CONGRUENCE BETWEEN PARENT SATISFACTION WITH NURSING CARE OF THEIR CHILDREN AND NURSES' PERCEPTIONS OF PARENT SATISFACTION

By

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Abstract

The purpose of this descriptive study was to determine the degree of congruence between parents' satisfaction with nursing care and nurses' perceptions of parent satisfaction. The conceptual framework that guided this research was the enabling and empowering model of helping relationships by Dunst, Trivette, Davis, and Cornwell (1988). A convenience sample of twenty nurse-parent pairs was recruited from a 22-bed unit in a tertiary care pediatric hospital. Data were collected by means of a 25-item self-administered satisfaction with nursing care instrument and socio-demographic tools. Data were analyzed using descriptive and parametric statistics.

The study results revealed statistically significant differences between parent and nurse perceptions. As a group, nurses estimated parents to be less satisfied with nursing care than parents themselves reported. However, when a pair-by-pair analysis was conducted, it showed a lack of congruence between parents' and nurses' perceptions in both directions. The conclusions support the need for nurses to explicitly ask the consumers of their services whether or not their expectations of nursing care are being met. Unless nurses ensure that the care they provide is consistent with what consumers want, consumers are unlikely to be satisfied. Recommendations are made for nursing practice, education, administration, and research.

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CHAPTER ONE

Introduction

Background to the Problem

The nursing profession has been concerned about measuring the quality of nursing care and establishing standards of care since Florence Nightingale's description of her experience in the Crimean War (Baker, 1983; Giovannetti, Kerr, Bay, & Buchan 1986; Lang & Clinton, 1983). Over the past few decades social forces such as consumerism and fiscal restraint have contributed to a growing public demand that nurses, as well as other health care professionals, demonstrate that they are delivering a high quality of care to the consumers of that care (Doering, 1983; O'Sullivan, 1983; Rempusheski, Chamberlain, Picard, Ruzanski, and Collier, 1988; Spitzer, 1988; Vuori, 1991). However, health care providers and consumers may differ in their perceptions of quality care. This study was designed to explore the degree of congruence between nurses' and parents' (the consumers) perceptions of the quality of care provided for children in a pediatric setting.

Quality of care is defined differently by different people or groups of people (Ehrat, 1987; Peterson, 1989; Rempusheski et al., 1988). Donabedian (1980) attributes these differences to the uniqueness of individual perceptions, expectations, and values:

> This may be because each definition is legitimate within an appropriate context. In fact, many differences in how quality is viewed and defined arise from differences in what might be called the scope and level of concern for the quality of care (p. 16).

In an effort to promote the delivery of high quality care, regulatory bodies such as the Canadian Council on Health Facilities Accreditation (CCHFA) have articulated various quality requirements through quality assurance and quality improvement standards. However, while authors like Hoesing and Kirk (1990) and James (1989) acknowledge the value of periodic external reviews such as accreditation surveys, they emphasize that real quality care requires front-line care givers themselves ensuring the delivery of high quality care.

In this researcher's experience in the area of nursing quality assurance in a tertiary care pediatric hospital, patient or consumer satisfaction has been increasingly regarded as an important yet largely untapped measure of the quality of care. For the purposes of this research, the term parent satisfaction is used as one representation of consumer satisfaction. In a pediatric setting, parents must be recognized and acknowledged as consumers of nursing care services (Leebov, 1988). "By their presence and their participation, parents have become clients in the pediatric ward" (Kristjansdottir, 1991, p. 55).

Katz and Green (1992) stress the need for health care organizations to regard consumer satisfaction as an important aspect of the quality of care and direct those health care organizations to establish formal methods of evaluating consumer satisfaction. Krumberger (1991) describes the evaluation of consumer satisfaction as a complex phenomenon, especially in identifying aspects of care which consumers consider most important. Patient values related to nursing care must be clarified and expectations related to these associated variables defined. Pearson, Durant, and Punton (1989) suggest a variety of approaches be used when measuring and quantifying quality, rather than relying on any single measure. Just as patient satisfaction data should not be the sole measure of the quality of nursing care, neither should measures which reflect only professional perspectives be relied upon (O'Sullivan, 1983).

Currently at British Columbia's Children's Hospital (BCCH) where this researcher is employed, the nursing quality monitoring tool in use assigns very little weight to consumer satisfaction. Despite this, no other formal mechanism is established which solicits consumer satisfaction data. The assumption is that if the quality monitoring score, which has only minimally measured patient satisfaction, surpasses an established target, then a high quality of nursing care has been delivered.

Possible lack of agreement between health care providers and consumers in terms of perceived quality of care has been

identified in the literature of the last decade (Bond & Thomas, 1992; Leebov, 1988; Oberst, 1984; Peterson, 1989; Pettit and White, 1991; Rempusheski et al., 1988). In this researcher's five-year experience as a head nurse and four-year experience in nursing quality assurance at BCCH, the parents of patients and the nurses delivering the direct patient care sometimes have different perceptions about the quality of nursing care. Occasionally these conflicting views become apparent while the child is still hospitalized, and attempts are made to allay the parents' concerns. At other times the complaints come to light through a letter long after discharge. By the time this occurs, it is particularly difficult to address the parents' concerns. If the nurses providing care were sensitized to parent satisfaction, some of the complaints might be avoided or at least dealt with at the time of the dissatisfaction. Nurses would be better equipped to evaluate the quality of care they deliver if they were aware of how accurately they estimate consumer satisfaction with their nursing care.

The Registered Nurses Association of British Columbia (RNABC) Standards for Practice (1992) direct nurses to be attuned to their clients' needs and to work collaboratively with them. The importance of such an approach from the perspective of parents of hospitalized children is also well-documented in the literature (Knafl, Breitmayer, Gallo & Zoeller, 1992; Knox & Hayes, 1983; Ogilvie, 1990).

In an effort to deliver optimal care, nurses should be continually monitoring consumers' level of satisfaction with that care (Peterson, 1989). According to Dunst, Trivette, Davis, and Cornwell (1988), "help-giving experiences are likely to influence the subsequent attitudes, beliefs, and behaviors of help givers toward help seekers" (p. 73). Only as nurses recognize where their service meets or falls short of consumer expectations can they improve their nursing services. Due to an absence of research in this area, it is unknown how accurately pediatric nurses perceive consumer satisfaction with nursing care.

Problem Statement

Despite the recognition that quality assessment measures should be multi-dimensional and that quality of care should be considered from a variety of perspectives, in the pediatric setting, parent (consumer) satisfaction is an important yet neglected component of quality assessment. Nurses generally base their perceptions of parent satisfaction with nursing care on intuition and subjective interpretation of the informal feedback that parents sometimes provide. In their day-to-day work nurses do make judgments, although not formally articulated, about the quality of care they are delivering, and parent satisfaction with this care. The congruence of perceptions of nurses and parents requires exploration.

Purpose

The purpose of this study was to determine the level of congruence between parents' satisfaction with nursing care of their children in a pediatric setting and the nurses' perceptions of parents' satisfaction.

Research Questions

The following research questions directed this study.

1. How do parents of hospitalized children rate their satisfaction with nursing care using the adapted Patient Satisfaction Instrument (Risser, 1975) (APSI) (See Appendix A).
2. How do pediatric hospital nurses rate these parents' satisfaction with nursing care using the adapted PSI (See Appendix B).
3. What is the degree of congruence between the ratings by parents and nurses?

Conceptual Framework

The conceptual framework that guided this research was the enabling and empowering model of helping relationships proposed by Dunst, Trivette, Davis, and Cornwell (1988). The purpose of the model is to promote increased parent participation in caring for health-impaired children. It provides professional helpers such as nurses with concrete

direction in providing care to the whole family by operationally defining both empowerment and effective helping.

In defining empowerment, Dunst and his colleagues stress that helpers must view people as being already competent. When people are unable to display competence it is due to the social context rather than inherent personal deficits. Finally, if people are to be empowered, they must have whatever information they need to make truly informed decisions. These authors define effective helping as:

> The act of enabling individuals or groups (e.g., family) to become better able to solve problems, meet needs, or achieve aspirations by promoting acquisition of competencies that support and strengthen functioning in a way that permits a greater sense of individual or group control over its developmental course (p. 1).

The enablement model consists of three clusters of variables which contribute to effective helping and the empowerment of the family. These are: prehelping attitudes and beliefs which refer to the "posture and stance the help giver takes toward the help seeker and helping relationships," help-giving behaviors which refer to the "interactional styles used by help givers during helping acts," and posthelping responses and consequences which refer to "ensuing influences of the help giver's behavior on the help seeker" (p. 72). Figure 1 illustrates the influences of help givers' actions upon help giver outcomes.

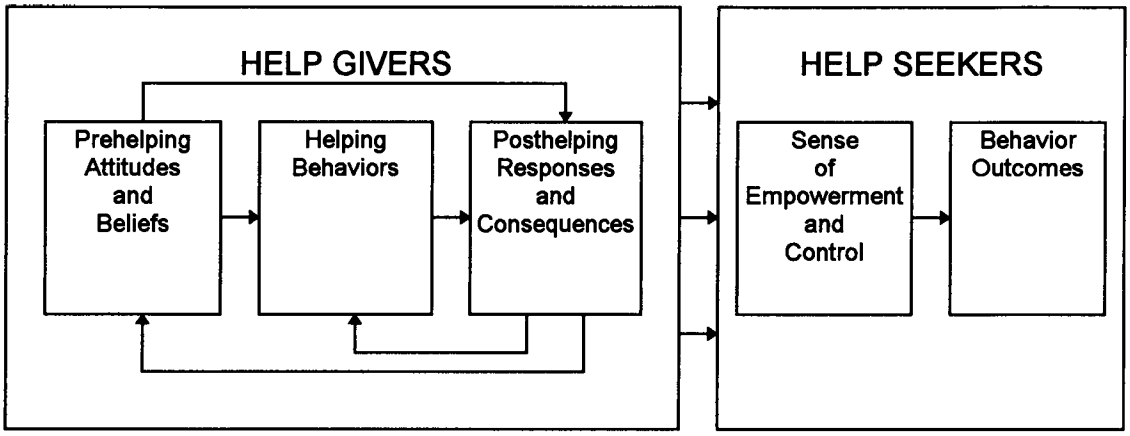

Figure 1. A Model Depicting the Influences of Prehelping, Helping, and Posthelping Behavior on Help Giver Outcomes (Dunst et al., 1988).

