Are patient satisfaction surveys tools for quality improvement or mere symbolism? The case of Østfold Hospital Trust in Norway

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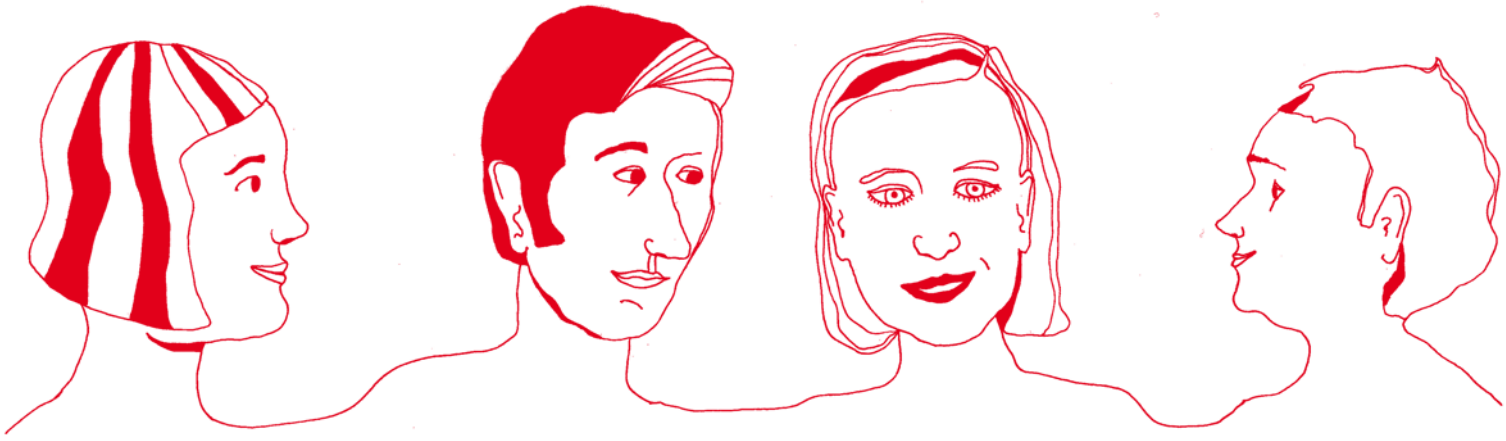

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– Uppsats –

Uppsatsens titel och undertitel

Er pasienttilfredshetsundersøkelser kvalitetsforbedringstiltak eller symbolsk handling? Sykehuset Østfold som case.

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Sammanfattning

I 1997 og 2002 gjennomførte Sykehuset Østfold to pasienttilfredshetsundersøkelser.
Dette studiet har presentert resultatet av undersøkelsen fra 2002 og sammenlignet det med resultatet fra 1997. Dette for å se om det er forskjell på dimensjonene sykehuset har scoret dårlig på i de to forskjellige undersøkelsene.
Hensikten med studiet er å undersøke om pasienttilfredshetsundersøkelsen gjennomført ved Sykehuset Østfold i 1997 var et kvalitetsforbedringstiltak eller en symbolskhandling.
Fra organisasjonsteori ble begreper som innovasjon, ”Rational Choice” og institusjonsteori brukt som briller for å analysere det som har skjedd.
Valg av metode var ikke en enten eller situasjon i forhold til kvantitativ eller kvalitativ metode, siden metodene kan styrke hverandre. Studiet legger vekt på metodetriangulering
Funnene fra studiet har vist at Sykehuset Østfold kan betegnes som en innovativ organisasjon da organisasjonen gjennomførte undersøkelsen i 1997. Dette fordi det ikke var krav fra omgivelsene for å gjennomføre undersøkelsen, kun signaler i form av strategidokumenter fra sentrale myndigheter. Selv om organisasjonen er innovativ hva gjelder initiering og implementering av pasienttilfredshetsundersøkelsen, har sykehusledelsen ikke brukt resultatet til kvalitetsforbedringstiltak.
Ut fra funnene kan studiet konkludere med at gjennomføringen av pasienttilfredsundersøkelsen i 1997 var mer preget av en symbolskhandling enn et kvalitetsforbedringstiltak.Ser en utover 1997 er det viktig å nevne at sykehusledelsen har vedtatt flere kvalitetsforbedringstiltak basert på undersøkelsen fra 2002. Akkurat nå er pasienttilfredshetsundersøkelser som kvalitetsforbedringstiltak satt høyt på dagsorden av sykehusledelsen. Utviklingen kan betegnes som et paradigmeskifte.

Nyckelord

pasienttilfredshetsundersøkelser, kvalitetsforbedring, symbol, sykehus, ”rational choice” (instrumentell) teori, institusjonsteori.

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– Essay –

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Abstract

In 1997 and 2002 the Østfold Hospital Trust conducted patient satisfaction surveys.
This study presented the results of the 2002 survey and compares them with the 1997 results. This is done to ascertain if there are any changes with regards to the dimensions the hospital scored poorly on in 1997.
The purpose of this study is to find out if the patient satisfaction survey conducted at the Østfold Hospital Trust in 1997 was a serious attempt to improve the quality of the health care provided or only a symbolic act. The concepts of innovation, rational choice and institutional theory were used as spectacles to analyse how the Østfold Hospital Trust acted on the results of the 1997 patient satisfaction survey. The choice of study design is not an "either / or" situation between the quantitative and qualitative approach, since both methods can strengthen each other. This study has therefore employed a form of methodological triangulation. The finding of the study showed that the Østfold Hospital Trust can be termed as innovative, when they implemented the patient satisfaction survey in 1997. This because there was no coercive forces from the hospital owners to implement such surveys. There were only signals in the form of strategy documents. In spite of the hospitals innovative action in implementing the non-mandatory survey in 1997, the hospital leadership did not use the results to improve quality.

Based on the findings, the study can conclude that the implementation of the patient satisfaction survey in 1997 was more symbolic, rather than a quality improvement act.
Looking further than 1997, it's important to remark that the hospital leadership resolved a number measures to improve quality, based on the 2002 patient survey. At the time of writing the issue of patient feedback as a quality improvement tool is high on the agenda at the Østfold Hospital Trust. The development point in the direction of a paradigm shift.

Key words
patient satisfaction surveys, quality improvement, symbol, hospitals, rational choice (instrumental) theory, institutional theory, process.

Are patient satisfaction surveys tools for quality improvement or mere symbolism? The case of Østfold Hospital Trust in Norway[1]

1. Introduction

"Health services are for the users. We will all become users of health services during our life time – the health services are our common value, and they should serve everyone. I therefore want the users of the health services to have power and influence over the way services are delivered."
Ansgar Gabrielsen, Minister of Health, Norway (Andreassen, 2005)

From a public health perspective, the conducting of patient satisfaction surveys can be viewed as an endeavour to empower patients. This is so, because the patients are asked to give feedback on different dimensions of the services offered in order to improve quality. Patient satisfaction is measured in relation to physical standard of the hospital, such as buildings and hygiene factors; experience with the staff, with regards to for example attitude; experience with the organisation of the services, for example waiting time and experience with information, for example about the treatment and preventive health.

This involvement of patients in how the services they receive are perceived and/or ought to be, is a departure from the traditional paternalistic approach to patients by healthcare providers(Andreassen, 1997). The concept of empowerment in public health is mainly used in situation were vulnerable groups or patients with chronic diseases are enabled to have better control of their conditions(Werner & Matterud, 2005; Messias et al. 2005; Salmon & Hall 2003; Fields & Gomez, 2001; Rissel 1994). Empowerment in this study is used to emphasis the strengthening of the patients with regards to the general delivery of health services.

Improving performance in health care systems has become increasingly important. Quality in the health care delivery system has been focused on in the 1990's, and many thought it was just another "trend" that would go away, but which is still with us. Several factors can explain the continued focus on the quality of health services. One important factor is the continuous demand for more effective and efficient delivery of services taking into consideration the limited nature of resources. The liberalisation of the health sector, that is the "opening" of the sector for more private actors to compete with the public actors, urges the public sector to focus more on quality. Patients have

[1] Østfold Hospital Trust is a daughter enterprise in the Eastern Norway Regional Health Authority and is one of Norway's largest health enterprises. The enterprise has clinics in Fredrikstad, Moss, Askim, Halden and Sarpsborg.
The hospital offers specialised health services within somatic and psychiatry and has approximately 4000 man-labour year.
In 2004, the hospital treated 48 323 admitted patients, 10 133 day patients and conducted 150 093 outpatient consultations. In 2004, 2877 babies were born at the hospital. The hospital has a running cost of NOK 2.753 million in 2004.

become more knowledgeable with the help of the information technology, and tend to demand better quality of services.

In Norway, the concept of quality improvement in the health services was introduced through the World Health Organization's strategy document "Health for All by the Year 2000" (HFA 2000). Target 31 in the European version of HFA 2000 prescribes the development of effective systems to monitor and guarantee the quality of health care. A Norwegian strategy for quality improvement in health care was drawn up by the national health authorities: the Ministry of Health and Social Affairs and the Norwegian Board of health. This strategy sets out overall objectives and values and specifies the tasks and responsibilities of each health care facility within stipulated time frames. In the strategy it was among other things stated that: *"By 1 July 1996, systems will have been established for feedback from users to individual health care staff and treatment units, so that they can utilise this information in their work"*. It was further stated that *"Quality in health care is based on the concept that the overall goal is to satisfy the requirements, needs and expectations of the patient or user…"* The overall goal of the Norwegian strategy was that *"All providers of health services shall have established effective quality systems for their activities by the end of year 2000"*.

The Norwegian policy makers have contributed to the continued focus on quality through legislation. They strengthened the patients' position by adapting a "Patient Rights Act" in 1999. Patients in Norway have the right to choose where and when to be treated, as of 1997. In September 2001 the Ministry of Health and Social Affairs sent out a public hearing on quality indicators in hospitals. Feedback on patients experience was one of the indicators recommended by an expert-group.

Health care systems have been increasingly concerned with user-perspectives on their services (Draper *et al*, 2001). Patient satisfaction has been the object of interest in health care for some time, and is now increasingly used as a basis for quality management and improvement. However, despite the increasing focus on customer satisfaction, research into health care patients' perceptions of the dimensions of service quality has been scarce in Norway, until recent years. A study of Patient Satisfaction at the Regional Hospital in the northern city of Tromsø, in Norway, concluded that satisfaction with care was strongly influenced by how the patients perceived the quality of contact between nurses and doctors (Sørlie, 2000).

