersonal relations is the issue of consumer choice. Sullivan and Beeman (1982) addressed this issue in their study. In addition to establishing two way communication between care providers and patients, they hypothesized offering choices should promote the consumer's level of satisfaction with their care. This study supports today's trend towards deroutinizing maternal care and increasing the childbearing couple's role in decision making.

Evidence of growing consumer dissatisfaction with the non-individualistic, routine approach to maternal care is cited in the literature. In many hospitals routinized patient care in the labor and delivery suite consisted of mandatory practices and procedures. A few examples of these procedures are: administration of intravenous fluids, shave preps, enemas, electronic fetal monitoring, artificial rupture of membranes, sedation, and episiotomy. Until recently, patients' freedom to make choices affecting their labor and delivery experience was limited. Now, routine practices are being replaced with choices/options as health care providers are beginning to realize the significance of choice to the consumer and that many of these procedures are not essential to the mother's or infant's wellbeing. As Pridham and Schultz (1983, p. 50) concluded in their article "having the choice about what happens at a time of life

crisis may be a critical developmental force in both mother's and father's lives."

Specific conflicts between care providers and childbirth consumers have centered around their right to refuse certain procedures. Increasingly, mothers are demanding the right to choose different care options, such as the presence of significant others during labor an delivery, the opportunity to deliver in labor or birthing rooms, and extending the time of initial infant contact after birth.

No longer can care providers assume women consent to all routine hospital practices when they go to the hospital to deliver. Providers must take care to treat maternity patients in all legal respects just as they would any other patient, and "where treatment is proposed, the patient's express consent, should, if at all practical, be sought and obtained" (Finch, 1983, p. 40).

It is time to resolve the old power conflict between consumers and care providers. Now is the time for care providers to start developing interpersonal skills which will open up communication and promote joint decision-making in the best interests of better care and increased patient satisfaction. With these thoughts in mind, and going one step further, institutions and practitioners should be creating mechanisms such as inpatient surveys to help gather information. Through the use of patient surveys and/or questionnaires consumer satisfaction with services rendered can be more consistently assessed and evaluated.

The purpose this study is to assess whether or not greater Oklahoma City hospitals with inpatient obstetrical services are seeking consumer input through the use of questionnaires. If area hospitals are using questionnaires, then the study will attempt to determine whether the questionnaire or a part of the questionnaire is designed to measure consumers' perceived level of satisfaction. In hospitals not using patient questionnaires/surveys, the study will try to establish whether: (1) there is a perceived need for patient surveys/questionnaires and/or (2) other mechanisms are employed to obtain information from their patient population.

CHAPTER III

METHOD AND PROCEDURES

This chapter explains methods and procedures employed in this study. First, the type of research methods employed to determine the relationships between selected demographic variables and the survey's questions are examined. Then the population and ethical considerations are described, followed by a brief explanation of the study's survey instrument. Finally, the method for interpreting the data and data analysis are discussed.

Type of Research

The type of research conducted in this study was a combination of exploratory and descriptive research. As defined by Babbie (1983, p. 74), the purpose of exploratory research is to examine a new interest or "explore a topic, to provide a beginning familiarity with that topic." This study's rather extensive literature review revealed that the topic selected was relatively new with few reported research studies. However, it provided a basis of familiarity for this researcher. On the other hand, the purpose of descriptive research "is to describe situations and events" (Babbie, 1983, p. 75) and the researcher accomplishes these

activities by observing then describing what was observed. The smaller portion of this study involved the actual survey designed to collect common demographic characteristics of obstetrical units using and those units not using patient surveys/questionnaires.

The method of data collection used for this study was telephone survey. According to Babbie (1983) survey research is the preferred method of design when individual people are used as the unit of analysis. It is also an excellent way to measure individuals' attitudes and orientations. Since this study was intended to determine whether or not consumer satisfaction surveys are being used in inpatient obstetrical unit settings and unit charge nurses were targeted as the unit of analysis, a survey design seemed the most appropriate approach. Even though the population surveyed is representing the institution in which they work, the survey is structured to obtain their individual opinions and attitudes. These opinions and attitudes may or may not be influenced by their institution of employment. Furthermore, as anticipated, by conducting a telephone survey all of the targeted population participated in the study.

The Population

The population identified to participate in the telephone survey were the unit charge or assistant charge nurses of inpatient obstetrical units in greater Oklahoma City hospitals. As managers responsible for the nursing care

on their respective units, this population should be the most knowledgeable about and best qualified to answer questions regarding mechanisms used to seek consumer feedback within their facilities.

The Oklahoma City area included Oklahoma City, and the surrounding communities of Midwest City, Del City, Edmond, Gutherie, Moore, and Norman. Tinker hospital was excluded from the study because the researcher is associated with that facility. Twelve hospitals in this area were identified as having inpatient obstetrical units, therefore, the population for this study was limited to these hospitals' obstetrical unit(s) charge nurses or assistant charge nurses. Since the population size was small, an effective sampling design could not be used.