The competency-producing helping styles described by Dunst and his colleagues counteract the traditional approach of many helping professionals who have been "socialized to believe that they and only they are capable of improving their clients' lot" (p. 71). Dunst et al. recommend that help givers use the lists of help giver attitudes, beliefs, and behaviors associated with empowering and competency-producing influences that they have developed as a basis for self-evaluation and planning for professional development.

The model by Dunst et al. (1988) suits the proposed research for two reasons. First, the operational definitions of empowerment and effective helping fit with the Total Quality Management (TQM) approach recommended in current quality assurance literature. For example, the approach by

Dunst et al. to help seekers who are having difficulty navigating the health care system would be to look for the problem inherent in the system rather than in the family. They suggest that helpers foster and develop positive, proactive attitudes toward help seekers:

> People are already competent or they have the capacity to become competent. The failure to display competence is not due to inherent personal deficits but rather to the failure of social systems to create opportunities for competencies to be displayed (p. 72).

Second, the way in which the consumer or help seeker is viewed is consistent with the approach toward parents of hospitalized children recommended in the theoretical and research-based nursing literature, as well as in the consumer satisfaction literature. Consumers need to be consulted and asked for their evaluation of help-giving practices in order for helpers such as nurses to meet consumer expectations.

Definition of Terms

For the purposes of this study the following terms were used.

Parent: Mother, father, or legal guardian of a pediatric patient hospitalized at BCCH.

Registered Nurse: A person in possession of a current, practicing membership with the Registered Nurses Association of British Columbia.

Parent Satisfaction: level of satisfaction with nursing care, as measured by an adaptation of the Patient Satisfaction Instrument (APSI)(Risser, 1975).

Quality Assurance: the measurement of performance against pre-established standards.

Assumptions

For the purposes of this study, the following assumptions were made:

1. In a pediatric setting, parents are considered consumers of nursing care.
2. Consumer satisfaction with nursing care can be measured.
3. Participants will respond honestly to the instrument used in this study.

Limitations

This study has several limitations. The generalizability of findings may be limited by:

- the use of a non-random sample
- the Hawthorne effect
- the use of one hospital unit only
- the use of parametric statistics with a very small sample.

Significance of the Study

This study is primarily of significance to the nurses on the unit where the research took place, and to those in the organization concerned with the methods used in BCCH quality assessment and quality improvement activities. By providing the results to the unit nurses and through involving them in planning what to do with the findings, the TQM concepts of making the pursuit of quality "everyone's job" and a "bottom-up" approach to quality assurance is operationalized.

According to the enabling and empowering model of helping relationships by Dunst et al. (1988), the findings of this study will influence the prehelping attitudes and beliefs of the nurses, thereby contributing to the evolution of their practice. For example, the helping behaviors described by Dunst and his colleagues direct helpers to encourage consumers to clarify and articulate their concerns and needs, and then to work collaboratively with them in meeting those needs. If nurses do not know whether the consumers of their care are satisfied with that care, they cannot effectively improve upon it (Peterson, 1989).

According to the Canadian Nurses Association (1980), nurses value a holistic view of their clients, regarding them as biopsychosocial beings with the capability of setting goals and making decisions. Clients also have both the right and the responsibility to make informed choices in accordance with their own values and beliefs. This study applies this

holistic perspective to the evaluation of the quality of nursing care by acknowledging parents' perceptions of the quality of nursing care, and testing nurses' ability to accurately "read" parent satisfaction.

Organization of Thesis

This thesis is comprised of five chapters. Chapter One introduced the background to the problem, problem statement, purpose, conceptual framework, research questions, definitions of terms, significance of the study, and its assumptions and limitations. In Chapter Two, selected literature is reviewed and presented. Chapter Three describes the study methodology and in Chapter Four, research findings are presented and discussed. Chapter Five presents the summary, conclusions, and implications of the study.

CHAPTER TWO

Review of the Literature

Introduction

The literature reviewed for the purposes of this study falls into three broad categories: nursing quality assurance literature, patient/consumer satisfaction literature, and the literature addressing parents' experiences of their children's hospitalizations. The nursing quality assurance literature is relevant because in this body of literature quality is defined and methods of evaluating quality are debated. The other two categories are important because if nurses are to consider parents of hospitalized children as recipients or consumers of nursing care, it is crucial to understand their perspectives.

Quality Assurance/Quality Improvement

The nursing quality assurance literature is primarily descriptive and addresses topics such as the nature of quality, the need for the development and maintenance of quality assurance or quality improvement programs, quality assurance vis-à-vis accreditation standards and, most recently, the principles of Total Quality Management or continuous quality improvement (CQI). Numerous authors (Coyne & Killien, 1987; Katz & Green, 1992; Kerfoot & Watson, 1985; Maciorowski, Larson & Keane, 1985) describe the quality assurance program as a management process established to

define and evaluate the quality of care provided to consumers. Others discuss methods for coordinating quality assurance activities through committees and describe the key members of such committees (Harris, Kerger & Davis, 1989; O'Brian, 1988).

In the last five years there have been a number of articles in the nursing literature comparing the "top-down" and "bottom-up" approaches to quality assurance. The "top-down" approach fits with the traditional centralized control of evaluation and involves the use of pre-formulated generic instruments and the application of "expert-generated" criteria and standards. The "bottom-up" approach requires that front-line staff nurses view quality assurance and quality assessment as an integral part of their professional practice (Harvey, 1991; New & New, 1989; Redfern & Norman, 1990). Staff nurses might, for example, lead unit-based quality assurance committees where concerns unique to the specific units can be effectively addressed (Acorn, Love & Mills, 1990; Hirth & Lauzon, 1989). The value of the "bottom-up" approach is that prevention of errors, rather than remedial action, can become a focus when those in the organization closest to the service being delivered are actually empowered to make change (Koch & Fairly, 1993).

Much of the quality assurance research literature focuses on the use of quality assurance measures as dependent variables. While some of this research has included reliability and validity testing of nursing quality monitoring instruments, such testing has been minimal. One Canadian

study (Giovanetti et al., 1986) concluded that different quality monitoring instruments measured different aspects of quality and, therefore, results from one could not really be compared to results from another. Other studies (Redfern & Norman, 1990) question the reliability and validity of commonly used quality monitoring instruments.

The newest terms being used in the quality assurance literature are TQM and CQI. These terms are used interchangeably, and for the purpose of this discussion, TQM will be used. TQM is a proactive approach to quality with a greater emphasis on the consumer. The TQM concept is attributed to Deming who originally worked in the manufacturing industry in the United States in the 1940s. Not finding much interest in his management theory at home, Deming took his ideas and approaches to Japan in the early 1950s and is credited with having revitalized that economy (Arikian, 1991; Masters & Schmele, 1991). Over the past decade, various North American companies have implemented TQM and, most recently, some organizations within the health care industry are doing the same (Koch & Fairly, 1993; Masters & Schmele, 1991; Melum & Sinioris, 1992).

In a hospital setting, TQM integrates the functions of quality assurance, risk management, and utilization management and focuses on the organization as a whole rather than on separate departments and services. The TQM approach is believed to be the way of the future for health care facilities, and organizations such as the Canadian Council on

Health Facilities Accreditation as well as their American counterparts (O'Leary, 1991) are aligning their standards and requirements with TQM principles.

TQM emphasizes the importance of the customer and customer satisfaction. Problem-solving is believed to be most effective when it is approached by a "team" with representation from different disciplines and different levels within the traditional hierarchy. Most problems are believed to be systems problems rather than people problems, and collaborative work toward improvement of the system is considered essential. The targets and thresholds used in traditional quality assurance are no longer the goal, but rather the organization makes a commitment to continuous improvement. "Problem prevention rather than problem correction" (Masters & Schmele, 1991, p. 9) becomes the focus.

In a TQM organization, quality is identified by everyone as "their" job (Laza & Wheaton, 1990). "TQM places trust in the employee as knowledgeable, accountable, and responsible. A critical premise is that employees have an in-depth understanding of their jobs, believe they are valued, and feel encouraged to improve product or service quality" (Arikian, 1991, p. 46). TQM is congruent with the "bottom-up" approach to quality assurance.

Nurses have not traditionally measured consumer satisfaction with the services they provide (Greeneich, Long & Miller, 1992). However, increased consumer demands for quality care also require increased nurse sensitivity to

consumer needs and expectations. Moreover, in organizations where TQM is being implemented, nurses will require consumer satisfaction data in order to do their jobs effectively.

Patient/Consumer Satisfaction

Over the past few decades, the notion of measuring consumer satisfaction in the health care sector has been of increasing interest to health care providers (Doering, 1983; Peterson, 1989; Repusheski et al., 1988). Patients who are satisfied with their health care services are said to show better rates of compliance with treatment and to demonstrate more willingness to both seek health care services and maintain a role of health care consumer (Greeneich et al., 1992; McMillan, 1987; Naylor, Munro, & Brooten, 1991). For over a decade there has been debate as to whether consumer satisfaction is an indicator of quality or an outcome of quality. Outcome measures are defined by Giovanetti and her colleagues (1986) as "the results of health care, the measurement of which constitutes one aspect of quality assessment" (p. 5). At present, consumer satisfaction is generally considered to be one of the outcome measures of the quality of service delivered (Cass & Kugler, 1993; Katz & Green, 1992; Kovner, 1989). Therefore, the evaluation of consumer satisfaction must be recognized as an important dimension of quality assessment (Brown, Nelson, Bronkesh, & Wood, 1993; Canadian Council on Health Facilities

Accreditation, 1992; Cleary & McNeil, 1988; Cunningham, 1991; Leebov, Vergare, & Scott, 1990; Prehn, Mayo, & Weisman, 1989).

Lehr and Strosberg (1991) believe that successfully including the patient and family in quality improvement efforts is one of the greatest challenges facing health care professionals today, particularly considering traditional approaches to quality issues. Greeneich et al. (1992) state that the demand by consumers for quality care requires that care givers develop an increased sensitivity to patient needs. They also stress the importance of developing tools which accurately measure aspects of patient satisfaction with nursing care.