The results of a Patients' perceptions of service quality dimensions of health care in New Zealand suggest that patients with different geographic, demographic, and behaviouristic characteristics have different needs and wants during health care delivery and therefore perceive different service quality dimensions as important **(**Clemes, *et al*, 2001).

There has been increasing emphasis on the use of patient satisfaction surveys in publicly funded health services to assess elements of quality of care in Norway (Holte *et al,*

2003: 13, 14, 17 & 18). This development escalated after the Health Reform in 2002.[2] How patient satisfaction surveys are utilised to change policy and improve services has received less attention. This study will be a contribution in that direction.

[2] In June 2001, the Norwegian parliament resolved that central government should take over the responsibility for all public hospitals. From January 2002, responsibility for the hospitals was transferred to central government. The takeover of responsibility for all hospitals by central government breaks with a more than 30-year long tradition of hospitals being owned and run by the counties.

2. Purpose of the study

"Today the patients represents an unused resource with regards to supplying information on how the hospital services should be delivered. The patients and to a certain degree the relatives have first hand knowledge to services that the hospitals can utilise in a better way to for improvement. Also in this area the hospitals will find it useful to systematically collect information about patient perceived quality. The committee would like to emphasis that, this should not develop to be ritual acts, where the hospitals conduct regular surveys, without the data being used for anything other than general information internally in the hospital". NOU 1997:2 Pasienten først! 7.5.3

Empowerment of the patients in the form rules and regulation is meaningless if these rules and regulations are not followed or only lead to for example to the implementation of satisfaction surveys for symbolic purposes. A dictionary definition of a symbol is the practice of representing things by means of symbols or of attributing symbolic meanings or significance to objects, events, or relationships. The concept of symbolism is broadly discussed in various social science disciplines especially in organisation theory, anthropology and sociology. A detail discussion of the concept in such terms is beyond the scope of this study[3].

Symbolic act in this study refers to a practice that officially aims at doing one thing, but does not have a real plan of action to achieve it. In our case, the decision to implement a patient satisfaction survey to get feedback from the users of the hospital in order to utilise the information to improve quality, but failed to act on the results as officially intended.

There is also an economic aspect of patient satisfaction surveys, since much resource are used in the planning and implementation of such surveys.

The purpose of this study is to find out if the patient satisfaction survey conducted at the Østfold Hospital Trust in 1997 was a serious attempt to improve the quality of the health care provided or only a symbolic act.

In 1997 and 2002, the Østfold Hospital Trust conducted patient satisfaction surveys.
This study will present the results of the 2002 survey, to compare the results with the results of the 1997 patient satisfaction survey, to examine if there are changes with regards to the dimensions the hospital scored poorly on in the 1997 survey. The study will also examine if and how the results of the 1997 patient satisfaction survey were used to improve quality.

Improving the performance of the Østfold Hospital Trust has been a concern for the hospital leadership. Patient satisfaction surveys have been regarded as a good indicator for the hospital to monitor its performance over time and perhaps to be able to compare itself with other hospitals using similar tools. However, there is no basis to use the

[3] For a detailed discussion of the concept of symbols and symbolism from an organisational perspective see March & Olsen, 1987. The positive dimensions of symbols are also discussed by the authors.

measurement of patient satisfaction as a sole indicator of the quality of care, because the satisfied patients expressed also reasons for dissatisfaction. Results of most patient satisfaction studies will probably be more appropriate as a knowledge base to unveil essential issues concerning quality in hospitals, than being a basis for comparison with other hospitals. This applies to the Østfold Hospital Trust as well.

This study will hopefully contribute knowledge, which can be used to improve the services to the patients at the Østfold hospital. The study will also explore if the findings deviate from similar studies in the Eastern Norway Regional Health Authority[4]. The Ministry of Health and Social Affairs mandated the implementation of patient feedback systems where inter-hospital comparisons are possible. Patient feedback systems at hospital level are also demanded by the Eastern Norway Regional Health Authority which is the formal owner of the hospitals.

The Patients' Rights Act of 2 July 1999 no. 63 relating to Patients' Rights regulates individual rights, hereunder the right to participation and information (chapter 3), while the desire for collective participation is stipulated in The Health Enterprise Act of 15. June 200 no. 93. At §35 of The Health Enterprise Act : The Regional Health Authorities should make sure that the institutions that offer specialised health services and other related services established systems for collecting patients' and other users experiences and viewpoints.

The **research questions** in this study can be formulated as follows:

If and how the Østfold Hospital Trust acted on the results of the 1997 patient satisfaction survey to improve quality?

Have the results of the patient satisfaction survey of 2002 shown any improvements on the dimensions where the Østfold Hospital scored poorly in 1997?

[4] From 01.01.2003 the Eastern Norway Regional Health Authority has eight daughter enterprises in the form of seven health enterprises and one pharmacy enterprise. The health authority has also close co-operation with private hospitals.
The health enterprises under the regional authority are autonomous entities.
The regional authority's enterprises offers specialised health services within somatic and psychiatry and has approximately 31 000 employees. It has a running cost of NOK 25 billion.

3. Theoretical Framework

3.1. Introduction

Theories are said to be spectacles through which we can look at reality. Everyone has a theory or a perspective on how organisations function. Based on personal experience, we create “mental maps” of what is connected to what and how things happen. In many respects, organisation theory consists of the systematic examination of these mental maps of how things work (Shortell & Kaluzny, 2000). Over the years, a number of major perspectives of how organisations work have evolved: classical bureaucratic theory (mainly associated with Max Weber), the scientific management school (mainly associated with Taylor), the human relations school, the contingency theory, and the institutional theory. These perspectives can be used to gain insight into the structure and functioning of health care organisations.

In an effort to investigate the questions posed earlier, the study will borrow the concepts of innovation, rational choice (which is much influence by bureaucratic theory and scientific management) and institutional theory. These theories will be used as glasses through which the study will investigate actions of the hospital management with regards to the patient satisfaction surveys. The study will also examine the action or lack of action by the hospital management in connection with the results of the patient satisfaction surveys, through the above mentioned glasses.

3. 2. Innovation

The concept of innovation can be very difficult. According to Gran (1995): "innovation means a departure from routine, a movement away from and beyond the established programmes of action, invention, commitment to the development of new products, change in an organisation's fixed and established connections with the environment" (Gran, 1995).

Innovation may be defined as a consequence oriented decision process, i.e., as decisions that are constantly under critical evaluation. At the opposite end of the consequence-oriented decisions we have the rule oriented decision-making, where the decision maker is not concerned with the consequences of the decisions, but with whether the decision has been reached in a way that is consistent with rules for solving the type of problem at hand.

The introduction of the patient satisfaction studies marked the dropping of old routines and practices that reproduced them. Can the Østfold Hospital Trust be characterised as being innovative, just because it conducted patient satisfaction studies? On the one hand yes, since there is a departure from old routines and procedures. On the other hand, one can say that since the health bureaucracy is a rule-oriented one, changing the rules will make them continue to implement the rules without reflecting on their impact. The attribute as rule oriented, would make the health bureaucracy effective tool of change. Consequence oriented decision-makers are said to be loyal to their client group

(Jacobsen, 1965). In Jacobsen's study the clients were the farmers, and the decision-makers were the agronomists at the Department of Agriculture in Norway. If we consider the health bureaucracy to be consequence oriented, then we should expect them to be loyal to the client group that is the users of health services. If the bureaucrats show more loyalty to the patients for example, they can still be referred to as consequence oriented, in relation to the demands by the health professions. The situation of the patients at the Østfold Hospital Trust, with regards to responsiveness by the health providers and the decision alternatives of the decision-makers will be discussed later, until then, we cannot place the decision-makers on the continuum between rule oriented and consequence oriented decision-making.

3. 4. A rational choice perspective

Health services organisations are complex social systems. In managing these organisations, there is a constant tension between the need for predictability, order, and efficiency on the one hand and openness, adaptability, and innovation on the other. The need for predictability, order, and efficiency is consistent with a close system view of an organisation (Scott, 1987; Shortell & Kaluzny, 2000). The close system view assumes that at least parts of an organisation can be sealed off from the external environment.

In a rational choice perspective, organisations are used as instruments to achieve desired goals. One can say they are a means to an end. The analogy most often used is that of a machine. This view is mainly the rational choice view of organisations. The rational choice model has an instrumental explanation of phenomena. The model would offer to explain the introduction of patient satisfaction studies as a means to an end. Theorists utilising this perspective focus on the normative structure of organisations: on the specificity of goals and the formalisation of rules and roles (Scott, 1987: 48).

Almost all the other theories in organisation theory are built on a critique of the rational choice model. Herbert Simon's *Theory of Administrative Behaviour* with the concept *bounded rationality* is one of the theories built on the critique of the economic man model (March & Simon, 1958). For the "economic man" motivated by self-interest and completely informed about all available alternatives, Simon proposed to substitute a more human "administrative man" who seeks to pursue his self interests but does not always know what they are, is aware of only a few of all the possible alternatives, and is willing to settle for an adequate solution in contrast with an optimal one. Hence the development of the concept of *satisficing* instead of maximising. This study made an effort to analyse the implementation of patient the satisfaction survey and how the results were utilised, from a rational choice perspective.

In a decision-making situation there is a decision and access structure. The decision structure is a relationship between decision-makers and choice opportunities. This simply defines those who can be allowed to participate in the decision. The access structure refers to the problems and solutions that are entertained in the decision-making arena (March & Olsen 1987; Cohen *et al*, 1979). These concepts were used in connection with Garbage Can choice situations. According to Cohen, March and Olsen:

"the Garbage can process, as it has been observed, is one in which problems, solutions and participants move from one choice opportunity to another in such a way that the nature of the choice, the time it takes, and the problems it solves all depend on a relatively complicated intermeshing of the mix of choices available at any one time, the mix of problems that have access to the organisation, the mix of solutions looking for problems, and the outside demands on the decision-makers" (Cohen *et al,* 1979:36) The study examined whether the decision-making process which led to the patient satisfaction survey and the utilisation of the results to better quality, can be categorised as garbage can situations.

3. 5. The institutional perspective

The need for openness, adaptability, and innovation is consistent with an open system view (Scott, 1987; Shortell & Kaluzny, 2000). This view emphasises that organisations are part of the external environment and, as such, must continually change and adapt to meet the challenges posed by the environment. The emphasis is meeting the needs of the external customers and stakeholders with relatively less emphasis given to issues of internal efficiency.