The survey's results are reported by an assigned number in an effort to protect the confidentiality of the nurse manager respondents.

The Instrument

The survey instrument was designed to collect information from a small population of obstetrical charge nurses respondents over the telephone. A copy of the questionnaire is reproduced in the Appendix. The survey developed consists of three parts. The first part is the introduction portion which ascertains the identity of the respondent by job position/title, and explains the purpose of the study to the respondent. Two sets of questions make

up the second section. Since the researcher was interested in obtaining information from respondents regardless of whether or not patient surveys/questionnaires were being used, a set of seven questions was developed for both possibilities. The survey's third part contains a series of eight demographic questions.

Some further discussion of the survey's second parts is needed. Two series of seven questions were written, one for respondents who indicated patient surveys were used and one for respondents who indicated patient surveys were not used. With the exception of first question, the wording of these questions is similar. This was done purposefully, so comparisons between the two groups could be made. These questions relate to the respondent's feelings about: (1) mechanisms being used in their facility to gather information about patient satisfaction, (2) types of patient surveys, (3) survey design, and (4) application of patient surveys to nursing practice.

The demographic questions were designed to describe hospital size, obstetrical unit size, number of births/month, number of labor and delivery beds, staffing patterns, type of nursery and availability of physicians, in an attempt to correlate characteristics with either of the two groups.

Data Analysis

Descriptive statistics were used to analyze the data. This type of analysis is employed to describe single

variables or to describe associations between several variables (Babbie, 1983). Table I represents the demographic data collected from twelve hospitals. The first column of the table lists each hospital by it's assigned number. Responses to the demographic questions and whether or not the hospital's obstetrical unit is using a patient survey are located to the right of the hospital's number (refer to Table I).

Responses to the seven questions in the survey's second portion are reported by frequency and represented by percentages in Figures 1 to 7. With the exception of Figures 1a. and 1b. all the figures are bivariant. Each question's responses is represented by the number of units with the same reply for each question over the number of hospitals using patient surveys ("Yes") or over the number of hospitals not using patient surveys ("No"). From this numerical expression a percentage can be calculated. These statistics are purely descriptive in nature.

CHAPTER IV

RESULTS AND DISCUSSION

This chapter presents the findings of this research study. The findings are divided into three areas: (1) features of the surveyed population, (2) statistical analysis of the survey's findings, and (3) descriptions of each hospital. A brief discussion of the findings concludes the chapter.

Features of the Surveyed Population

The telephone survey was conducted as outlined in the previous chapter between 31 July-15 August 1986. Eleven of twelve hospitals in the Oklahoma City area met the criteria of separate inpatient obstetrical units. One other community hospital was included because the hospital offers comprehensive obstetrical care even though it does not have a dedicated separate unit. The hospital at Tinker Air Force Base was excluded from this survey since the researcher is employed at that facility.

All hospitals contacted participated in the study. In every instance a nurse manager was the respondent. However, in two larger facilities where obstetrical nursing was decentralized, more than one nurse manager was contacted.

Although the obstetrical nurse managers' position titles varied from Charge Nurse, Postpartum Unit to Perinatal Coordinator to Shift Supervisor, nurses in these positions were responsible for the nursing management of the unit/hospital as well as providing direct patient care.

Statistical Analysis of Survey Findings

Demographic Data

Table I on page 30 represents the demographic data collected in this study. The following findings are depicted in Table I. Eight of twelve obstetrical units in Oklahoma City hospitals are using a patient survey. In this study three types of hospitals predominated: (1) community, (2) corporation, and (3) religion sponsored. Community hospitals (42%) were the primary type of hospital. All of these hospital types varied in their bed capacity from smaller (<100 beds) to larger facilities (>300). However, one third of the facilities surveyed were larger hospitals.

The data reflected a wide variance in the number of available beds on the obstetrical units. Seventy-five percent of the obstetrical units had bed capacities ranging from 16 to 45 beds. Likewise, the number of labor/birthing beds ranged from 2 to 12 beds, with an average (58%) bed capacity ranging between 4 to 9. Two hospitals with birth rates of >150 per month had 10 to 12 labor/birthing beds.

TABLE 1

DEMOGRAPHIC DATA

Hospital by Number	Hospitals Utilizing Patient Surveys/ Questionnaires YES	NO	Question #1 Type of Hospital	Question #2 Number of Hospital Beds	Question #3 Bed Capacity of OB Unit	Question #4 Number of Labor/ Birthing Beds	Question #5 Number of Births/Month	Question #6 Seperate Staff for Each Area	Question #7 Level of Newborn Nursery	Question #8 Type of Physician Coverage
1	+		Community	51-100	1-15	4-6	26-50	Combination	One	On Call
2	+		Corporation	51-100	1-15	1-3	51-75	Combination	Two	On Call
3	+		Religion sponsored	300 or more	16-30	4-6	51-75	Separate	Two	On Call
4	+		Religion sponsored	151-200	31-45	7-9	150 or more	Other	Two	On Call
5	+		Community	1-50	1-15	1-3	1-25	Combination	One	On Call
6	+		Corporation	300 or more	31-45	4-6	150 or more	Separate	Two	On Call
7	+		Community	300 or more	16-30	4-6	51-75	Combination	Two	On Call
8	+		Corporation	300 or more	31-45	10-12	101-125	Combination	One	On Call
9		+	Community	151-200	16-30	4-6	101-125	Separate	Two	On Call
10		+	State	251-200	46-60	10-12	150 or more	Combination	One	24 Hour In-House
11		+	Religion sponsored	251-300	16-30	10-12	150 or more	Separate	Three	On Call
12		+	Community	101-151	16-30	7-9	76-100	Combination	Two	On Call

