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Developing a Consumer Satisfaction Scale Modelled on the Confirmation/Disconfirmation Paradigm

by

Elizabeth Heather May White 

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Science

in

Consumer Studies

Department of Human Ecology

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled Developing a Consumer Satisfaction Scale Modelled on the Confirmation/ Disconfirmation Paradigm submitted by Elizabeth Heather May White in partial fulfillment of the requirements for the degree of Master of Science in Consumer Studies.

Janet Fast, Ph.D

Norah Keating, Ph.D

Adam Finn, Ph.D

This thesis is dedicated to

my children,

Julian Kyle and Melissa Karma,

who have given me so much more than I expected.

ABSTRACT

The adoption of a client-centred health care system in Alberta requires the development of outcome indicators to assess newly implemented, innovative programs. This thesis describes the development of a suitable measurement tool, a consumer satisfaction questionnaire, to evaluate transitional care programs, a new model for continuing care. A theoretical framework which shares the assumptions of a client-centred system was used to identify the appropriate service characteristics. The confirmation/disconfirmation paradigm, a model of consumer satisfaction/dissatisfaction which has been experimentally tested in marketing research and practice, was used to conceptualize satisfaction. The results of the pilot test supported the validity of this model with this population and were used to revise the questionnaire. The product of this study is a valid, reliable, and manageable tool which can be used to evaluate these programs.

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Chapter 1: Introduction

Transitional care programs are one of six models of care which are being offered at 12 demonstration sites in Alberta where new models of continuing care are being tried out and monitored through the New Models in Continuing Care Demonstration Project (New Models in Continuing Care Demonstration Project, 1995). Transitional care programs are restricted to admissions from the community of elderly people who need short-term care to restore their baseline functioning level so that they can continue to live independently in the community. Eligible clients include those who have experienced a medical emergency which required monitoring and treatment or a change in health status which reduced their functional level.

The development of new models of continuing care is in response to significant changes in the health care system in Alberta. The basis for these changes was set out in the Alberta Health Three Year Business Plan (Alberta Health, 1996). This plan emphasizes that services are to be based on consumer needs. Services should support consumer involvement in decision-making and consumer independence and self-reliance (Alberta Health, 1996). The goal of the business plan is to create a client-centred approach to service delivery, in which services and processes will be tailored to meet the needs of individuals.

The client-centred approach is reflected in the reforms which are occurring in the way that long term care is delivered in Alberta. Alberta is abandoning the "one size fits all", facility-based approach to providing long term care programs and services, and is developing a wider array of services which will meet individual needs (Alberta Health, 1993). The desirability of adopting a client-centred approach is supported by research which indicates that the experience of autonomy and control by elders has a

positive impact on their health and well-being (Cox, Kaeser, Montgomery, & Marion, 1991) and results in less depression and better functioning (Kane & Kane, 1987).

The adoption of a client-centred system for continuing care also requires a shift in the way that seniors are viewed. Seniors are no longer "patients", but "clients." While the senior "patient" was expected to be a relatively passive recipient of services provided by medical professionals, the senior "client" is expected to take a more active role in deciding what services he/she will receive (Keating, Fast, Connidis, Penning, & Keefe, 1996).

A goal of transitional care programs is to support the client-centred approach by offering the senior "client" an alternative to hospitalization. The purpose of these programs is to promote the individual autonomy and independence of people over 65 years of age by offering them rehabilitative and restorative services with the goal of maintaining their ability to function safely in their own homes.

The Three Year Business Plan calls for the development of health outcome indicators (Alberta Health, 1996). The adoption of a client-centred system necessitates a change in the way that outcomes are measured. When seniors were viewed as patients who received services in order to maintain their health and functional status, outcomes were best assessed through the measurement of changes in patients' physical health and functional status. But when seniors are viewed as clients who choose a set of services in order to enhance or maintain their quality of life, consumer satisfaction with the services received is an appropriate outcome measure (Keating et al., 1996).

To date, there has been little assessment of consumer satisfaction within the new client centred paradigm, although the need for this outcome measure is called for. Many health care researchers have used satisfaction

questionnaires as a measurement tool. However, the assumptions driving the development of these instruments were not consistent with those underlying a client centred system. These studies usually examined service characteristics which had been selected by the service providers, rather than seeing that the client was an active agent in the service, that it was his/her needs which were being served, and that it should be the characteristics which were important to the clients which should be considered. Furthermore, health care researchers have failed to agree upon an appropriate conceptualization of satisfaction, thereby producing instruments with questionable construct validity.

Statement of the Problem:

Research in the field of health care services has been carried out under assumptions which are not consistent with the new client-centred system and does not provide a consistent conceptualization of satisfaction. Therefore, a reliable and valid instrument with which to measure satisfaction with client-centred transitional care programs does not currently exist.

Purpose of this Project:

The purpose of this project was to develop and pilot test a satisfaction questionnaire, specifically designed to evaluate the important characteristics of client-centred transitional care programs, using the conceptualization of satisfaction provided by the confirmation/disconfirmation model.

Chapter 2: Review of Literature and Conceptual Framework

The Need for a Conceptualization of Satisfaction

A major deficiency within the health care services literature is that, although many health care researchers are using satisfaction questionnaires as a measurement tool, they have failed to reach consensus about a definition of satisfaction. Many researchers provided no conceptual definition for satisfaction. For example, while suggesting that patient expectations play a role in satisfaction formation, Abramowitz, Cote, and Berry (1987) did not offer a definition for satisfaction. Kasper and Riley (1992) state that satisfaction can be regarded as an important indicator of the quality and effectiveness of medical care, without defining it. Allanach and Golden (1988), while recognizing the importance of patient perceptions, treat satisfaction as the equivalent of expectations. Without an adequate definition of the concept of satisfaction, the construct validity of these instruments is questionable.

The researchers who did offer a definition of satisfaction lacked consistency in the way it was conceptualized. Client satisfaction was conceptualized as an attitude toward health care (Mangelsdorff, 1979); the fulfilment of expectations (Noyes, Levy, Chase, & Udry, 1974; Davis & Hobbs, 1989; Kleinsorge & Koenig, 1991); the fulfilment of expectations and needs (Ryan, Collins, Dowd, & Pierce, 1995); a multiple evaluation of distinct aspects of health care determined by the individual's perceptions, attitudes, and comparison processes (Linder-Pelz & Struening, 1985); or the degree of congruency between a patient's expectations of ideal nursing care and his/her perception of the real nursing care he/she received (Megivern, Halm, & Jones, 1992; La Monica, Oberst, Madea, & Wolf, 1986). These studies illustrate the various theoretical definitions of satisfaction which have been used. Therefore, these studies cannot be used to compare

satisfaction ratings across surveys.

This review of the health care services literature underscored the need for a good definition of satisfaction. Satisfaction questionnaires are sought in a wide variety of settings, as valuable tools with which to get feedback from consumers. However, without a standardized conceptualization of satisfaction, these instruments may not be valid.

The Concept of Satisfaction in Marketing Practice:

The concept of consumer satisfaction occupies a central position in marketing thought and practice (LaTour & Peat, 1979). The centrality of this concept is reflected by its inclusion in the marketing concept that profits are generated through the satisfaction of consumer wants and needs (Churchill & Suprenant, 1982). Satisfied consumers are essential for the marketer's economic survival, as consumer satisfaction is the key to consumer retention (Engel, Blackwell, & Miniard, 1993). For the marketing practitioner, an understanding of consumer satisfaction and dissatisfaction is necessary if the needs of consumers and business are to be met (Bond & Thomas, 1992). The need to translate the marketing concept into operational guidelines has led to a proliferation of research on consumer satisfaction and dissatisfaction (CS/D) in marketing over the past two decades.

The marketing orientation is becoming increasingly relevant in the health care services area. Consumers of health care are beginning to expect and demand a say in the health care that they receive (McDaniel & Nash, 1990). The relationship between consumer satisfaction and the consumer's likelihood of returning for medical care has been observed (Miller-Hohl, 1992). Alberta is adopting a client-centred approach to the delivery of health care services (Alberta Health, 1996). In this demanding, client-centred

environment, the application of a concept which has been used in marketing research is appropriate.

The confirmation/disconfirmation paradigm (Oliver, 1980) has become the dominant model used to conceptualize consumer satisfaction. According to this model, the consumer forms satisfaction judgments by comparing his/her expectations for a product or service to the actual performance of that product or service. If the consumer's expectations are confirmed with performance equal to his/her expectations, or positively disconfirmed with performance exceeding his/her expectations, the consumer will be satisfied. If the consumer's expectations are negatively disconfirmed as a result of his/her expectations exceeding the actual performance of the product or service, he/she will be dissatisfied. Oliver (1980) provides definitions for each of the four constructs (expectations, performance, disconfirmation, and satisfaction) which are encompassed by this model.

