Assessing Family Satisfaction With Care of Critically Ill Patients: A Pilot Study

Susan M. Roberti, RN, MS, DNP
Joyce J. Fitzpatrick, RN, MBA, PhD

In today’s society, developing a competitive edge has become crucial for survival in any industry. In health care, patient satisfaction has become one of the most important and challenging competitive elements. Health care professionals are expected to provide both high quality of care and exceed customers’ expectations while being cost conscious and efficient. Satisfaction is typically measured by satisfaction surveys that patients complete about their recent hospital experience. However, assessing patient satisfaction in critical care environments becomes complicated. Often patients are not making decisions related to their own care because of their severity of illness and level of consciousness.1 Patients are typically too sick to determine the level of satisfaction with care provided or may not even remember their critical care experience, which makes patient satisfaction surveys inadequate. As a result, family members are often the ones who determine satisfaction with care provided, as well as with the overall critical care experience. Thus, satisfaction may be measured by the

PRIME POINTS

• In critical care environments, patient satisfaction is often difficult to obtain; family satisfaction with care can be used as a substitute for patient satisfaction.

• The assessment tool used in this pilot study can assist nurses and other professionals to improve practice and increase family satisfaction.

CE Continuing Education

This article has been designated for CE credit. A closed-book, multiple-choice examination follows this article, which tests your knowledge of the following objectives:
1. Describe the challenges associated with assessing patient satisfaction in critical care environments
2. Identify key factors that family members are likely to consider when assessing their level of satisfaction with the overall patient care provided
3. Discuss relevant nursing implications for delivery and improvement of care that resulted from this study

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perception of family members who determine if the patient received high-quality care regardless of clinical outcomes. The challenge for health care providers is to determine what family members consider when assessing their level of satisfaction with the overall care provided.

A patient’s family is an integral part of the care of the patient. Family provides support to the patient and can thus be instrumental in the patient’s recovery. Harvey described how the crisis of a critical illness affects both the patient and the family, identifying family satisfaction as a surrogate for patient satisfaction in critical care. Only a few studies, however, have described family satisfaction with care of patients who are in a critical care setting. The purpose of the present pilot study was to build on this previous research by assessing the level of family satisfaction with overall care of critically ill patients and identifying areas for future research.

Review of Literature

Since 2001, a number of studies have been done in which researchers have investigated family satisfaction with care. Most studies have included use of the Critical Care Family Needs Inventory (CCFNI), which is focused specifically on the needs of the family members while the patient is being cared for in the critical care unit. The CCFNI was used in several studies with large samples that included family members from different cultures. This instrument had been developed and validated by Johnson and colleagues. In the studies with this instrument, researchers identified the following predictors of family satisfaction: patient to nurse ratio of 3 or less; information provided by physicians; information provided to the family; knowledge of the role of each caregiver; involvement of their usual doctor; desired/allowed time ratio.

The CCFNI also was used in a prospective randomized trial in 34 French intensive care units to determine if those family members who received a structured family information leaflet would have higher satisfaction scores. Those who understood the diagnosis, prognosis, and treatment had higher satisfaction levels. Although satisfaction did not differ significantly between the leaflet and the control groups, family members who had good comprehension and received a leaflet had significantly higher median satisfaction scores than did family members who did not.

Previous research on family satisfaction with care is summarized in Table 1. These studies are presented chronologically, with the study purpose, sample, and instrument identified. Major findings and recommendations by the researchers also are presented.

As indicated in Table 1, several researchers have developed their own questionnaires to measure family satisfaction with care. These studies were conducted among family members of various groups of patients, but all included the same goal of assessing some aspect of family satisfaction.

Heyland and colleagues were particularly interested in the area of communication and decision making, and thus their instrument includes an emphasis on those dimensions. They found a positive relationship between satisfaction with overall care and satisfaction with decision making regarding care. In addition, the measurement of overall satisfaction with care was reliable. The researchers concluded that the instrument had acceptable reliability and validity for use with next of kin of critically ill patients.

