



Report to Health of Older Adult Service
Waitemata District Health Board

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“Literature review of older adult involvement in the service
delivery quality monitoring process”

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Introduction

Given the emphasis on patient satisfaction as a quality indicator in health care, it is considered an important outcome measure. How and when such a measure is undertaken influences how patients and their families respond. Some patients and families find it difficult to know how service decisions are made, when interventions should be undertaken and what they should expect regarding their care and discharge. Therefore, these factors present a challenge for gathering feedback in the form of a satisfaction survey, whether by self report, focus group, face-to-face or telephone interviews.

The research literature suggests there is a need to review quality monitoring processes to ascertain how information is gathered and how the processes required are conveyed to patients in ways that they can readily respond to. The interest in gaining feedback from patients and families is generally driven by a desire to highlight the aspects of service that require change or improvement. However, any resulting service changes ought to be in the best interests of the patient and family, with a shared investment in ensuring the best outcomes for all including the institution and the health professional staff.

Therefore, careful consideration needs to be given to what to measure and how to measure it. A first concern is the reliability and validity of the data gathering tool which affects the specificity and usefulness of the information gathered. Ware (1981, 1983) cautions that it is wrong to equate all patient survey information with satisfaction, as there are differences in expectations and time frames of care. Where the patients are at on their journey of recovery or care is also influential. Jenkinson et al (2002) agrees with Ware in that patient satisfaction scores are limited, and measuring patient's experiences can be more useful toward improving healthcare.

Ovretveit (1998:244) believes that patients will only communicate their perceptions and experiences depending on:

- How easy it is for them to do so;
- Whether they think the staff really want to know;
- How strongly they feel;
- Their social background;
- Their personality;
- Their personal state at the time; and
- Their wish to make things better for other patients.

Ovretveit (1992) emphasizes that healthcare quality has three dimensions: quality for clients, professional quality and management quality, and involves a set of methods with its own philosophy. “However, when services are under more pressure than ever, it is extremely difficult to find development finance to invest in a quality programme, along with the time and energy of staff to apply these methods” (Ovretveit, 1992:7).

The purpose of this literature review is to identify the involvement of older adults in service delivery quality monitoring processes.

Process for Review of the Literature

Three AUT University staff members formed the review team; two academic experts on the subject and a Reference Librarian. Initially only literature published in the last five years was included. However this was extended when very little recent literature measuring older patients' satisfaction was found. In addition, where recent projects were informed by earlier studies, the search was extended to consider all relevant literature. As the review progressed, it became apparent that studies measuring patient dissatisfaction and patient experience needed to be included.

The search was limited to studies published in English.

Types of Studies Reviewed

1. Patient satisfaction with health care
2. Patient dissatisfaction with health care
3. Patient experiences of health care and health providers
4. Validity and reliability of instruments measuring patient satisfaction, dissatisfaction or patient experiences
5. Priority given to studies involving participants aged 65 years and older.

Two bibliographies from recent in-house literature searches were used initially to identify useful articles, followed electronic Searches of Medline, Cinahl, Hapi, Scopus.

Search Strategy

Key words used:

Older adult or geriatric
 quality monitor* or checklist or instrument*
 satisfaction

(Note: * by the term denotes truncating the term and searching it as a text word)

Results of Literature Search

The electronic search yielded over 200 citations and 10 additional citations from the reference lists. The studies were screened in two stages. Firstly, two members of the review team independently screened the titles and abstracts from these citations. They discussed and resolved differences of opinion, where possible, and eliminated all studies for which they agreed did not meet preset criteria for participants, what was being measured, and outcome measures used. 85 full text articles were obtained, plus further articles of interest cited in the

reference lists of these papers. Secondly, members of the team independently read the full text and screened all 85 studies according to the preset criteria for types of studies.

Data Extraction and Management

A spreadsheet categorizing all full text articles in relation to the nature of the study, study methods, emergent themes, age of participants, outcome measures was established. As the literature review progressed, the spreadsheet was sorted into categories related to measuring patient satisfaction, patient dissatisfaction and patient experiences of care.

Measuring Patient Satisfaction

Forty-two research and literature review articles of patient satisfaction were reviewed.