Institutionalists reject the notion that organisational structure and behaviour can be understood in rational terms, as means to the achievement of individual or organisational goals (Moe, 1991). What constitutes an institutional approach or model varies from author to author. Powell and DiMaggio argued that: "Institutionalism purportedly represents a distinctive approach to the study of social, economic, and political phenomena; yet it is often easier to gain agreement about what it is *not* than what it *is* (Powell & DiMaggio 1991:1).

The study will not embark on either a rational-actor or a sociological approach of the concept of institutions, but a combination. Neither will it choose an "old" or a "new" institutional approach. The old institutional approach is associated with Selznick (Selznick, 1949, 1957), while according to Powell and DiMaggio, "If in retrospect, one could assign a birth to the new institutionalism in organisational studies, it would have to be 1977, the year in which John Meyer published two seminal papers, 'The Effects of Education as an institution' and 'Institutionalised Organisations: Formal Structure as Myth and Ceremony' (with Brian Rowan), which set out many of the components of neo-institutional thought" (Powell & DiMaggio 1991:11).

Without going into a detailed discussion of what the different authors in different fields have said about the institutional approach, the different theorists, old or new, will be used in different parts of the study as they compliment one another. The study's point of departure is Selznick's definition of institutions as organisations "infused with values" beyond the technical requirement of the task at hand (Selznick, 1957:17). In other words, institutions are organisations that have value for the members of the society it operates in (Gran, 1995). The values or norms seek legitimacy within the institution and the environment within which it exists. In addition to his definition of institutionalisation as the infusion of values beyond the technical task at hand, Selznick

argued for his awareness of "the prevalence of or importance of other institutionalising processes, including the creation of a formal structure, the emergence of informal norms, selective recruiting, administrative rituals, ideologies, and much else that results from a special history of goal seeking, problem solving, and adaptation" (Selznick 1996:271).

An important attribute of institutions is their persistence overtime. Institutions once established are said to persist. An institutionalist perspective must delineate mechanisms that account for the perpetuation of institutions overtime (Krasner, 1988). One mechanism that explains institutional persistence is what Krasner called *path-dependency*. Institutions are likely to persist because they follow path-dependent patterns of development. Path-dependent patterns are characterised by self reinforcing positive feedback (Krasner, 1988:83). That is, when a certain way of doing things is decided, it can prevent the future searching of alternatives, for doing the same thing. Krasner further said "There are circumstances in which classes of institutions, if not particular members of that class, are very likely to persist, namely, situations in which competition is limited, survival is not an issue, and the most important element of the environment is other organisations" (Krasner, 1988:84).

Under such circumstances, institutions tend to turn towards isomorphism, not because of competition over limited resources but because of their need to fit into a larger organisational environment (Krasner, 1988; Powell & DiMaggio, 1991). The Institutional Isomorphic process can be said to be a kind of diffusion (unconscious process), that is to say institutions are pressured in one way or the other to look more alike. Powell and DiMaggio presented three ways of institutional isomorphic change: coercive, mimetic and normative processes.

Coercive processes result from both formal and informal pressures exerted on institutions by other institutions upon which they are dependent and by cultural expectations in the society within which the institution function. Such pressures may be felt as force, as persuasion, or as invitations to join in collusion (DiMaggio & Powell, 1991).

Mimetic processes is a way to deal with uncertainty through imitation. When organisational technologies are poorly understood (March & Olsen, 1976), when goals are ambiguous, or when the environment creates symbolic uncertainty, organisations may model themselves on other organisations.

Normative processes stems primarily from professionalisation. For example routines communicated through formal and informal educational institutions, through experts, and through trade and popular publications (Heimer, 1985).

According to Krasner, "an institutionalist perspective regards enduring institutional structures as the building blocks of social and political life. The preferences, capabilities, and basic self-identities of individuals are conditioned by these institutional structures" (Krasner, 1988). Looking at the conducting of patient satisfaction studies, by the Østfold Hospital Trust, after many years of what seems to be a lack of interest for

patient anonymous feedback systems, one can talk of a change within an institution. When an institution is transformed - endogenously, as the rules of procedure are changed or a contract renegotiated in a prearranged fashion, or exogenously by some unanticipated shock to the system - it is not the same anymore (Shepsel, 1989).

Figure 1 below illustrates the immense size, diversity, and complexity of health care systems.

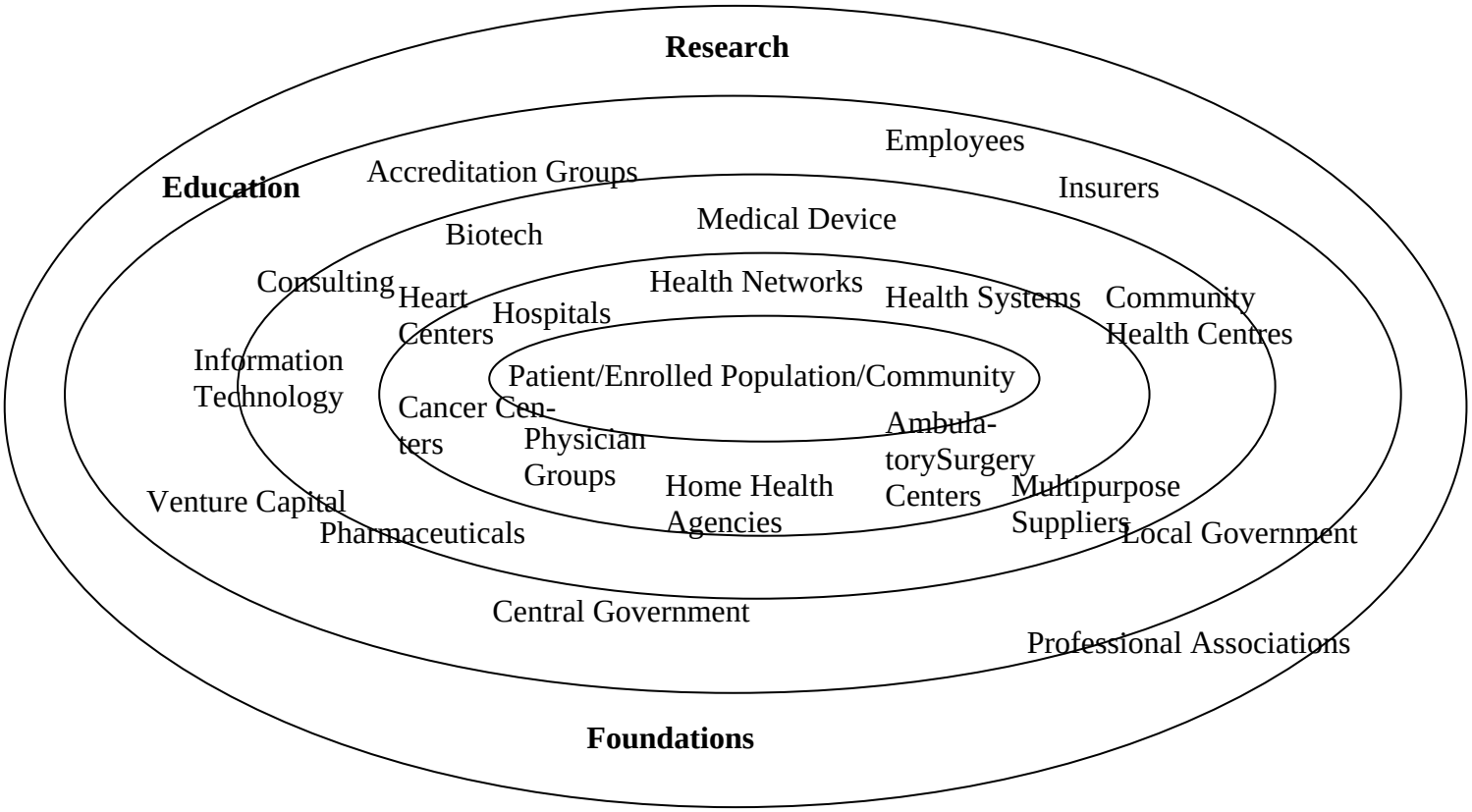

Figure 1. The Concentric Ecology of Organisations in the Health Care Sector.
Adapted from Shortell & Kaluzny, 2000.

4. Methods

This study presents the results of the 2002 patient satisfaction survey in the Østfold Hospital Trust and compares the results with those of the 1997 patient satisfaction survey. This is done in order to examine if there are major differences in the results. If and how the leadership of the Østfold Hospital Trust acted on the results of the 1997 patient satisfaction survey is also explored. This is done through interviews with persons who were involved or had information about the process, as well as document analysis. Finally, the patient satisfaction surveys in the Østfold Hospital Trust were compared with other surveys in Eastern Norway Regional Authority.

The choice of study design is not an "either / or" situation between the quantitative and qualitative approach, since both methods can strengthen each other. This study has therefore employed a form of methodological triangulation (Silverman, 2000). The survey was conducted with a quantitative approach while the studies of how the results were used in Østfold and other parts of the region were conducted with qualitative methods. With triangulation, the potential problems of construct validity also can be addressed, because multiple sources of evidence essentially provide multiple measures of the same phenomena (Yin, 1994).

4.1. The patient satisfaction survey

Since the patient satisfaction survey of 2002 should be similar to the one implemented in 1997, the questionnaire used was almost identical to the one used in 1997. In other words, a replication of the 1997 survey. Some questions were slightly altered to make them more precise and to suit the present hospital structure. Few dimensions that were not analysed in the 1997 survey were removed from questionnaire. The review resulted in 59 instead of 75 questions, including two open-ended questions.

The surveys were carried out during the same time period in 1997 and in 2002. Postal questionnaires were sent to the patients, and they were followed up with one reminder. The questionnaire combined qualitative and quantitative datasets (Hyrkas & Paunonen, 2000). The traditional measurement of patient satisfaction with only fixed-choice questions, were supplemented with other datasets to strengthen the findings. This was done by formulating two open-ended questions at the end of the questionnaire, in addition to the fixed-choice questions. The open-ended questions answered by the patients were:

1. *"Do you have any comments or viewpoints on how your stay at the Østfold Hospital Trust could have been better or more successful than it really was?"*

2. *"Do you have comments or viewpoints on issues which were specially positive or pleasant during your admission at the Østfold Hospital Trust?"*

Answers to these open-ended questions are analysed to give a "deeper" understanding of the outcome of the survey. The data from the open-ended questions enriched the

survey, in the sense that we could illustrate the findings from the fixed-choice questions with quotations directly from the patients. Another advantage of these qualitative datasets is that they captured issues one could not "get hold of" through the fixed-choice questions.