In a follow-up study, Heyland and colleagues evaluated family satisfaction with care provided to critically ill patients and their families in 6 intensive care units across Canada. In this study, both family members of survivors and family members of nonsurvivors were included. Of the 624 respondents, 54% considered their satisfaction with care to be excellent, and 41% considered their satisfaction with decision making to be excellent. The researchers concluded that most family members were satisfied with the overall care provided in the intensive care unit. However, opportunities for improvement were present in physician-patient communication and in the

Authors

Susan M. Roberti is a clinical assistant professor at Lienhard School of Nursing, Pace University in Pleasantville, New York, and is founder and president of SMR Enterprises in New York, New York.

Joyce J. Fitzpatrick is the Elizabeth Brooks Ford Professor of Nursing at Frances Payne Bolton School of Nursing, Case Western Reserve University in Cleveland, Ohio.

Corresponding author: Joyce J. Fitzpatrick, RN, MBA, PhD, EAN. Elizabeth Brooks Ford Professor of Nursing, Frances Payne Bolton School of Nursing, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, OH 44106 (e-mail: jff4@case.edu).

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<table>
<thead>
<tr>
<th>Reference (year)</th>
<th>Purpose and sample</th>
<th>Instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azoulay et al. (2001)</td>
<td>Assess family satisfaction with care and their needs in the intensive care unit (ICU) (N = 895)</td>
<td>Modified version of Molter's Critical Care Family Needs Inventory (CCFNI)</td>
</tr>
<tr>
<td>Heyland and Tranmer (2001)</td>
<td>Evaluate satisfaction of family members of nonsurvivors with the care provided to their seriously ill family member during stay in ICU (N = 33)</td>
<td>Questionnaire with 2 sections: first section served as a screening tool to assess level of family satisfaction with care; second section measured aspects of family satisfaction with decision making</td>
</tr>
<tr>
<td>Wasser et al. (2001)</td>
<td>Develop and validate an instrument to measure family satisfaction with care on 5 dimensions of care provided in ICUs (N = 237)</td>
<td>Critical Care Family Satisfaction Survey (CCFSS)</td>
</tr>
<tr>
<td>Azoulay et al. (2002)</td>
<td>Compare satisfaction among family representatives who received only standard information to those who received standard information in addition to an investigator-designed family information leaflet (N = 175)</td>
<td>Modified version of the CCFNI that provided scores ranging from extreme satisfaction to extreme dissatisfaction</td>
</tr>
<tr>
<td>Heyland et al. (2002)</td>
<td>Evaluate family satisfaction with care provided to critically ill patients and their families in 6 ICUs across Canada (N = 624)</td>
<td>Validated questionnaire used in their pilot study was provided to family members who made at least 1 visit to patients who received mechanical ventilation for &gt;48 hours</td>
</tr>
<tr>
<td>McDonagh et al. (2004)</td>
<td>Assess family satisfaction as related to the amount of time family members spoke in clinical conferences (N = 214)</td>
<td>Questionnaire consisting of 4 questions was distributed to family members and clinicians after the clinical conference to assess satisfaction with communication; duration of time that the family members and clinicians spoke also was measured</td>
</tr>
<tr>
<td>Wasser et al. (2004)</td>
<td>To further assess validity of the instrument among family members admitted to 10 critical care units in a 3-year period (N = 2494)</td>
<td>CCFSS</td>
</tr>
<tr>
<td>Fox-Wasylyshyn et al. (2005)</td>
<td>Examine family satisfaction by assessing degree to which family members felt nurses were fulfilling their needs (N = 29)</td>
<td>A 2-section instrument was developed: section 1 measured family members' perceptions of how often nurses should perform selected family interventions (behavioral role expectations); section 2 measured family members' perception of how often the nurses actually performed family interventions (perceived role enactment)</td>
</tr>
<tr>
<td>Stricker et al. (2007)</td>
<td>Assess cross-cultural adaptability of an instrument to measure family satisfaction (N = 115)</td>
<td>Questionnaire covering overall satisfaction, satisfaction with care and satisfaction with information/decision making; translated in different languages</td>
</tr>
<tr>
<td>Damghi et al. (2008)</td>
<td>Evaluate the satisfaction of ICU patients' family members in a Moroccan sample (N = 194)</td>
<td>The Arabic version of the CCFNI was administered between the third and fifth days after admission</td>
</tr>
<tr>
<td>Stricker et al. (2009)</td>
<td>Assess family satisfaction in the ICU and identify parameters for improvement (N = 996)</td>
<td>Questionnaire covering overall satisfaction, satisfaction with care, and satisfaction with information/decision making</td>
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</table>
Fox-Wasylyshyn et al.11 focused their study specifically on patients’ family members’ perceptions of how well nurses were fulfilling their needs. The study was conducted with 29 family members from a 19-bed intensive care unit. The researchers found the expectations that family members held regarding nurses’ roles with families were not different from their perceptions of what nurses actually did. In addition, family members were more satisfied with care when nurses’ performance either met or exceeded their expectations.