Expectations are a central construct in the confirmation/disconfirmation model, and are defined as beliefs regarding the product or service's anticipated performance, including beliefs about the satisfaction expected from the product or service (Oliver, 1980). Expectations occupy a central position in the model because Oliver (1980) developed the model within the framework of Helson's (1964) adaptation level (AL) theory and, in the case of satisfaction evaluations, the individual's level of expectation about a product or service can be seen as an adaption level (Oliver, 1980).

According to adaptation level theory, adaptation is a physiological/psychological process whereby the individual organism adjusts to changes in the environment (Helson, 1964). All the adjustments that the individual makes to external stimuli are made relative to a standard, or a baseline, that the individual has formed for that particular

stimuli. This standard is the adaptation level, or AL, and it is formed, and continually modified, by the individual's experiences with external stimuli, the context, and the psychological and physiological characteristics of the individual (Helson, 1964). All the positive or negative evaluations that the individual makes are made relative to this standard. An indifference zone surrounds the AL (Helson, 1964). Experiences which are perceived to be within the indifference zone will be perceived to be no different from those which coincide with the AL, and adaptation will not occur. However, experiences which are perceived to be outside the indifference zone will cause adaptation in the direction of the experience. Once formed, the AL serves to sustain relatively stable evaluations, as only experiences which are very discrepant from AL cause adjustments (Oliver, 1980).

Like the individual's AL, expectations are influenced by the consumer's prior experience, the product or service attributes, marketing activities such as advertising, communications from social referents, the context, and the consumer's individual characteristics. Like the individual's AL, expectations create a frame of reference, or a standard, about which the consumer makes comparative judgments. Therefore, Oliver (1980) conceptualized expectations as the consumer's initial standard, equivalent to his/her AL.

The consumer is presumed to judge the performance of the product based on the attributes of the product which he/she considers to be important (Oliver, 1980). Confirmation/disconfirmation is the result of the consumer's comparison of the product's performance to the consumer's expectations (Oliver, 1989; 1993). Positive disconfirmation is said to occur if the product performance exceeds expectations, and negative disconfirmation occurs if the product performance is less than expected. Confirmation

occurs if the product performs as expected (Oliver, 1989). Oliver (1977) introduced the concept of a latitude of acceptance, the equivalent of Helson's (1964) indifference zone. This entire interval produces confirmation.

Satisfaction is defined as the consumer's post-consumption evaluation of, and emotional reaction to, his/her perception of whether the product met or exceeded his/her expectations (Oliver, 1993). In other words, satisfaction is the consumer's reaction to confirmation or disconfirmation. Therefore, confirmation/disconfirmation has a major, direct influence on satisfaction (Oliver, 1993). The disconfirmation effects originate from their associated emotional experiences. The delight of a positive disconfirmation enhances a satisfaction judgment, while the disappointment of a negative disconfirmation produces dissatisfaction, the polar opposite of satisfaction.

However, expectations and performance also influence the satisfaction judgment. As expectations include, by definition, a belief about the amount of satisfaction that can be expected from a product or service, high expectations, which are confirmed, will produce higher satisfaction judgments than will low expectations that are confirmed. Confirmation produces the level of satisfaction that was expected from the product (Oliver, 1989). The consumer's evaluation of the product or service's performance will also influence the satisfaction judgment, as high performance is more likely to produce positive disconfirmation and low performance is more likely to produce negative disconfirmation. Research has supported the assumption that the level of expectations, the level of performance, and the confirmation/disconfirmation which is produced by these two constructs, influence the satisfaction which is reported with that product or service (Churchill & Surprenant, 1982; Oliver & DeSarbo, 1988). Therefore, when using the confirmation/disconfirmation paradigm to measure

satisfaction, all four constructs must be assessed as their values are interdependent.

Most of the research inspired by the confirmation/ disconfirmation paradigm has focused on the measurement of consumer satisfaction with products. However, the hypotheses that high satisfaction ratings are directly related to positive disconfirmation produced by high performance ratings, and that low satisfaction ratings are produced by high expectation levels which have been negatively disconfirmed by low performance, has been supported in studies conducted with services (Bearden & Teal, 1983; Swan & Trawick, 1985; Bolton & Drew, 1991; Cadotte, Woodruff, & Jenkins, 1987; Oliver & DeSarbo, 1988). This suggests that, although services have unique characteristics which distinguish them from products (Parasuramen, Ziethaml, & Berry, 1985), the confirmation/disconfirmation model is a valid paradigm within which satisfaction with both services and products can be conceptualized.

The confirmation/disconfirmation paradigm can therefore be used as an empirically-tested model with which to measure consumer satisfaction with transitional care programs. This model specifies that all four constructs (expectations, disconfirmation, performance, and satisfaction) must be assessed. However, the model does not inform the researcher as to what the relevant service characteristics for these programs are.

Elements of a Health Care Service

A questionnaire which is intended to measure the outcomes of the client-centred transitional care programs in Alberta should focus on the needs of the clients for whom the service is intended, and poll the clients on service characteristics which are important to them. There has been a considerable amount of research conducted on client

satisfaction within the health care services sector. Rather than considering the client's perceptions to be central to the evaluation, many researchers made assumptions about which dimensions of care consumers evaluate, without validating the importance of these aspects of care with the consumers themselves. For example, the development of Michie and Rosebert's (1994) instrument was based on input from doctors and hospital management. However, caregivers' perceptions of what is important may be different from the patients' perceptions (Miller-Hohl, 1992). Rather than consulting with the consumers of these services, researchers frequently developed instruments on the basis of a literature review of previous surveys (Kasper & Riley, 1992; Zinn, Lavizzo-Mourey, & Taylor, 1993). Therefore, the assumptions underlying these studies were not consistent with a client-centred approach. These studies do not provide any information about which service characteristics the consumer is considering when making satisfaction judgments.

In the interaction framework for a service (Klaus, 1985), the service encounter is the elementary unit of observation. It is during the service encounter that the client's subjective experience and behavior is manifested. The interaction framework for a service provides a useful map for selecting the service characteristics for transitional care programs which are important to the clients by describing the external factors which influence the client's subjective experience and behavior during a service encounter. These factors are the organizational, cultural, and social characteristics of the service which will influence the characteristics, attitudes, skills, and behaviors of both the client and the caregiver. In addition, the physical characteristics of the service setting surround these factors, setting constraints and conditions for the encounter.

The interaction framework for a service suggests that procedural elements (task-related, instrumental behaviors of the care providers), content elements (psychological and care needs of the clients), client and agent characteristics, organizational and social characteristics (cultural norms and the organization's philosophy), and the situational context (the physical setting of the service) must all be assessed for satisfaction judgments when evaluating a service.

The interaction framework of a service stresses that all of these elements must be assessed when measuring satisfaction evaluations. The results of client satisfaction surveys conducted by health care services researchers support the assumption that, when making satisfaction evaluations, clients are assessing discrete elements of that service. It was found that satisfaction is a multidimensional concept, consisting of multiple evaluations of distinct aspects of health care (Linder-Pelz & Strueing, 1985). These evaluations are determined by the individual consumer's perceptions and comparison processes (Linder-Pelz et al., 1985). Of paramount importance to consumer perceptions of care, particularly nursing care, is the value they assign to that care (Allanach & Golden, 1988). These findings highlight the central position that the consumer holds when obtaining satisfaction measures with a health care service.

Some health care services researchers have recognized that the service characteristics specified in the survey instrument must be the characteristics which the clients themselves believe to be important. These researchers did attempt to identify characteristics of the health care service in question which were important to the consumers of these services. Through methodologies such as factor analysis of survey results, interviews with members of the target population, and focus groups, several common elements

of satisfaction were revealed, with the focus groups generally providing a richer array of dimensions. Megivern, Halm, and Jones' (1992) focus groups identified 7 themes: art of care, physical environment, continuity, availability, recognition of individual qualities and needs, promotion of patient autonomy, and outcomes of care. Cryns, Nichols, Katz, and Calkins' (1989) focus groups identified a somewhat different array of themes: access to care, good value/finances, accessory programs, continuity, interpersonal manner of doctor, and quality of care. However, there is some overlap between these elements and those identified in other studies, using different methodologies. For example, using client interviews, Ryan, Collins, Dowd, and Pierce (1995) identified five similar dimensions: coordination of care, information and education, physical comfort, involvement of family and friends, and continuity of care. This indicated that a synthesis of the elements identified by these studies could be used as the basis of the questions for the satisfaction questionnaire for transitional care programs.