However, consumer satisfaction data alone should not form the basis for quality assessment (Rempusheski, 1988). This point was clearly demonstrated by Eriksen's (1987) study correlating patient satisfaction with quality of nursing care. Nursing care quality was measured by a nursing quality monitoring tool called the Methodology for Monitoring Quality of Nursing Care (MMQNC) developed in 1974 by Jelinek, Haussman, Hegyvary, and Newman (cited by Eriksen, 1987). Patient satisfaction was measured by the Patient Satisfaction with Nursing Care check list developed by Abdellah and Levine (1957). Both instruments were completed by each subject with no more than an hour between measurements. The results of Eriksen's (1987) study "did not support the presence of high positive and significant relationships between the quality of nursing care, as measured by the MMQNC, and patient

satisfaction with nursing care, as measured by the Patient Satisfaction with Nursing Care check list" (p. 32). In fact, Eriksen went on to conclude that "staff nurses should be aware that they may receive reports of patient dissatisfaction when they provide high quality care" (p. 35).

A major implication of Eriksen's study is that consumer satisfaction should not be used as the sole measure of the quality of nursing care. One could argue that Eriksen's (1987) study also suggests the MMQNC should not be used as a sole measure of the quality of nursing care. Yet, it is common practice to use quality monitoring instruments as the only formal method of evaluating nursing care in an acute care hospital setting, as is done at BCCH.

The majority of patient satisfaction literature originates in the United States where the health care system is based on patients as paying customers (Cunningham, 1991; Koch and Fairly, 1993; Louden, 1989). It is, therefore, not surprising that much of this literature takes a marketing approach and explores why patients choose and return to certain health care providers (Abramowitz, Cote, & Berry, 1987; Cleary, Keroy, Karpanos, & McMullen, 1989). In Canada, it is only recently that patients are being recognized as consumers who want to be, and should be, involved in decisions relating to health care delivery (O'Brien, Lowe, & Rennebohm, 1987).

Research conducted with adult patients in the United States has shown satisfaction with nursing care to be a

reliable predictor of overall satisfaction with hospital care (Abramowitz et al., 1987; Cleary et al., 1989; Hinshaw & Atwood, 1982b; Lemke, 1987; Oberst, 1984). For example, Lemke's (1987) study explored the relationship between ancillary services and overall opinions of an institution. Over the course of a year and four mailings, 1,600 survey forms were sent to randomly selected adult patients discharged from a large midwestern hospital. The researcher reported that of those patients who rated the hospital as excellent, 95% also rated nursing as excellent. According to Spitzer's (1988) review of similar research, studies which demonstrate this relationship also delineate what consumers want from nurses. They want nurses to be caring and attentive, to answer questions and explain procedures, and to be sensitive to both the physical and emotional needs of consumers.

One Canadian study by Heffring, Neilsen, Szklarz, and Dobson (1986) examined overall patient satisfaction in a large teaching hospital in Alberta. The researchers employed a telephone interview survey technique and the sample included 1,300 adult patients over a one-year period. They reported that 50% of the respondents assigned the hospital the top rating of 10 for: open and approachable physicians, attentive and friendly nurses, respect for confidentiality, and a high calibre of medical care. The researchers concluded that prompt, individualized attention and being provided with adequate and accurate information regarding their conditions

was more important to patients than was the ultimate medical outcome.

The above findings are inconsistent with more recent research conducted by Cleary, Edgman-Levitan, McMullen, and Delbanco (1992) who used multivariate statistical methods in an attempt to describe the factors which influence patient satisfaction. They conducted a nationwide telephone survey of 6,455 adult patients within six months of discharge from medical and surgical units of 62 general hospitals across the continental United States. The interview addressed five dimensions, including evaluation of care and perceived health status. The researchers reported that the patient characteristic most strongly correlated with positive patient evaluations was perceived health status. They also reported that patients who said they wanted to be more involved in their care and low income patients generally gave the worst evaluations of their care.

There have been very few nursing research studies which compare perceptions of nurses with those of patients, or family members of patients. Interestingly, of six such studies located in the literature, three are Canadian, though only one of these was conducted in a pediatric setting.

Morales-Mann (1989) conducted a pilot study on a postpartum unit in an Ottawa hospital comparing perceptions of patients and nurses regarding the importance of nursing activities. Separate but similar questionnaires were given to 50 patients and 25 nurses. Nursing activities were classified

as teaching, physical care, and psychosocial and subjects were asked to rate the degree of importance each nursing activity held for them. The questionnaire for nurses included one column for the degree of importance in practice and a second column for the degree of importance they would like to assign to the particular activity.

The researcher reported that the nurses and patients did not assign the same importance to nursing activities. The nurse subjects also reported significant differences between the importance they assigned to each activity in practice and the importance they would like to assign. Morales-Mann concluded that "the performed role of the nurse is not congruent with the nurse's perceived role" (p. 484), and attributed this gap to pressures such as lack of staff, time limitations, and the emphasis of the employer on physical care. She recommended that essential nursing care for the postpartum patient be reconsidered, particularly since both patients and nurses expressed the belief that it was lacking. Moreover, this "must be done in congress with the patient in order to better meet her needs and her family's" (p. 484).

Another Canadian study (Ward-Griffin & Bramwell, 1990) explored the congruence of elderly client and nurse perceptions regarding the clients' self-care agency and perceived health status. Forty client subjects were interviewed by the researchers during individual home visits. Within 72 hours of the home visits, the related forty nurse subjects were asked to complete a parallel questionnaire.

While the researchers reported a significant positive relationship between nurse and client perceptions regarding the clients' self-care agency, they also found that the degree of congruence between client and nurse perceptions declined with the increasing age of clients. They also concluded that clients and nurses perceived the clients' health status differently. Moreover, clients and nurses "need to validate their perceptions" if nurses and clients are to work toward common goals.

Tilley, Gregor, and Thiessen (1987), also Canadians, examined the amount of congruence between the perceptions of 38 matched nurse-patient dyads regarding the nurse's role in patient education. Perceptions of patients and nurses were measured with two complementary sets of questions designed for the study.

The researchers reported incongruencies between nurses' and patients' perceptions of the nurse's role in patient education. They concluded that nurses "incorrectly assumed the desires of their patients for patient education were similar to their own" (p. 291). Consistent with the recommendations by Ward-Griffin and Bramwell (1990), Tilley and her colleagues recommended that nurses validate their perceptions with their clients. They also suggested nurses develop a clear definition of their role in patient education and examine forces within their organization which influence their ability to carry out patient teaching.

A small pilot study conducted on a geriatric ward in Britain (Forgan Morle, 1984) yielded similar findings to those of Morales-Mann (1989). The British study explored elderly patients' perceptions of nursing care activities and their link with satisfaction. The researcher found that elderly patients' satisfaction with nursing care was related to how well nurses met the patients' psychosocial needs. A recommendation was made that nurses place as much importance on the emotional and psychological needs of patients as on their physical needs.

An American study by Lynn-McHale and Bellinger (1988), also conducted with adults, compared needs satisfaction levels of family members of critical care patients with the accuracy of nurses' perceptions. They recruited a convenience sample of 52 family members and 92 nurses. The researchers reported that family members were more satisfied than dissatisfied for 43 of the 46 items addressing potential needs. They also reported nurses to be "moderately successful at identifying the level at which family members perceive needs as being met" (p. 450). However, by examining individual items on the instrument, the researchers identified numerous and specific instances where nurses' perceptions were inaccurate. In several areas the nurses perceived family members to have high needs, yet the family members ranked them as low and vice versa. They also found lack of agreement between the nurses and family members regarding needs relating to psychological aspects and the environment. The nurses thought family

members were more satisfied than the family members reported in these areas. The researchers concluded that unless critical care nurses accurately identify which family needs are and are not being met, individualized nursing interventions with family members cannot take place. They recommended strategies such as the routine use of family assessment forms.

A study conducted in an American pediatric hospital setting compared mothers', fathers', nurses', and physicians' perceptions of parental stress during a child's hospitalization (Graves & Ware, 1990). The parent sample consisted of 36 mothers and 14 fathers of children under 10 years of age who had been hospitalized in an acute, non-psychiatric hospital within the previous two-year period. Convenience samples of 27 nurses and 23 physicians comprised the other two groups. The results indicated that there were significant differences among the four study groups in perceptions of parental stress. Interestingly, the mothers' and nurses' ratings were the most similar, suggesting a gender issue. The researchers linked this finding to previous research suggesting that males do not recognize stress as readily as females.

While patient or consumer satisfaction data are important, equally important are the methods by which health care providers obtain the data (Cleary et al., 1989; Nelson, Hays, Larson, and Batalden, 1989). Consumer satisfaction data must be interpreted within the context of the particular

sample, the aspects of care examined, and the reliability and validity of the instruments.

The body of research which addresses congruence between perceptions of nurses and perceptions of consumers of nursing care is very limited. Most such studies reported in the literature have involved adults in hospital and community settings. The few studies to date suggest a lack of congruence between perceptions of nurses and consumers of their services. More research in this area is required, and the pediatric setting should be included in such research. As all of the previous research suggests, unless nurses validate their perceptions with the consumers of their care, effective nursing care is less likely to be planned, delivered, and evaluated.

Parents' Experience of their Children's Hospitalization

In the past five years alone there have been over 500 theoretical and research-based articles in the nursing literature which address the experiences of parents when their children are hospitalized. A large body of this work pertains to either the critical care setting or addresses the unique needs and perspectives of parents of chronically ill children. Overall, the needs of parents in hospital have been well-documented and many of these needs have been found to exist across different hospital settings (Hickey, 1990; Kristjansdottir, 1991; Turner, Tomlinson, & Harbaugh, 1990).

The reported research has been both qualitative and quantitative in nature and has identified key stressors experienced by parents of hospitalized children, such as role revision. Hickey and Rykerson (1992) cite Jay's (1977) definition of role revision as "giving up the role of the parent of a well child and taking on the unfamiliar role of the parent of a sick child" (p. 565). Role revision and role strain have also been found by other researchers to be major sources of stress for parents of hospitalized children (Hayes & Knox, 1984; Miles & Carter, 1983).

In an effort to measure or quantify this stress, Miles and Carter (1983) developed a tool called the Pediatric Stressor Scale: Pediatric Intensive Care Unit (PSS:PICU). The original PSS:PICU has been tested and revised by Carter and Miles (1989), and used by other researchers over ten years. In numerous studies, stress scores were highest in the domain of alteration in parental role (Hickey and Rykerson, 1992).

In two separate studies conducted in pediatric critical care settings, the Nursing Mutual Participation Model of Care (Curley, 1988) was found effective in reducing parental stress (Curley & Wallace, 1992). This model "helps to establish an individually appealing parental role" and "is supportive to and guided by the perceived individual needs of parents" (p. 37).