Another approach was that designed by McDonagh and colleagues,9 who studied family satisfaction as related to the amount of time family members spoke in clinical conferences. They conducted a cross-sectional study in 4 hospitals with 214 family members from 51 different families and 36 different physicians who led the family conferences. Based on their analysis of conference videotapes, the researchers suggested that allowing family members more opportunity to speak during conferences could improve family satisfaction.

More recently, Stricker and colleagues12,13 have developed and evaluated an instrument focused on family satisfaction with intensive care, but with particular focus on satisfaction with information and decision making. This team of researchers also has assessed the potential use of this instrument with family members from different cultures and demonstrated that the instrument had high reliability and validity.

### Findings and recommendations

**Identified predictors of family satisfaction:**
- Patient to nurse ratio ≤3
- Information provided by physicians
- Information provided to the family
- Knowledge of the role of each caregiver
- Involvement of their usual doctor
- Desired/allowed time ratio

Researchers suggested that these predictors are amenable to intervention and should be further investigated to improve satisfaction levels.

**Positive relationship between satisfaction with overall care and satisfaction with decision making regarding care**

Measurement of overall satisfaction with care was reliable.

Researchers concluded that the instrument had acceptable reliability and validity for use with next of kin of critically ill patients.

**Validity of the scale supported; high reliability determined for the instrument**

Those who understood the diagnosis, prognosis, and treatment had higher satisfaction.

Family satisfaction did not differ significantly between the leaflet and control groups; however, family members with good comprehension who had received a leaflet had significantly better satisfaction scores than did those who had not.

**Overall, family members satisfied with care in the 25 aspects of care related to overall experience, communication, and decision making**

54% considered satisfaction with care excellent; 41% considered satisfaction with decision making excellent.

Opportunities for improvement existed with physician-patient communication and manner in which health care providers interact.

According to their analysis of conference videotapes, allowing family members more opportunity to speak during conferences improves family satisfaction.

**Validity and reliability of instrument were supported**

Support for a total score on the instrument.

**Expectations that family members held regarding nurses’ roles with families were not different from their perceptions of what nurses actually did**

Family members were more satisfied with care when nurses’ performance either met or exceeded their expectations.

**High reliability and validity for the translated questionnaire**

Cross-cultural adaptation feasible, reliable, and sensitive.

81% of family representatives were satisfied with information provided by physicians, 27% would like more information about the diagnosis, 30% about prognosis, and 45% about treatment.

Family satisfaction increased with lower family education level, when information was given by a senior physician, and when the questionnaire was administered by an investigator.

Findings suggest that caregivers should develop structured communication programs considering satisfaction predictors.

**High overall satisfaction, satisfaction with care, and satisfaction with information/decision making**

Higher severity of illness was associated with higher satisfaction; higher patient/nurse ratio and written admission/discharge criteria were associated with lower overall satisfaction.