Although several common elements thereby emerged, there was also variability in the service characteristics which were identified in these studies. This is due, in part, to the wide range of settings in which they were conducted. Settings ranged from medical clinics (Ludwig-Beymer, Ryan, Johnson, Hennessy, Gattuso, Epsom, & Czurylo, 1993); acute care wards in a hospital (Ryan et al., 1995; Megivern et al., 1992); nursing homes (Kleinsorge & Koenig, 1991); to Health Maintenance Organizations, or HMO's (Cryns et al., 1989). Both the elements of the service which the client would consider when making satisfaction judgments, and the relative importance of these elements, would differ, depending on the setting. For example, the doctor's conduct is the major focus for clients visiting a medical clinic (Cryns et al., 1989), but not to a resident of a nursing

home where there is no doctor on site. For nursing home residents, the housekeeping service is an important element (Kleinsorge & Koening, 1991), although this would not be an element of a medical clinic visit. For an acute care patient in a hospital, general nursing care is perceived to be more important than the doctor's presence, although both elements are present (Ludwig-Beymer et al., 1993). These differences highlight the influence of both the situational context and the organizational characteristics on the client's perception of important elements. In fact, the interaction framework of a service (Klaus, 1985) stipulates that elements specific to the situational context and the organizational characteristics must be assessed.

Therefore, the elements for the satisfaction questionnaire for transitional care programs were selected from the common elements which had been identified in the literature so that they were specific to the organizational and social characteristics, as well as the situational context, of these programs. Furthermore, they were selected so that all the elements suggested by the interaction framework for a service were covered. The procedural elements which were selected were professional skills of staff, attentiveness of staff to needs, self care instructions, explanations about treatment, and therapeutic treatments. The content elements which were selected were food, same level of care on all shifts (continuity of care), and improvement in health. Elements specific to organizational and social characteristics were family involvement in decisions about care, personal involvement in decisions about care, and improvement in ability to manage at home. The situational context elements selected were cleanliness of room, homey surroundings, privacy, and cost. These elements therefore formed the questionnare items on the satisfaction questionnaire for a unique service, transitional care.

Chapter 3: Methodology

The project was carried out in three phases. In Phase I, the consumer satisfaction questionnaire was developed. Once the format of the questionnaire was established, University of Alberta ethics approval was obtained. The pilot testing of this instrument constituted Phase II. In Phase III, the data were analyzed. The results of this analysis were used to reword and reformat the questionnaire. Results and conclusions were subsequently reported to the administrators of the two host facilities. Procedures used during each phase are described in the remainder of this chapter.

Phase I - Development of the Questionnaire:

Several factors were considered when selecting the service characteristics for the questionnaire. To create a valid instrument, it would be necessary to capture as much of the domain of satisfaction elements for this service as possible. However, using the confirmation/disconfirmation model, it was necessary to measure all four constructs for each characteristic. This would make the questionnaire very long if all of the characteristics identified in the literature were to be used. The length of an interview has been found to be directly related to the refusal rate (Churchill, 1995). Interviews which take any longer than 15 minutes can have refusal rates as high as 47% (Churchill, 1995). Furthermore, this population is frail and elderly, and completing a long questionnaire may fatigue the respondents. Therefore, it was decided to limit the number of characteristics to no more than 15. Using 15 elements, the questionnaire would offer 60 items. It should then take about 20 minutes to complete the questionnaire.

Twelve service characteristics which were specific to the characteristics and setting of transitional care programs were selected from the qualitative studies. The

selected characteristics covered three of the four domains of satisfaction elements specified by Klaus' (1985) interaction framework for a service: procedural elements, content elements, and situational context elements. The interaction framework also specifies that elements specific to the organizational and social characteristics of the service must be assessed. The goals of transitional care programs include imperatives to involve both the client and his/her family in care-related decisions and to restore the client's baseline functioning so that he/she can live independently. Therefore, three organizational and social elements specific to these goals were selected. It was also intended that additional elements could be identified by the clients themselves, during the debriefing.

Each question was phrased in the first person, using the pronoun, "I". For each characteristic, the respondent was asked to indicate what his/her expectations were, whether his/her expectations were confirmed or positively or negatively disconfirmed, whether or not he/she was satisfied with the characteristic, and how he/she rated the site's performance on that characteristic. For example, for the element of food, the expectations item read, "I expected that I would like the food provided here." The confirmation/disconfirmation item read, "The food provided here is..." The satisfaction item for this element read, "I am satisfied with the food provided here," while the performance item read, "I like the food provided here."

The four questions relating to each element were presented randomly throughout the questionnaire for two reasons. First, random presentation would prevent the formation of a response set and, secondly, it would test the respondents' comprehension of both the constructs and the wording of each question.

All the scales were 5-point Likert-type scales, with a high positive anchor point at one end of the scale, and a

low negative anchor point at the other end. The anchor points for the "Expectations", "Satisfaction", and "Performance" scales were "Strongly Agree" and "Strongly Disagree". For the "Disconfirmation" scale, the anchor points were "Much better than expected" and "Much worse than expected".

The confirmation/disconfirmation model suggests that both personal characteristics and the previous experiences of the consumer influence expectations and, in turn, satisfaction judgments. In the health care services literature, personal characteristics such as age (Kasper & Riley, 1992), gender (Mangelsdorff, 1979), health status (Cleary & McNeil, 1988), income level (Miller-Hohl, 1992), and beliefs in personal control (Pearson, Hocking, Mott, & Riggs, 1993) have been found to influence satisfaction evaluations of health care services. Once developed, the questionnaire could be used to analyze satisfaction and its predictors in this setting. Therefore, in order to develop valid and reliable scales with which this data could be collected in future surveys, a section of the questionnaire was designed to collect information on these factors. Each respondent was asked to rate: his/her health status prior to receiving the service, on a scale of "Very good" to "Very poor"; the amount of control they believed they had in making decisions that affected their everyday life, on a scale of "No control" to "Control over all decisions"; and their annual income level, on a scale of "Less than $10,000" to "$80,000 or more". The respondents were also asked to give their age, and their gender was noted by the interviewer.

Information on whether the client returned home and the diagnosis of the problem which caused the temporary loss of his/her independence was obtained from the clients' onsite medical files, and recorded in a final section of the questionnaire. This data would inform program

administrators about the proportions of their clients who were actually returned to the community, and provide them with a profile of clients who have been successfully rehabilitated. Therefore, this data could be used to determine whether the goal to increase clients' independence had been met, as well as what the prognosis for certain clients would be, if the questionnaire was adopted for long-term use by these programs.

It is likely that satisfaction ratings may change over a period of time with different residents as a result of changes in care delivery procedures or seasonal changes that affect the incidence of certain health problems. Furthermore, some theorists predict that satisfaction judgments will vary over time (Hill, 1986). Therefore, a client's satisfaction may change over the course of his/her residency. In order to enable the questionnaire to track fluctuations in satisfaction ratings both at the individual and program level, information about the length of the client's residency to date, as well as the current date, was needed.

The first site, where data collection began, performed mini mental assessments on clients of the program, if the client's mental competence was in question. Therefore, for interviews which were completed at this site, this file information was recorded on a line which was provided in the final section of the questionnaire. As cognitive limitations may affect the reliability of responses, these assessments were useful when analyzing word and construct comprehension. However, as the second data collection site did not perform these assessments, this information was not available for the respondents from this site.

The tasks which were involved in the pilot test were demanding. The respondents would be required to conceptually distinguish between the four constructs, and then explain their cognitions. Therefore, sampling criteria

were established: clients who had severe visual or auditory deficiencies, who were cognitively impaired, or who had a language barrier, would not be included in this study. The program's nurse manager would assist the researcher in choosing respondents who met these requirements. However, it was anticipated that problems with hearing and/or communication would, on occasion, only become apparent during the interview, subsequently affecting the reliability of the responses. Therefore, a section was included to note the occurrence of such problems, and their nature. (The original questionnaire is appended in Appendix B.)

During the developmental phase, a pretest was conducted with four persons who had been recently admitted as permanent residents to the first site. It was originally intended that these persons would be similar to the clients of the transitional care programs in age and length of time in the facility. Ideally, the maximum length of a client's stay in a transitional care program is six weeks. However, because of the sampling criteria, it became necessary to waive the restriction on the length of residency in order to obtain even four pre-test participants. Consequently, most of the people selected had been residents for several months.

During the pre-test, the participants were given information about the study and signed the consent form. (See Appendix A for a copy of the information sheet and consent form). They completed the questionnaire immediately thereafter. As it was anticipated that many of the participants would have visual impairments, the PI read the questions aloud and recorded the responses. The response choices were presented in large letters on cue cards, to assist those who had auditory impairments. The respondents could, if they so desired, point to their response on the card. These interviews were not tape recorded. The responses were analyzed to determine whether the respondents

were able to respond to the questions and if the questionnaire could be completed in 20 minutes. The administration procedure was found to be suitable for the respondents and no comprehension difficulties were detected. However, in most cases, it took more than the prescribed 20 minutes to complete the questionnaire. Subsequently, precise pre-interview instructions were developed in order to increase the efficiency and speed of the interviewing process.