In the most recent study, which replicates the first, Curley & Wallace (1992) employed a quasi-experimental design on an 18-bed pediatric intensive care unit in a large American

teaching hospital. A control group received the usual primary nursing care from the nursing staff while an experimental group was cared for by nurses who used the Nursing Mutual Participation Model of Care. A parental stressor scale for the pediatric intensive care setting was used to measure parental perceptions.

The researchers reported that parents in the experimental group perceived less stress than the parents in the control group. This was particularly true of the stress related to alterations in parental role. They concluded that the use of the Nursing Mutual Participation Model of Care significantly reduced parental stress in the pediatric intensive care setting. This model directs nurses to recognize parents as unique, autonomous individuals who offer "vital elements of care" to their critically ill children.

Through exploration of parents' experiences related to their children's hospitalizations, nurse researchers have contributed to theory development. For example the work of Turner, Tomlinson, and Harbaugh (1990) has built upon Mishel's theory of uncertainty (1983) and contributions to role theory have been made by Knox and Hayes (1983) and Brown and Ritchie (1990).

The nursing literature in this area directs nurses in their work with parents to recognize that parents often have views of the hospitalization experience that differ from those of nurses (Knox & Hayes 1983; Tilley, Gregor & Thiessen, 1987). Parents have said they want to be collaborators in

care and that nurses need to negotiate roles with them (Brown & Ritchie, 1989; Callery & Smith, 1991; Knox & Hayes, 1983; Kristjansdottir, 1991; Robinson, 1985a). Moreover, as Graves (1991) suggests, nurses need to identify where there are differing perspectives between parents and nurses and establish mutual priorities and goals.

Summary of Literature Review

Traditional quality assurance programs are evolving toward a philosophy of Total Quality Management (TQM). According to this model, consumer satisfaction is one important aspect of quality to be considered when evaluating health care services.

In a health care setting, the purpose of monitoring consumer satisfaction is to improve the quality of care. To do this, care givers must first understand the extent to which consumers' service expectations are met. This can best be done by direct consultation with the consumers themselves (Gerber, 1993; Peterson, 1989; Steiber & Krowinski, 1990). Satisfaction tools are one means of such consultation.

According to Kalmanson and Seligman (1992), it is crucial for health care providers to develop a working alliance with consumers of health care if interventions are to be successful. In a pediatric setting, parents are the consumers, and understanding parental perceptions is key to the development of such an alliance (Curley & Wallace, 1992;

Graves, 1991; Knox & Hayes, 1983; Tilley, Gregor, & Thiessen, 1987).

There is very little research which examines how accurately nurses perceive consumer perceptions in any health care setting. To date, no studies have specifically explored the congruence between parent satisfaction with nursing care in a pediatric setting and nurses' perceptions of parent satisfaction. This study addresses that gap in the nursing literature.

CHAPTER THREE

Methodology

This chapter describes the research design, sample, and sampling procedures used in this study. Protection of human rights is also discussed, followed by a description of the study instruments and methods of data analysis.

Research Design

The design for this research was descriptive, that is, a non-experimental approach which is used to describe phenomena of interest and which may also examine relationships (Schalk Thomas, 1990).

Setting

This study was conducted on a 22-bed, 10-room nursing unit at British Columbia's Children's Hospital (BCCH), referred to as the neurosciences unit. The patient care areas of this unit consist of four single rooms, three double rooms, and three four-bed rooms, one of which is designated as a nursing observation room. Parents and nurses who participated in the study were given the choice of completing the study instrument in a patient care area, at the nursing station, or in a small office just off the unit. Most of the study participants selected the small office where there were fewer distractions.

Sample and Sampling Procedures

Convenience samples of 20 parents and 20 nurses from the neurosciences unit participated in this study. The patients admitted to this unit range in age from newborn to early adolescence. Many are admitted with neurological or neurosurgical conditions.

The parents met the following inclusion criteria:

- able to read and write English
- their child was an inpatient on the selected unit for a minimum of three days
- their child was admitted with a neurological or neurosurgical condition and was, therefore, being medically managed by the same group of physicians.

Parents were excluded from the study if they were:

- in crisis
- mentally ill
- if their children were critically ill or dying.

The parents were recruited by the following process: One to two days prior to their child's anticipated discharge, the head nurse (or delegate) of the study unit provided parents who met the recruitment criteria with a brief introduction to the study. If interested, they were invited to read the information sheet (Appendix C) and asked to inform the head nurse (or delegate) if they were willing to participate in the study. The researcher then approached only parents who expressed an interest in the study and answered any questions

they had. Once they indicated they were adequately informed, parents were asked to sign a consent form (Appendix D) prior to completing the Adapted Patient Satisfaction Instrument (APSI) (Appendix A) and socio-demographic tool for parents (Appendix E). Parents were given a copy of the consent form for their own records, and mailing addresses were obtained for parents interested in receiving a summary of the study findings. The parents completed the APSI as close to discharge as possible.

Each nurse met the following criteria:

- had cared for the hospitalized child for a minimum of two 12-hour shifts.
- was a regular employee on the particular nursing unit.

Recruitment of the nurses was not difficult in the selected setting because the unit has an all-RN staff, the nurses have a strong interest in nursing research, and this unit has a unit-based quality assurance committee committed to investigating aspects of the quality of nursing care. All the nurses were provided with a study information sheet (Appendix F). As their particular "parent" entered the study, the researcher recruited each eligible nurse into the study. They also signed informed consent forms (Appendix G) prior to completing the APSI (Appendix B) and the socio-demographic tool for nurses (Appendix H). The researcher was frequently available, either in person or by telephone, if any of the nurses had questions.

In order to avoid a test-retest effect, each nurse participant filled in only one instrument during the study. Therefore, the total number of subjects was restricted by the number of nurses employed on the unit. The target was a minimum of 20 parent:nurse pairs and, in the end, 22 pairs were recruited. However, two sets of data were discarded due to questions about the validity of responses. The final 20 nurse participants constituted 80% of the unit's nursing staff.

To protect the integrity of the study, the parents and the nurses who participated were asked not to discuss their responses on the instruments with one another.

Protection of Human Rights

This study was approved by the In-Hospital Research Review Committee at BCCH and by the University of British Columbia's Behavioral Sciences Screening Committee for Research and Other Studies Involving Human Subjects. An information sheet describing the study and the measures being taken to protect confidentiality was provided to each parent and nurse asked to complete an APSI. Parents were reassured that refusing to participate would not jeopardize their child's care in any manner, and they were informed that they could choose to withdraw from the study at any point. There was no identification of the nurse, parent or patient on the instruments. Both the instruments and the demographic survey

sheets were coded and matched prior to distribution. Participants were assured that any identifying information would be confidential and that no such information would be used in any future publications of the research results.

Instruments

Patient Satisfaction Instrument

The instrument used in this study is an adaptation of Risser's (1975) Patient Satisfaction Instrument, and throughout this study is referred to as the adapted PSI (APSI). Risser's original 25-item self-report instrument was designed to measure patient satisfaction with nursing care in an outpatient care setting. It was subsequently revised by Hinshaw and Atwood (1982a) to measure inpatient satisfaction with nursing care without altering the basic conceptual framework and structure of the instrument.

As originally designed, the APSI is divided into three subscales which measure patient attitudes toward nursing and nursing care. The subscales are professional (7 items), educational (7 items), and trust (11 items). The professional subscale measures satisfaction with technical activities and the knowledge base required to competently complete nursing care tasks. The education subscale measures the nurse's ability to provide information for parents including answering questions, explaining care, and demonstrating techniques. The trust subscale deals with nursing characteristics that allow

for constructive and comfortable patient-nurse interaction and the communication aspects of the interaction. A five-point Likert-type scale ranging from strongly agree to strongly disagree is used to measure the level of agreement or disagreement with each item. Items are evenly divided between positively and negatively worded statements, with negative responses being inversely weighted. Scores range from 1 to 5, with low scores representing a high degree of satisfaction with nursing care. Subscale values are created by computing an average for all items in each subscale. An overall APSI value is calculated by computing the average for all 25 items.

For the purposes of this research, questions 2, 11, 12, and 18 were altered to refer to parents of patients instead of patients. While these changes did not alter the intent of the questions, it is recognized that any changes to a data collection tool may affect previously reported reliability and validity data (Woods & Cantanzaro, 1988).

The nurse instrument was amended further by stating: "In an effort to determine how accurately we judge parent satisfaction with our nursing care to be, please complete this instrument as you think the parent of the patient identified to you by the researcher will complete it."

To date, there are at least six studies reported in the nursing literature in which the Risser (1975) Patient Satisfaction Instrument was used (Hinshaw & Atwood, 1982b; Risser, 1975; Turner & Matthews, 1991). Reliability estimates

across all these studies indicate good overall instrument reliability.

In this study, instrument reliability was tested using Cronbach's (1951) alpha. Table 1 sets out the APSI and subscale values, standard deviations, and Cronbach's alphas for the parents and nurses in this study and for three other studies. The standard deviation and Cronbach's alpha values in this study compare favorably to those reported in previous uses of this instrument (Hinshaw, & Atwood, 1982; Risser, 1975; Turner & Matthews, 1991). The scale values are also compatible with those reported by Risser (1975) and Turner and Matthews (1991).

In developing the PSI for use with inpatients, Hinshaw and Atwood used three construct validity techniques: convergent and discriminant strategy, discriminance, and predictive modeling. In the predictive modeling, one study compared the results to three other measures predicted to influence patient satisfaction. These were: unit, patient and staffing characteristics; job satisfaction of nursing staff; and the actual delivery of certain care-comfort activities.

Face validity for this study was addressed by having the instrument reviewed by three nurses and three parents who did not participate in the study. All reviewers reported that the questions were clear and understandable, and reflected values consistent with their own values related to nursing care.

Table 1.

Reliability Measure Comparisons

APSI and Subscales		Parents	Nurses	Risser (1975) Trial 1	Risser (1975) Trial 2	Turner & Matthews (1991)
APSI	Value	1.75	2.07		2.05	2.23
	StDev	.46	.40		.48	.45
	Alpha	.94	.93		.92	.84
Education	Value	1.89	2.22	2.49	2.20	2.34
	StDev	.56	.53	.69	.56	.45
	Alpha	.83	.85	.87	.83	.84
Trust	Value	1.68	1.98	2.19	2.08	2.24
	StDev	.44	.41	.63	.54	.57
	Alpha	.85	.86	.89	.82	.72
Professional	Value	1.74	2.04	1.96	1.91	2.12
	StDev	.48	.41	.48	.44	.47
	Alpha	.84	.81	.80	.64	.82

There is no copyright on the PSI as it has been published in its entirety (Risser, 1975). However, the researcher discussed the proposed use of the APSI with Hinshaw (personal communication, August, 1992), who is currently Director of the National Institute for Nursing Research in Bethesda, Maryland. She was enthusiastic and supportive of using the APSI in this manner and indicated that no permission was required for use of the instrument.