To what degree patient satisfaction surveys are sufficient tools to measure quality will not be dwelled on in this study. We assume that patient surveys for satisfaction are good enough tools.

4.1. 1. Validity and reliability of the surveys

Validity, according to Silverman, is another word for truth (Silverman, 2000). Hammersley defines the concept in a similar way. "By validity, I mean truth: interpreted as the extent to which an account accurately represents the social phenomena to which it refers" (Hammersley, 1990). Reliability, according to Hammersley refers to "the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions" (Hammersley, 1992).

The validity and reliability of the questionnaire utilised had been evaluated earlier since the study was a repetition of an earlier study. Thus the questionnaire is validated and has been used in various Norwegian hospitals (PS-RESKVA). The reliability and acceptability of this patient-satisfaction questionnaire for use in hospitals has been assessed. The PS-RESKVA satisfied the psychometric criteria for internal consistency. Earlier results indicate that the PS-RESKVA is a possible measure of patient satisfaction after discharge from hospital. It seems acceptable to patients in general, and is a reliable measure of satisfaction for a wide range of patients. Further studies on its validity are warranted (Guldvog *et al*, 1998). Analysis of the open-ended questions about dissatisfying aspects of hospital services not included on the fixed-choice questions was performed to examine the instrument's content validity.

4.1. 2. Study object/population for the patient satisfaction survey

The study population for the survey was patients who fulfil the following inclusion criteria: all inpatients discharged from the Østfold Hospital Trust within a 2-4 weeks period and who satisfy the following conditions:

1. Age: respondents should be of age, that is, over 18 years. We had, however, no possibility to exclude patients who are over 18 years and have a guardian.
2. The patients in the study should be discharged to their own homes, local hospitals or rehabilitation institution, hospitals with national functions or nursing homes.
3. They should be discharged from ordinary units and should have a minimum of one overnight stay (emergency, observation, dialyse and other service units are excluded).

4. 1.3. Response rate on the patient satisfaction survey

The 2002 survey included a total of 2005 consecutive patients. Twenty-five of these were excluded either because they died or discharged to an unknown address. 997 patients returned their questionnaires, and this gives a response rate of 50.3%.

The survey at the Østfold Hospital Trust in 1997 included 2000 patients who got their questionnaires sent to them by mail. 1188 patients responded, which is 59.4 % of the sample.

4. 2. The qualitative studies

Ascertaining whether the results of the 1997 survey were acted upon, or not, is a process review. Much of the information from this process review is obtained from personal interviews with the main actors during the planning and implementation of the patient satisfaction survey.

The analysis of documents in the hospital archives and personal notes or archives of the main actors, during the planning and implementation of the 1997 survey, has been an important source of data. Two of the most central actors in the planning and implementation of the patient satisfaction survey, surrendered their personal notes and files to the study, to be scrutinised. Relevant official documents from the Ministry of Health and Social Affairs, The Eastern Norway Regional Health Authority and the Østfold Hospital Trust, relating to the patient satisfaction were assessed.

A brief study of clips from the local newspapers in the Østfold and some national papers was conducted. This was done to get a picture of what kind of information was available to the public, and the way the issue of patient satisfaction was portrayed in the media.

As most of the data used in the qualitative analysis are official documents produced or authorised by the Ministry of Health and Social Affairs, the Eastern Norway Regional Health Authority or the Østfold Hospital Trust for public use; interviews with officials who were involved in the planning and the implementation of the patient satisfaction survey are essential in getting actors' opinions. These are employees and leaders at the hospital, mainly at the Quality department. The interviews conducted were mainly formal, semi-structured and open-ended. Informal and unstructured interviews were also conducted with some of the interviewees. One of the interviews was conducted by telephone for practical reasons. All interviewees have been assured anonymity before the interviews started. The group which was responsible for the implementation of the 1997 survey comprised of the persons in the following positions:

- the acting director for the quality department,
- two consultants at the quality department,
- the teaching/research and development midwife,
- two research and development registered nurses,

- the county ombudsman for patients, and
- an assistant professor from the county college.

Different forms of interviews have been conducted with all the available members of the group excluding the assistant professor. Her role in the group was to give academic support (in the form of data-analysis and report-writing) to the group. She did not have the same possibility as other actors to follow the changes that occurred after the patient satisfaction report was written. This is because of her position as an external actor.

The acting director for the quality department, the two consultants at the quality department, the teaching/research and development midwife, the two research and development registered nurses, and the county ombudsman for patients have been identied as the potential interviewees who can shed light on the process around the planning and implementation of the pasient satisfaction survey and the way the results were utilised.

Five of the seven above named potential interviewees have been interviewed. These five included the most central actors in the planning and implementation of the 1997 survey. The county patient's ombudsman, who is one of the interviewees, could not recall much of what happened. She is also not an employee in the hospital and has limited possibilities to notice any direct changes. Two of the remaining potential interviewees could not be traced.

The interviews were noted down on a note pad and later rewritten properly on a PC while the impressions from the conversations were still fresh.

Personal observations and experience were also an important source of data. The author has been working in the central administration of the county council at the department of health and social affairs between 1999 and 2002. As illustrated earlier, the county council was responsible for the specialised health services (hospitals) until January 2002. Since January 2002, the author has been working at the Østfold Hospital Trust, at the Research and Development Department.

4. 3. Ethical considerations

The patient satisfaction surveys were anonymous. This was secured by not keeping track of the respondents of the patient satisfaction surveys. By producing reminders for the whole population of the survey at the same time as we produce the first letters. Reminders were sent to the whole population with an explanation that it was because of anonymity of the survey. The list of patients was destroyed after the addresses were pasted on the envelopes, since keeping a record of respondent's identity was not necessary. Patients were not requested to write their names or dates of birth, and the questionnaires were not coded for identification, since as mentioned earlier, the reminder was send to all the respondents. Participation was voluntary, and this was clearly stated in the information letter attached to the questionnaire. The completed questionnaire was returned in a prepaid enveloped addressed to the hospital. The Data

Protection Registrar was consulted on the ethical issues of the survey, and the survey was approved.

Concerning the qualitative study, the interviewees were all assured anonymity, before the interviews started. Two of the actors who could have probably enlightened the study have been traced, but to no avail. With the assistance of the personal office, it was confirmed that they no longer worked at the hospital. The interviews were open-ended and they could come with additional information to enlighten the case.

A thorough search was made of the hospital administrative archives, to make sure no written information was missing. This was done with the help of the employees at the central administrative archives.

5. Results

5. 1. Results of the patient satisfaction surveys

Patient satisfaction is multidimensional, therefore will satisfaction with one aspect of care not necessarily carry over to other aspects of care (Hsieh & Kagle 1991). Both the survey conducted in 1997 and the one conducted in 2002 measured different dimensions of patient satisfaction. Patient satisfaction was measured in relation to the physical standard of the hospital, such as buildings and hygiene factors; Patient experience with the staff, with regards to for example respect; Patient reported experience with the organisation of the services, for example waiting time and Patient reported experience with information, with regards to for example, treatment, tests and preventive health.

As in many patient satisfaction studies, background variables such as sex, age, educational background and civil status were registered. The data from the 1997 and 2002 surveys do not show any marked differences in age distribution and other socio-demographic variables. Several studies have shown a relationship between several socio-demographic and health variables on the one hand, and patient's evaluation of health services on the other. Age for instance matters, when it comes to how patients rate hospitals, in the sense that older patients tend to answer more positively than younger patients (Brekke. *et al*, 1/2003; Aharoney & Strasser, 1993). Male patients usually rate hospitals more positively than female patients. Patients with higher education are generally less satisfied than patients with less or no education. The 2002 patient satisfaction survey at Østfold Hospital Trust followed this pattern.

There are several ways to process and analyse patient satisfaction data. Statistical analysis can vary from simple counting or frequencies of the patient's answers to more sophisticated procedures such as regression analyses, which can outline in a refined way, relationship and variation in the data. In both surveys the latter analysis was utilised. The analysis of the 2002 data was made identical to that of 1997 to make comparison of the results easier. Comparison is discussed later in a subsection.

In the analysis of the results of the survey, the study focused on the main findings of the 1997 survey, this was done to ease comparison of the two studies. Most of the questions posed to the respondents are in the form of multiple choices. In the analysis of the answers the extreme values in the answers are added together to represent either the positive or negative feedbacks. For example, if the respondents rate the hospital on a scale from 1 to 5, values 1 and 2 are put in one category and values 4 and 5 in another. This dichotomising of the answers is made to simply the analysis of the results.

The main findings of the 2002 survey showed that patients at the Østfold Hospital Trust were mainly satisfied with the services they received. Tables 1 and 2 below from the surveys showed that 90 % and 93 % of the respondents respectively, are satisfied with the services they received from the hospital. This is in concordance with the findings in other patient satisfaction surveys conducted at other hospitals in Norway and abroad (Brekke *et al*, 1/2003; Pedersen, 2002; Fields & Gomez, 2001; Riiskjær, 2001; Hofoss, 1986). However, important areas for improvement were unveiled through the surveys,

when the patients were posed questions about specific aspects of their experience with the hospital. Among other things, waiting time before admittance and under admittance, continuity in doctor-patient and or nurse-patient relationship and information were mentioned.

Table 1 Overall impression in 1997

What is your overall impression of the treatment you received at Østfold Hospital Trust?(1997)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Outstanding	535	45,0	46,9	46,9
	Good	525	44,2	46,1	93,0
	Both good and bad	50	4,2	4,4	97,4
	Bad	19	1,6	1,7	99,0
	Unacceptable	11	0,9	1,0	100,0
	Total	1140	96,0	100,0	
Missing	0	48	4,0		
Total		1188	100,0		

Table 2 Overall impression in 2002

What is your overall impression of the treatment you received at Østfold Hospital Trust? (2002)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Outstanding	378	38,5	40,0	40,0
	Good	478	48,7	50,5	90,5
	Both good and bad	63	6,4	6,7	97,1
	Bad	18	1,8	1,9	99,0
	Unacceptable	9	0,9	1,0	100,0
	Total	946	96,3	100,0	
Missing	0	36	3,7		
Total		982	100,0		

Waiting time in connection to admission into the hospital and during the stay at the hospital can have an impact on the patients' satisfaction. In the 1997 survey only 54% of the patients responded that they did not wait too long at the wards. This tendency is also found in the 2002 survey, were 45 % were dissatisfied with the waiting time. Table 3 and 4 below illustrates. It is therefore prudent to think that the patients' time is as important as that of the health professionals. Good organisation and planning combined

with good information while the patients are waiting can be a way of alleviating the problem highlighted by the patients in both surveys.

