Residents' satisfaction with multi-purpose services

Judith K Anderson, John B Rae, Linda E Grenade and Duncan P Boldy

Abstract

Aim: To establish a system for measuring resident satisfaction in multi-purpose services, benchmarking and performance improvement.

Setting: Six multi-purpose services in rural New South Wales were involved in the project.

Design: Residents were surveyed and the results benchmarked. Benchmarking included a comparison of results along with an exploration of work processes across participating sites. This preceded quality improvement activities conducted by individual multi-purpose services. Resident surveys were repeated and staff and managers interviewed.

Outcomes: Benchmarking was a useful method for identifying performance leaders and enabling the dissemination of better practice. The majority of staff members were comfortable with the PDSA (Plan, Do, Study, Act) quality improvement cycle to guide their improvement efforts. The ability of staff to complete quality improvement cycles was related to the management styles of their supervisors. Resident satisfaction was related to the understanding and confidence of staff.

Conclusion: A resident satisfaction survey can provide the direction for effective quality improvement activities. Benchmarking results with other sites not only empowers staff members at those sites recognised as leaders, but can also stimulate dissemination of leading practice. Management styles which empower staff enhance their ability to implement quality improvement projects.

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What is known about the topic?

Although benchmarking is a common activity, it frequently involves a comparison of results with little further action. Quality improvement cycles are well-established methods of creating improvement within the health care environment.

What does this paper add?

This paper adds to the limited material on resident satisfaction and how it is related to staff confidence and management style. It demonstrates the benefits of benchmarking within a group to identify better practice and disseminate this information to peer groups.

What are the implications for practitioners?

Before undertaking satisfaction surveys, it is useful to determine how action will be taken on the results and to consider how staff may be engaged and supported to implement change. Forming a benchmarking group will enhance improvement by allowing the dissemination of information among sites. It is essential that the survey utilised is designed for the population being studied and can be reliably administered in different sites.

recruiting staff, increased need for appropriate aged care services and the duplication of resources and infrastructure.[1] Multi-purpose services combine existing health services and aged care services under one management structure to improve coordination and cost-effectiveness.[2] Each multi-purpose service has a Health Council, made up of

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The concept of multi-purpose services arose from rural hospitals becoming economically unviable, difficulties

volunteers from within the local community to facilitate community consultation.

The experience of life in residential aged care and resident satisfaction has not been well investigated. This is especially true for rural areas where aged care is frequently provided in multi-purpose services, rather than privately funded nursing homes. There is no statewide approach to the measurement of resident satisfaction in multi-purpose services, despite the National Quality Improvement Framework for multi-purpose services which supports the consumer as "central to the planning, operation and review processes".[3]

Literature review

Very little is written about the satisfaction of residents of aged care facilities with the services they are receiving.[4] There is considerably more literature on patient satisfaction with acute health care services. This is possibly because of the limited popularity and low status of nursing and other health service provision to older people.[5]

There is an important place for seeking residents' views about the care they receive and their care environment. Of course, residents or patients can only partially evaluate service provision.[6,7] Their ability to evaluate technical quality in particular is questionable.[8] Nevertheless, a good quality service needs to address the satisfaction of its residents as part of its overall quality program.[9,10]

Many methods of measuring resident perceptions of service quality exist. For example, it is possible to measure complaints, but not all dissatisfied residents will complain. In health services, only 4% of dissatisfied customers complain.[9,11] This means that an absence of complaints does not indicate an absence of dissatisfied residents.

Resident satisfaction surveys provide recognition that residents and their family members are a credible source of information about the quality of the care being provided.[7,8,12-17] Indeed, acknowledgement of the residents' perspectives of long-term care reflects a shift from regarding them as passive entities to establishing a partnership with them.

Satisfaction surveys can be of two general designs — quantitative (eg, self-complete questionnaires based on ratings), or qualitative (eg, in-depth personal interviews). Quantitative designs allow comparisons for internal or external benchmarking. Qualitative designs provide more detailed resident feedback and increased ability to identify areas requiring improvement, but may require specialised training to avoid inaccuracies in interpretation. Some surveys incorporate elements of both approaches — for example, providing an opportunity within a largely quantitative survey for residents to make additional comments. This is important in order to solicit information that may not be covered by the questions provided.[18]

Surveys based on personal interviews generally have a better response rate than those using questionnaires and can be more suitable for older people where eyesight and the ability to provide written responses may have deteriorated.[19] Chou, Boldy and Lee[20] found that about two-thirds of the residents participating in their survey required some assistance to complete a written survey. Furthermore, the personal contact involved in interviewing conveys a sense of interest and commitment to improving the service provided. This may reveal information not initially explored in the survey, or a greater depth of information than other methods.[21,22]

Interviews do have a number of limitations, however. These include problems associated with inter-rater reliability, and time required to collect data.[18] A further problem is the associated loss of anonymity and possible fear of impact on the care being delivered, which may increase the number of positive responses received[18,23] compared with other methods such as questionnaires. Byrne and MacLean[24] compared resident satisfaction scores for questionnaires when they were self-administered and when they were completed with the assistance of nursing and other staff. They found that nursing staff received more positive responses while other staff received less positive responses than the self-administered approach. The latter represented a middle ground, and as this group were less likely to be influenced by

others, the authors determined these results to be the best representation of reality.