Four hospitals reported birth rates of 150 per month, one of these four hospitals averages 550 births per month. Two of the four hospitals with higher birth rates are religion sponsored while the hospital with the highest birth rate was a state funded facility.

Fifty-eight percent of the hospitals had obstetrical and nursery personnel rotating between two or more obstetrical/ nursery work areas. The most common areas where personnel were crosstrained to were between the ante/postpartum and labor and delivery work areas. Units practicing rotation schedules said it afforded greater flexibility for adjusting staffing to match patient workloads.

More than half of the hospitals had level II nurseries. Level II nurseries are able to care for sicker newborns, where level I nurseries provide care for healthy infants and level III nurseries are intensive care settings for seriously ill newborns. Interestingly enough a higher number of births per month did not directly correlate with a higher level of nursery.

With the exception of one hospital, all the hospitals were covered by physicians on call. That is physicians were available by phone or beeper, but a physician was not necessarily present in the hospital. The one exception to this finding was in the teaching hospital where medical students, interns, and/or residents were available in-house 24 hour a day.

In summary, the demographic data is varied as one might expect in a small study population. There did not appear to be any correlation between the variables and whether or not a patient survey is used.

Summary of the Survey's Questions: 1-7

The following eight figures (1a-7) represent the findings to the seven questions found in parts 2a and 2b of the survey (refer to the telephone survey located in the Appendix). With the exception of the first question, the figures represent questions asked on both the "YES" (part 2a- patient survey is used) and the "NO" (part 2b- patient survey is not used) surveys.

Question #1: from the "YES" survey- "Is the survey being used in your hospital?"

General	6/8 = 75%
Unit specific	1/8 = 12.5%
Other	1/8 = 12.5%
	8/8 = 100%

Figure 1a. Question #1 - "YES"

Question #1 from the "NO" survey: "If your hospital doesn't use an instrument to gather information from patients...?"

There is an office tasked to provide this service	1/4 = 25%
Other	3/4 = 75%
	4/4 = 100%

Figure 1b. Question #1 - "NO"

In figure 1a, the one respondent marked as "other" is in fact using a general type and a unit specific questionnaire Therefore, 7 of 8 hospitals are currently using general type patient surveys. Likewise, in figure 1b, the three hospitals marked as "other" are providing a service by one of these other methods: social workers, clinical coordinators or random follow-up telephone calls.

Question #2: "If you had a choice between a general type of survey or one specific to your unit...?"

	"Yes"	%	"No"	%
Hospital based	4/8	50	0	0
Unit specific	3/8	38	4/4	100
Combination	1/8	12	0	0
	8/8	100	4/4	100

Figure 2. Question #2

An interesting finding to this question was, of the group already using a patient questionnaire there is almost a fifty/fifty split in preference between the general or specific type survey. However, in the group of respondents not using patient questionnaires all respondents indicated a preference for a specific type of questionnaire if one was to be implemented at their facility.

Question #3: "As a nurse manager how important do you think it is to gather information from patients about their feelings and experiences in order to provide quality patient care?"

	"Yes"	%	"No"	%
Very important	5/8	63	3/4	75
Important	3/8	37	1/4	25
	8/8	100	4/4	100

Figure 3. Question #3

In both groups the majority (75%) of the respondents replied "very important" to this question and the other 25% responded as "important." The overwhelming positive response to this question given five possible answers (very important, important, not important, uncertain, other) suggests nurse managers are truly cognizant of finding out how people feel about their hospitalization to provide quality patient care.

Question #4: "...questionnaire ask patients how they feel about specific procedures and choices available to them during labor and delivery...?"

	"Yes"	%	"No"	%
Yes	1/8	12	2/4	50
No	6/8	75	0	0
Uncertain	0	0	1/4	25
Other	1/8	13	1/4	25
	8/8	100	4/4	100

Figure 4. Question #4

The majority (75%) of the "Yes" group replied their present questionnaires do not ask questions specific to the labor and delivery experiences. This finding corresponds with the previous finding (figure 1a.) where 75% of the "yes" group are using general type patient questionnaires. Half of the "no" group responded they would like to see questions specific to the labor and delivery experience if a patient questionnaire were to be implemented in their hospitals.

Question #5: "...survey design should/does...?"