Emotional support, coordination of care, and communication were associated with poor satisfaction, suggesting need for improvement.

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validity across cultures. They also reported overall high satisfaction with care; higher severity of illness was associated with higher satisfaction as were a higher nurse to patient ratio and written admission and discharge instructions.

On the basis of the increasing value placed on family satisfaction with care of critically ill patients and the concern that existing instruments did not measure overall satisfaction with care, Wasser and colleagues developed and validated the Critical Care Family Satisfaction Survey (CCFSS), which consists of 20 items. The instrument was developed to serve as a proxy for patient satisfaction, and it measures overall satisfaction with care. The researchers assessed the psychometric qualities of the instrument with 2494 family members of patients admitted to 10 critical care units in a 3-year period and found high reliability and validity for their instrument. Wasser and colleagues considered it important to include all dimensions of care when evaluating family members’ satisfaction with care provided in critical care units.

The CCFSS was considered the most inclusive survey and thus was selected for use in the present study. Previous research had been focused on specific aspects of family satisfaction with care rather than on families’ satisfaction with overall care of critically ill patients.

Methods

Sample

After approval was received from the institutional review board, this pilot study was conducted in a 10-bed medical surgical intensive care unit (MSICU) and a 14-bed telemetry/intermediate care unit in a community hospital in the Northeast. A convenience sample of 31 participants, family members of patients in the MSICU and the telemetry/intermediate care unit, was used. Any family member of a surviving patient who was transferred out or discharged from the MSICU or the telemetry/intermediate care unit who was 18 years of age or older and consented to participate could be included in the study.

Surveys were limited to 1 family member per patient. The family was asked to designate a spokesperson to fill out the survey when multiple family members were available. The exclusion criteria were family members with a language barrier, which was determined on the basis of the unit secretary’s assessment and ability to communicate effectively with the family member in English. Family members of nonsurvivors were excluded to avoid unnecessary burden. Upon receiving an order to transfer or discharge a patient, the unit secretary provided a family member with a packet consisting of an informed consent document, survey, and envelope. The unit secretary was selected to distribute the packets for optimal consistency and because the unit secretaries were not providers of patient care. Locked drop boxes were available in the MSICU, the telemetry/intermediate care unit, and the family lounge so that surveys could be returned confidentially. Participation was voluntary.

Instrument

The CCFSS, developed by Wasser and colleagues, was used to measure family satisfaction with overall care. Wasser and colleagues evaluated the psychometrics of the CCFSS, and delineated the scoring for both total and subscale scores. Content and construct validity were examined and the 2001 study provided support that the CCFSS was reliable and valid; the Cronbach alpha was 0.93 for the 5-factor model. The survey yields the following 5 subscales: assurance (the need to feel hope for a desired outcome), information (the need for consistent, realistic, and timely information), proximity (the need for personal contact and to be physically and emotionally near the patient), support (the need for resources, support systems, and ventilation), and comfort (the need for personal comfort). The survey contains the following background questions: your age (referring to participant), number of days your loved one is/was in the critical care unit, relationship of person filling out the survey to the patient, and why the family member was in the critical care unit. Twenty items are related to satisfaction with care; each item is ranked by the family member on a scale with responses from 1 to 5 (1 = very dissatisfied and 5 = very satisfied).

Scoring for the 20 items was completed by the researchers and based on the following scale:

- Excellent or completely satisfied = 100 (highest possible score)
- Very good or very satisfied = 75
- Good or mostly satisfied = 50
- Poor or slightly dissatisfied = 25
- Very poor or very dissatisfied = 0 (lowest possible score).

Permission to use the tool was granted by Wasser, and the following information was provided to calculate the subscales: for assurance, add up the scores for items 3, 4, 7,
and 19 and divide by 4; for information, add up the scores for items 2, 6, 10, 12, and 20 and divide by 5; for proximity, add up the scores for items 5, 15, and 18 and divide by 3; for support, add up the scores for items 1, 9, 11, 13, 14, and 16 and divide by 6; and for comfort, add up the scores for items 8 and 17 and divide by 2.