Project aims

The development of multi-purpose services has facilitated capital development of small rural health services to allow the attraction of Commonwealth funding of aged care services. In order to provide a service that meets the needs of these residents, a method of measuring their satisfaction with the service needs to be developed. Due to the limited numbers found in each facility, such results will only be significant if combined throughout the area health service. This project aimed to establish a system of measuring resident satisfaction which allows benchmarking between sites and improved performance through dissemination of leading practice.

Methods

Residents were initially interviewed in 2003 and again in 2004 by Health Council volunteers. Results from these interviews were benchmarked. Presentations by sites with the highest scores were designed to disseminate leading practice, and all sites agreed to introduce quality improvement activities before the second interviews in 2004.

Instrument selection

In order to ensure validity and reliability of the methods used, a resident satisfaction survey manual[25] comprising two types of survey instrument — a self-complete questionnaire and a personal interview schedule — plus guidelines for their use was purchased. Both instruments were developed in the Australian environment, based primarily on information obtained via focus groups with residents of aged care facilities. The country of development was thought to be an important characteristic to maintain validity, as was the population for whom it was developed — permanent residents in aged care facilities. In addition, each instrument provided for the collection of both qualitative and quantitative data (ie,

in relation to each general issue explored, respondents are invited to make additional comments [questionnaire] or to give an overall rating for that aspect of service [interview schedule]). The self-complete instrument was tested by Chou, Boldy and Lee[20] and found to have convergent validity and discriminant validity. Internal consistency was high and test–retest reliability for both instruments was also good.

The interview schedule was selected for the purposes of this project, particularly as the incorporation of a rating scale at the end of each section provided a basis for comparison across facilities. The interview schedule consists of eleven sections: moving to the home; resident's room/unit; the home; passing the time; social life; links with the community; resident services; staff care; resident representative involvement; other issues; overall rating and general comments. A pilot survey was undertaken and feedback indicated that that schedule was too long to be administered in a single sitting for this client group. For this reason it was decided that only six sections would be utilised in each survey round.
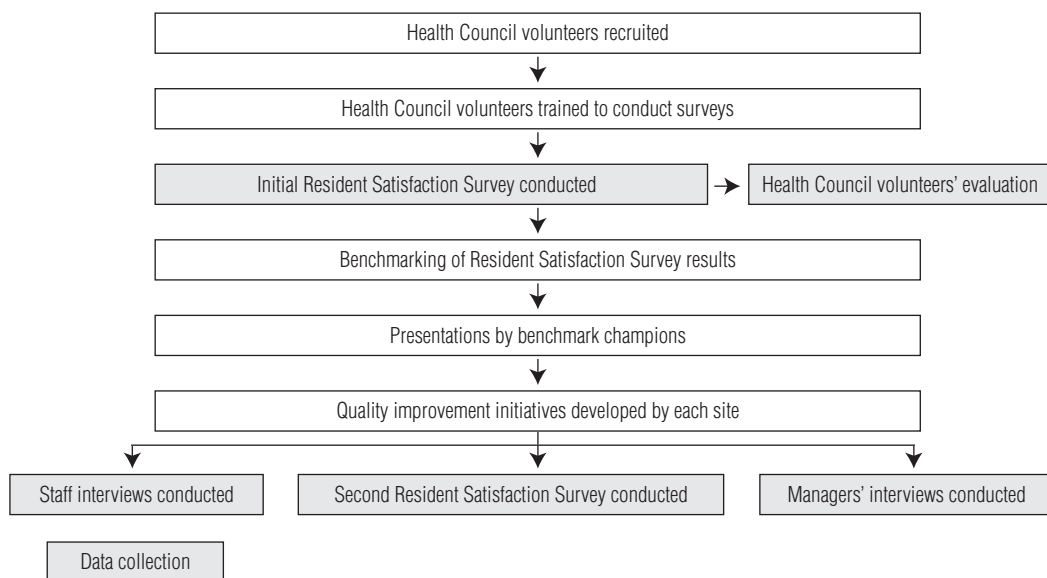
Ethical considerations

As this was a quality improvement activity, no ethical clearance was considered necessary by the area health service involved. Residents were interviewed about their opinions of the service provided and this was not expected to have any adverse consequences. Participation was voluntary and no names were recorded.