	"Yes"	%	"No"	%
Encourages positive input	1/8	13	0	0
Encourages negative input	0	0	0	0
Encourages both/ combination	2/8	25	3/4	75
Neither	1/8	12	0	0
Other	4/8	50	1/4	25
	8/8	100	4/4	100

Figure 5. Question #5

A significant portion of the "yes" group (representing hospitals using patient surveys) responded to this question as "other." In this instance "other" means their survey designs did not encourage either positive or negative responses but left an area on the survey for their comments. On the other hand most of the "no" group (representing hospitals not using patient surveys) indicated that if they had a survey, the survey should be designed to elicit positive and negative input from patients.

Question #6: "...information gathered from these surveys is used/should be used to change how you practice nursing on your unit?"

	"Yes"	%	"No"	%
Yes	5/8	38	3/4	75
No	2/8	25	0	0
Uncertain	1/8	12	0	0
Other	0	0	1/4	0
	8/8	100	4/4	100

Figure 6. Question #6

Seventy-five percent of the "yes" group responded yes to this question, indicating at least some changes in nursing practices were made based on feedback from patient surveys. However, only two of these respondents could actually think of a specific example. The other portion of the "yes" group replied negatively to this question. In both of these cases, the respondents replied that the feedback from patient surveys is not consistently passed on to the nursing staff so changes can be effected. Only one respondent in the "no" group responded to this question as "other." This respondent indicated many changes in the way nursing practices had occurred, but not as a result of feedback from surveys since patient surveys are not utilized at her facility. She did clarify the issue by saying if a survey were used, then she would expect to receive feedback which would impact upon

nursing practice.

Question #7: "Would you be interested in a patient questionnaire like I just described?"

	"Yes"	%	"No"	%
Yes	3/8	38	1/4	25
No	5/8	62	3/4	75
	8/8	100	4/4	100

Figure 7. Question #7

A third of the nurse managers interviewed expressed an interest in a unit specific patient survey with a focus on the labor and delivery experience. Most of those expressing interest are already using a patient survey at their hospital.

Hospital Descriptions

The following brief descriptions contain demographical information and additional findings of each obstetrical inpatient unit surveyed. The information is presented in a narrative form, and each unit will be referred to by the number assigned to it's hospital. This is an honest effort to protect the anonymity of the hospitals and nurse managers who participated in this study.

Hospital #1

Hospital #1 is a relatively small community hospital with less than 100 beds. The Obstetrical/GYN Unit has a fourteen bed and four to six labor/birthing bed capacity. Some nurses work more than one area, i.e., labor and delivery and postpartum/GYN. The Newborn Nursery is a level I, providing care for 26 to 50 healthy infants per month.

The charge nurse indicated a general type patient survey is in use. She feels this is an appropriate tool since the postpartum beds also serve as GYN beds. As a nurse manager, she feels this survey allows patients to give positive and negative feedback to the staff. Although she admitted that most of the feedback is of a negative nature, she feels it is usually warranted.

Hospital #2

The second hospital contacted is a small hospital run by a large corporation. Bed capacity of the Obstetrical Unit is less than 15 with three or less labor/birthing beds. The unit is managed by a charge nurse and her assistant charge person. Staff assigned to the labor and delivery and postpartum areas are trained to work both areas. The level II Nursery cares for 51-75 healthy and sicker newborns/month.

The assistant charge nurse was interviewed as the charge nurse was on vacation. Two surveys are in use, one is a general type questionnaire, the other is specifically designed for patients who attended their Prepared Childbirth

classes. The assistant charge nurse expressed satisfaction with both tools, particularly the specific type survey. She also stated these surveys are important for information gathering and in changing nursing practices.

Hospital #3

This is a large religion sponsored 300 bed facility with a comparatively small obstetrical inpatient unit managed by a perinatal coordinator. Sixteen to thirty ante/postpartum beds and four to six labor/birthing beds are available for occupancy. A level II Nursery provides care to 51-75 healthy and sick infants per month. Staffing for the three work areas is separate.

The perinatal coordinator indicated a general type survey is made available to all patients. Additionally, all obstetrical patients are contacted by phone 24 hours after discharge. She feels the follow-up phone calls help focus on problem areas the patient may have had in the hospital or is having at home. A log of phone calls and problems is maintained. In the past the respondent has worked with specific type surveys and generally prefers this type of survey. However, for this facility she feels the follow-up phone call system replaces the need for a specific type survey.

Hospital #4

Hospital #4 is a moderate size hospital which is religion sponsored. The large obstetrical unit of 31 to 45 beds and seven to nine labor/birthing beds is run by charge nurse. This unit is one of two interviewed which has implemented a new concept in maternity care: nurses caring for the mother also are primarily responsible for the infant's care. More than 150 infants per month receive care in a level II nursery.

This unit was the only one surveyed using a patient questionnaire designed specifically for obstetrical patients. The charge nurse is a strong advocate of it's use as an indicator of patient satisfaction through positive and negative feedback. Changes in nursing practices have been implemented as result of patients' comments surveys. Positive and negative questionnaires are posted where staff members can review them.