**Statistical Analyses**

Fifty-one surveys were distributed, with an overall response rate of 61% and a total of 31 participants. In the MSICU, 19 surveys were distributed and 13 were returned, for a response rate of 68%. In the telemetry/intermediate care unit, 32 surveys were distributed and 18 were returned, for a 56% response rate. Of the 31 participants, 42% were from the MSICU and 58% were from the telemetry/intermediate care unit. The instructions to the participants were to fill out one survey per patient. Most of the participants were 35 to 59 years of age; the second largest age group of participants was 60 years of age or older. Most participants were the patient’s wife; the next highest category was the patient’s daughter.

**Results Related to the CCFSS**

The reliability of the CCFSS in this pilot study was assessed; the Cronbach alpha for the total scale was 0.96. The Cronbach alphas for the subscales ranged from 0.74 (assurance subscale) to 0.92 (information subscale; Table 2).

The CCFSS mean score for the MSICU was 94; for the telemetry/intermediate care unit, the CCFSS mean score was 94.17. An analysis was done to determine the frequency and percentage of participants’ responses for each question in the survey. Question 11 (“Quality of care given to my family member”) had the most responses of very satisfied (n=27, 87%) and the highest mean score (4.87) of all questions. Question 3 (waiting time for results of tests and radiographs) had the fewest responses for very satisfied (n=19, 61%) and the lowest mean score (4.48; Table 3). In examining the 5 subscales, support had the highest mean score (4.74; SD, 0.43) and comfort had the lowest mean score (4.62; SD, 0.60; Table 4).

Qualitative data were assessed in 3 questions, which were part of the

<table>
<thead>
<tr>
<th>Topic of question</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Honesty of staff about family member’s condition</td>
<td>4.77</td>
<td>0.43</td>
</tr>
<tr>
<td>2. Availability of doctor to speak with me on regular basis</td>
<td>4.65</td>
<td>0.61</td>
</tr>
<tr>
<td>3. Waiting time for results of tests and radiographs</td>
<td>4.48</td>
<td>0.72</td>
</tr>
<tr>
<td>4. Peace of mind in knowing my family member’s nurse(s)</td>
<td>4.77</td>
<td>0.43</td>
</tr>
<tr>
<td>5. Ability to share in the care of my family member</td>
<td>4.74</td>
<td>0.51</td>
</tr>
<tr>
<td>6. Clear explanations of tests, procedures, and treatments</td>
<td>4.71</td>
<td>0.53</td>
</tr>
<tr>
<td>7. Promptness of staff in responding to alarms and requests for assistance</td>
<td>4.71</td>
<td>0.46</td>
</tr>
<tr>
<td>8. Cleanliness and appearance of the waiting room</td>
<td>4.65</td>
<td>0.61</td>
</tr>
<tr>
<td>9. Support and encouragement given to me during family member’s stay in the critical care unit</td>
<td>4.74</td>
<td>0.51</td>
</tr>
<tr>
<td>10. Clear answers to my questions</td>
<td>4.84</td>
<td>0.37</td>
</tr>
<tr>
<td>11. Quality of care given to my family member</td>
<td>4.87</td>
<td>0.34</td>
</tr>
<tr>
<td>12. Sharing in decisions regarding my family member’s care on a regular basis</td>
<td>4.68</td>
<td>0.65</td>
</tr>
<tr>
<td>13. Nurses’ availability to speak with me every day about my family member’s care</td>
<td>4.77</td>
<td>0.50</td>
</tr>
<tr>
<td>14. Sensitivity of the doctor(s) to my family member’s needs</td>
<td>4.71</td>
<td>0.64</td>
</tr>
<tr>
<td>15. Privacy provided for me and my family members during our visits</td>
<td>4.77</td>
<td>0.43</td>
</tr>
<tr>
<td>16. Preparation for my family member’s transfer from critical care</td>
<td>4.61</td>
<td>0.72</td>
</tr>
<tr>
<td>17. Peacefulness of the waiting room</td>
<td>4.61</td>
<td>0.67</td>
</tr>
<tr>
<td>18. Flexibility of visiting hours</td>
<td>4.71</td>
<td>0.64</td>
</tr>
<tr>
<td>19. Noise level in the critical care unit</td>
<td>4.58</td>
<td>0.62</td>
</tr>
<tr>
<td>20. Sharing in discussions regarding my family member’s recovery</td>
<td>4.71</td>
<td>0.53</td>
</tr>
</tbody>
</table>
Critical Care Nurse