Phase II - The Pilot Test:

The pilot test was conducted over six months - from June 12, 1994 to November 21, 1996. All clients who used the transitional care programs during this time and who met the criteria were asked to participate in the study. At that time, they were given the information sheet and asked to sign the consent form.

The original time line limited the pilot test to a three-month period at one site only. It was expected that this period would be sufficient to obtain at least 9 interviews, since 17 clients had used the program in the five months since the program began. The average length of stay for these clients had been 2 to 3 weeks, and only 4 had exhibited any kind of cognitive impairment which would have excluded them from a study of this nature. However, during the designated three months, the occupancy rate at that site was very low. During this time five clients used the service, and only three interviews were completed. Because of this unexpected slump in the program, two of the four beds which had been allocated to the program were reassigned to respite care. This action further jeopardized the chances of obtaining an adequate number of participants at this site, and it became necessary to recruit an additional site in order to obtain more participants.

Subsequently, data collection was also undertaken at a

second transitional care program site. This program was housed in a continuing care centre which serves a population with a higher level of need for medical care than does a nursing home. However, the goals and objectives of the transitional care programs at these two sites were the same. Furthermore, a review of the history of the program at this site revealed that many of the case histories of clients of this program were similar to those of clients from the first site. For example, at both sites, the condition of clients had sometimes failed to improve, and they had to be admitted to a hospital.

Four more respondents were procured at the second site. As three of them were immediately available, a change in the timing of the interviews relative to the client's admission to the program was necessary. Originally, it was intended that the length of residency prior to the interview would be controlled by conducting the interviews after the client had been in the program for two weeks. Exceptions were to be made only if the client was to be discharged within two weeks, in which case the interview would be conducted one day prior to his/her discharge. Recruiting participants at the second site required that this condition be waived, as those who were immediately available had been in the program for varying periods of time, ranging from several days to 2.5 months.

The small sample size made it possible for the PI to administer all the questionnaires personally. This eliminated the possibility of reliability problems which frequently arise when there is more than one interviewer.

The purpose of the pilot test was to assess whether the four constructs, as well as the questions themselves, were comprehensible to the respondents. In addition, the pilot test explored the importance of each characteristic and the need for any additional characteristics. It was anticipated that, if the respondent was unable to conceptualize a

construct, unable to comprehend a question, or simply felt that a particular item was not important to him/her, then he/she would experience difficulty responding to that question. Difficulty in responding to a particular item could also indicate that the words were unclear or ambiguous. Symptoms of difficulty would be manifested by a respondent if he/she required a great deal of effort to produce an answer, if he/she hesitated, or if he/she was unable to produce an answer. However, this was not what happened. The respondents, as a rule, answered the questions quite quickly. Others did spend some time considering the questions, but they carefully considered all the questions, so that this appeared to be their response style. Rather, if they were uncertain about the meaning of an item (and, frequently, even if they were certain) they would describe their experiences in relation to that item. In other words, they talked about the aspects of that characteristic that were important to them and described what their understanding of the item was. Important events are more easily remembered than unimportant events (Churchill, 1995). Therefore, these comments were valuable sources of information which could subsequently be used to evaluate the meaning and importance of each item, from the respondent's perspective.

Once all the responses had been recorded, the interviewer conducted a debriefing session with each respondent. During this session, the comprehension of the constructs, the meaning of the words, the importance of the characteristics, and the need for additional important characteristics, were explored.

Evidence that the respondents could comprehend the constructs was sought by asking them to explain the differences between the statements pertaining to expectations, performance, and satisfaction for a single service characteristic. Evidence of construct comprehension

was also sought by asking each respondent to explain what selected expectations, performance, or satisfaction statements meant to them.

The meaning of the words used to describe each service characteristic was explored by asking the respondents to explain what selected words and phrases from the questionnaire items meant to them. See Appendix C for a list of the probes which evolved as the pilot test proceeded.

The importance of the selected characteristics to the clients and the need for additional important characteristics was explored in a separate exercise, during the debriefing. Each respondent was presented with cards describing each characteristic, and asked to evaluate each item on an "Importance" scale running from "Very Important" to "Very Unimportant". Each respondent was then asked to name any additional items which were important to him/her that were not included in the questionnaire. It was originally proposed that elements which were rated "Unimportant" would subsequently be eliminated from the questionnaire, and important items, if not previously included, would be added to the questionnaire.

In order to validate any additional items, it was proposed that a list of these items would be compiled throughout the pilot test. Then after the completion of the pilot test, all respondents would be contacted one more time, either in person or by telephone, and asked to evaluate these items on the "Importance" scale. However, this exercise proved to be unnecessary as, during the debriefing, the respondents universally declared that there were no additional items which were important to them. Furthermore, it was not possible to eliminate any elements on the basis of the results from the "Importance" scale, as most of the elements were described as either "Important" or "Very important", and no elements were consistently rated

"Unimportant".

It was originally proposed that the debriefing would take no more than 30 minutes. In order to minimize both the refusal rate and respondent fatigue, the goal was to keep the entire session as short as possible. However, as more and more probes were developed, the debriefing proved to be quite a time consuming procedure, frequently taking up to one hour.

The entire session, including the completion of the questionnaire and the debriefing, was recorded on tape. The tapes were used in the development of additional probes, and in the analysis in Phase III.

Phase III - Data Analysis and Questionnaire Revision:

The test results were coded and tabulated directly onto a coding sheet at the end of each questionnaire. Thereby, each respondent's response patterns could be analyzed. First, all the scores on the four scales were converted to a numerical code, on a scale of "1" to "5". All scales were coded in the same direction, with the most negative responses (i.e., "Strongly Disagree") receiving a code of "1", and the most positive responses (i.e., "Strongly Agree") receiving a code of "5."

It was known from the onset of this study that the sample size would not be large enough to permit inferential statistical testing of the results. Rather, the analysis of the tabulated scores consisted of an examination of the overall response patterns and examples of either conformity to, or deviance from, the confirmation/disconfirmation model's predictions. Evidence that the respondents could comprehend the constructs would be provided by response patterns consistent with the predicted relationships between the constructs. The tabulated scores also permitted a visual check for evidence of a response set within each respondent's responses, through an examination of how much

variation there was within the scores for each construct. Response set formation threatens the reliability of responses.

The recorded comments of each respondent were transcribed, by hand, directly onto that respondent's completed questionnaire. These comments were analyzed to determine whether the respondents could comprehend the four concepts and distinguish among them. Construct comprehension was evaluated on the basis of whether the comments made during questionnaire administration were consistent with the question which had been posed.

The comments were analyzed to ascertain the meaning and importance which the respondents ascribed to each characteristic. This analysis was necessary because of the client-centred nature of the programs which were being evaluated, an approach which made it necessary that the importance and meaning of each characteristic be viewed from the client's perspective. Therefore, the comments which respondents made during questionnaire administration were analyzed for consistency between the respondent's interpretation of a characteristic and the meaning that had been intended. The wording of individual items was subsequently modified to make the wording consistent with the respondents' perspective of each characteristic, as it was discrepancies between the intended meanings and the perceived meanings which caused difficulties for the respondents. These difficulties were manifested in the respondents' attempts to describe what that item meant to them.

These comments also were found to contain evidence about additional important aspects of the service which were not specifically referred to in the questions. The analysis of the respondents' commentary was used to determine whether any aspects of the service characteristics should be added to, or deleted from, the questionnaire.

Chapter 4: Results and Discussion

In this chapter results of the pre-test and the pilot test are described. The results from the pilot test arose from three areas of analysis which are described under three separate headings: comprehension of the constructs, wording of the elements, and analysis of the "Importance" scale. The wording of each element is discussed separately. The chapter closes with a discussion of the scales which were developed to collect selected demographic data from the respondents.

The Pre-test

The pre-test was conducted at the nursing home which housed one of the transitional care programs where the pilot test was to be conducted. Four female residents were interviewed over a period of two weeks. Their residency ranged from one month to 4 months, and their ages ranged from 80 to 94 years.

With the use of both auditory and visual cues, the respondents did not appear to have any difficulty completing the questionnaire. Participants had no difficulty comprehending either the constructs or the service characteristics, as they responded readily to each question. However, two of the respondents took over an hour to complete the questionnaire. A third participant became bored and fatigued by the fortieth question and asked to terminate the interview after 30 minutes. This suggested that completing the questionnaire was a long and arduous process for the participants and would take longer than the prescribed 20 minutes.