Table 3 Waiting time in 1997

Did you feel there was unnecessary waiting time during your admission? (1997)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes, definitely	142	12,0	13,8	13,8
	Yes, to some extent	181	15,2	17,6	31,4
	Both yes and no	154	13,0	15,0	46,4
	No, just a little	120	10,1	11,7	58,0
	Not at all	432	36,4	42,0	100,0
	Total	1029	86,6	100,0	
Missing	0	159	13,4		
Total		1188	100,0		

Table 4 Waiting time in 2002

Did you feel there was unnecessary waiting time during your admission?(2002)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes, definitely	169	17,2	20,0	20,0
	Yes, to some extent	155	15,8	18,3	38,3
	Both yes and no	143	14,6	16,9	55,3
	No, just a little	99	10,1	11,7	67,0
	Not at all	279	28,4	33,0	100,0
	Total	845	86,0	100,0	
Missing	0	137	14,0		
Total		982	100,0		

5. 2. Comparison of the results of the patient satisfaction surveys

A comparison of the results of the 1997 patient survey with the survey in 2002 can be problematic due to several factors. The composition of the patients though similar, is not the same in the studies being compared. There are many other confounders such as the reorganisation processes implemented between 1997 and 2002. In the patient satisfaction survey conducted in 1997, it was only the two clinics in Sarpsborg and Fredrikstad which participated. While in the 2002 all the five clinics of the hospital in

Sarpsborg, Fredrikstad, Moss, Askim and Halden participated. In spite of the comparative limitations, the results from the two surveys can highlight tendencies with regards to the responsiveness of decisions makers on patient feedback.

The main findings in 1997 showed that the patients were very satisfied with that the nurses and that the doctors spoke to them in a language they could easily grasp, free from medical jargon. The results of the 2002 survey, also demonstrates satisfaction with the way the health personnel talked to the patients. Tables 5, 6, 7, and 8 displayed very similar scores in both the 1997 and 2002 surveys.

Table 5 Nurses spoke in a language patients understood

Did the nurses speak to you in a language you understood?(1997)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very easy to understand	853	71,8	76,2	76,2
	Easy to understand	213	17,9	19,0	95,3
	Not so difficult to understand	40	3,4	3,6	98,8
	Difficult to understand	10	0,8	0,9	99,7
	Very difficult to understand	3	0,3	0,3	100,0
	Total	1119	94,2	100,0	
Missing	0	69	5,8		
Total		1188	100,0		

Table 6 Nurses spoke in a language patients understood

Did the nurses speak to you in a language you understood?(2002)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very easy to understand	717	73,0	75,2	75,2
	Easy to understand	176	17,9	18,4	93,6
	Not so difficult to understand	47	4,8	4,9	98,5
	Difficult to understand	7	0,7	0,7	99,3
	Very difficult to understand	7	0,7	0,7	100,0
	Total	954	97,1	100,0	
Missing	0	28	2,9		
Total		982	100,0		

Table 7 Doctors spoke in a language patients understood

Did the doctors speak to you in a language you understood?(1997)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very easy to understand	646	54,4	60,4	60,4
	Easy to understand	264	22,2	24,7	85,1
	Not so difficult to understand	118	9,9	11,0	96,2
	Difficult to understand	21	1,8	2,0	98,1
	Very difficult to understand	20	1,7	1,9	100,0
	Total	1069	90,0	100,0	
Missing	0	119	10,0		
Total		1188	100,0		

Table 8 Doctors spoke in a language patients understood

Did the doctors speak to you in a language you understood? (2002)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very easy to understand	568	57,8	61,1	61,1
	Easy to understand	226	23,0	24,3	85,5
	Not so difficult to understand	89	9,1	9,6	95,0
	Difficult to understand	23	2,3	2,5	97,5
	Very difficult to understand	23	2,3	2,5	100,0
	Total	929	94,6	100,0	
Missing	0	53	5,4		
Total		982	100,0		

As tables 9 and 10 reveal the patients were also satisfied with the information they received about tests, examination and treatment. The 2002 results as shown in table 10 illustrate a little worsening of the situation with regards to the information the patients received about tests, examination and treatment (Sanyang, 2003; Aagaard, 1998*)*.

Table 9 Information about results

Did you get the information you needed about the results of examinations and tests?(1997)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes, definitely	702	59,1	62,5	62,5
	Yes, to some extent	276	23,2	24,6	87,0
	No, I got little info.	115	9,7	10,2	97,2
	No, I did not get any info	31	2,6	2,8	100,0
	Total	1124	94,6	100,0	
Missing	0	64	5,4		
Total		1188	100,0		

Table 10 Information about results

Did you get the information you needed about the results of examinations and tests? (2002)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes, definitely	570	58,0	61,2	61,2
	Yes, to some extent	243	24,7	26,1	87,2
	No, I got little info.	91	9,3	9,8	97,0
	No, I did not get any info	28	2,9	3,0	100,0
	Total	932	94,9	100,0	
Missing	0	50	5,1		
Total		982	100,0		

In both surveys the Østfold Hospital Trust scored relatively poorly on the organisation of the services. For example, that the patients did not have one particular doctor who is primarily responsible for them (tables 11 and 12). As illustrated by tables 3 and 4 earlier, the patients were relatively dissatisfied in both surveys with that there was much unanticipated waiting.

Table 11 One particular doctor who had the main responsibility

Did you feel that there was one particular doctor who had the main responsibility for you during your admission? (1997)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes, completely	366	30,8	33,1	33,1
	Yes, to some extent	252	21,2	22,8	55,9
	Both yes and no	164	13,8	14,8	70,8
	No, just a little	96	8,1	8,7	79,5
	Not at all	227	19,1	20,5	100,0
	Total	1105	93,0	100,0	
Missing	0	83	7,0		
Total		1188	100,0		

Table 12 One particular doctor who had the main responsibility

Did you feel that there was one particular doctor who had the main responsibility for you during your admission?(2002)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes, completely	300	30,5	35,3	35,3
	Yes, to some extent	167	17,0	19,6	54,9
	Both yes and no	139	14,2	16,4	71,3
	No, just a little	76	7,7	8,9	80,2
	Not at all	168	17,1	19,8	100,0
	Total	850	86,6	100,0	
Missing	0	132	13,4		
Total		982	100,0		

In the 1997 survey patients were satisfied with the nurses' and doctors' knowledge 89.1% and 89.4% respectively), but when it concerns continuity in patient-nurse and patient-doctor relationship, or the doctors availability, they were less satisfied. These questions received similar scores in the 2002 survey as tables 13 and 14 demonstrates.

Table 13 Nurses good at their profession

Did you get the impression, that the nurses were good at their profession? (1997)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Outstanding	550	38,9	48,0	48,0
	Good	469	37,0	41,0	89,0
	Both good and bad	94	10,6	8,2	97,2
	Bad	23	2,0	2,0	99,2
	Unacceptable	9	0,4	0,8	100,0
	Total	1145	88,9	100,0	
Missing	0	43	11,1		
Total		1188	100,0		

Table 14 Nurses good at their profession

Did you get the impression, that the nurses were good at their profession? (2002)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Outstanding	382	38,9	43,8	43,8
	Good	363	37,0	41,6	85,3
	Both good and bad	104	10,6	11,9	97,3
	Bad	20	2,0	2,3	99,5
	Unacceptable	4	0,4	0,5	100,0
	Total	873	88,9	100,0	
Missing	0	109	11,1		
Total		982	100,0		

In the 1997 survey, the patients were less satisfied with the guidance / advice they received in connection with what they could do to be better or prevent the worsening of their situation. Only 53 % of the patients answered that they received such information (Table 15). As illustrated in table 16, the 2002 survey marked a slight improvement in this direction, were 61 % answered that they received information about preventive health.

Table 15 Avoid getting worst

Did someone on the hospital staff talk to you about what to do to get better or avoid getting worst?(1997)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes, definitely	215	18,1	25,7	25,7
	Yes, to some extent	228	19,2	27,2	52,9
	Both yes and no	197	16,6	23,5	76,5
	No, just a little	75	6,3	9,0	85,4
	Not at all	122	10,3	14,6	100,0
	Total	837	70,5	100,0	
Missing	0	351	29,5		
Total		1188	100,0		

Table 16 Avoid getting worst

Did someone on the hospital staff talk to you about what to do to get better or avoid getting worst?(2002)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes, definitely	247	25,2	31,0	31,0
	Yes, to some extent	244	24,8	30,6	61,5
	Both yes and no	149	15,2	18,7	80,2
	No, just a little	63	6,4	7,9	88,1
	Not at all	95	9,7	11,9	100,0
	Total	798	81,3	100,0	
Missing	0	184	18,7		
Total		982	100,0		

There were also relatively few patients who meant that they received information on how they could prevent future accidents, illness or pain. Twenty percent of the patients answered that they received poor or no information with regards to preventive health. There is a slight improvement with regards to counselling and information on preventive health in the 2002 survey. This improvement could be explain because the patients in the 2002 survey have the possibly to choose the alternative “Not applicable”. This was not the case in the 1997 survey as tables 17 and 18 illustrates.

Table 17 Prevention of future illness…

Did someone on the hospital staff talk to you about how prevent future illness, damage or pain?(1997)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	369	31,1	38,9	38,9
	No	515	43,4	54,3	93,2
	I don't know	64	5,4	6,8	100,0
	Total	948	79,8	100,0	
Missing	0	240	20,2		
Total		1188	100,0		

Table 18 Prevention of future illness…

Did someone on the hospital staff talk to you about how to prevent future illness, damage or pain?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	326	33,2	36,3	36,3
	No	347	35,3	38,6	74,9
	I don't know	28	2,9	3,1	78,0
	Not applicable	198	20,2	22,0	100,0
	Total	899	91,5	100,0	
Missing	0	83	8,5		
Total		982	100,0		

On the whole we can conclude that the results of the 1997 and the 2002 surveys were quite similar. The hospital scored poorly on basically the same dimensions. The focus will now move to the findings of the qualitative sources of data.