Participants

Six multi-purpose services were involved in the project. The size of the facilities included in the project ranged from five residents to 34 residents. Due to the limited numbers available at each facility all residents were approached and all who agreed to participate were interviewed.

Data collection and analysis

Interviews were conducted in person either with the resident or the resident and their carer, or with the resident's carer, in person or by telephone. These options are listed in order of prefer-

1 Project flowchart

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┌─────────────────────────────────────────────────────────┐
│           Health Council volunteers recruited            │
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                             ↓
┌─────────────────────────────────────────────────────────┐
│      Health Council volunteers trained to conduct surveys│
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┌───────────────────────────────────────┐     ┌──────────────────────────────────┐
│ Initial Resident Satisfaction Survey   │ →   │ Health Council volunteers'         │
│ conducted                              │     │ evaluation                         │
└───────────────────────────────────────┘     └──────────────────────────────────┘
                             ↓
┌─────────────────────────────────────────────────────────┐
│      Benchmarking of Resident Satisfaction Survey results│
└─────────────────────────────────────────────────────────┘
                             ↓
┌─────────────────────────────────────────────────────────┐
│           Presentations by benchmark champions           │
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┌─────────────────────────────────────────────────────────┐
│     Quality improvement initiatives developed by each site│
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         ↓                   ↓                    ↓
┌──────────────────┐ ┌───────────────────────────┐ ┌──────────────────────┐
│ Staff interviews  │ │ Second Resident           │ │ Managers' interviews  │
│ conducted         │ │ Satisfaction Survey       │ │ conducted             │
│                   │ │ conducted                 │ │                       │
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┌──────────────────┐
│ Data collection  │
└──────────────────┘
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ence, with the last option only taking place when the others had not been possible. Including carers in the survey allowed the inclusion of residents who would otherwise have been excluded due to their inability to respond to the interview schedule themselves. As multi-purpose services frequently have low numbers of residents, this adds to the significance of the results.

Interviews were conducted by the project team or by trained Health Council volunteers. Health Council volunteers rather than staff members conducted the surveys to guard against interview bias and so enhance the validity of the data being collected. A training program was developed to provide Health Council volunteers with the skills required to conduct the interviews. Satisfaction with the training provided was evaluated by the Health Council volunteers, and feedback was positive. There were no reports of adverse effects on interviewers or interviewees.

Where possible, resident responses were recorded verbatim. All interview reports were considered to be suitable for analysis, that is, legible and with sufficient detail. The re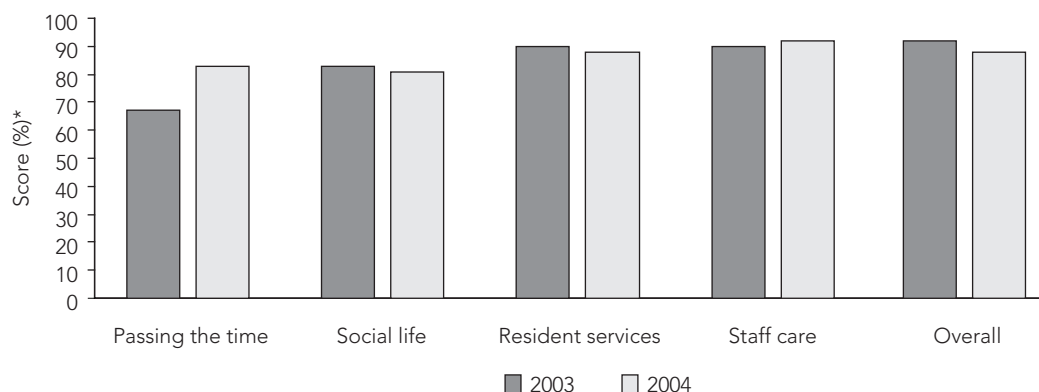sident satisfaction manual also includes a "summary of responses" form for each survey instrument. This was used to collate the responses from both rounds of interviews. These data were then graphed for each facility and percentage scores determined, as suggested by the manual authors. Qualitative data were categorised into themes, and key areas for improvement identified.

In addition to the resident interviews, Health Council volunteers ($n = 11$) were interviewed to determine their understanding of resident satisfaction and whether any difficulties were encountered in the process of interviewing residents. Staff ($n = 36$) and managers ($n = 8$) were also interviewed at various stages of the project in order to determine their roles in and understanding of the quality improvement process.

Benchmarking and follow-up

The results of the initial resident interviews were benchmarked and two factors of the interview schedule (see later) were identified as key opportunities for improvement. The sites with the highest score in these areas provided a presentation to other multi-purpose services and

2 Resident satisfaction at multi-purpose service (MPS) 1, 2003 and 2004

Bar chart showing Score (%)* on the y-axis (0 to 100) for categories: Passing the time, Social life, Resident services, Staff care, Overall. Legend: ■ 2003 □ 2004.