Socio-demographic Tool

The socio-demographic tool attached to the parent APSI (Appendix E), requested information such as age, gender, and number of previous admissions for the patient, and age, gender, educational level, and marital status of the parent. Parents were also asked whether their child had a long-standing health problem. Attached to the APSI for nurses, the socio-demographic tool (Appendix H) requested data regarding age, educational level achieved, total number of years of nursing experience, and number of years of nursing experience at BCCH.

Data Analysis

In order to answer the first two research questions, that is, "How do parents of hospitalized children rate their satisfaction with nursing care using the APSI?" and "How do pediatric hospital nurses rate these parents' satisfaction with nursing care using the APSI?", data analysis included descriptive statistics. The means, ranges and standard deviations of the instrument items were calculated for each group. To answer the third research question: "What is the degree of congruence between the ratings by parents and by nurses?", Pearson product-moment correlations and mean scores comparisons were used. Alpha was set at .05.

CHAPTER FOUR

Presentation and Discussion of Findings

The findings of this study are presented and discussed in five sections. The first section contains demographic data describing the two groups of study participants and characteristics of the hospitalized children. In the second and third sections parents' and nurses' responses to the APSI are presented to answer the first and second research questions. The fourth section describes the degree of congruence between parent and nurse responses. Discussion of the findings is presented in the final section.

Description of Study Participants

Parents

Age. The parent sample consisted of 16 mothers and four fathers. Most of the mothers were between 21 and 40 (75%). In total, mothers represented 80% of the study parents. Despite the increase in two-career families and an increase in male unemployment, the majority of children admitted to this unit have their mothers with them for most of their hospitalization. Three of the four fathers were between 31 and 40 and one was between 41 and 50.

Education. Seven parents had completed secondary school, three had completed some post-secondary school training, and 10 parents (or 50% of the sample) had completed a college or

university program. Four study parents, all mothers, volunteered the information that they were registered nurses. Professions or occupations of the other parent participants are unknown.

Marital Status. Eighteen out of 20 (or 90%) of the parents were married. Of the remaining two, one reported her status as common-law, and the other as separated or divorced.

Children

Most of the hospitalized children were under 10, and the boys (60% of the children) were older than the girls (40% of the sample). Six children were under one, six were between the ages of one and five, five were between five and 10, and three were between 10 and 13.

Number of hospitalizations in past year. The number of times the children had been hospitalized in the last year ranged from one to 10. Three of the children had not been hospitalized in the past year. Of the other 17, eight had been hospitalized one or two times, six had been hospitalized three to 10 times, and one parent simply responded "lots" on the demographic sheet.

Perceptions of chronic illness. Fifteen parents reported that their hospitalized children had long-standing health problems. Of the fifteen, four had been hospitalized only once in the last year, and four more had been hospitalized twice. Excepting those children who were not hospitalized at all in the past year, the number of hospitalizations did not

appear to be a good predictor of whether parents reported their children as having chronic health problems.

Nurses

Education. Of the 20 nurse participants, 15 (75%) held the diploma in nursing and five (25%) held baccalaureate degrees. Five of the diploma-prepared nurses were currently working toward a baccalaureate degree in nursing.

Nursing Experience. Fifteen of the 20 nurse participants had worked as nurses for five years or less, with the other five having six to 20 years nursing experience. The length of time the study nurses had worked at British Columbia's Children's Hospital (BCCH) ranged from two months to 10 years. Five nurses had worked there for a year or less, eight for one to three years, three nurses for three to four years, two for four and half years, and two for 10 years. Thus, 75% of the nurse participants had four or fewer years of nursing experience at BCCH.

APSI Responses

Parent

Parent responses to the 25-item rating scale answer the first research question: "How do parents rate their satisfaction with nursing care using the APSI?" Table 2 sets out the APSI and subscale values for the parents and comparative values from the Risser (1975) and Turner and Matthews (1991) studies.

Table 2.

Parent APSI values

APSI and Subscales	Parent APSI Values this Study	PSI Value Range from Other Studies
APSI	1.75	2.05 - 2.23
Professional	1.74	1.91 - 2.12
Trust	1.68	2.08 - 2.24
Education	1.86	2.20 - 2.49

The parent scores in this study indicate a higher level of satisfaction with nursing care than that found in the other studies, on a scale in which 1 indicates the highest level of satisfaction, and 5 the highest level of dissatisfaction. Other unpublished studies, as summarized by Hinshaw and Atwood (1982), are reported with other values but without an explanation of how they were computed, and are, therefore, not presented for comparison here.

Nurse

Nurse responses to the 25-item rating scale answer the second research question: "How do nurses rate parent satisfaction with nursing care using the APSI?" Table 3 sets out the APSI and subscale values for the nurses.

Table 3.

Nurse APSI Values

APSI and Subscales	Nurse APSI Values
APSI	2.07
Professional	2.04
Trust	1.98
Education	2.22

Overall, the nurses rated parents as reasonably satisfied with nursing care. These findings must be viewed cautiously, given that the APSI was not designed to measure nurse perceptions of parent or patient satisfaction, and to date has not been used in this manner.

Comparisons of Parents' and Nurses' APSI Responses

Comparisons of parent and nurse responses on the 25-item APSI answer the third research question: "What is the degree of congruence between the ratings by parents and by nurses?"

The responses are presented in two ways: comparisons of pairs of responses and comparisons of group means. In the pairs presentation the responses are analyzed by examining each parent-nurse pair of APSI and subscale values, and how the parent and nurse values compare within the individual pairs. In the means presentation the parents and nurses are analyzed as two separate groups, and the APSI and subscale

values are analyzed to see how they differ between the two groups. Correlation coefficients are presented to compare the APSI and subscale values of the pairs of parents and nurses. The comparisons between the parents and nurses as two groups are made by presenting the differences in means between the two groups.

The findings presented here must be considered only suggestive because the sample size in this study is smaller than that recommended for data analysis involving a statistical method such as a correlation coefficient. Generally, each group should consist of at least 30 subjects (Dr. R. Schutz, personal communication, February 18, 1994). However, the correlation statistics are included because they allow a more accurate measurement of how each parent-nurse pair rated parent satisfaction.

Mean Scores Comparisons

The earlier discussion illustrated that the mean values for nurses were higher than those of parents; that is, the nurses as a group thought the parents were less satisfied than the parents' scores would indicate. These differences are significant when measured with a correlated or paired t-test, the recommended statistical test when the two groups being compared are paired on some basis (Munro, Visintainer, & Page, 1986). The values are significant at $p < .05$ as summarized in Table 4.

Table 4.

Difference of Means Comparisons

APSI and Subscales	Means and Standard Deviations		Difference of Means	t	P
	Parents	Nurses			
APSI	1.75 .46	2.07 .40	.32	2.78	.012
Education	1.89 .56	2.22 .53	.33	-2.40	.027
Trust	1.68 .44	1.98 .41	.30	2.67	.015
Professional	1.74 .48	2.04 .41	.30	2.29	.034

The differences in means are remarkably consistent, being in the range of .30 to .33. Taken on their own, these would suggest that nurses consistently rate parents as somewhat less satisfied with nursing care than the parents rate themselves.

Parent-Nurse Pairs Comparisons

This analysis examines how consistently each pair of nurses and parents scores the APSI by reporting correlation coefficients and illustrating them with scatterplots. A scatterplot graphically illustrates the magnitude of a correlation coefficient through its slope and by the degree to which the scatterplot points cluster around an imaginary line

depicting the slope (Shavelson, 1988). Figure 2 is a scatterplot of the APSI values for nurse-parent pairs.

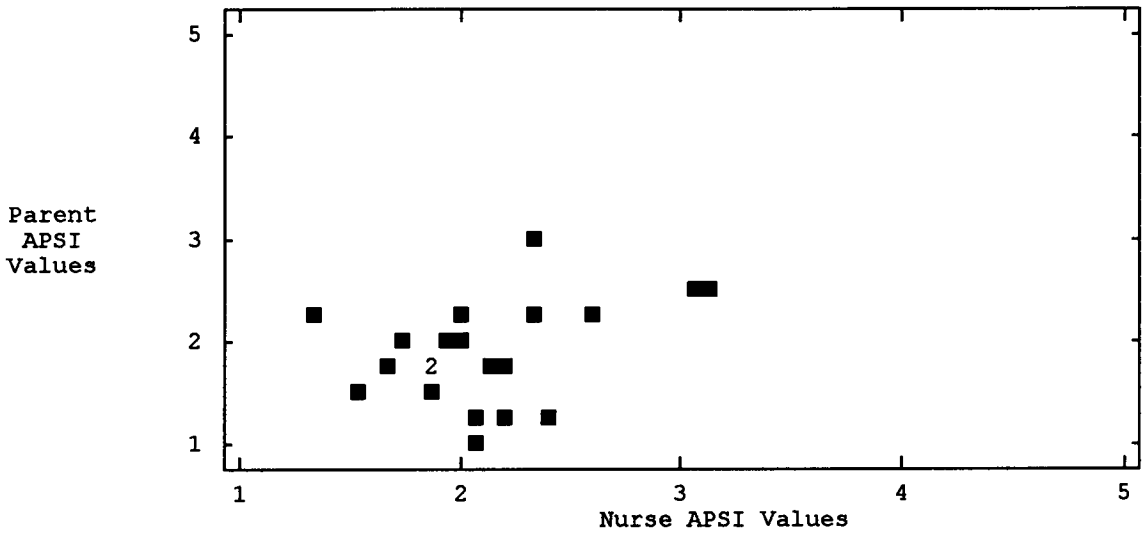

Figure 2. Scatterplot of Pairs of Parent-Nurse APSI Values

The comparison of means shows that, as a group, nurses provide higher APSI scores than parents, indicating less parent satisfaction. This finding is reflected in the scatterplot, in which the score pairs appear in the same quadrant, indicating that the nurse APSI scores follow the same general direction as the parent APSI scores. In this case the direction is toward the "satisfied" end of the scale, as indicated by the group means.