Measuring Older Patients' Satisfaction

Nine studies were conducted with only *older adults*, aged 62 years or older (Boldy, Chou & Lee, 2004; Chen et al., 2006; Chou, Boldy, & Lee, 2001; Chou, Boldy, & Lee, 2002; Covinsky, et al., 1998; Hsieh, 2006; Morin et al., 2007; Scotti, 2005; Wilson et al., 2006).

The instruments used included the:

- Client Satisfaction Questionnaire (CSQ) (Chen, 2006; Wilson, 2006);
- Resident Satisfaction Questionnaire (RSQ) (Chou, Boldy. & Lee, 2001, 2002); and the
- Client Satisfaction: Case Management (CSAT-CM) (Hsieh, 2006);

Qualitative, semi-structured interviews were used in one study (Morin et al., 2007); and a systematic review of 17 individual studies is reported by Scotti (2005).

Cross-sectional Studies Measuring Satisfaction

Fourteen studies were conducted with a *cross-section of ages*, including older adults aged 65 or older (Benjamins, 2006; Braun et al., 2008; Caljouw, Van Beuzekom, & Boer, 2008; Collins & O'Cathain, 2003; Edwards, Staniszewska, & Crichton, 2004; Gutteling et al., 2008; Hayes, 2007; Hendriks et al., 2001; Hyrkas & Paunonen, 2000; Iliffe et al., 2008; Jaipaul & Rosenthal, 2003; Kong et al., 2007; Liu & Wang, 2007; Young, Meterko, & Desai, 2000).

The instruments used included the:

- Leiden Perioperative care Patient Satisfaction questionnaire (LPPS) (Caljouw, Van Beuzekom, & Boer, 2008);
- Quality Of health care services Through the patients' Eyes (QUOTE) (Gutteling et al., 2008);
- Satisfaction with Communication Tool (Hayes, 2007);
- Primary Care Assessment Survey (PCAS), (Hayes, 2007);
- modified Visser (Hendriks et al., 2001);
- Quality of Hospital Care (Hyrkas & Paunonen, 2000);
- Patient Judgement System (Jaipaul & Rosenthal, 2003); and the
- modified Picker (Young, Meterko, & Desai, 2000).

Further to these standardized instruments, researcher-designed questionnaires involving one or multiple questions on satisfaction were used in six studies (Benjamins, 2006; Braun et al., 2008; Collins & O’Cathain, 2003; Iliffe et al., 2008; Kong et al., 2007; Liu & Wang, 2007).

Qualitative interviews were used in two studies (Edwards, Staniszweska, & Crichton, 2004; Hyrkas & Paunonen, 2000).

Measuring Adults’ Satisfaction

The remaining 19 studies were conducted solely with *young adults* and *adults*.

The instruments used included the:

- Patient Satisfaction Questionnaire (Etter & Perneger, 1997);
- Modified La Monica-Obert (O’Connell, Young & Twigg, 1999);
- Picker (Perneger et al., 2003);
- Patient Judgement System (Perneger et al., 2003);
- SEQUS (Perneger et al., 2003);
- The Lausanne questionnaire (Perneger et al., 2003);
- Home Care Satisfaction Measure (HCSM) (Porter, 2004);
- Home Care Client Satisfaction Instrument (HCCSI) (Porter, 2004);
- Consumer Assessment of Health Care Providers & Systems Survey (CAHPS) (Shea et al., 2008);
- Patient Satisfaction Questionnaire (PSQ) (Ware et al., 1983; Walker & Restuccia, 1984);
- Visit Specific Questionnaire (VSQ) (Ware & Hays, 1988); and the
- Client Satisfaction Questionnaire (CSQ) (Williams, Coyle & Healy, 1998).

Qualitative interviews were used in two studies (Haas, 1999; Williams, Coyle & Healy, 1998).

Interpretation and Comments

At least 8,000 articles, both research and theoretical discussions, of patient satisfaction have been reported in the literature in the last three decades (Coyle & Williams, 1999). However, “the resources directed towards satisfaction studies may not be well spent” (Coyle & Williams, p. 7).

Measuring ‘patient satisfaction’ is well-documented in the literature as a useful indicator of quality of health services. However, older people are under-represented in the research, with

the predominance of studies focusing on the adult population (Scotti, 2005). Furthermore, patient satisfaction is a complex construct which is interpreted and operationalised in many different ways in the research. These differences give weight to the criticism that “satisfaction is under-theorized and no widely accepted definition exists” (Aspinal et al., 2003, p. 324). Complicating the matter even further, the things that influence ‘patient satisfaction’ with particular services or health professional groups, such as doctors or nurses, may be very different from the things that influence making a judgment of ‘overall satisfaction’ with a health service.