Hospital #5

A small community run hospital serving a suburb of Oklahoma City, this hospital has a bed capacity of less than fifty. Obstetrical patients occupy two to three beds on the surgical unit. The nursing supervisor monitors labor patients in a two bed labor suite, while coverage for a level I nursery is managed by on call nursing staff. There are less than 25 infants born per month.

The nursing supervisor feels too little benefit would be derived from using a specific type survey considering the hospital and population sizes. A general type survey is available to patients. Returned patient surveys are reviewed monthly as part of the Quality Assurance program. The supervisor stated she sees the surveys as a means for focusing on problems nursing can solve.

Hospital #6

This corporation owned hospital has greater than 300 beds. Bed capacity of the obstetrical unit is 31 to 45, with 4 to 6 labor/birthing beds. More than 150 newborns per month are cared for in the level II nursery. Separate staffs work the three obstetrical/nursery areas managed by a OB supervisor.

The Obstetrical Unit utilizes the general survey used hospital wide. Although the survey is general, the supervisor was able to give an example to support how it has been used to change/improve nursing practices. Furthermore, she stated that a specific type survey is being developed to identify problems and needs of new parents. She feels both types of patient surveys have a place in her facility.

Hospital #7

Hospital #7 is a large community hospital with more than 300 beds. The obstetrical unit has a 16 to 30 bed ante/postpartum area and four to six labor/birthing bed

capacity. Approximately 50% of the nurses are trained to work in any of the three obstetrical/nursery areas. A level II nursery cares for 51 to 75 newborns/month.

Two surveys are available to obstetrical patients. The first is a general type questionnaire, the second a specific questionnaire focusing on breast feeding and infant care. Of the two, the charge nurse feels the second type gives feedback which impacts on how they do nursing care.

Hospital #8

This 300 plus bed hospital is owned by a corporation. Obstetrical care includes a 31-45 ante/postpartum and GYN area, a 10 to 12 bed birthing suite, and a level I nursery. Crosstraining between the three work areas is encouraged, presently less than half the staff is trained to work more than two areas. Births average between 101 and 125 per month.

The charge nurse expressed dissatisfaction with the general questionnaire given to patients. In her opinion the respondents to surveys tend to represent the two extremes, the very satisfied and very dissatisfied patient. Although she and her staff see patient feedback as important, she sees very little feedback from these surveys. She expressed an active interest in developing a unit specific questionnaire.

Hospital #9

Hospital #9 is a moderate size community hospital (151-200 beds). The capacity of the ante/postpartum unit is 16 to 30 beds with 4 to 6 labor/birthing beds in the labor and delivery area. There is separate staffing for each of the three obstetrical/nursery areas. A level II nursery provides care for 101 to 125 newborns per month.

No type of patient survey/questionnaire is available at this facility. Twice a year the unit does random telephone follow-up surveys of discharged patients. This is done as part of their quality assurance program. Although the charge nurse feels patient opinions and feelings are important, the present method of surveying gives the staff a general idea of their strengths and weaknesses. Furthermore, since these surveys are designed to elicit information specific to the care rendered, she feels the quality of feedback is better than a general survey given to all patients.

Hospital #10

State supported, this hospital is a 251 to 300 bed facility which provides obstetrical care to high risk pregnant women. The bed capacity of the obstetrical unit is the largest, ranging between 46 to 60 ante/postpartum beds and 10 to 12 labor/birthing beds. Births per month are about 550. A level I nursery provides care to the healthy infants, sick infants are transferred to Children's level III nursery. Staff members are assigned to one of three areas, but

expected to gain expertise in at least two areas.

There is no patient survey available, however, there is a patient advocate officer to whom patients may address their satisfaction and dissatisfaction. The charge nurse indicated she would prefer a specific type questionnaire if one were to be used. She is an advocate of patients feelings and makes daily rounds in an attempt to gather information from patients. Likewise, she feels a specific type survey would help identify nursing problems, trends unique to the obstetrical area.

Hospital #11

Hospital #11 is a religion sponsored facility with a 251 to 300 bed capacity. It is the only Oklahoma City hospital with a level III nursery. The level III nursery is a neonatal intensive care unit capable of caring for extremely sick infants. This nursery provides care to more than 150 infants per month. The obstetrical unit consists of 16 to 30 beds and the labor and delivery area contains 10 to 12 labor/birthing beds. Staffing for each of the work areas is separate.

Patient surveys are not available at this hospital. Each specialty area has a clinical coordinators who is often utilized as a facilitator when a patient has problem or need the staff is unable to assist them with. The charge nurse stated she would prefer a unit specific survey if one were used with questions addressing the labor and delivery

experience. Although surveys are not used, obstetrical patients are contacted by phone two days after discharge. This method of follow-up she feels is sufficient to give the staff an idea where their strengths and weaknesses are. Changes in nursing practices have occurred as a result of information received from telephone calls.