However, the lack of a strong central grouping in this scatterplot shows not only that the pairs score differently, but also that the parent and nurse in each pair provide scores which are inconsistently different. Thus, the nurses do not provide uniformly lower satisfaction ratings as the difference

of means comparisons might suggest, but instead differ by being either lower or higher.

If nurses were capable of accurately judging the satisfaction level of parents, one would expect a strong central tendency along a sloped line, and a resulting high correlation coefficient. The impression from the scatterplot is reflected in a low Pearson product-moment correlation coefficient of 0.30.

An examination of correlation coefficients for subscale to subscale correlations between parents and nurses reveals the same lack of consistency. In this analysis each of the three subscale values for each pair of parents and nurses is correlated. The correlation coefficients range from 0.10 to 0.31, as summarized in Table 5.

Table 5.

Between Group Subscale Correlations

Parents	Nurses		
	Professional Subscale	Education Subscale	Trust Subscale
Professional Subscale	.10		
Education Subscale		.26	
Trust Subscale			.31

Values in this range show low or little, if any relationship between the scores (Munro, Visintainer & Page, 1986). They are illustrated graphically in the scatterplots in Figures 3, 4 and 5.

There is the least agreement between parents and nurses in this study on the value of the professional subscale, which deals with technical activities and the knowledge base required to competently complete the nursing care tasks (correlation coefficient = 0.10). For example, as shown in Figure 3, five nurses rated at just below Agree (2.2), while the parent values in those five pairs ranged from Strongly Agree to somewhat less than Agree (1.0 to 2.4).

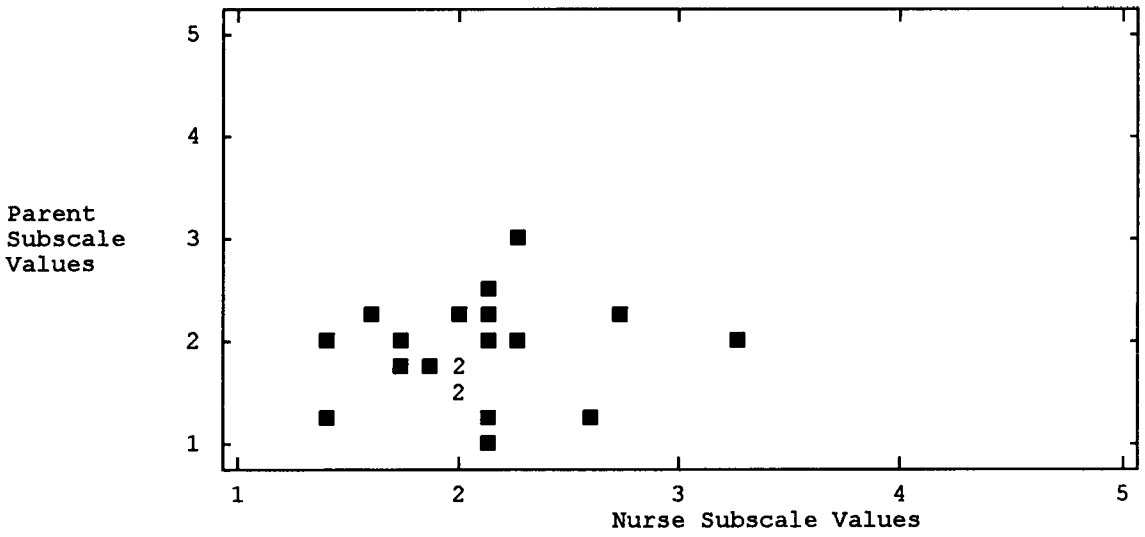

Figure 3. Scatterplot of Pairs of Parent-Nurse Professional Subscale Values

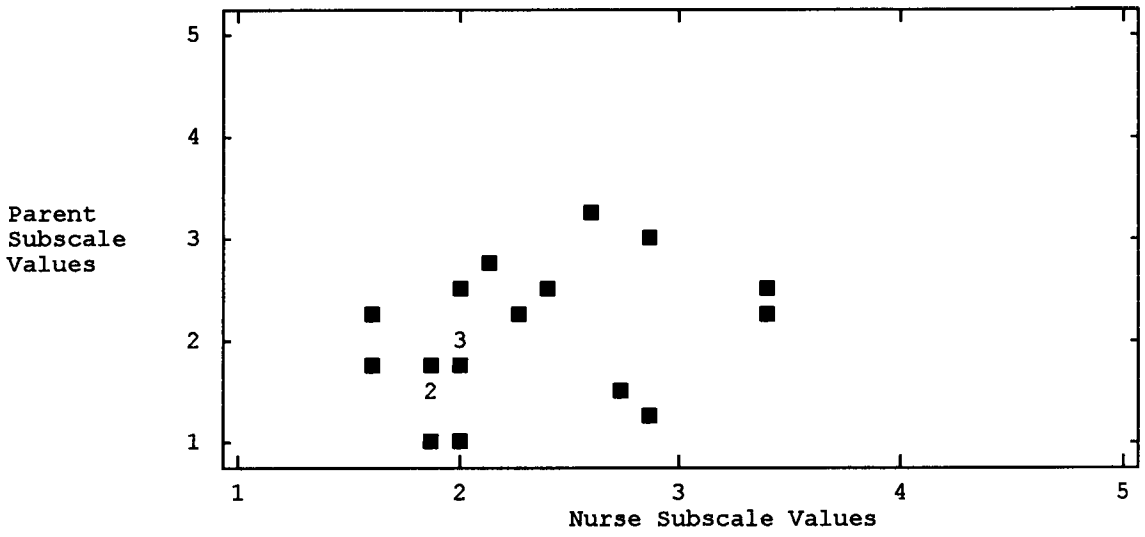

Figure 4. Scatterplot of Pairs of Parent-Nurse Education

The widely dispersed points in Figure 4 illustrate the low correlation coefficient of .26 when the Education subscale values for parents and nurses are compared. Two pairs on the right of the plot points are out of the lower left quadrant, and show the nurses perceiving the parent satisfaction level moving toward the dissatisfied end of the scale while the parents are still on the satisfied end.

Parents and nurses score the trust subscale quite differently (correlation coefficient = 0.31), perhaps indicating their different perceptions of whether the ideal degree of trust is present. In Figure 5, for instance, two nurses scored the subscale at just below Agree (2.1 and 2.2) while the two parents in those pairs scored at Strongly Agree (both at 1.0). On the other hand one of the parents scored at Agree (2.0) while the nurse scored at Strongly Agree (1.0). As in the scatterplot of APSI values in Figure 2, most of the

pairs appear in the same quadrant, indicating that both nurses and parents tend to the satisfied end of the scale.

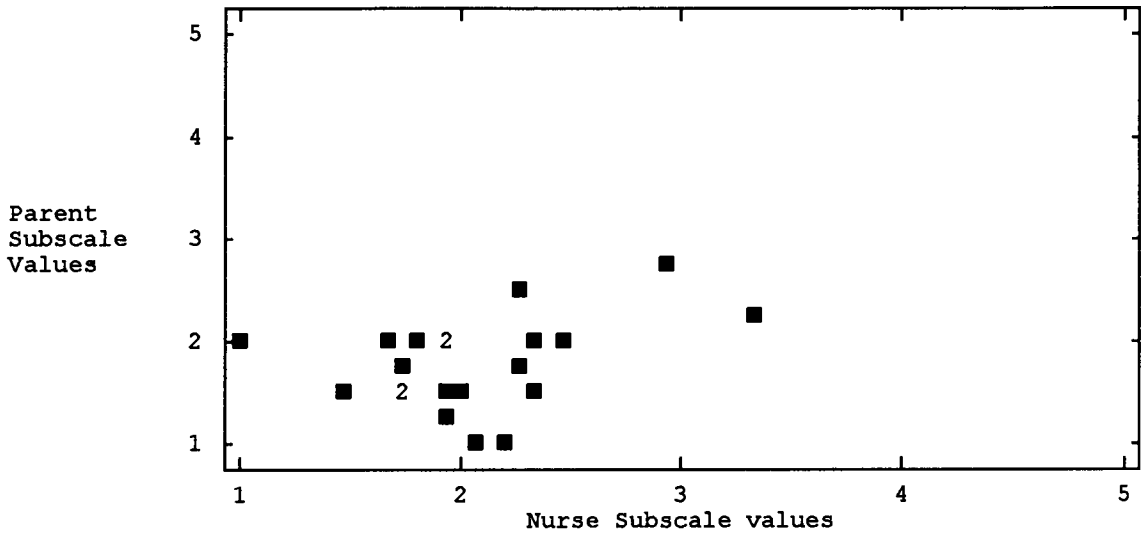

Figure 5. Scatterplot of Pairs of Parent-Nurse Trust Subscale Values

Discussion of Findings

As a group, the parents in this study have rated themselves as more satisfied with nursing care than have patients in other studies where the instrument values were calculated in the same fashion (Risser, 1975; Turner & Matthews, 1991). Given the many different variables in each setting, it is only possible to speculate as to why this is the case.

The study unit had an unusually high percentage of BSN-prepared nurses (25% of the nurse sample), as well as a large number of nurses pursuing further education. Not only were 25% of the study nurses enrolled in BSN programs, many others

were pursuing credentials such as neuroscience nursing certification through the Canadian Nurses' Association, and were attending regular study sessions to that end. The sample was not large enough to study the impact this factor may have had on the nurses' ability to judge the satisfaction level of parents.

Within BCCH, the study unit has been the place where competency-based education and a performance appraisal tool built on the Registered Nurses Association of British Columbia's (1992) Standards for Practice were first developed and implemented. These documents established new nursing documentation standards. For example, the admission process to the unit requires nurses to complete a patient data base in consultation with the parents/patient, and then to validate nursing diagnoses with them. Perhaps this initial clarification of the parents' perceptions regarding the reason for hospitalization, hopes for the hospitalization, and parents' learning needs, promotes parent satisfaction with nursing care. According to Greeneich et al. (1992), consumers bring expectations of nursing care with them to the health care setting. These expectations may be the result of prior contacts with nurses or may be related to portrayals of nurses through the media. If nurses want consumers of their services to be satisfied, they must ensure that clarification and an alignment of consumer expectations occurs early in the parent-nurse relationship.