What is immediately noticeable is the number of different instruments, both standardised and researcher-developed, reported in the literature over the last two decades. In this review, the only patient satisfaction instrument used in more than one study with older people was the Client Satisfaction Questionnaire (CSQ). Three studies involving solely older people, or a cross section of ages, including older people, employed qualitative interviews to gather patient satisfaction data. While there is a predominance of quantitative methods using questionnaire-based outcome measures, in the last eight years, qualitative studies using unstructured or semi-structured interviews are more evident in the literature.

The advantages of using a questionnaire-based method for measuring older patients’ satisfaction with health services seems to be outweighed by the overwhelming pattern of findings showing older age to be strongly correlated with higher levels of satisfaction (Caljouw, Van Beuzekom, & Boer, 2008; Jaipaul & Rosenthal, 2003; Kong et al., 2007; Liu & Wang, 2007; Young, 2000). This means, as patients’ ages increase, so does their reporting of satisfaction. There may be no simple answer why older patients consistently report being more satisfied than younger patients receiving the same health services, but it does mean the validity of patient satisfaction data is thrown into question. Interestingly, Jaipaul and Rosenthal (2003) found “patient satisfaction scores increased with age until age 65-80 years and then declined” (p. 27).

The most common settings for the studies were aged care facilities, hospitals, follow up after discharge from hospital, in the home and those identified by a general practitioner.

The most common data collection methods were self report surveys, telephone interviews and focus groups. The important items measured varied. In some studies the relationship between the patient and staff was seen as a major determinant of patient satisfaction. All studies reported the treatments including medication information, actual care given, discharge information and experience with the health professional care received. Other areas of exploration of patient satisfaction were diverse, depending on the context within which the participants were located, for example residential care hospital or home.

As the focus of quality monitoring has tended to be on satisfaction, the surveys used have not explicitly sought comment on patient dissatisfaction.

Measuring Patient Dissatisfaction

There seems to be no agreement on how patient dissatisfaction is defined in the literature. Various authors have linked it to the non-fulfillment of patient expectations. More recently, the feeling of dissatisfaction is defined as occurring when a person attributes the blame for a troublesome event or unpleasant experience on the health practitioner or service (Coyle, 1999; Eriksson & Svedlund, 2007). This definition interprets dissatisfaction as being experienced when the “vague undifferentiated feelings initially felt, had crystallized into a more settled negative interpretation” (Coyle & Williams, 1999, p. 5). It is suggested that feelings of dissatisfaction are common amongst health care patients, but they typically remain unexpressed. This means formal complaints are not a good indicator of the scope of patient dissatisfaction (Mulcahy & Tritter, 1998).

Of the four articles reporting research and review of the literature on patient dissatisfaction, none were conducted solely with older adults. Three reported research projects and the remaining article discussed the underpinning assumptions and concepts of patient dissatisfaction through reviewing previous studies of patient satisfaction (Coyle & Williams, 1999).

Cross-sectional Studies Measuring Dissatisfaction

Neither of the cross-sectional studies reviewed used a standardised instrument.

Coyle (1999) used a qualitative, grounded theory method to explore the meaning of dissatisfaction with participants aged 16 to 60 plus, and to understand “how dissatisfied users attribute[d] cause, responsibility and blame for their untoward experiences” (p. 723).

Mulcahy and Tritter (1998) used a researcher-designed interview gathering both quantitative and qualitative data with participants recruited from the general population across different urban and semi-rural regions. Although they did not report participant ages, presumably the participants included older adults. The interview schedule is not included in the article, however questions gathered data on health service contacts as well as the use, appraisal of care, and the impacts of and actions taken in response to dissatisfaction.

Studies Measuring Adults' Dissatisfaction

Eriksson and Svedlund, (2007) used a qualitative methodology, conducting personal narrative interviews with participants aged 59 or less, who had expressed dissatisfaction with hospital services.