* Percentage of achievable score for the MPS.

answered questions about their success. Each site then developed a quality project in an attempt to improve their resident satisfaction scores in one of the two key areas. When completed, these quality improvement initiatives were presented in a "bulletin" format and distributed to all sites as examples of leading practice.

The steps involved in the process are described in the flowchart (Box 1).

Results

Data were gathered from 82 resident satisfaction interviews in 2003 and again from 82 interviews in 2004/05. The data involved qualitative comments and quantitative scores in response to questions in each section. In the initial round in 2003 seven sections of the interview schedule were used: residents' room/unit; the home; passing the time; social life; resident services; staff care; and overall rating. The benchmarking process conducted after this round of interviews indicated that "social life" and "passing the time" were key areas for improvement and hence were included in the second round (2004/5), together with "overall rating" and those areas that were not explored in the first round (ie, links with the community; staff care; resident involvement).

Improved resident satisfaction was documented in some but not all multi-purpose serv-ices. Box 2 displays the results of one multi-purpose service where minor changes occurred in some areas, but the area selected for a quality improvement initiative ("passing the time") demonstrates a marked improvement. Sites where quality improvement initiatives were implemented had no difficulty identifying the resulting benefits to residents and spoke about the bonds they had formed with them: "It's hard not to form a bond with them when you spend so much time with them". Sites unable to implement a quality improvement initiative, on the other hand, spoke of the residents' need to be responsible for initiating their own activities and their lack of motivation when activities were organised for them: "They won't go. They whinge there is nothing to do, but won't come to anything when it's on".

Interviews with managers, staff and Health Council volunteers indicated that all had a good understanding of the benefits of resident satisfaction surveys and the process followed during the project. However, several managers spoke of difficulties in motivating staff. Sites of successful quality improvement initiatives were more likely to adapt existing organisational structures specifically to meet the needs of the project than were the other sites: "Had a couple of meetings to explain what and why". Managers at the other sites spoke of rigid structures, which were not altered for any purpose: "I'm a systems-operated

person, there is a system in place and I follow it". Those managers who led initiatives spoke of providing encouragement and support for their staff and empowering them to take control: "They came for advice sometimes, but mainly it was allowing them to do their job". These managers provided time during working hours, materials and education to provide tangible support, unlike the managers who led sites unable to implement initiatives. Instead, these managers spoke of the lack of support that they received from each other and nominated staff members to participate. Many of these staff were already struggling to manage existing duties and were not provided with any additional on-site support.

Discussion

Although the resident satisfaction survey data indicated that residents wanted an improved social life and ways of passing the time, merely providing those activities did not result in improved satisfaction. Results of the staff interviews with staff at each site indicated that improved resident satisfaction in these areas was more closely related to the understanding and confidence of the staff working at each site. Those sites that were successful in implementing quality improvement projects had managers who described the importance of empowering their staff and staff who felt they had bonds with their residents. This is supported by Metlen, Eveleth and Bailey[26] who report that active management support leads to increased employee satisfaction and effectiveness among nursing assistants and that this is related to consumer satisfaction. Managers who provide support to clinical staff are more likely to have a positive impact on residents. Studies by Chou, Boldy and Lee[27,28] also indicated that staff attitudes influence the quality of care provided.

A prerequisite for supportive management may be what is termed "emotional intelligence". The components of emotional intelligence are self-awareness, self-regulation, motivation, empathy and social skill. The proponents of emotional intelligence report that high emotional intelligence is required for effective leadership which in turn is associated with organisational success.[29] This would be in keeping with the results of the present study.

A better understanding of the importance of the relationships between management approach, staff satisfaction and effectiveness, and resident satisfaction may lead to more comprehensive strategies for improving resident satisfaction. Rather than focusing solely on direct services to residents as part of quality improvement initiatives, aged care facilities may be advised to put in place processes to facilitate a more supportive management. The results of the present study suggest that this may have an enabling effect and enhance direct services. Greater utilisation of team problem solving (where the manager is more facilitative than directive) and mentoring would serve as examples of how supportive management may be achieved. These strategies strengthen the understanding and confidence of staff, which in this study are related to resident satisfaction.

These relationships between management approach, staff satisfaction and effectiveness, and resident satisfaction also raise questions about manager recruitment. This is not to say that "supportive management style" or "high emotional intelligence" should be listed as essential criteria on position descriptions for multi-purpose service managers. Rather, it is acknowledgement that such attributes should be considered when selecting managers, alongside more traditional characteristics.

When managers are experiencing difficulty in demonstrating supportive management they may want to work at building their strengths in this area and there are various means, such as coaching, for achieving this. Indeed, the benefits that may arise from managers taking such steps may have a very positive effect on not only their staff but also the residents.

Competing interests

The authors declare that they have no competing interests.

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