It took a long time to complete the questionnaire because the participants were spending a lot of time talking about their experiences between each question. In fact, the one participant who only answered the questions, and did not engage in any discussions during the actual questionnaire

completion, was able to complete the questionnaire in less than 30 minutes. It was concluded that this problem was occurring because the interviewer was not asserting sufficient control over administration of the questionnaire from the onset of the interview. To remedy this situation and to increase the speed and efficiency with which the questionnaire would be completed, it was decided that concise instructions would be delivered at the beginning of the interview. The participants would be informed that their comments are important but should be reserved for the debriefing - the "chatty" portion of the interview - after the questions have been answered.

The Pilot Test

Over the six-month period of the pilot test, 13 clients used the first transitional care program. Three of these clients were not approached about participation in the study. One showed evidence of having cognitive disabilities. One was in too much pain throughout the 13 days of her residency, and was ultimately transferred to the hospital. The third client was admitted during the last week of the pilot test, and was too ill and nauseous during that time to be able to participate.

Five of the ten clients who were approached refused to participate. Therefore, the refusal rate at this site was 50%. There were two reasons for these refusals: three clients were too ill and did not feel "up to it", and two clients were not interested and did not "want to bother".

In addition, interviews were not completed for two of the clients who did agree to participate because their health condition failed to improve while they were in the program. One of these clients was eventually readmitted to hospital, and continued to suffer from a series of medical crises. The other asked to be removed from the study as her condition continued to deteriorate.

Interviewing at the second transitional care program began on September 20, 1996. During the next two months, 9 clients used the transitional care program at this site. All of these clients were approached about participation in the study, and four declined, making the refusal rate at this site 44%. The reasons for refusal which were given at this site were the same as those provided at the first site.

Interviews were completed with a total of seven clients from the two sites. Two of these clients were male, the rest were female, and they ranged in age from 75 years to 92 years. All had come to the facility from their homes, via the hospital, following either a collapse or an injury-producing fall. Five of these clients ultimately returned to their homes. Two experienced a prolonged stay in the transitional care program as they waited for placements elsewhere. One of these participants was from the first site, and he finally procured a nursing home placement. The other participant, who was from the second site, secured an apartment in a private seniors' housing project.

These scenarios indicate that a high refusal rate can be expected for studies conducted within these and similar short-term care programs. The clients of such programs are very ill, most of them having experienced a recent health crisis. They had come to the facility to rest and recuperate and, for the most part, were not predisposed to do a lot of talking. Many did not feel comfortable talking to strangers either because they had poor English comprehension or because they had cognitive, auditory, or visual deficiencies. Such clients could not, therefore, comprehend the purpose of the study. Therefore, achieving an adequate sample size in order to acquire overall satisfaction measures from this population will be a very challenging exercise. However, this population has a high level of need for appropriate health care services, and for this reason, their input into the planning and development

of such services is essential.

Clients who did participate were systematically different from those who refused in ways that may affect both the evaluation of the instrument being developed and the consumer satisfaction measures obtained with it. The participants were less ill, possessed better verbal skills, and had fewer cognitive, visual, and auditory deficiencies than the clients who did not participate in the study. The participants might have higher expectations about the level of their own involvement in their care than the non-participants would. On the other hand, the participants would not need the same level of care from the service providers. Therefore, they may have lower expectations about the care they would receive while in the program. The confirmation/disconfirmation model predicts that the level of these expectations will affect the level of satisfaction/dissatisfaction that the participants will report. Clients who have low expectations that are confirmed by low performance on a service characteristic may report satisfaction. On the other hand, if clients have high expectations for that service characteristic, negative disconfirmation will be produced by the low level of performance, and dissatisfaction will be reported. Because the respondents were not representative of the majority of the recipients of these services, their responses would not be representative of either the expectations for, or the satisfaction with, these programs in general.

Because of the size and characteristics of the sample, the consumer satisfaction/dissatisfaction data collected during the pilot test provides little information for the evaluation of the transitional care programs. However, this was not an objective of this study, and the data is useful in evaluating the validity of the instrument. Moreover, recommendations for revision of the instrument that emerge from the analysis of the pilot study participants' responses

will yield a more representative sample in future studies so that valid measures of satisfaction/dissatisfaction can be obtained.

The completed questionnaires were analyzed to determine the importance and meaning of each service characteristic to the participants, as well as the participants' ability to comprehend the scales and concepts. The patterns which emerged, and the recommendations which followed from their analysis, are described below.

Comprehension of Constructs

The purpose of this evaluation was to determine whether the respondents comprehended the constructs described in the confirmation/disconfirmation model. Evidence that they did comprehend the constructs would support the validity of the questionnaire.

Comments made during the questionnaire administration indicated the respondent comprehended the construct of expectations and, furthermore, understood that expectations were influenced by his/her previous experiences:

Q: "I expected that the staff would involve me in decisions about my care."

A: "Oh yes, I'm getting what I expected. This isn't the first facility I've been in, so I know what to expect." (Interview No. 1).

The debriefing sessions also yielded evidence that the participants understood the concepts of expectations and satisfaction and could distinguish between them:

Q: "How is the statement, 'I expected that my room would always be clean,' different from the statement, 'I am satisfied with the cleanliness of my room?'"

A1: "Yeah, there is a difference, because you expect something. You haven't yet seen enough of it to alter your judgment. So 'expected' is sort of a pre-use analysis." (Interview No. 3).

A2: "On one hand you're asking what we'd expect and on the other hand you're asking what did we get. So they are two different questions." (Interview No. 6).

In the questionnaire, the statements relating to room cleanliness were not consistent as the word "always" was included in the expectation and performance statements, but not in the satisfaction and disconfirmation statements. A discussion during debriefing about this ambiguity illustrated one respondent's understanding that performance and satisfaction were distinct constructs:

Q: "Is the statement, 'My room is always clean,' any different from the statement, 'I am satisfied with the cleanliness of my room?'"

A: "No, they're not quite the same. You might be satisfied with it and yet it might not always be clean. It might be off a little bit some way or another, but to the extent that it doesn't bother you." (Interview No. 5).

Comments made during the questionnaire administration indicated that the respondent comprehended not only the specific construct, but how that construct was related to another construct. For example, the following comment indicates that the respondent understands that satisfaction is related to confirmation of expectations:

Q: "I am satisfied with the privacy I have in my room."

A: "Yes, I am. For a two-person room, it's as good as can be expected." (Interview No. 5).

While the participants perceived that satisfaction and performance were two separate constructs, they were not necessarily able to articulate a distinction between these two constructs during the debriefing as they intuitively felt that satisfaction was dependent on performance. In other words, they indicated that these two constructs were related:

Q: "Is there any difference between saying, 'I am satisfied with the cleanliness of my room,' and saying, 'My room is always clean?'"

A: "Well, they're about the same aren't they? You wouldn't be satisfied if your room wasn't always clean. You're satisfied if it's always clean." (Interview No. 6).

In fact, the respondents were able to describe their common-sense understanding that the three constructs were related in the manner predicted by the confirmation/disconfirmation model:

Q: "How do you feel that the statement, 'I expected that my room would always be clean,' differs from the statement, 'I am satisfied with the cleanliness of my room?'"

A: "I expected it to be clean, and it is clean. It's too complex. It's two different things."

Q: "But what if you expected it to be clean and it wasn't clean?"

A: "Then it wouldn't be clean."

Q: "Right! If you expected it to be clean and it was clean, would you be satisfied?"

A: "Yes. And if it weren't clean, I wouldn't be satisfied." (Interview No. 4).

This dialogue indicates that the respondent can comprehend that expectations, performance, and satisfaction are separate constructs. Furthermore, since she comprehends that the constructs are related in the manner predicted by the model, this indicates that she comprehends the constructs as they are defined by the model.

The coded questionnaire results revealed response patterns which indicated that the constructs were related in the directions predicted by the confirmation/disconfirmation model (Interview Nos. 1, 2, 3, 4, and 5). On the 5-point expectations scale, where a score of "1" meant very low expectations and a score of "5" meant very high

expectations, the participants generally provided a score of "4" for most elements, indicating that they had relatively high expectations. On the 5-point disconfirmation scale, where a score of "1" meant very high negative disconfirmation and a score of "5" meant very high positive disconfirmation, the general response was a score of "3", indicating that these expectations were confirmed. Since the general response on the 5-point performance scale was a score of "4", it is concluded that these high expectations were confirmed by high performance. Generally speaking, confirmation of expectations produced high levels of satisfaction, as most of the scores on the 5-point satisfaction scale were a "4".