Interpretation and Comments

In spite of the suggestion that dissatisfaction with health services is a common concern (Eriksson & Svedlund, 2007), there is little research measuring ‘patient dissatisfaction.’ This suggests the topic has been ignored until relatively recently. A number of researchers suggest attention should turn away from evaluating patient satisfaction toward evaluating patient dissatisfaction (Annandale & Hunt, 1998; Coyle, 1999; Coyle & Williams, 1999; Eriksson &

Svedlund, 2007; Sitzia & Wood, 1997). This argument is based on the relative insensitivity of satisfaction measures (Coyle & Williams, 1999; Ware & Davies, 1983), and the indication that the measuring of patient dissatisfaction may provide better knowledge of how health services ought to be improved (Eriksson & Svedlund, 2007).

Suggestions that dissatisfaction and satisfaction represent the opposite ends of one continuum are unfounded (Coyle & Williams, 1999; Mulcahy & Tritter, 1998). Patient dissatisfaction seems to be a complex construct in its own right, and not merely the absence of satisfaction. However the paucity of research on the topic means the theoretical development for understanding and explaining patient dissatisfaction is in the early stages. Accordingly, the current research on this topic is very exploratory. Ovretveit (1998) stresses that surveys of dissatisfaction should include counting complaints over a fixed time as well as recording the types of complaints received. However, several studies have found no clear relationship between patient dissatisfaction and complaining. This means complaint monitoring in itself is not a good indicator of patient dissatisfaction (Coyle, 1999; Mulcahy & Tritter, 1998).

This leads to the discussion that experiences are more important to measure than either patient satisfaction or dissatisfaction.

Measuring Patient Experiences of Health Care

Twenty-one articles reporting studies and the review of the literature on patient experiences within rest homes, home care services or community health services were considered.

Included under the measurement of 'patient experiences' are studies related to how users define quality of care (Bowers, Fibich & Jacobson, 2001); expectations of service quality (Duffy, Duffy & Kilbourne, 2001); evaluation of care by providers (Blendon et al., 2003; Borders et al., 2004; Denley, Rao & Stewart, 2003; Milano et al., 2007; Suhonen, Schmidt & Radwin, 2007); perceived quality of health care (Borders et al., 2004; Boulton et al., 2008; Krevers & Oberg, 2002; Muntlin, Gunningberg & Carlsson, 2006; Wressle et al., 2006); client-centredness of care (de Witte, Schoot & Proot, 2006; Eales, Keating & Damsma, 2001); experiences of care (Bruster et al., 1994; Jenkinson et al., 2002); the experience of being a patient (Sorlie et al., 2006); and disagreements with practitioners (Annandale & Hunt, 1997).

Measuring Older Patients' Experiences

Seven studies were conducted with older adults (Borders et al., 2004; Boulton et al., 2008; Bowers, Fibich & Jacobson, 2001; Duffy, Duffy & Kilbourne, 2001; Eales, Keating & Damsma, 2001; Krevers & Oberg, 2002; Wressle et al., 2006).

Three of these studies were conducted in rest home or residential care settings (Bowers, Fibich & Jacobson, 2001; Duffy, Duffy & Kilbourne, 2001; Eales, Keating & Damsma, 2001). The remainder were conducted with 'non-institutionalised' elders or within primary health care settings.

A number of questionnaire-based instruments were used across these studies:

- Overall Care Rating (OCR) (Borders et al., 2004)
- Personal Doctor Rating (PDR) (Borders et al., 2004)
- Patient Assessment of Chronic Illness Care (PACIC) (Boulton et al., 2008)
- SERVQUAL (Duffy, Duffy & Kilbourne, 2001)
- Patient perspective On Care and Rehabilitation process (POCR) (Krevers & Oberg, 2002)
- Patient Perspective on care and Rehabilitation (PaPeR) (Wressle et al., 2006).

Two qualitative studies were conducted utilising in-depth interviews (Bowers, Fibich & Jacobson, 2001; Eales, Keating & Damsma, 2001).

Cross-sectional Studies Measuring Patient Experiences

Eight studies were conducted with a cross-section of ages, including older adults (Denley, Rao & Stewart, 2003; de Witte, Schoot & Proot, 2006; Jenkinson et al., 2002; Jenkinson, Coulter & Bruster, 2002, Milano et al., 2007; Muntlin, Gunningberg & Carlsson, 2006; Sorlie et al., 2006; Suhonen, Schmidt & Radwin, 2007). A range of standardised instruments were used across the studies:

- Patient Enablement Score (Denley, Rao & Stewart, 2003);
- Client-Centred Care Questionnaire (CCCQ) (de Witte, Schoot & Proot, 2006);
- Picker Inpatient Survey (Jenkinson et al., 2002);
- Picker Patient Experience Questionnaire (PPE-15) for acute inpatients (Jenkinson, Coulter & Bruster, 2002);
- Patient evaluation of general practice care (EUROPEP) (Milano et al., 2007);
- Quality of care from the Patient's Perspective (QPP) (Muntlin, Gunningberg & Carlsson, 2006);
- Individualized Care Scale (Suhonen, Schmidt & Radwin, 2007);
- Schmidt's Perceptions of Nursing Care Survey (Suhonen, Schmidt & Radwin, 2007); and the
- Oncology Patients' Perceptions of the Quality of Nursing Care Scale (Suhonen, Schmidt & Radwin, 2007).

One qualitative, hermeneutic phenomenological study explored the experience of being a patient (Sorlie et al., 2006).

One further article presented a review of the research literature on hospital patients' perceptions of care. Although ages of the participants is not reported for each study reviewed, it is assumed that many would represent a cross-section of ages, including older people (Castle et al., 2005).

Measuring Adult Patients' Experiences

Seven studies of adults' experiences of care were reviewed, of which six used a questionnaire-based methodology (Annandale & Hunt, 1997; Blendon et al., 2003; Bruster et al., 1994; Castle et al., 2005; Harmsen et al., 2008).

A variety of standardised instruments were used across the studies:

- Survey of Sicker Adults (Blendon et al., 2003);
- Patient experiences of care (un-named structured interview) (Bruster et al., 1994);

- Quality Of health care services Through the patients' Eyes (QUOTE) [Part II only on evaluation of performance of health service] (Harmsen et al., 2008); and the
- Quality of care through the patient's eyes_for migrants (Quote-mi) (Harmsen et al., 2008).

One further study used a qualitative, grounded theory methodology exploring the patient's perspective of quality nursing care (Irurita, 1999).

Interpretation and Comments

Patient experiences of care and evaluations of care quality have become important ways of measuring service performance and, therefore, for guiding developments in service quality (Borders et al., 2004). While again there is a large number of instruments and methods reported in the literature, what is common across the studies reviewed is the focus on gathering data about events and what happens in a care process. Perhaps due to research being conducted in residential care and rest home settings, older adults are reasonably well represented within these studies.

While some might argue that patients or residents cannot reasonably judge quality of the technical aspects of care, there is good evidence that patient perspectives on the care processes, their relationships with practitioners and the consequences of care can inform quality management (Bowers, Fibich & Jacobson, 2001; Castle et al., 2005). The growing emphasis on this type of quality monitoring measure suggests its merits are recognised by service providers and funders. In spite of this, the range of methods used across the different studies suggests good standardised instruments are yet to be developed (Castle et al., 2005).

One recognizable pattern in the studies involving only older adults is the predominant use of interviews for gathering the patient experience data. In-person interviews were used by Boulton et al., (2008), Bowers, Fibich & Jacobson (2001), Duffy, Duffy & Kilbourne (2001), Eales, Keating & Damsma (2001), and Krevers & Oberg (2002). Telephone interviews were used by Wressle et al., (2006) and telephone survey follow-up by Boulton et al., (2008).

In comparison de Witte, Schoot & Proot (2006) used a mail survey with home care recipients.

Looking across the studies of hospital patient experiences, mail surveys conducted two to four weeks post-discharge using self-administered questionnaires were predominantly used. Mail surveys (de Witte, Schoot & Proot, 2006), telephone surveys and in-person interviews typically included more questions than drop box surveys. On average, response rates were lowest for mail surveys and highest for in-person surveys. Responses for telephone surveys were higher than drop box surveys (Castle et al., 2005).

Two studies offer some guidance on the selection criteria and timeframes for gathering patient experience data from elders receiving long-term care. Bowers (2001) included residents with a length of stay of two months to four years within a residential care facility. Two months would be a reasonable timeframe for residents to 'experience' being in the

setting and contact with professional and auxiliary staff. De Witte, Schoot, and Proot (2006) explored experiences of community-dwelling patients (average age 73.5 years) receiving professional domiciliary nursing care. Participants had experienced one domiciliary care event and were expected to receive care for at least six months. This suggests the expectation of ongoing care may influence how patients experience their first or subsequent care events.