One suggestion was that staff obtain a contact person and phone number for a family member so that staff can call with questions/discussions. Two negative comments were focused on the incompetence and poor bedside manner of 3 staff members (none of whom were staff on the unit and none of whom were nursing staff).

Results for the third question (“Please feel free to name any individuals you feel are worthy of ‘special recognition’”) included 6 responses from the MSICU and 11 responses from the telemetry/intermediate care unit. In the MSICU, 3 physicians, 13 nurses, 1 nursing assistant, 4 respiratory therapists, the respiratory department, and 2 staff from the magnetic resonance imaging department were named for positive recognition. Two nurses were mentioned 3 times, and 2 other nurses were mentioned twice positively. One nurse received 2 comments, 1 of which was very positive and the other comment very negative. In the telemetry/intermediate care unit, 4 physicians (1 from the emergency department), 5 nurses (1 from the emergency department), 2 technicians, and 1 unit secretary were named for positive recognition.

Discussion

The overall results of this pilot study indicate that family members of critically ill patients in the MSICU and the telemetry/intermediate care units were generally satisfied with care provided. In addition to the favorable results based on the quantitative data, most of the responses in the qualitative data also were positive. Also, some specific suggestions were made for improvements in the overall care that could be provided.

Table 4 Descriptive statistics for scores on subscales (N = 31)

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assurance</td>
<td>4.63</td>
<td>0.42</td>
</tr>
<tr>
<td>Information</td>
<td>4.71</td>
<td>0.47</td>
</tr>
<tr>
<td>Proximity</td>
<td>4.73</td>
<td>0.44</td>
</tr>
<tr>
<td>Support</td>
<td>4.74</td>
<td>0.43</td>
</tr>
<tr>
<td>Comfort</td>
<td>4.62</td>
<td>0.60</td>
</tr>
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</table>

Limitations

The results of this pilot study are limited by the use of a convenience sample, the small sample size, the single site for data collection, the limited time period, and the small community hospital setting. In addition, the results do not account for patient acuity or telemetry/intermediate care patients that may have been admitted to the MSICU because of lack of room availability. The survey does not take into account patients who remained in one of the units because an appropriate bed for transfer was not available.

Implications for Delivery and Improvement of Care

The results of this pilot study are relevant to the design and implementation of care delivery for clinical nurse managers, clinical educators, and hospital administrators. Waiting time for results of tests and radiographs had the overall lowest score, and noise level in the critical care unit had the second overall lowest score. For the MSICU, noise level was the lowest score and for the telemetry/intermediate care unit, waiting time for results of tests and radiographs was the lowest score.

On the unit level, nurse managers and staff can focus on waiting time for results based on the most frequent tests performed and identified delays and/or communication gaps in reporting those results. Conducting a root cause analysis for waiting time for results and noise level can also provide useful information that allows a corrective action plan to be implemented. Raising awareness can sensitize staff to the problematic areas so they can communicate more effectively with
patients and their families in regard to waiting for important test results and interpretations of radiographs.

Hospital administrators need to be involved in identification of these problems, because the problems identified may be greater than on the unit level and might affect other areas within the hospital. In addition, administrators may be able to offer solutions or suggestions that unit level managers cannot. For example, if laboratory turnaround time is delayed because of an inadequate workforce, hospital administrators may be able to reallocate staffing or work flow. The process for radiography requires an official interpretation of the images by a radiologist, communication of the results to a physician, then either communication of the results to the nurse or in some cases communication directly to the patient and/or the patient’s family. In critical care environments, multiple tests and procedures are typically being conducted on several patients, challenging health care providers to prioritize their time, which may bump communication of information to a low level.