Hospital #12

Number #12 is a comparatively small (101-150 bed) community hospital. Obstetrical unit has 16 to 30 beds for ante/postpartum patients and 7 to 9 labor/birthing beds. Births per month average between 76 to 100. Personnel assigned to a level II nursery care for healthy and sick newborns. Crosstraining among personnel assigned to the postpartum and labor and delivery areas occurs and is encouraged.

Although patient surveys are not used in this hospital a social worker is available to help patients. As part of the social work program a patient survey is being developed. The unit charge nurse indicated she feels gathering input from patients is extremely important to the nursing process. Given a choice between a general type or specific type survey, she chose the specific type. If a specific questionnaire is utilized, she feels information from these surveys should be used to make appropriate changes in nursing practices.

Discussion

In summary, of the twelve units surveyed, eight were using patient surveys. Five obstetrical units were using or planning to use alternative methods of gathering patient input in addition to the general type surveys already in use. Only one unit is using a unit specific patient survey. The remaining four hospitals have patient advocate programs and/or other mechanisms for gathering patient feedback, usually by follow-up telephone calls. All the nurse managers indicated they feel obtaining information from patients is essential to giving quality nursing care. Four managers expressed an interest in receiving a specific type survey for obstetrical patients focusing on the labor and delivery experience.

Probably the most significant finding of this study is the variety of methods local hospitals are employing to obtain patient input/feedback. Seven of the twelve obstetrical units are using general type surveys, and four of these units are either, presently using or in the process of developing unit specific surveys. Even though four of the hospitals do not have surveys available to their patients, they are actively seeking their patient/consumer feedback through other mechanisms. These mechanisms include: (1) making individuals such as social workers and patient advocates available to patients and their family members and (2) follow-up telephone calls. At the unit level the wide

range of methods for obtaining information from their patient population suggests have a definite interest patient/consumer opinions and feelings.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This study was designed to investigate whether or not Oklahoma City area hospitals with inpatient obstetrical units were utilizing patient surveys. Review of the literature indicates increasing consumer involvement, particularly in the obstetrical specialty. Use of patient/consumer surveys as an indicator for measuring quality care has been reported in a number of studies conducted in the last fifteen years. The literature also suggests the health care industry is a booming business, and like most businesses is looking to the consumer for feedback regarding his/her likes and dislikes, i.e., a satisfied consumer is more likely to invest money the same facility than a dissatisfied consumer. The obstetrical specialty is an excellent example of consumers' recent impact in the health industry. As a result of growing consumer criticism the specialty has undergone drastic changes in the last twenty years. It seemed logical then to want to take what is being reported in the literature and see if it applies to hospitals in the Oklahoma City area.

The study's first objective was to "determine if Oklahoma City Hospitals with obstetrical units are using a

tool to survey consumer/patient satisfaction." The study showed without any doubt that the local hospitals are utilizing tools to survey patients. As defined in this study a tool is a written survey/questionnaire made available to patients during their hospitalization. By this definition eight of twelve obstetrical units are using patient surveys. Four obstetrical units do not use written questionnaires, but three of these units routinely survey their discharged patients by telephone calls. Surveying then in either a verbal or written form is being accomplished by all but one hospital.

What remains unclear is whether or not these hospital/unit surveys were designed to measure patient satisfaction. Of the eight hospitals using written questionnaires, all eight either: (1) pose open ended questions asking patients about their feelings during their hospitalization, or (2) left an area on the survey for patients to make additional comments. In a sense asking for someone's feelings or thoughts or giving them space on a form to express their thoughts and feelings is an assumption on the surveyor's part that people will use the opportunity to express their feelings, likes, dislikes, satisfaction and/or dissatisfaction. Since the eight surveys did allow for some form of self expression, one could assume a covert patient satisfaction is being indirectly addressed in these surveys.

The second objective of this study was to "assess whether obstetrical nurse managers perceive a need to survey

their consumer population if they do not have/use a tool designed to solicit consumer/patient satisfaction." Question number 3 which asked nurse managers "how important do you think it is to gather information from patients about their feelings and experiences...?" was designed to answer the second objective. All the nurse managers working in facilities where patient survey are not used advocated obtaining information from patients. Although a formal tool was not in use, all had a method or methods of accumulating input/feedback from their patient population. Likewise, nurse managers employed in hospitals where a formal tool is used unanimously agreed upon the importance of gathering information from their patients. There is an overall consensus among all the nurse managers surveyed regarding this objective.

Again what remains somewhat obscured is the issue of satisfaction. Since question number 3 does not actually use the word "satisfaction" in the question's stem, one can argue the satisfaction portion of the objective is not directly addressed. However, it can be argued that satisfaction is indirectly addressed in the question by the phrase "to gather information from patients about their feelings and experiences...." The question is asking in a round about way "how important do you, as a nurse manager consider others (patients) feelings?" Furthermore, it can be argued "feelings" encompasses a whole array of self expression, more often than not likes, dislikes, satisfaction and

dissatisfaction.