The nursing documentation standards on the study unit also direct nurses to review and revise the nursing care plan in consultation with parents on a shift-by-shift basis. This mechanism is in keeping with the "bottom-up" approach recommended in current quality assurance and TQM literature. Additionally, parents of hospitalized children have said they want to be collaborators in their children's care. This approach responds to that expectation.

BCCH typically has a much higher nurse-patient staffing level than that found in most adult settings (Thornton, 1993), which may have made it easier to meet the expectations of the parents. The nursing unit is also managed in such a way that continuity of care is maximized, particularly for patients with long hospitalization periods and chronic health problems. This may also have contributed to the high level of parent satisfaction.

The nurses in the study rated parent satisfaction in a range consistent with those in the other studies available. Because the instrument was not designed for use by nurses, one has to be careful in interpreting this finding. It may be consistent with the instrument measuring the extent to which expectations of nursing care are met: these nurses have high standards, and generally they are met to the same degree as the patients in the other studies felt their expectations were met. Alternatively, despite the high reliability coefficient value for the nurses in this study (Cronbach's alpha = 0.93), the nursing scores may not hold any significance. Instead,

the nursing scores may illustrate how inaccurately nurses estimate the level of consumer satisfaction with nursing care because of nurses' general lack of awareness of their influence and impact upon parents in the hospital setting (Brown & Ritchie, 1989).

The comparisons of ratings by parents and nurses demonstrate that nurses not only rated differently than parents, but also that they did so on an inconsistent basis and are thus unreliable estimators of parent perceptions (Knafl, Breitmayer, et al., 1992). Although, in most cases, the nurses rate in the same direction as the parents, in some situations they judge parents as being on the dissatisfied side of the scale when the parents rate themselves on the satisfied side. This finding is consistent with the experience with one parent-nurse pair, in which the parent had been labeled by nurses as very demanding and difficult. He was accordingly rated by the nurse as reasonably unsatisfied, yet rated himself as quite satisfied.

The inconsistent basis on which nurses estimate parent satisfaction with nursing care underscores the importance of nurses themselves seeking satisfaction data directly from the consumers of their care. Current TQM theory emphasizes the need to base decisions on accurate and comprehensive information: to "close the loop" by ensuring that multi-faceted evaluation data are collected, analyzed, and used to guide future practice. For example, understanding the consequences of their helping behaviors can influence the

attitudes and beliefs of the helpers (Dunst et al., 1988). At a staff nurse level, this awareness may result in helping behaviors which are better aligned with consumer expectations.

Summary

The findings of this study have been presented and discussed in this chapter. The results are consistent with the limited research conducted in this area to date which suggests nurses and consumers of nursing care perceive the health care experience very differently. The differences between parent and nurse perceptions were found to be statistically significant.

CHAPTER FIVE

Summary, Conclusions, and Recommendations

Summary

The nursing profession has long been concerned with measuring the quality of nursing care and establishing standards of care (Baker, 1983; Canadian Nurses Association, 1980; Lang & Clinton, 1983). Accurately measuring quality of care is difficult, however, as health care providers and consumers may differ in their perceptions of quality care. The literature of the past ten years suggests a lack of agreement between the perceptions of health care providers and consumers regarding the quality of nursing care (Bond & Thomas, 1992; Oberst, 1984). Yet to date little research has actually compared nurses' and consumers' perceptions regarding the quality of nursing care, particularly in the pediatric setting.

This study was specifically designed to examine the degree of congruence between the perceptions of nurses and parents in a pediatric setting regarding the quality of nursing care. A 25-item satisfaction with nursing care instrument was used as the data collection tool. Twenty nurse-parent pairs constituted the sample in this descriptive study which was conducted on a 22-bed inpatient unit at British Columbia's Children's Hospital. Eighty percent of the

parent participants were mothers and 20% were fathers. The majority of parents were married and between the ages of 31 and 40.

Most of the 20 nurse respondents had worked in pediatric nursing for less than five years. Twenty-five percent of this study group held a BSN degree, and another 25% were enrolled in BSN programs.

The Patient Satisfaction Instrument designed by Risser (1975), adapted by Hinshaw and Atwood (1983a) for use with inpatients, and further adapted for parents by this investigator, was used along with socio-demographic instruments for parents and nurses. The adapted PSI (APSI) contains 25 items and a five-point Likert-type scale, with an equal number of positively and negatively worded questions. A low score indicates high satisfaction and vice versa.

The study results revealed that, as a group, nurses estimate parents to be less satisfied with nursing care than parents report themselves to be. However, when a pair-by-pair analysis was conducted, it showed a lack of congruence between parents' and nurses' perceptions in both directions.

Conclusions

The following conclusions are drawn from the findings of this research study:

1. The high level of satisfaction with nursing care reported by the parents indicates that the nurses' helping

behaviors were meeting the parents' expectations at the time of the study.

2. Nurses' perceptions of parent satisfaction with nursing care were not congruent with parents' reported satisfaction.

Implications

The findings of this study have implications for nursing in the realms of practice, education, and administration.

Nursing Practice and Nursing Education

According to the conceptual framework which directed this study (Dunst et al., 1988), it is the beliefs and attitudes of helpers such as nurses that most influence help giving behavior. While often overlooked, it is important to evaluate the effects or outcomes of helping interventions from recipients' or help seekers' perspectives. Without formal mechanisms which direct nurses to monitor the effects of their caregiving upon the recipients of their nursing care, nurses risk basing nursing interventions on assumptions and erroneous perceptions. Thus, soliciting consumer satisfaction with nursing care data should be incorporated into such mechanisms. Nurses will have the opportunity to be influenced at the critical level of attitudes and beliefs if they receive and understand direct feedback from the consumers of their care.

Nurses must explicitly ask the consumers of their services whether or not their expectations of nursing care are

being met (Graves & Ware, 1990; Morales-Mann, 1989; Tilley, Gregor, & Thiessen, 1987; Ward-Griffin & Bramwell, 1990). According to Peterson (1989), the methods used to monitor consumer satisfaction are not nearly as important as asking consumers on a daily basis: "What do you expect from your caregiver today?" and "How satisfied were you with care today?" (p. 168).

According to Gohsman (1981) the young child experiences hospitalization through the eyes of his or her parents. Given the increasing incidence of chronic illness in childhood and the consequent frequent contact with health care providers that many children will have, nurses should be proactive and ensure that such experiences these children have are of a positive nature.

From a broader perspective, professional nursing organizations such as the Canadian Nurses Association (1980) direct nurses to include the consumer in the planning, delivery, and evaluation of nursing care. At the provincial level, the Registered Nurses Association of British Columbia (RNABC) incorporates consumer input in much of its policy development and strategic planning. As a result, the recently revised Standards for Nursing Practice (1992) provide meaningful direction for practicing nurses in British Columbia by reflecting consumer perspectives.

As nurses are ethically required to consider the best interests of their consumers as paramount (CNA, 1991), nurses should recognize their responsibility in promoting consumer

satisfaction with nursing care. Consumer satisfaction with nursing care is a reliable predictor of overall satisfaction with hospital care (Abramowitz et al., 1987; Cleary et al., 1989). Nurses need to understand the link between consumer satisfaction with health care and their resulting compliance with treatment as well as the willingness on the part of the consumer to maintain contact with health care providers (Greeneich et al., 1992; Naylor et al., 1991). These concepts should be introduced to nurses early in their basic education, with periodic reinforcement throughout their careers.

Consumer satisfaction data can provide invaluable information to hospital-based nurse educators, enabling them to plan inservice education that addresses issues relevant to consumers. In these times of fiscal restraint, it is essential that the limited dollars allocated for nursing education be spent on improvements in practice that are visible to and seen as effective by those who fund health care, that is, consumers. Unless nurses ensure that the care they provide is consistent with what consumers want, consumers are unlikely to be satisfied. This view is supported by the limited research that compares the perceptions of consumers and nurses (Forgan Morle, 1984; Graves, 1991; Graves & Ware, 1990; Lynn-McHale & Bellinger, 1988; Morales-Mann, 1989; Tilley et al., 1987; Ward-Griffin & Bramwell, 1990).

Nursing Administration

Nurse administrators are ultimately responsible for ensuring that consumers are satisfied with the nursing care they receive, and should thus support initiatives that solicit satisfaction with nursing care data. At BCCH, for example, the Parent Advisory Group, which is philosophically and financially supported by the hospital's Chief Nursing Officer, provides feedback on nursing care that helps guide planning within the Nursing Division. Nurse administrators should also ensure that consideration of consumer satisfaction data is a routine part of nursing quality assessment.

At a unit level, consumer satisfaction information can be useful to the nursing manager in a number of arenas. Among these are identifying problem areas, planning quality improvement initiatives, and monitoring the performance of individual nursing staff.

The current management theory of TQM advocates the involvement of front-line workers in quality improvement activities. Unit-based committees armed with consumer satisfaction data are much more likely to succeed in ensuring that consumer expectations are met than a quality assurance nurse who visits particular units on a random and infrequent basis. As Fong (1993) points out, while systems may be put in place which support the delivery of nursing care, in the final analysis it is the individuals and groups of individuals in any particular setting who ultimately make the difference.

Further Research

This study should be replicated with a larger sample, thereby permitting further testing of both the instrument and methods. The instrument was originally designed and tested for use with patients themselves, not with parents or nurses. This descriptive study was the first to use the APSI as an instrument to capture both parent satisfaction with nursing care and nurses' perceptions of parent satisfaction with nursing care. The reliability and validity testing conducted in this study suggest that the APSI may be appropriate to use with parents of hospitalized children. However, more validity and reliability testing should be conducted if the tool is to be used with nurses in a similar manner.

The instrument now only purports to gather information useful in the determination of the APSI values. In the course of data collection input from parents was received both orally and, in some cases, in writing. It would be useful to collect and analyze these data more systematically, both in looking at the congruence issues relevant to this study, and also for use of the instrument as a quality assurance tool which needs to be sensitive to changing trends which may not be detected by this instrument.

The demographics of the parent and nurse samples in this research were similar with respect to culture and education. It would be interesting to conduct such research with parents from different backgrounds, incorporating a qualitative

approach to explore variables such as culture, education, perceptions of previous hospitalizations, and values and beliefs related to nursing care.

According to Thurston and Best (1990), blending research findings and research methods into the quality assurance process can both improve the scientific basis of nursing practice and enhance the quality of nursing care. Research involving this approach would be timely given the current emphasis on consumer satisfaction and outcome measures.