One area that can be corrected through education and intervention in regard to waiting time for results is to explain before the procedure what the process is for determining test results, which staff member is responsible for communicating those results, and what is the expected time frame for receiving those results.

Hospital staff may consider the use of a patient/family communication board or log, such as a “communication corner,” where patients and/or family members can document questions or concerns to address with the physician or other appropriate health care providers. This proactive approach to communication raises awareness of staff about what concerns need to be addressed in a timely manner based on what the patient and/or family member determines to be a high priority. Hospitals may also consider part of the requirements for documentation of test results to include providing that information to the patient and/or family members.

Noise level in any environment that operates 24 hours a day, 7 days a week is challenging. Staff members often need to be reminded that although they are in the hospital to work, the patients are there to rest and recover. Providing a quiet environment is as important as providing high-quality care to patients, especially for certain diagnoses in which reduced stimulation is necessary. Some suggestions for health care providers are as follows: closing doors to patients’ rooms when appropriate, using pagers rather than an overhead paging system, requiring pagers to be set on vibrate rather than audible alerts, assessing equipment that requires maintenance, such as “squeaky wheels,” dimming lights during night time hours to serve as a reminder for staff to keep voices down, implementing a decibel alarm system that flashes when noise level exceeds the desired limit, making sure that doors to the unit have devices to prevent banging or slamming shut, providing appropriate space for staff to take their breaks in and for conferences to be conducted in, requiring that doors to patients’ rooms be closed during physician rounds and/or peak activity times for the unit, and implementing a sound system that plays soothing music for patients and their family members to listen to rather than letting them focus on noise levels.

In assessing satisfaction with care, patients’ families often assess the environment. Staff, managers, and administrators should recognize that the environment of care is part of the overall satisfaction. The comfort subscale addresses the environment and the results revealed the lowest scores overall. Two questions are addressed: cleanliness and appearance of the waiting room and peacefulness of the waiting room. In the pilot study hospital, one waiting area called the “MSICU Family Lounge” is designated for use by families of patients from both the MSICU and the telemetry/intermediate care unit. This room is also shared by families of patients having surgery. The room has no windows and poor signage, which may have contributed to the lower scores. The design of the unit/hospital may or may not allow for a dedicated waiting area or lounge for the telemetry/intermediate care unit; however, the designated purpose of the room needs to be clear and consistent. Alternative solutions for waiting family members, such as a beeper system as used in other businesses, could be investigated to help alleviate this problem. If space is an issue, the beeper system would provide more flexibility and comfort for family members to know they can
be reached regardless of where in the hospital they are waiting.

Recommendations for Future Research

The findings of this pilot study provide a foundation for future benchmarking and opportunities for improvement in family satisfaction of critically ill patients. Replication of this pilot study with a larger sample size could provide useful information and better comparisons between like units. Serial studies at the same organization can also provide ongoing opportunities to evaluate if scores in a particular area are improving or declining.

Conclusion

In summary, the results of this pilot study indicate that family members of critically ill patients in this setting are generally satisfied with care. In today’s competitive health care market, hospitals must strive to increase customer satisfaction. Sharing this information with all members of the health care team can provide specific details regarding the expectations of family members. Proper education of staff and provision of strategies to address the concerns of patients’ families can significantly improve overall customer satisfaction scores. Such changes will ultimately foster a more rewarding experience for both patients and their families, creating an environment of comfort, peace, and healing.

Financial Disclosures

None reported.

References

CE Test  Test ID C1063: Assessing Family Satisfaction With Care of Critically Ill Patients

Learning objectives: 1. Describe the challenges associated with assessing patient satisfaction in critical care environments. 2. Identify key factors that family members are likely to consider when assessing their level of satisfaction with the overall patient care provided. 3. Discuss relevant nursing implications for delivery and improvement of care that resulted from this study.