Specific examples also support the predictions of the model. For the element of therapeutic treatments, the respondent in Interview No. 4 reported a score of "4" on the expectations scale (high expectations), a score of "2" on the disconfirmation scale (negative disconfirmation), a score of "3" on the performance scale (mediocre performance), and a score of "2" on the satisfaction scale (dissatisfaction). This example supports the prediction that the negative disconfirmation of high expectations by mediocre performance will produce dissatisfaction.

An example of positive disconfirmation of low or neutral expectations producing satisfaction was provided by the respondent in Interview No. 3. For the element of personal involvement in decisions about care, he reported a score of "3" on the expectations scale (neutral expectations), a score of "4" on the disconfirmation scale (positive disconfirmation), and a score of "4" on the satisfaction scale (satisfaction).

The respondent in Interview No. 1 demonstrated that the negative disconfirmation of neutral expectations will produce dissatisfaction. For the element of privacy in room, she reported a score of "3" on the expectations scale

(neutral expectations), a score of "2" on the disconfirmation scale (negative disconfirmation), a score of "2" on the performance scale (poor performance), and a score of "2" on the satisfaction scale (dissatisfaction).

The dialogues recorded during debriefing, the spontaneous comments, the general pattern of response scores, and these specific examples indicate that the constructs are related in the directions that would be predicted by the model. This is evidence that the respondents' understanding of the constructs is consistent with the conceptualization of satisfaction provided by the model. Therefore, the assumption that the questionnaire is measuring the four constructs encompassed by the model is validated, and the construct validity of the questionnaire is supported.

However, response patterns were not always consistent with the model's predictions. In fact, the presence of another general pattern indicated the influence of a powerful factor on the expectations scores. The pattern that emerged was that the responses for expectations, performance, and satisfaction were homogeneous: the scores on these three scales was generally a "4".

Generally, all the respondents in Interview Nos. 1, 2, 3, 4, and 5 reported a score of "4" for expectations, performance, and satisfaction. However, their scores on the disconfirmation scale were less consistent. The confirmation/disconfirmation model stipulates that when a consumer with high expectations for a service characteristic perceives high performance for that characteristic, he/she will report confirmation, as the characteristic is performing as he/she expected. Most of the time, the respondents did report confirmation when they reported high expectations and high performance, and this is consistent with the relationships predicted by the model. However, for some elements, respondents sometimes reported positive

disconfirmation, while reporting high expectations and high performance. This suggests that respondents who reported positive disconfirmation had adjusted their ratings of their expectations; i.e., their expectations were originally lower than what they reported, and upon perceiving positive disconfirmation of these expectations, the respondents raised their expectations to be consistent with their performance ratings.

According to AL theory, adaptation is a physiological/ psychological process whereby the consumer adjusts his/her expectations on the basis of his/her experiences. Adaptation would influence expectations, assimilating expectations ratings towards performance ratings, and would be predicted to occur when there is a discrepancy between expectations and performance. The variations on the disconfirmation scale, in spite of the homogeneity of the scores on the expectations and performance scales, suggests that adaptation is the source of the homogenizing effect.

As adaptation causes an enduring change in the individual's expectations, it can be viewed as an endogenous change in the client. Adaptation would therefore affect the validity of the expectation scores, as the respondents' expectations have actually changed since they were in the program. While the expectations scale is intended to measure a priori expectations, the respondents can no longer accurately report what these expectations were.

This effect is quite predominant in Interview No. 3. Although this respondent had only been in the program for five days, he alluded to the fact that his expectations may have adapted:

> Q: "So when you think of answering that question [about the difference between expectations and performance], are you looking back to the very beginning? When you came here?
>
> A: "Well, I've been here awhile, and what I've

> seen.... From what I understand, this is one of the better ones." (Interview No. 3).

The effects of adaptation appear to occur shortly after a respondent's exposure to a service. This suggests that valid measurements of a priori expectations cannot be obtained after the respondent has actually experienced the service and, ideally, should be obtained at the time of a client's admission to a program.

On occasion, responses to a particular element were not consistent with the model's predictions and either the comments or the responses were not consistent with the question. Sometimes these two outcomes occurred simultaneously, indicating the presence of a factor which would affect the respondent's ability to give a reliable response.

At times, some of the respondents appeared to be having difficulty attending to the questions. Many of the respondents were physically frail and became fatigued by the end of the session. Initially, the respondent in Interview No. 5 frequently interjected questions such as "How was that one worded?" or "I expected what?" into the question/answer portion of the interview, indicating that he was listening intently to the questions. However, by the fiftieth question, he became very tired, and was literally nodding off to sleep. By that point, he was indicating his agreement to statements by murmuring "Umhmmmm...." His ability to attend adequately to the questions by that point was obviously challenged and would explain some of the inconsistencies in his responses.

Some of the respondents had difficulty attending to the questions because they were evidently suffering from short term memory loss and/or attention deficits. Attention deficits affected their ability to comprehend the questions and were manifested by inconsistent comments and inconsistent response scores. For example, the respondent

in Interview No. 2 was described as having rambling speech and distorted thoughts in the mini-mental assessment which was completed at the time of her admission. Her condition appeared to improve as she recovered from her accident. However, during the questionnaire administration, she occasionally made statements that were inconsistent with the question, indicating that she did not comprehend the question. In response to the statement, "I expected that I would like the food provided here," she said, "I like the food provided here, I agree." In response to the statement "My room is always clean," she said, "I strongly agree that it's expected to be clean." Also, this respondent's response scores were frequently inconsistent with the predicted relationships between the constructs. In view of this respondent's memory and attention deficits, the randomized presentation of the questions would have made the questionnaire even more confusing for her. If all the expectations, disconfirmation, performance, and satisfaction questions had been presented together, this respondent's attention could have been facilitated by enabling her to focus on one construct at a time.

Some of the respondents wore hearing aides, indicating that they had experienced some loss of hearing which would, in turn, affect the reliability of their responses. For example, the respondent in Interview No. 7 indicated that she was having difficulty hearing some of the questions by occasionally interjecting questions such as "What was that?" and "Pardon me?" This respondent's overall response pattern was inconsistent with the model: she reported very high expectations, very high performance, and very high satisfaction with all elements; while reporting very high positive disconfirmation, positive disconfirmation, or confirmation with some of the elements. However, this respondent did indicate during debriefing that she could distinguish between the constructs. Therefore, auditory

deficiencies may have threatened the reliability of her responses, although she could comprehend the constructs.

Inconsistent response scores in conjunction with the respondents' commentary suggest another factor which may have affected the validity of some of the responses. In spite of indications that the staff was not completely attentive, some of the respondents seemed to be unwilling to make a statement or judgment which could be construed to be critical of the staff:

> Q: "With the health care cutbacks here in Alberta, even if the nurses were not able to be there for you, would you still say you were satisfied?"
>
> A "Well, they do the best they can. You can't criticize them." (Interview No. 4).

The respondents appeared to perceive that the interview was part of a staff evaluation and, therefore, wanted to provide positive feedback. Subsequently, their responses were positively biased. The most outstanding example of this phenomenon is the respondent in Interview No. 7 who would only give "Strongly Agree" responses. However, the overall scarcity of "Strongly Disagree" or "Disagree" ratings, in spite of the negative comments made by some respondents, suggests that the respondents really didn't agree with the statements, but avoided making negative statements.

Frequently, the conditions under which the interviews were conducted were not optimal, and distractions were unavoidable. For example, Interview No. 2 had to be completed in the client's room, as she had limited mobility. The effect of one particular distraction, when a nurse came in with bedding, was immediately evident in the response scores. Immediately after the nurse left, the respondent indicated low satisfaction with personal involvement, while earlier reporting confirmation of neutral expectations by neutral performance for that element. A neutral satisfaction response would have been predicted by the

model. The fact that this inconsistent response coincided with the moment of the distraction indicates that the distraction may have produced an unreliable response.

In summary, the consistencies in the results indicated that the respondents could comprehend the constructs and differentiate between them. However, instances of inconsistent comments and inconsistent responses indicated the presence of several factors which affected both the validity and reliability of responses. The effects of adaptation may have affected the validity of the responses on the expectation scale. Some of the respondents demonstrated a positive bias in their judgments, which may have affected the validity of all of their responses. The reliability of all the responses is threatened by the physical and cognitive limitations of the respondents as well as environmental factors such as external distractions. In this study, physical limitations included hearing loss and age- and illness-induced frailty. Cognitive limitations included short-term memory loss and attention deficits.

These factors must be considered when revising the questionnaire. Clients with a higher level of functioning were deliberately chosen to participate in this study. However, even these clients demonstrated that they were, at times, having difficulty comprehending the questions. Therefore, the challenge is to simplify the questionnaire so that reliable responses from clients who are even more disabled can be captured. The implications of these findings, and the subsequent recommendations for questionnaire revision, are discussed in Chapter Five.