Finally, more research is required which explores and compares the perceptions of the parents of hospitalized children with the perceptions of the nurses caring for those children. This research should consist of both qualitative and quantitative studies, or research which combines both methodologies. The development of such a body of knowledge would greatly assist pediatric nurses in their efforts to deliver theoretically sound nursing care.

In the pediatric setting parents are consumers of nursing care. Despite the recognition of consumer satisfaction as an outcome measure of the quality of care, parent satisfaction has not been included in quality assessment methods. The purpose of this descriptive study was to determine the level of congruence between parents' satisfaction with nursing care of their children and the nurses' perceptions of parents' satisfaction. The differences between parent and nurse perceptions were found to be statistically significant and to

have an number of implications for improvement of the quality of nursing care.

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Appendix A. APSI (Parents)

Parent Satisfaction with Nursing Care

Please give your honest opinion for each statement on this list by circling one of the five answers to describe the nurse(s) caring for your child:

1. The nurse should be more attentive than he/she is.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

2. Too often the nurse thinks you can't understand the medical explanation of your child's illness, so he/she just doesn't bother to explain.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

3. The nurse is pleasant to be around.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

4. A person feels free to ask the nurse questions.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

5. The nurse should be more friendly than he/she is.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

6. The nurse is a person who can understand how I feel.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

7. The nurse explains things in simple language.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

8. The nurse asks a lot of questions, but once he/she finds the answers, he/she doesn't seem to do anything.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

9. When I need to talk to someone, I can go to the nurse with my problems.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

10. The nurse is too busy at the desk to spend time talking with me.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

11. I wish the nurse would tell me about the results of my child's tests more than he/she does.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

12. The nurse makes it a point to show me how to carry out my child's doctor's orders.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

13. The nurse is often too disorganized to appear calm.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

14. The nurse is understanding in listening to a parents problems.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

15. The nurse gives good advice.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

16. The nurse really knows what he/she is talking about.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

17. It is always easy to understand what the nurse is talking about.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

18. The nurse is too slow to do things for my child.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

19. The nurse is just not patient enough.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

20. The nurse is not precise enough in doing her/his work.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

21. The nurse gives directions at just the right speed.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

22. I'm tired of the nurse talking down to me.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

23. Just talking to the nurse makes me feel better.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

24. The nurse always gives complete enough explanations of why tests are ordered.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

25. The nurse is skillful in assisting the doctor with procedures.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

Adapted from The Patient Satisfaction Instrument by Risser (1975).

Nancy Thornton, R.N., MSN student. 875-3059 or 876-9772

M. Dewis, UBC School of Nursing faculty advisor, 822-7496

Appendix B. APSI (Nurses)

CONGRUENCE BETWEEN PARENT SATISFACTION WITH NURSING CARE OF THEIR CHILDREN AND NURSES' PERCEPTIONS OF PARENT SATISFACTION

(Nurses' version)

Parent Satisfaction with Nursing Care Instrument

Please answer the following questions as you think the parent identified to you by the researcher will answer them:

1. The nurse should be more attentive than he/she is.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

2. Too often the nurse thinks you can't understand the medical explanation of your child's illness, so he/she just doesn't bother to explain.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

3. The nurse is pleasant to be around.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

4. A person feels free to ask the nurse questions.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

5. The nurse should be more friendly than he/she is.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

6. The nurse is a person who can understand how I feel.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

7. The nurse explains things in simple language.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

8. The nurse asks a lot of questions, but once he/she finds the answers, he/she doesn't seem to do anything.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

9. When I need to talk to someone, I can go to the nurse with my problems.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

10. The nurse is too busy at the desk to spend time talking with me.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

11. I wish the nurse would tell me about the results of my child's tests more than he/she does.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

12. The nurse makes it a point to show me how to carry out my child's doctor's orders.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

13. The nurse is often too disorganized to appear calm.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

14. The nurse is understanding in listening to a parents problems.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

15. The nurse gives good advice.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

16. The nurse really knows what he/she is talking about.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

17. It is always easy to understand what the nurse is talking about.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

18. The nurse is too slow to do things for my child.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

19. The nurse is just not patient enough.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

20. The nurse is not precise enough in doing her/his work.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

21. The nurse gives directions at just the right speed.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

22. I'm tired of the nurse talking down to me.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

23. Just talking to the nurse makes me feel better.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

24. The nurse always gives complete enough explanations of why tests are ordered.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

25. The nurse is skillful in assisting the doctor with procedures.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

Adapted from The Patient Satisfaction Instrument by Risser (1975).

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Appendix C. Parent Information Sheet

CONGRUENCE BETWEEN PARENT SATISFACTION WITH NURSING CARE OF THEIR CHILDREN AND NURSES' PERCEPTION OF PARENT SATISFACTION

Information for Study Participants (Parents)

I am currently a student in the Master of Science in Nursing Program at the University of British Columbia. From my personal experience as a parent as well as my professional experience as a nurse, I am very interested in studying how accurately nurses estimate parent satisfaction with the nursing care they receive in hospital. The results of this study will enhance nurses' understanding of how well they do this. If nurses do not know whether the consumers of their care are satisfied with that care, they cannot improve upon it.

I would like to request your participation in my study. If you consent you will be asked to complete a satisfaction with nursing care questionnaire as well as some questions related to general information about you and your family. The process should take between ten and 15 minutes of your time. You will be given the questionnaire shortly before your child is discharged from hospital.

To protect the quality of the study, you will be asked not to discuss the content of the questionnaires or your responses to the questions with the unit nurses. Your participation is entirely voluntary, and if you participate, confidentiality will be assured. If you do consent to participate, you may also change your mind at any time. Your name and any other identifying information will not be used in future publication of the findings of this study. Should you elect not to participate, please understand that the care which your child is currently receiving or will receive in the future will not be jeopardized because of your decision. Thank you.

Nancy Thornton

U.B.C. School of Nursing

876-9772(H) or 875-3059(W)

Faculty: M.Dewis 822-7496

Appendix D. Parent Consent Form

Consent for Participation in the Study
(for parents)

"Congruence between parent satisfaction with nursing care of their children and nurses' perceptions of parent satisfaction"

I agree_____I do not agree_____to participate in the study to determine how closely nurses' estimate parent satisfaction with nursing care to be. The results of this study will enhance nurses' understanding of how well they do this. If nurses do not know whether the consumers of their care are satisfied with that care, they cannot improve upon it. I understand:

(1) that I will be asked to complete a satisfaction with nursing care questionnaire as well as some questions related to general information about me and my family. This will take between ten and 15 minutes,

(2) that my participation is voluntary and that I may withdraw at any time,

(3) that any information identifying me as a participant in this study will remain strictly confidential,

(4) that withdrawal from the study at any time will not affect the care that my child is currently receiving or will receive in the future.

Date _____

Signature _____

Witness _____

If you would like to receive a summary of the results of this study please provide your name and mailing address below.

Name _____

Address _____

_____

Appendix E. Socio-demographic Tool (Parents)

SOCIO-DEMOGRAPHIC TOOL FOR PARENTS

PLEASE ANSWER THE FOLLOWING QUESTIONS:

What is your relationship to child? _____

What is your age? (PLEASE CIRCLE ONE)

under 20 21-30 31-40 41-50 51-60

What level of education have you achieved? (PLEASE CIRCLE ONE)

elementary school secondary school university or college post-secondary school training

What is your marital status? (PLEASE CIRCLE ONE)

married separated/divorced common-law single

What is the gender of your child?

male female

How old is your child? _____

How many times has your child been hospitalized in the past year? _____

Does your child have a long-standing health problem? (CIRCLE ONE)

yes no

THANK YOU FOR YOUR TIME

Appendix F. Nurse Information Sheet

CONGRUENCE BETWEEN PARENT SATISFACTION WITH NURSING CARE OF THEIR CHILDREN AND NURSES' PERCEPTION OF PARENT SATISFACTION

Information for Study Participants (Nurses)

I am currently a student in the Master of Science in Nursing Program at the University of British Columbia. From my personal experience as a parent and my professional experience as a nurse at British Columbia's Children's Hospital, I am very interested in studying how accurately nurses estimate parent satisfaction with the nursing care they receive in hospital. The results of this study will enhance nurses' understanding of how well we do this. If nurses do not know whether the consumers of their care are satisfied with that care, they cannot improve upon it.

For the purposes of this study, I would like to pair parents and their respective nurse caregivers and compare how each parent-nurse pair rate the level of parental satisfaction with nursing care. The parents will be asked to complete a satisfaction with nursing care questionnaire, and shortly after their child is discharged, a nurse who cared for their child for a minimum of two shifts will be asked to complete the same questionnaire, AS SHE/HE THINKS THE PARENT WOULD RESPOND.

Completing the questionnaire should take between ten and 15 minutes of your time. You will also be asked for some information about you and your professional experience.

To protect the quality of this study, please do not discuss the content of the questionnaires or your proposed responses to the questions with the parent participants or with other unit nurses participating in the study. Confidentiality will be assured in the presentation of any study findings. Your participation in this study is voluntary and may be withdrawn at any time.

I would be pleased to answer any questions you might have about my research. Thank you.

Nancy Thornton
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Phone:876-9772(H) 875-3059(W)
Faculty: M.Dewis (822-7496)

Appendix G. Nurse Consent Form

Consent for Participation in the Study
(for nurses)

"Congruence between parent satisfaction with nursing care of their children and nurses' perceptions of parent satisfaction"

I agree_____I do not agree_____to participate in the study to determine how closely nurses' estimate parent satisfaction with nursing care to be. The results of this study will enhance nurses' understanding of how well they do this. If nurses do not know whether the consumers of their care are satisfied with that care, they cannot improve upon it. I understand:

(1) that I will be asked to complete a parent satisfaction with nursing care questionnaire as well as some questions related to me,

(2) that my participation is voluntary and that I may withdraw at any time,

(3) that any information identifying me as a participant in this study will remain strictly confidential.

Date _____

Signature _____

Witness _____

Appendix H. Socio-demographic Tool (Nurses)

SOCIO-DEMOGRAPHIC TOOL FOR NURSES

Please answer the following questions:

1. What level of nursing education have your achieved? (CIRCLE ONE)

   Diploma

   Baccalaureate

   Masters

2. How long have you worked as a registered nurse? (CIRCLE ONE)

   1-3 years

   4-5 years

   6-10 years

   11-15 years

   16-20 years

3. How long have you worked as a registered nurse at B.C.C.H?

   _____

THANK YOU FOR YOUR TIME