1. To create an effective satisfaction survey for families, health care provider need to face which of the following challenges?
   a. Ensuring that a majority of the communication from physicians involves the family member who will be filling out the survey
   b. Overcoming families' perceptions that high-quality care was not provided in cases of poor clinical outcomes
   c. Meeting the needs of multiple family members rather than a single patient
   d. Determining what family members consider when assessing their satisfaction with the patient care provided

2. The Critical Care Family Satisfaction Survey was selected for use in this research study for which of the following reasons?
   a. It was demonstrated to be the most reliable
   b. It was considered the most inclusive
   c. It was the easiest to administer and interpret
   d. It was available in both English and Spanish.

3. What name identifies the type of small sample chosen for this study?
   a. Convenience sample
   b. Homogenous sample
   c. Psychometric sample
   d. Cross-sectional sample

4. Which of the following is a reason satisfaction surveys may be more suitable for family members of critical care patients than for the patients themselves?
   a. Families are less likely to be significantly affected by the crisis of a critical illness.
   b. Families are more likely to have multiple perspectives and broader overall views than the patient.
   c. Patients are often not making choices related to their own care.
   d. Patients generally do not fill out the surveys in a timely manner.

5. Which of the following families would have met exclusion criteria for this study?
   a. Family members of a 17-year-old patient who consented to participate in the study
   b. Family members of a patient who was placed in the medical/surgical intensive care unit (MSICU) while awaiting bed availability on another unit
   c. Family members of a patient who survived his stay in the MSICU and on the telemetry/intermediate care unit, but died several weeks later on the rehabilitation unit
   d. English-speaking family members of a non-English-speaking patient

6. Which of the following options is one of the 5 subscales of the Critical Care Family Satisfaction Survey?
   a. Communication
   b. Reassurance
   c. Proximity
   d. Confidence

7. Why were unit secretaries selected to distribute the survey packets to patients' families?
   a. They were unit patient care providers.
   b. They were best able to take on the additional tasks associated with survey distribution without disrupting patient care activities.
   c. They were less likely to make family members feel pressured into participating in the study.
   d. They were trained to assess family member abilities to communicate effectively.

8. The survey question related to which area of satisfaction had the fewest responses for very satisfied and the lowest overall mean score?
   a. Physician communication to patients and family members
   b. Waiting time for results of tests and radiographs
   c. Involvement of patients and family members in decision-making processes
   d. Noise level in the patient care unit

9. Which of the following statements regarding the overall results of the pilot study discussed in this article is true?
   a. Higher nurse to patient ratio was associated with higher satisfaction of care.
   b. Higher nurse to patient ratio was associated with higher satisfaction of care.
   c. The overall mean score for “cleanliness and appearance of the waiting room” was higher than the overall mean score for “peacefulness of the waiting room.”
   d. The overall mean scores for “cleanliness and appearance of the waiting room” and for “peacefulness of the waiting room” were identical.

10. A root cause analysis for waiting time for results and noise level could accomplish which of the following?
    a. Creation of a communication log where results and answers to questions could be provided for patients and/or family members
    b. Gaining useful information to allow for implementation of a corrective action plan
    c. Expanded requirements for documentation of test results to include providing the information to the patient and/or family members
    d. Reallocation of staff or work flow by hospital administrators

11. Use of a beeper system for family members was offered as a suggestion by the authors to improve satisfaction in which of the survey subscales?
    a. Information
    b. Reassurance
    c. Support
    d. Comfort

Test answers: Mark only one box for your answer to each question. You may photocopy this form.

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Program evaluation

Objective 1 was met [Yes] [No]
Objective 2 was met [Yes] [No]
Objective 3 was met [Yes] [No]
Content was relevant to my nursing practice [Yes] [No]
My expectations were met [Yes] [No]
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Susan M. Roberti and Joyce J. Fitzpatrick

Crit Care Nurse 2010;30 18-26 10.4037/ccn2010448
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