Wording of Elements:

The purpose of this analysis was to assess whether the respondents could comprehend the selected service characteristics from the way they were described in the questionnaire. Any ambiguous or unclear words would be

identified so that, upon questionnaire revision, the service characteristics would be presented in words and phrases which were relevant and meaningful to the clients themselves. The comments proved to be a particularly fertile source of evidence about the respondents' understanding of each service characteristic as respondents frequently wanted to talk about their experiences in relation to that element of the service, thereby actually describing what that element meant to them. In addition, this analysis provided evidence that certain important aspects of the service should be added to the questionnaire.

1. **Food:**

The food itself did appear to be the core element, as the food items themselves were the main topic of debriefing discussions. In fact, when asked about the food, some participants described the menu items in detail:

> "I like rice. I like my potatoes and gravy. I like my meat and my vegetables. I like my vegetables cooked, though, not raw." (Interview No. 7).

> "Today the lunch was triangle cheeses and the cheese was all chopped up. It wasn't much of a lunch." (Interview No. 4).

> "Today, it was weiners and beans with a bun. Well, everyone got that unless they were on a special diet. And that's agreeable with me." (Interview No. 1).

The food could be modified by other factors, such as service;

> "It's just basic hospital fare. But, if they serve you politely, it makes it better. You know, if you go to one meal you get a nice waitress. At another time, you get one who's surly." (Interview No. 3).

or preparation;

> "Well, the preparation of the food is not what it could be. Sometimes they take good food and ruin it. I guess that's all I can say." (Interview No. 5).

or having choices available:

> "If you don't like what they're offering, they give you lots of salad. So actually, the food is pretty good here. If I don't like the entrée, I make up for it with salad." (Interview No. 6).

However, these factors were incidental to the food itself. Therefore, "the food provided here" is a suitable description of this element.

2. **Cleanliness of room:**

The main problem with this element was that the wording of the questions was not consistent: the word "always" appeared in the expectations and performance items, but not in the satisfaction and disconfirmation items. This ambiguity threatened the reliability of these questions. However, this discrepancy in the wording revealed that not all of the respondents felt that the room should necessarily be clean all the time. Some did expect that it should always be clean:

> Q: "I expected that my room would always be clean."
>
> A: "Certainly! It couldn't be anything else but." (Interview No. 4).

But not all the respondents shared this high standard:

> "You might be satisfied with it and yet it might not always be clean. It might be off a little bit some way or another, but to the extent that it doesn't bother you." (Interview No. 5).

Therefore, using the word "always" changed the focus of the questions as, rather than evaluating room cleanliness as an elementary service characteristic, the respondents were evaluating whether or not the room was always clean, which was not necessarily the relevant characteristic for all of them. Therefore, removing this word from the expectations and performance items would facilitate the respondents' comprehension of this characteristic, as well as the reliability of these questions.

3. **Privacy in room when wanted:**

The respondents' comments illustrated the various meanings that the word "privacy" has for different people. Some felt they could have privacy in their room, even with a roommate present, as long as they were able to go somewhere where they could be alone with visitors, or simply alone with their thoughts:

> "Privacy means if people come in you should be able to have some privacy. If you're up you're alright; you can go to the library. But the ones that are in bed don't have any privacy when someone comes to visit." (Interview No. 6).

> "Privacy means having your own space to go to where you can be alone with your thoughts." (Interview No. 3).

Privacy can be constructed (or threatened) by the behaviors of others:

> "Sometimes they [the staff] are a little negligent with the door being closed while dressing and things like that. If I'm in the bathroom and they're attending to me, they don't always ensure the door is closed." (Interview No. 1).

> "It's important that they warn you before they come in." (Interview No. 2).

However, there are things the individual can do to ensure privacy:

> "If I want privacy, I pull the curtain." (Interview No. 6).

Staff members were not the only ones who demonstrated inconsiderate behavior which threatened the privacy of the client. Interrelationship issues with a roommate were also factors:

> "Yes, I am satisfied [with the privacy I have in my room], but she wasn't! She didn't like me. I know that. She showed it. Everybody has a different personality. After all, living with someone else.... Put neutral, because it depends on who's in with you, you know." (Interview No. 6).

> "I think that for some people it would be quite possible to feel private in their operations in a room which is shared. It just depends on who the other person is." (Interview No. 5).

However, for some people, privacy will only be experienced when they have their own room(s):

> Q: "What do you mean by privacy?"
>
> A: "Well, when I have a private room to myself. I can play my little radio and I can read to all hours of the night. And I can go to the bathroom when I want to." (Interview No. 4).

Different standards for privacy arise because individuals have different tolerance levels for environmental "noise":

> "Some people get along with a little bit of disturbance. It wouldn't bother them at all. Other people want absolute silence - no disturbance at all. It just depends on who the person may be. I can take a little bit of disturbance." (Interview No. 5).

These comments suggest that "privacy" involves the individual's personal space requirements. Individuals differ in the amount of personal space they require, and the amount of "noise" they will tolerate. "Privacy" is what is constructed through actions or structural implementations which serve to protect the individual's personal space. The word "privacy" captures this range of meanings, which is consistent with the meaning that the questions were intended to capture. However, the phrase "when/whenever I want it" appeared in the performance and expectations items, and should be removed to make the questions consistent.

4. **Family involvement in decisions about care:**

These questions were intended to evaluate the way the facility involved each client's family in decisions related to the client's care. Overall, the respondents reported high expectations, performance, and satisfaction with this element. However, they described different levels of family involvement, both before and after their admission. In

fact, some respondents did not experience any family involvement in decisions about their care. The consistent pattern which emerged was that the level of family involvement before the respondent's admission remained the same after admission. For example, before her admission, one respondent was very involved with her family, and involved them in all of her decisions:

Q: "Is family involvement in decisions about care important to you?"

A: "Oh, I like my family involved."

Q: "And you have family here?"

A: "Well, I have just one son and a daughter-in-law and two grandsons. And he [my son] does everything for me, and she does, too. That helps you a lot."

Q: "Is your house close to theirs?"

A: "Right next door. I have no troubles. I tell my son, 'You have to go shopping for me.' He don't like shopping, but he does my shopping. Oh, I have no trouble with them at all. When I make a decision I go and talk it over with them." (Interview No. 7).

After her admission to the program, this respondent continued to involve her family in her decisions, and this involvement was manifested in the active role her son took in her care while she was in the program:

Q: "Is there any time when you felt that the staff listened to you, that you had some input?"

A: "No, they listen to him. He tells them something, they listen."

Q: "So, as long as your son is involved, it's not as necessary for you to be involved?"

A: "That's right, I think." (Interview No. 7).

In contrast to the intense day-to-day involvement between the above respondent and her family, another respondent

relied on her brother primarily for instrumental support both before and after her admission. This respondent did not expect any direct involvement from her brother in decisions about her care:

> Q: "What part does your family play in your life now that you are in this program?"
>
> A: "Not any part at the moment. Except that my brother's coming here tomorrow. He's also involved in giving me instructions about my business when I need it. Things I can't do. Things I can't do very well. I need him to drive me around now. You make your own decisions and don't involve your family any more than you have to."
>
> Q: "So it's mainly your brother that you have contact with while you're here?"
>
> A: "That's all I have." (Interview No. 4).

Another respondent described her family's involvement as being primarily of a social nature, both before and after her admission to the program:

> "They [my family members] can't do too much cause they're all working. I see them whenever they have time off. Here, I don't see them as often because they're further away. At home, I saw them more." (Interview No. 6).

Therefore, the respondents gave positive responses to these questions, in spite of the fact that they did not necessarily experience involvement of their family in decisions about their care. This suggests that they had high expectations that their family would be involved in the same way that they were before the client entered the facility, and that these expectations were confirmed, producing satisfaction. This is not consistent with the intent of these questions, which was driven by the program administrators' goal to actively involve clients' family members in care-related decisions. From the clients' perspective, the service characteristic in question is

whether or not they maintained the same level of involvement with their family once they were in the program. If a client-centred approach is to be maintained in this evaluation, these questions need to be revised so that this element is viewed from the client's perspective. For example, the expectations question should read, "While in this program, I expect to be as involved with my family as I was before I came here," and the performance question should read, "Since coming here, I am as involved with my family as I was before."

5. **"Homey" surroundings:**

The questions about the "homey" surroundings were intended to evaluate the ambience or atmosphere of the facilities, which were designed to be home like. The word "homey" held various associations for different individuals. For one respondent, hominess could be imparted by simply having a window to look out of:

> "Well, I would think it [homey surroundings] is important. Like here, I've done a lot of relaxation watching the way the trees move with the wind and the shape of the leaves and everything." (Interview No. 2).