Conclusion

Patients' views are an important consideration for developing, changing and improving health services. However the measurement and evaluation needs to be multidimensional, including the evaluation of patient experiences, staff processes as well as management structures and processes. Such multidimensional quality measures promote the implementation of management processes directed towards meeting patient needs (Overtviet,1992).

Patient satisfaction measures alone have numerous theoretical and methodological problems. These include a lack of definition of what satisfaction means for the patient, along with an insufficient understanding of the theory underpinning the questionnaire in the first place. Therefore, measuring older patients' experiences of health care events and processes is likely to offer the most useful information for contributing to quality management decisions.

The meaning and significance of the information gathered will be determined by the quality management team, prior to undertaking the project, defining a clear purpose, as well as making a commitment to service improvement and following through on the findings. As the focus of this literature review was "development of a methodology for ongoing exploration of satisfaction with services provided to older adults and their families," possible methodologies are now summarized:

It is important to remember that there is no one best method. The method or methods selected should be driven by the question/s being asked by the Quality Improvement committee. This will lead to identifying what type of data is needed and how it will be used (Wilson,1995).

The most pragmatic measure is a rating scale which can be used with older adults, staff and managers (Overtveit,1992).

A mixed methods design is likely to render the most useful information for addressing changes in service quality. Initially a quantitative, descriptive method offers the most time and cost efficient approach to measuring older patients' experiences. Such an approach can be conducted with a high number of participants, allow for randomization to enhance rigor, and be readily repeated over time in order to monitor changes. The effectiveness will be reliant upon the relevance of the research instrument, good data gathering and data analysis mechanisms, a commitment by senior management to interpret the findings and propose service changes, as well as the provision of support mechanisms to implement and evaluate results. The contextual culture ought to be one of 'inviting' comments on how service is experienced within a context of ongoing improvement.

Complementary to the quantitative information, qualitative interview-based data gathered from a small number of patients, would provide a descriptive understanding of experiences. Qualitative interviews can be conducted individually or by focus group. They would open up the opportunity to hear about experiences that are not elicited by standardized questions and

would enable a greater understanding of why things, events, or care processes are experienced in particular ways.

Gathering the information by way of in-person interviews (either face to face or by telephone) is likely to be received more positively by older patients and yield a higher response rate. To promote the likelihood of full data sets from each participant, the usual implementation time of a questionnaire should be kept to a minimum, taking no longer than 10-15 minutes. Individual qualitative interviews might be expected to take 30 minutes or longer.

A standardised instrument, showing good reliability and validity for use with older people should be used, and chosen for its relevance to the service area or areas being evaluated. This may mean more than one research instrument will be used to cover the scope of Health of Older Adult Services.

The following instruments are recommended for consideration:

- Emergency Department Care
 - Quality of care from the Patient's Perspective (QPP) (Muntlin, Gunningberg & Carlsson, 2006);
- In-patient Care
 - Picker Patient Experience Questionnaire (PPE-15) (Jenkinson, Coulter & Bruster, 2002);
- Domiciliary and Rest Home Care
 - Client-Centred Care Questionnaire (CCCQ) (de Witte, Schoot & Proot, 2006);
- Rehabilitation Services
 - Patient Perspective on care and Rehabilitation (PaPeR) (Wressle et al., 2006).

Copyright restrictions on the copying and use of any named or standardized instruments must be incorporated into any quality monitoring process.

There is little emphasis in the literature on the dimensions of the cultural appropriateness or cultural relevance of questions and measures. There was no evidence found that any of the above instruments included in this review have been standardized for the New Zealand population. Given the ethnic diversity of the Waitemata District Health Board catchment, cultural relevance is an important consideration for gathering and interpreting data for quality management.

Recommendations

The recommendations in relation to the quality monitoring processes involving older adults within DHB services are that:

1. The purpose and commitment to interpreting the outcomes are explicit prior to undertaking the quality management process;
2. A multidimensional approach is used incorporating information from patients as well as professional and management quality data;
3. Patient experience be evaluated rather than patient satisfaction;
4. A mixed methods design using a short telephone or in-person survey (quantitative) supplemented by a sample of in-person interviews (qualitative) will render the most useful information for addressing changes in service quality;
5. A person, independent from the service delivery team, is appointed to undertake the data gathering and analysis processes;
6. Decisions and actions from the quality management processes are informed and lead to quality improvement; and that
7. Ethical approval be sought and a commitment made to use the data to address service improvement.

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