The last objective for this study was "to determine if a tool is being used, whether it is designed to solicit information specific to consumers'/patients' satisfaction with their labor and delivery experience." Question number four asked nurse managers of units using a patient survey, "Does your questionnaire ask patients how they feel about specific procedures and choices available to them during labor and delivery...?" The overwhelming response to this question is "no." This was an expected finding since the information reported from question #1 indicated all but one hospital utilize a general type of patient questionnaire, and one would not expect to see specific questions, especially related to labor and delivery on a general survey. Even the one obstetrical unit using a specific type survey does not ask questions about specific labor and delivery procedures and choices. Although the questionnaire contains three questions about labor and delivery, they are general in nature,i.e., "Have you been satisfied with the care your have received at (name of hospital), including Labor and Delivery?" However, there does appear to be some interest for a specific type survey focusing on the labor and delivery experience as four respondents of twelve showed an active interest in receiving an example of such a survey.

Conclusions

This study did establish Oklahoma City hospitals with inpatient obstetrical units are using patient surveys. Eight of twelve hospitals surveyed are making written questionnaires available to patients. Of the other four hospitals, three units are surveying patient after discharge by telephone calls. All of the obstetrical unit nurse managers perceived the need to survey their patient population about their feelings regardless of whether questionnaires were available to them. Although two units supplement their general hospital survey with a unit specific questionnaire, only one unit relies exclusively on input from a unit specific survey. This unit's survey happens to be the only survey which addresses questions to the labor and delivery experience. Therefore, while patient surveys are being used in Oklahoma City hospitals, they are predominately of the general variety.

What this study does not clearly establish is whether or not these hospital patient surveys are designed to elicit information related to patient satisfaction. Most of the blame lies with the design of the telephone survey. No where in the telephone survey is/are a question(s) phrased to ask "whether or not the intent of the hospital's patient survey is to find information relating to consumer satisfaction." Instead the telephone survey indirectly alludes to patient satisfaction through the use of questions about consumers' feelings. A better designed survey may have definitely

established that "Oklahoma city hospitals with inpatient obstetrical units are using patient satisfaction surveys." However, in the final analysis it is encouraging to ascertain inpatient obstetrical units in Oklahoma City hospitals are at the very least doing what the literature review suggested, surveying their patient population by either formal and informal methods.

Recommendations

Considering the limitations imposed upon this study, primarily the population size and the survey's design, the study proved to be worthwhile for a number of reasons. First and foremost it was a learning experience, starting with the research and ending with analysis of the data collected. Another was the challenge was trying to develop an instrument to gather the information needed to compare what is being done in the Oklahoma City community versus what is being reported in the literature. A third and unforeseen benefit was the study helped increase this researcher's appreciation for the many differences among this relatively small population of hospitals.

The weakest part of this study lies in the survey's design. As discovered by this researcher, a survey conducted over the phone has the following drawbacks: (1) familiarity with the survey is a must to keep the questions and answers free flowing, (2) it is difficult to ask the same questions in the same manner to all participants, therefore,

consistency in both questions and answers may be lacking, and (3) both the surveyor and participant have to rely on what they hear or think they are hearing and interpretation of the other's responses tends to be more subjective than objective. One strong argument for employing this method of survey is it's guarantee of a 90 to 100% response rate. Before this study is repeated, the survey needs revamping. At least one question needs to be added which would relate what the hospital's purpose is in surveying patients, i.e., is it to measure patient satisfaction?

The real value in conducting a study of this nature is applying the process of research to every day life. While the information gathered may not impact the health care industry, this researcher has a better understanding of consumerism and its impact on the industry. Since the literature indicates patient surveys are one example of the industry's effort to cultivate and appease the consumer, it behooves us to study health care settings in our local communities. This researcher recommends a follow-up study in two years, using a revised survey. A comparison of nurse manager attitudes and type of patient questionnaire used would be interesting and may be used to explain changes and/or predict health care and consumerism trends in Oklahoma City area hospitals.

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APPENDIX

TELEPHONE SURVEY

A TELEPHONE SURVEY

JULY-AUGUST 1986

Part 1

1. Date:

2. Hospital (indicate by number):

3. Position/Title of Respondent:

4. Introduction:

a. My name and position

b. Identify my place of employment

c. Explain purpose of study

(1) Survey of obstetrical units in Oklahoma City hospitals and use/nonuse of patient surveys

(2) Clarify term patient survey

d. Verify willingness to answer questions

(1) Explain how responses will be recorded, i.e., a number will be assigned to each hospital

(2) Terminate conversation if respondent is unwilling to participate

e. Determine whether or not patient surveys/ questionnaires are available and used by their patient population

(1) If patient surveys are used proceed to questions in Part 2a, starting on next page.

(2) If patient surveys are not used proceed to questions in Part 2b starting on page 63.