5. 3. Main findings from the qualitative studies

5. 3. 1. The Interviews

The county ombudsman for patients answered during our short interview that she did not recall much, from what happened in 1997. Memory bias can be a confounder here, since respondents are asked to reflect on an event that happened a long time ago. In spite of the possibility for memory bias, the main findings from the interviews can be summarised as follows.

The general impression from all the interviewees is that a lot of resources has been used in the planning and implementation of the patient satisfaction survey, but the results were not utilised to improve quality. The following citation from the interviews illustrates this point:

"We spend much time planning and implementing this survey, but the results were not used at all. The project demanded a lot of resources, but the results were not put into something useful."

"Nothing happened with the results. This is the problem with this organisation. We put into action so many work groups, and use enormous time on projects, but, when it comes to the implementation of the results, nothing happens."

One of the participants in the group which implemented the survey in 1997 systematised the qualitative remarks and made recommendations to the management of the hospital (Nyhagen, 1998-99). These quality improvement recommendations were not acted on by the hospital management. She remarked that changes have occurred in one or two areas, but these were not based on her recommendations or findings from the survey. The changes implemented were meant to be more or less random.

On the question on why nothing happened with the results, several factors were mentioned during the interviews. One of the factors for lack of follow-up of the results was that responsibility for the follow-up was left wholly to the division leadership. The following citation illustrates the point better:

"One of the reasons for lack of follow-up was that the case was referred to the division management, with data up to the ward level. No follow up at the division level. The divisions were totally left to themselves."

Another factor mentioned was that there was a shift in the leadership in the middle of the implementation process. The director general, who supported the implementation of the survey, was not there anymore, when the results were presented. The following citation illustrates:

"A system shift… There was a shift in the leadership in 1998, when the results of the survey were presented. General director "X" was replaced by "Y", as general director of the hospital."

5. 3. 2. Document analysis

With the help of the central administrative archives, a search was made into the hospital database for all documents relating to patient satisfaction surveys in general, from 1996 to 2003. We found a file from the 1997 survey. There was no record in the file, which shows that the results of the 1997 survey were discussed / processed by the hospital management with the intention of learning in order to improve quality. From the interviews one of the actors informed that the survey was handled in the highest

decision making organ at the hospital. The rest of the interviewees could not recall that the results were discussed at such a high level. There is no record of the handling of the results at such a level in the hospital administrative archives.

In the written documentation available in the hospital archives, there were several memos. A memo was sent from the acting director for the quality department to the deputy director general of the hospital, responsible for organisation affairs. In the memo, a copy of a resolution from "Committee for quality affairs" was attached. In the resolution it was stated, among other things, that the *"the committee is sending the report of the patient satisfaction survey to the hospital management for further processing"*.

From the deputy director a memo was sent to the head physicians and head nurses in all the divisions in the hospital, with the report from the survey attached. The divisions were informed that detailed statistics as well as systematised qualitative statements could be obtained from the Quality department if they were interested. It was only the head nurse at the surgical division who responded to the deputy director's memo.

What they did with the results is not easy to ascertain since there have been several structural changes since the survey was completed. Actors' perspectives are absent on this issue, because the main actors in the surgical department could not be traced. With the help of the personal office, it was conformed that they no longer work at the hospital.

The hospital records on the patient satisfaction survey of 1997 confirm the impression of the interviewees that not much happened with the results, with regards to quality improvement.

5. 3. 3. Experience of patient satisfaction surveys at the regional level

Østfold Hospital Trust is a daughter enterprise at the Eastern Norway Regional Health Authority. The regional health authorities in Norway were mandated to conduct patient satisfaction surveys by the ministry of health. The regional health authorities in turn mandated its daughter enterprises and the private hospitals they had contracts with, to conduct such surveys. The goal for the ministry of health was to benchmark the different regions, at a national level. While, for the Eastern Norway Regional Health Authority, the goal was to benchmark its daughter enterprises, and at the same time report back to the owner, which is the ministry. For the hospitals/enterprises the goal was to get data that they could use to improve services to the patients as well as report to regional health authority on the resolved quality indicators.

To reduce comparative limitations of the inter-hospital surveys, the Regional Health Authority decided to use one research centre to conduct all the surveys for the whole region. The Norwegian Knowledge Centre for the Health Services was chosen. The Centre is organised under the Directorate for Health and Social Affairs, but is

scientifically and professionally independent. The Centre has no authority to develop health policy or responsibility to implement policies.

The Regional Health Authority mandated an evaluation of the experiences with the 2003 inter-hospital patient satisfaction survey in the region.

The evaluation of the experience of patient satisfaction has shown that the lack of follow-up of patient satisfaction surveys is not limited to the Østfold Hospital Trust. The following citation from the report illustrates:

"According to the information reported from the hospitals/enterprises, the patient satisfaction survey of 2003 did not have any impact at the hospital/enterprise level, base on the goal of using such surveys as a data source for quality improvement".

In connection with the above mentioned evaluation, all the health enterprises in the Eastern Norway Regional Health Authority were asked if they conducted their own patient satisfaction surveys prior to the "mandatory" inter-hospital/enterprise patient satisfaction survey of 2003? In most hospitals where such surveys have been implemented they did not do much with the results, because of various reasons. The following citation illustrates:

"…we have had patient satisfaction surveys since 1998, but no systematic evaluation of the results. An earlier inter-hospital survey was systematically assessed both at the hospital, department and ward level, but because of constant changes, not much came out of survey, and the results were presented long after the survey was conducted".

The results of the two surveys from the Østfold Hospital Trust of 1997 and 2002 have shown the same tendencies, which suggests that not much was done to integrate the feedback from the patients in quality improvement. The findings from the interviews and the document analysis have shown that the results from the 1997 survey were not used as a base for quality improvement; and the evaluation mandated by the Eastern Norway Regional Health Authority on patient satisfaction surveys in the region has shown that not much has happened with the results of the 2003 inter-hospital survey.

Based on the above findings it is then probing to ask why patient satisfaction surveys are implemented? This question will now be explored in the following discussion, through the theoretical "glasses" presented earlier.

6. Discussion

Most health care organisations are extremely complex. Hospitals for instance can employ up to one hundred different professional/occupational groups, each with their own specialised training, norms, beliefs, and views of the world. Taking the above into consideration, the implementation of the patient satisfaction survey at the Østfold Hospital Trust in 1997 can be characterised as an innovative act. Though the results were not put into use, the quality department took the signals from the environment and acted. Earlier, under the theory chapter we discussed, where to place the hospital on the continuum between consequence oriented decision making and rule oriented decision making. The intention of the quality department to use the results of the patient satisfaction survey to improve quality placed the hospital on the consequence oriented continuum. On the other hand the lack of reaction by the hospital management to use the results of the survey, placed the hospital at the opposite end of the continuum, which is the rule oriented. This, because according to the existing rules at that time, they were not doing anything wrong, and hence no need to change the way things were done.

It may be illuminating to look at the findings of this study from the rational choice and institutional perspectives, to try to understand why patient satisfaction surveys are conducted as a quality improvement measure when the findings of this study have shown that this is not the case in the Østfold Hospital Trust.

6. 1. A rational choice perspective on patient satisfaction

From a rational choice perspective a patient satisfaction survey is conducted as a means towards an end. In order to obtain better quality and more satisfied patients, the hospital conducts patient satisfaction surveys to get feedback from patients on areas the hospital could do better. From such a perspective, the findings from the patient feedbacks are used to improve services, which in turn will lead to better satisfaction.

A closer look at what really happened at the Østfold Hospital Trust showed that there is no empirical base for such instrumental thinking. There is no written evidence at the hospital level on reasons for initiation of the patient satisfaction survey in 1997. From the interviews it was obvious that the main actors took it for granted that the results of the survey would be used to improve services, and hence give the patients better treatment. In the report published after the 1997 survey, it was stated that the purpose of the survey was to get patient feedback, which could be used for quality improvements.

Results from the 2002 survey showed that, the hospital scored poorly on basically the same dimensions as in the 1997 survey. In some dimensions the hospital scored worst. The findings of the interviews and the document analysis showed that no systematic action was taken to improve the conditions that patients reported they were dissatisfied with. This illustrates the limitations of the explanatory power of the rational choice theory.

There are tendencies of a Garbage can situation, where there seems to be no plan from the top management on why they want to conduct the survey, how the results would be utilised, who participated in deciding the further plan of action, and what actions were taken and when. This can be seen, in Garbage Can terms, as an intermingling of problems, solutions and participants moving from one choice opportunity to another in such a way that the nature of the choice, the time it takes, and the problems it solves all depend on a relatively complicated intermeshing of the mix of choices available at any one time, the mix of problems that have access to the organisation, the mix of solutions looking for problems, and the outside demands on the decision-makers.

6. 2. An institutional perspective on patient satisfaction

The institutional perspective is also referred to as an open system perspective, because of its perception of the organisation, which here is the Østfold Hospital as part of a bigger whole. The hospital is influenced by the internal and external environment and vice versa.

The health system in Norway in general and the Østfold Hospital Trust in particular can be said to be institutionalised or in Selznick's words, infused with values beyond the technical task at hand (Selznick, 1984). In other words the organisation's ability to legitimise itself in the environment (Gran, 1995). Individuals get into institutions with their baggage which shapes their world views, but they later internalised the values and norms in the institution. March and Olsen, who are among the critics of the rational model argued that:
"the behaviour we observe in political institutions reflects the routine way in which people do what they are supposed to do" (March & Olsen, 1989 :21).

Levitt and March also referred us to routines for the understanding of behaviour in organisations (Levitt & March, 1988). The routines the institution has developed on the recruitment and socialisation of their employees, can contribute very much to the prevention of new ways of seeing and doing things. The health managers as well as other health professionals will tend to employ "like-minded" people who have a tendency to be loyal to the system. Stinchcombe argued that:
"The more the individuals governing an institution can socialise and select their successors, control the conditions of incumbency, and depict themselves as models for subsequent generations, the easier it is for an institution to be effectively maintained" (Stinchcombe, 1968:112; Krasner, 1988:82).

An institutional perspective takes the reactions from the internal and external environment an institution operate in, as a necessary condition for survival. Scott wrote that:
"Although organisations are viewed as means to accomplish ends, the means themselves absorb much energy, and in extreme (but perhaps rare) cases become ends in themselves" (Scott, 1987:9).

The institutional perspectives emphasises the socialisation of the individuals in the existing norms and values, but, we observed how the then acting director for the quality department, an individual, effected changes in already existing institutions, with the support of the hospital management.

The introduction of the Patient satisfaction surveys was **not** presented as a change in the goals of the hospital, but, a change in the means to achieve the same goal. The hospital leadership was not threatened in this sense, since there could not be any foreseeable negative impact, directly on them.

The study did not register any intra-organisational disturbance or stress to the hospital decision making process to conduct patient satisfaction surveys. There is no registration that the health professionals did represent any demand or support group.

We now shift our focus to the extra-hospital environment of the Østfold Hospital Trust. Even though we cannot speak of coercive forces from the central government in 1997, the Norwegian National Strategy for Quality Improvement gave strong signals on what the hospitals were expected to do in regards to patient feedback systems as a tool in improving the quality of services. From 2003 the coercive forces of the environment have been observed in the form of mandatory patient satisfaction surveys, from the Regional Health Authority. We registered that the Regional Health Authority, had the power to make demands and give support which can threatened to drive the essential variables of the hospital beyond its critical range (Easton, 1965). This means without the support of the Regional Health Authority and the Ministry of Health, the existence of the hospital leadership at the hospital could be threatened.

As mentioned on our discussion on innovation earlier, the introduction of the Patient satisfaction surveys can be seen as a major policy shift at the Østfold Hospital Trust in 1997.

From an institutional perspective, the introduction of the patient satisfaction survey can be seen as a way an institutionalised system reacts to the changes in the environment within which it operates in order to survive. The inputs from the Ministry of Health and Social Affairs, the Norwegian Board of Health and the Regional Health Authority, in the form of demand and support were very crucial. We also observed that there was a wind of change blowing through the Norwegian health care system in favour of establishing patient feedback systems.

After examining the role of the environment in the change process, and how the main goal of implementing patient satisfaction surveys was displaced. The study will try to offer possible explanations for the changes and the persistence of institutions beyond the political and economic interest logic, from an institutional perspective. As earlier mentioned, in the late 1990s, several hospitals conducted patient satisfaction surveys, and the central authorities have given signals that patient feedback was an important quality indicator. The study observed that health regimes in Norway tend to look more and more alike, in the sense that, more and more hospitals conducted patient satisfaction surveys. This institutional isomorphic tendency can also explain the changes. Coercive

processes as earlier mentioned result from both formal and informal pressures exerted on institutions by other institutions upon which they are dependent and by cultural expectations in the society within which the institution function. Such pressures may be felt as force, as persuasion, or as invitations to join in collusion. If hospital after hospital were introducing patient satisfaction surveys, the Østfold Hospital Trust, will probably find it difficult to pursue its own path, due to the coercive function of the central government environment, and the mimetic processes of the other health institutions.

The Patients' Rights Act of 2 July 1999 also empowered patients in many aspects, by regulating individual rights, hereunder the right to participation and information. Patients are also free to choose when and where to be treated, when they are in need of medical attention. When the hospital owners expect the hospitals to implement patient satisfaction surveys, and the patients too expect to be taken more seriously, it is the hospitals that can adapt to these demands from the environment that will survive, looked from an institutional perspective.

It “seems” that the institutional framework is more fruitful for the understanding of what happened, and what did not happen in regard to the conducting of the patient satisfaction survey and the way the results were handle in connection to quality improvement.

7. Conclusion

This study has explored whether the conducting of patient satisfaction surveys are quality improvement tools or mere rituals. The Østfold Hospital Trust is used as a case.

In 1997 and 2002 the Østfold Hospital Trust conducted patient satisfaction surveys. This study presented the results of the 2002 survey and compared them with the 1997 results. This was done to ascertain if there were any changes with regards to the dimensions the hospital scored poorly on in 1997. The study examined if and how the results of the 1997 patient satisfaction survey were used to improve quality.

A brief analysis of an evaluation of all the health enterprises/hospitals in the Eastern Norway Health Authority gave the study a broader perspective. The study showed the link between what is happening in Norway and signals from the international arena, which here is the WHO. The first Norwegian Strategy for Quality improvement was based on the WHO's HFA2000. The Østfold Hospital Trust implemented its first patient satisfaction based on the signals from the central government through the national strategy document for quality improvement.

As mentioned earlier, theories are said to be spectacles through which we can look at reality. Everyone has a theory or a perspective on how organisations function. Based on personal experience, we create "mental maps" of what is connected to what and how things happen. In many respects, organisation theory consists of the systematic examination of these mental maps of how things work. In the study the concepts of innovation, rational choice and institutional theory were used as spectacles to assess whether the Østfold Hospital Trust acted on the results of the patient satisfaction survey or not.

The choice of study design is not an "either / or" situation between the quantitative and qualitative approach, since both methods can strengthen each other. Therefore, this study has employed a form of methodological triangulation. With triangulation, the potential problems of construct validity also can be addressed, because multiple sources of evidence essentially provide multiple measures of the same phenomena (Yin, 1994).

The findings of the study have shown that the Østfold Hospital Trust can be termed as innovative, when they implemented the patient satisfaction survey in 1997. This is because there was no coercive force from the hospital owners, only signals in the form of strategy documents.

In spite of the hospitals innovative action in implementing the non-mandatory survey in 1997, the hospital leadership did not use the results to improve quality.

Based on the findings, the study can conclude that the implementation of the patient satisfaction survey in 1997 was more symbolic rather than a quality improvement act.

Looking further than 1997, it is important to remark that the hospital leadership resolved a number measures based on the 2002 patient survey. The Østfold Hospital

Trust was also one of the enterprises which resolved measures based on the inter-enterprise patient survey mandated by the Regional Health Authority in 2003. At the time of writing the issue of patient feedback as a quality improvement tool is prioritised at the Østfold Hospital Trust. Interestingly, it is the hospital leadership which puts this on the agenda, and at the same, units up to ward level are also conducting their own patient satisfaction surveys as a means to improve quality. The development points in the direction of a paradigm shift (Kuhn, 1970).

7. 1. Limitation of the study

In addition to the comparative limitations identified earlier under the discussion of the results, the following methodological limitations are worth mentioning.

The dialectical nature of the study makes it difficult to come with linear causality. Many factors contributed to the introduction of the patient satisfaction surveys, and the way the results were handled in relation to quality improvement.

There was no direct actors' perspective from the general management involved in the decision-making process, which led to the introduction of the patient satisfaction surveys. The director general who supported the initiation and the one who replaced him, together with their leadership team, are no longer in the system. The division which ordered material from the patient satisfaction survey of 1997 was not investigated. This is because of the reorganisation processes in the hospital; that there are no written documents on what happened further with the results send to the division; and that the actors who were involved are no longer working in the hospital system.

7. 2. Suggestions for further research

An investigation of the consequences of the measures resolved by a hospital aimed at quality improvement should be conducted over a longer period, with a thorough analysis of many of the other factors affecting quality improvement. Such a study will give a better understanding of the processes involved and the impacts of patient satisfaction surveys as quality improvement tools.

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The contents of this thesis are my own, I should be held liable for any factual errors, misconceptions and omissions found in this study.

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Appendix 1 Questionnaire for the 2002 patient satisfaction survey (in Norwegian)

Sengepost (Fylles ut av sykehuset)

Om deg selv

1. Hvilken aldersgruppe tilhører du?

- ☐ Under 20 år
- ☐ 21- 40
- ☐ 41 - 60
- ☐ 61 - 80
- ☐ Over 80

2. Kjønn?

- ☐ Mann
- ☐ Kvinne

3. Hvilken utdannig har du fullført?
(Oppgi bare den høyeste fullførte utdanningen)

- ☐ 7-årig folkeskole eller kortere
- ☐ Framhaldskole, fortsettelsesskole
- ☐ 9-årig grunnskole
- ☐ Real-/middelskole, grunnskolens 10. år
- ☐ Ett- eller to-årig videregående skole/yrkesskole, handelsskole, folkehøgskole eller lignende
- ☐ Artium, økonomisk gymnas, allmennfaglig studieretning i videregående skole
- ☐ Høyskole eller universitet, mindre enn 4 år
- ☐ Høyskole eller universitet, 4 år eller mer

4. Hva har din arbeidssituasjon vært mesteparten av de siste 12 måneder?

- ☐ Yrkesaktiv
- ☐ Skoleelev/student
- ☐ Hjemmearbeidende
- ☐ Arbeidsledig
- ☐ Alderspensjonist
- ☐ Syke- eller uføretrygdet
- ☐ Attføring
- ☐ Verneplilktig

5. Sivilstand?

- ☐ Gift/samboer
- ☐ Ugift
- ☐ Enke/enkemann
- ☐ Skilt/separert

Før innleggelse

6. Hadde du vært til poliklinisk vurdering ved Sykehuset Østfold før denne innleggelsen ble bestemt?

☐ Ja

☐ Nei

NB: spørsmål 7-9 gjelder de som ble innlagt etter venteliste (andre går til spørsmål 10)

7. Hvor lang tid gikk det fra du var til undersøkelse ved poliklinikken til du ble innlagt?

☐ Mindre enn 2 uker

☐ 2 til 4 uker

☐ 1 til 2 måneder

☐ 3 til 6 måneder

☐ ½ til 1 år

8. Fikk du en kontaktperson ved Sykehuset Østfold eller et bestemt telefonnummer du kunne ringe i ventetiden?

☐ Ja

☐ Nei

☐ Husker ikke

9. Fikk du tilsendt noe informasjon fra Sykehuset Østfold før innleggelsen?

☐ Ingen informasjon

☐ Litt informasjon

☐ Den informasjon jeg trengte

10. Hva var grunnen til at du ble innlagt på Sykehuset Østfold? (Sett ett eller flere kryss)

☐ Behandling av livstruende sykdom

☐ Behandling av alvorlig sykdom

☐ Behandling av mindre alvorlig sykdom

☐ Operasjon

☐ Lindring av smerte/ubehag

☐ Behandling av skade/ulykke

☐ Opptrening

☐ Hjelp til å kunne greie meg bedre i det daglige

☐ Utredning (for å få stilt diagnose)

☐ Fødsel

☐ Annet

Spesifiser

11. Ble du innlagt

☐ - for øyeblikkelig hjelp?

☐ - etter venteliste?