Part 2a

1. Is the survey being used at your hospital:

a. One which addresses services provided by the hospital, i.e., a "general" survey?

b. One which is specifically designed for your unit?

c. A combination of a and b?

d. Uncertain?

e. Other_____

2. If you had a choice between a general type of survey or one specific to your unit which one would you choose?

a. Hospital based. Explanation_____
_____

b. Unit based. Explanation_____
_____

c. Combination. Explanation_____
_____

d. Uncertain. Explanation_____
_____

e. Other. Explanation_____
_____

3. As a nurse manager how important do you think it is to gather information from patients about their feelings and experiences in order to provide quality patient care?

a. Very important. Explanation_____
_____

b. Important. Explanation_____
_____

c. Not important. Explanation_____
_____

d. Uncertain. Explanation_____
_____

e. Other. Explanation_____
_____

4. Does your questionnaire ask patients how they feel about specific procedures and choices available to them during labor and delivery, i.e., electronic fetal monitoring, type of pain medication, type of anesthesia?

a. Yes. Explanation_____

b. No. Explanation_____

c. Uncertain. Explanation_____

d. Other. Explanation_____

5. Would you say the design of the survey you use:

a. Encourages positive input from the patient? Explanation_____

b. Encourages negative input from the patient? Explanation_____

c. A combination of a and b? Explanation_____

d. Neither. Explanation_____

e. Other. Explanation_____

6. Is information gathered from these surveys used to make changes in how you practice nursing on you unit?

a. Yes. Explanation_____

b. No. Explanation_____

c. Uncertain. Explanation_____

d. Other. Explanation_____

7. Would you be interested in a patient questionnaire like I just described? I can send you a copy of one I found.

a. Yes

b. No

c. Uncertain

d. Other

Now proceed to Part 3 of the survey starting on page 65.

Part 2b

1. If your hospital doesn't use an instrument to gather information from patients about their likes and dislikes how does it collect information from your patients?

a. There is a person/office appointed to listen patients express their likes and dislikes?

b. The staff asks patients about their feelings regarding their feeling and experiences during hospitalization?

c. Both services are available.

d. Neither service is available.

e. Other (specify)_____

_____

2. If you had a choice between a patient questionnaire addressing all the services the hospital provided or a questionnaire addressing the services provided by the obstetrical unit which type of questionnaire would you prefer?

a. Hospital based. Explanation_____

_____

b. Unit based. Explanation_____

_____

c. Combination. Explanation_____

_____

d. Uncertain. Explanation_____

_____

e. Other. Explanation_____

_____

3. As nurse manager how important do you think it is to gather information from patients about how their feelings and experiences in order to provide quality patient care?

a. Very important. Explanation_____

_____

b. Important. Explanation_____

_____

c. Not important. Explanation_____

_____

d. Uncertain. Explanation_____

_____

e. Other. Explanation_____

_____

4. If you had a unit based patient questionnaire would you like to see questions which asked the patient how they felt about specific procedures and choices available to them during labor and delivery, i.e., electronic fetal monitoring, type of pain medication, type of anesthesia?

a. Yes. Explanation_____

_____

b. No. Explanation_____

_____

c. Uncertain. Explanation_____

_____

d. Other. Explanation_____

_____

5. Do you think the survey should be designed to:

a. Encourage positive input from the patient? Explanation_____

b. Encourage negative input from the patient? Explanation_____

c. A combination of a and b? Explanation_____

_____

d. Neither. Explanation_____

_____

e. Other. Explanation_____

_____

6. Do you think the information gathered from these surveys would change how you practice nursing on your unit?

a. Yes. Explanation_____

_____

b. No. Explanation_____

_____

c. Uncertain. Explanation_____

_____

d. Other. Explanation_____

7. Would you be interested in a patient questionnaire like I just described? I can send you a copy of one I found.

a. Yes

b. No

c. Uncertain

d. Other

Now proceed to questions in Part 3

Part 3

Demographic Questions

1. Type of hospital:

a. Private

b. Religion sponsored

c. County

d. State

e. Federal/military

f. Other_____

2. Bed capacity of hospital:

a. 1 to 50 beds

b. 51 to 100 beds

c. 101 to 150 beds

d. 151 to 200 beds

e. 201 to 250 beds

f. 251 to 300 beds

g. 301 or more beds

3. Bed capacity of Obstetrical Unit:
    a. 1 to 15 beds
    b. 16 to 30 beds
    c. 31 to 45 beds
    d. 46 to 60 beds
    e. 61 to 75 beds
    f. 76 to 90 beds
    g. 91 or more beds
4. Number of labor/birthing beds:
    a. 1 to 3 beds
    b. 4 to 6 beds
    c. 7 to 9 beds
    d. 10 to 12 beds
    e. 13 to 15 beds
    f. 16 or more beds
5. Number of births per month:
    a. 1 to 25
    b. 26 to 50
    c. 51 to 75
    d. 76 to 100
    e. 101 to 125
    f. 126 to 150
    g. 151 or more

6. Is there separate nursing staff for each area (ante/postpartum unit, labor and delivery, and newborn nursery)?

   a. Yes

   b. No

   c. Combination_____

   d. Other_____

7. Level of Newborn Nursery:

   a. One

   b. Two

   c. Three

8. Obstetrical physician personnel availability:

   a. 24 hour in house coverage

   b. 8 hour in house coverage

   c. On call coverage

   d. Other_____