12. Hvor mange dager var du innlagt?

☐ 1 til 4 dager

☐ 5 til 9 dager

☐ 10 til 31 dager

☐ Mer enn 1 måned

Forventninger til resultat av behandlingen

13. Hvilke forventninger hadde du før du ble innlagt?

☐ Regnet med å bli helt frisk

☐ Regnet med å bli friskere

☐ Regnet ikke med å bli frisk, men få lindring

☐ Regnet ikke med å bli frisk eller få lindring

☐ Vet ikke

Oppholdet og behandlingen

Nedenfor blir du stilt endel spørsmål om hvordan du opplevde sykehusoppholdet. Du angir svarene dine ved å krysse av i rutene. Dersom du f.eks. er "ganske fornøyd" setter du kryss slik:

Svært fornøyd ☐ ☒ ☐ ☐ ☐ *Svært misfornøyd*

14. Samlet sett, hvordan er du fornøyd med den behandlingen du fikk ved sykehuset?

Svært fornøyd ☐ ☐ ☐ ☐ ☐ Svært misfornøyd

15. Hvordan vil du beskrive pleiepersonalets engasjement i deg som person (og ikke bare i sykdommen)?

Svært fornøyd ☐ ☐ ☐ ☐ ☐ Svært misfornøyd

16. Hvordan vil du beskrive din tillit til pleiepersonalets faglige dyktighet?

Svært stor ☐ ☐ ☐ ☐ ☐ Svært liten

17. Hvor ofte synes du pleiepersonalet var tilgjengelige når du trengte dem?

Svært ofte ☐ ☐ ☐ ☐ ☐ Nesten aldri

18. Følte du at det var en fast gruppe av pleiepersonalet som tok hånd om deg under sykehusoppholdet?

I stor grad ☐ ☐ ☐ ☐ ☐ I liten grad

19. Synes du pleiepersonalet hadde nok tid når de skulle hjelpe/stelle deg?

Ja, alltid ☐ ☐ ☐ ☐ ☐ Nei, aldri

20. Synes du pleiepersonalet hadde nok tid til å snakke med deg?

Ja, alltid ☐ ☐ ☐ ☐ ☐ Nei, aldri

21. I hvilken grad mener du pleiepersonalet behandlet deg på en respektfull måte?

I stor grad ☐ ☐ ☐ ☐ ☐ I liten grad

22. Opplevde du at det var en lege som hadde hovedansvaret for deg?

I stor grad ☐ ☐ ☐ ☐ ☐ I liten grad

23. Hvor ofte synes du lege var tilgjengelig når du trengte ham eller henne?

Svært ofte ☐ ☐ ☐ ☐ ☐ Nesten aldri

24. I hvilken grad mener du legen behandlet deg på en respektfull måte?

I stor grad ☐ ☐ ☐ ☐ ☐ I liten grad

25. Fikk du smertestillende raskt når du trengte det?

Ja, alltid ☐ ☐ ☐ ☐ ☐ Nei, aldri

26. Hva vil du si sykehusoppholdet betydde for sykdommen/helseproblemet du var lagt inn for denne gangen?

☐ Jeg ble frisk, helseproblemet er borte

☐ Jeg ble mye bedre

☐ Jeg ble noe bedre

☐ Jeg ble ikke bedre

☐ Jeg ble verre

☐ Vet ikke

27. I hvilken grad fikk du innfridd dine forventninger til den medisinske behandling?

Helt innfridd ☐ ☐ ☐ ☐ ☐ Absolutt ikke innfridd

28. Mens du var innlagt, fikk du vite det du synes var nødvendig om hvordan undersøkelsen skulle foregå?

☐ Ja, jeg fikk vite alt jeg trengte

☐ Jeg fikk vite noe

☐ Jeg fikk vite lite

☐ Nei, jeg fikk ikke vite noe

29. Mens du var innlagt, fikk du vite det du synes var nødvendig om resultatet av prøver og undersøkelser?

☐ Ja, jeg fikk vite alt jeg trengte

☐ Jeg fikk vite noe

☐ Jeg fikk vite lite

☐ Nei, jeg fikk ikke vite noe

30. Mens du var innlagt, fikk du vite om det du synes var nødvendig om hvordan behandlingen (evt. operasjonen) skulle foregå?

☐ Ja, jeg fikk vite alt jeg trengte

☐ Jeg fikk vite noe

☐ Jeg fikk vite lite

☐ Nei, jeg fikk ikke vite noe

31. Snakket legene til deg slik at du skjønte dem?

De var svært enkle å forstå ☐ ☐ ☐ ☐ ☐ De var svært vanskelig å forstå

32. Hadde du samtale med lege i enerom?

☐ Ja

☐ Nei

☐ Husker ikke

33. Hvis ja på spørsmål 32: Var denne samtalen i forbindelse med innleggelsen, selve oppholdet, eller utskrivingen?

☐ I forbindelse med innleggelsen

☐ Under selve oppholdet

☐ I forbindelse med utskrivingen

34. Hvis nei på spørsmål 32: Hadde du ønske eller behov for en samtale med lege i enerom?

☐ Ja

☐ Nei

☐ Husker ikke

35. Snakket pleierpersonalet til deg slik at du skjønte dem?

De var svært enkle å forstå ☐ ☐ ☐ ☐ ☐ De var svært vanskelig å forstå

36. Synes du det var mye unødvendig venting under oppholdet ved sykehuset?

I stor grad ☐ ☐ ☐ ☐ ☐ I liten grad

37. Hvordan vil du beskrive din tillit til legens faglige dyktighet?

Svært stor ☐ ☐ ☐ ☐ ☐ Svært liten

38. Hvordan er din tillit til sykehuset?

Svært stor ☐ ☐ ☐ ☐ ☐ Svært liten

39. Hvordan vil du beskrive legens engasjement i deg som person (og ikke bare sykdommen)?

Svært stor ☐ ☐ ☐ ☐ ☐ Svært liten

40. Fikk du inntrykk av at utstyret på sykehuset var i god stand?

I svært god stand ☐ ☐ ☐ ☐ ☐ I svært dårlig stand

41. Fikk du inntrykk av at sykehuset var i god stand?

I svært god stand ☐ ☐ ☐ ☐ ☐ I svært dårlig stand

42. Mener du at du på noen måte ble feilbehandlet?

☐ Ja, det er jeg sikker på

☐ Ja, det tror jeg

☐ Jeg vet ikke

☐ Nei, det tror jeg ikke

☐ Nei, helt sikkert ikke

Besøk og privatliv

43. Hvordan var muligheten for å få besøk mens du var på Sykehuset Østfold?

Svært god ☐ ☐ ☐ ☐ ☐ Svært dårlig

44. Var det vanskelig for deg å motta besøk på Sykehuset Østfold på grunn av noe av det følgende?

☐ Lang avstand fra hjemmet

☐ Vanskelig med innkvartering for pårørende

☐ For dyrt å reise for pårørende

☐ Svært syk medpasient på rommet

☐ Ikke noe sted å sitte sammen med besøkende

☐ Liten mulighet for å være alene med besøkende

☐ Begrenset visittid

☐ Ikke aktuelt for meg

45. Hvordan var muligheten for privatliv på Sykehuset Østfold?

Svært gode ☐ ☐ ☐ ☐ ☐ Svært dårlige

46. Hva synes du om måltidene på Sykehuset Østfold?

Svært bra ☐ ☐ ☐ ☐ ☐ Svært dårlige

Om utskrivelsen

47. Før du ble skrevet ut, fikk du vite det du synes var nødvendig om resultatet av operasjonen/behandlingen?

☐ Ja, jeg fikk vite alt jeg trengte

☐ Jeg fikk vite noe

☐ Jeg fikk vite lite

☐ Nei, jeg fikk ikke vite noe

48. Føler du at du ble utskrevet på rett tidspunkt?

☐ Ja

☐ Nei, for tidlig

☐ Nei, for sent

49. Ble du utskrevet til

☐ Annen helseinstitusjon

☐ Hjemmet

Om sykdom og helseproblemer fremover

50. Har noen ansatte ved Sykehuset Østfold gitt deg veiledning i hva du kan gjøre for å bli bedre eller hindre forverring?

Meget god veiledning ☐ ☐ ☐ ☐ ☐ Uforståelig eller dårlig veiledning

51. Har noen ansatte ved Sykehuset Østfold snakket med deg om hvordan du kan forebygge fremtidig sykdom, skade eller plage?

☐ Ja

☐ Nei

☐ Vet ikke

☐ Ikke aktuelt for meg

52. Hvis ja, snakket de om:
(Kryss av for flere dersom det passer.)

☐ Fysisk aktivitet og trening

☐ Betydning av sosial aktivitet og vennskap

☐ Kosthold og spisevaner

☐ Hvordan du kan unngå ulykker

☐ Alkohol

☐ Blodtrykk

☐ Røyking

☐ Andre forhold

53. Var du samlet sett fornøyd med denne informasjonen?

Svært fornøyd ☐ ☐ ☐ ☐ ☐ Svært misfornøyd

54. Føler du at det er god kontakt mellom den legen du vanligvis bruker og Sykehuset Østfold?

☐ Meget god kontakt

☐ God kontakt

☐ Dårlig kontakt

☐ Meget dårlig kontakt

☐ Vet ikke

Samlet inntrykk av Sykehuset Østfold

55. Når du tenker tilbake, i hvilken grad vil du si at oppholdet og behandlingen var i samsvar med den informasjonen du fikk ved innleggelsen?

☐ Meget godt samsvar

☐ Bra samsvar

☐ Mindre bra samsvar

☐ Dårlig samsvar

☐ Vet ikke

☐ Fikk ikke informasjon

☐ Ikke aktuelt for meg

56. Hvordan vurderer du samarbeidet og kommunikasjonen/informasjonsutvekslingen innen Sykehuset Østfold?

	Personalet imellom?	**Avdelingene imellom?**
Meget god	☐	☐
Bra	☐	☐
Mindre bra	☐	☐
Dårlig	☐	☐
Vet ikke	☐	☐

57. I hvilken grad er du samlet sett tilfreds med den behandlingen du fikk på Sykehuset Østfold for din sykdom/helsetilstand?

- ☐ Svært tilfreds
- ☐ Tilfreds
- ☐ Mindre tilfreds
- ☐ Utilfreds
- ☐ Svært utilfreds

58. Har du noen kommentarer eller synspunkter på hvordan ditt opphold ved Sykehuset Østfold kunne blitt bedre eller mer vellykket enn det faktisk var?

59. Har du noen kommentarer eller synspunkter på noe som var spesielt positivt eller gledelig ved ditt opphold på Sykehuset Østfold?

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