Other respondents mentioned other physical features which they felt were important:

> Q: "What makes a place homey to you?"
>
> A1: "One of the things is the interior decorations. Also, the exterior. How well the building is kept up. The comfort provided. They keep it pretty nice around here." (Interview No. 3).
>
> A2: "Well, the library is lovely, has chairs, friends can come in to talk. Also, the veranda outside is lovely in the summer." (Interview No. 4).

One respondent mentioned the significant role the people around you play in the creation of a homey environment:

> "I suppose this homey atmosphere depends on the family content. But other than family members, there can be

> people that you like and get along with. I suppose that would make a homey atmosphere, although it's not home." (Interview No. 5).

The underlying theme in all the comments was that "homey" did not imply that a place was like their residential home, but that it was whatever made the resident feel comfortable:

> "The root of it all is that everybody tries to make you comfortable." (Interview No. 2).

> "They try to make everything comfortable. It never feels like home, though." (Interview No. 7).

The word "homey" therefore had a common, underlying meaning for the respondents: how comfortable they felt while they were in the facility. This is consistent with the intent of these questions, which do not, therefore, require any revision.

6. **Professional skills of staff:**

These questions were intended to measure the professional expertise of the staff. This was, indeed, the general understanding that the respondents gleaned from them. Some respondents indicated that the professional training or the qualifications of the staff were their primary criteria for evaluating expertise:

> Q1: "What does 'professional skills of staff' mean to you?"
>
> A1: "It means they have proper training." (Interview No. 4).
>
> Q2: "What makes the staff professionally skilled?"
>
> A2: "There are one or more nurses with a RN on every shift." (Interview No. 5).

However, some respondents indicated that they were evaluating the behavior of the staff when they were considering their professional expertise:

> "Professional skills include a knowledge of duties,

courteous behavior, and efficiency." (Interview No. 3).

"This one little girl, she wanted me to get up before breakfast. I don't like getting up before breakfast. She wasn't professional. You know, it's the same way with nurses and doctors. Some are professionals and some aren't. The degree doesn't make them professional. I think personality counts more than the degree and how they apply it." (Interview No. 6).

In other words, the respondents perceived that professional skills were demonstrated by having the appropriate credentials and by the way the staff members performed their duties. Therefore, there appear to be two important aspects to the professional skills of the staff: the professional training of the staff, and the professional behavior of the staff. Two sets of questions are required to evaluate this element. The expectations items for these questions should read, "I expect that the staff will be professionally trained," and "I expect that the staff will treat me in a professional manner."

Many of the respondents perceived that the financial cutbacks had created lower staff levels, which influenced the ability of the staff to deliver professional care. In fact, the effects of the cutbacks were frequently discussed in conjunction with these questions:

Q: "I am satisfied with the professional skills of the staff."

A1: "I agree, but I understand these cutbacks are not their fault. They are trying to make do with two people instead of six." (Interview No. 3).

A2: "You must figure that they're understaffed. They're always on the run. That's old Klein's outfit. They should flush them down the [expletive] toilet and put a good rock on top of the lid." (Interview No. 7).

These respondents did not, therefore, blame the staff for the compromised professional care that they were receiving.

But not all of the respondents had shifted the responsibility for their professional care from the staff to the government:

> "You know, I really don't think they should blame everything on Klein. They still have to do their work. They're paid for doing it. If there weren't sick people, they [nurses] wouldn't have anything to do. They should still do their utmost to do their best." (Interview No. 6).

There are two separate elements being considered in these discussions: first, the professional skills of the staff; and secondly, the staffing levels. As there were no questions in the questionnaire to specifically evaluate staffing levels, this element should be added to the questionnaire. This element was also frequently commented on in relation to the continuity of care element, and will be discussed under the heading, "Same level of care on all shifts".

7. **Personal involvement in decisions about care:**

These questions were intended to evaluate the level of the client's involvement in the whole spectrum of their care while they were in the program. In fact, as these programs are driven by a client-centred approach, it is assumed that the client is actively involved in care-related decisions. However, although all the respondents indicated that this item was either "Important" or "Very important", none of them expected to be involved in decisions about their medical care. These decisions were left entirely up to the doctor:

> "Once in a facility, you get a normal program as per the physician's instructions. You do not have the information to argue with the doctor." (Interview No. 3).

> "I'm not the one to tell them what pills to give me because I don't know. It's just what the doctor ordered and that's that." (Interview No. 4).

Rather, the respondents expected to passively receive their medical care:

> "If they care for you, they're going to look after you." (Interview No. 7).

However, on all the items relating to this element, the ratings for expectations, performance, and satisfaction were high. From the comments, it appears that the respondents were evaluating their involvement in their non-medical, day-to-day interactions with the staff, and that this was the extent of their involvement in their care:

> "They always ask you what you need. But sometimes they go away and forget it. Last night, for instance, it took her [the nurse] two hours to get my ice water." (Interview No. 6).

> "They ask, 'Do you want to do this now or then, this way or that way.'" (Interview No. 5).

There is, therefore, an inconsistency between the program administrators' understanding of this element, and the clients' understanding. If the questions are to be consistently framed in the clients' perspective, this item should be reworded to reflect the clients' expectations that they will only be involved in day-to-day, non-medical decisions, which appears to be the case for this particular population. The expectations question should read, "I expect to be involved in non-medical, day-to-day decisions about my care," and the satisfaction question should read, "I am satisfied with my involvement in non-medical, day-to-day decisions about my care."

However, it is possible that expectations within this population may change, or that other populations may have different expectations than this one. If a future administration of this questionnaire provides evidence that the client expects to play a more active role in his/her medical care, an item relating to the client's personal involvement in medical care decisions may be desired. In

the meantime, that aspect of a health care service does not appear to be relevant to the population in this study.

8. Attentiveness of staff to needs:

The respondents reported relatively high expectations, performance, and satisfaction with these items, in spite of frequent comments about slow responses from the staff:

> Q: "The attentiveness of the staff to my needs is....."
>
> A1: "About the same as expected. When there are only two nurses to a whole ward, there's only so much they can do. You can expect to wait a long time. I think they're very good here." (Interview No. 4).
>
> A2: "The staff is doing an excellent job in dealing with what they have." (Interview No. 3).

Therefore, staff members were not really expected to respond very quickly because of the cutbacks, which had produced reduced staff levels. The respondents were giving high ratings to the individual staff members with whom they were involved, but the overall level of attention which they were receiving was affected by the reduced number of staff members. Again, this points to the presence of another element which needs to be evaluated: the adequacy of staffing levels, which is discussed under the heading, "Same level of care on all shifts".

However, the attentiveness of the staff members does appear to be an important service characteristic. Therefore, these questions should remain in the questionnaire in their present form.

9. Same level of care on all shifts:

The element in question here was the continuity of the care provided. Ideally, the client should feel that he/she is constantly cared for, and that this care is not disrupted by shift changes. However, there was a discrepancy between the way the expectations, disconfirmation, performance, and

satisfaction items were worded, and the way the question relating to importance was worded. The first four items asked the respondent to evaluate the way the staff on all the shifts worked together, while the last item asked the respondent to evaluate the importance of the same level of care on all shifts. The first four items were interpreted to mean the communication of information between the different shifts:

> "Well, last night, for example, the nurses were checking with the previous shift to see if there were any changes in medicine." (Interview No. 3).
>
> "Yeah, they work together very well." (Interview No. 6).

On the other hand, the importance question was interpreted to mean the staffing levels:

> "There are only two nurses on at night, but you are sleeping at that time anyway." (Interview No. 4).
>
> "You don't need much care at night when you're sleeping. They do come in at night and check you." (Interview No. 6).

These two respondents are saying that they are experiencing continuous care across both the day shift and the night shift, although the staffing levels on these two shifts are not equal. They understand that they are receiving the same level of care on both shifts when the level of that care is adequate to meet their needs, which are different at night from what they are during the day. The clients' interpretation of the importance question matches the original intent of the element: to evaluate the continuity of care. Therefore, the expectations, disconfirmation, performance, and satisfaction questions should be changed so that the focus is on the adequacy of staffing levels on both shifts which would make them consistent with both the intent of this element and the respondents' understanding of it.

The need for a question relating specifically to

staffing levels has also been mentioned in relation to both the professional expertise and the attentiveness that is experienced. Therefore, to understand the continuity of care, as well as the professionalism and attentiveness that is imparted with this care, a set of questions is required to evaluate whether the staffing levels are adequate to meet the client's needs. The satisfaction item for these questions should read, "I am satisfied that the number of staff members on all shifts is adequate to meet my needs."

10. **Therapeutic treatments:**

These questions were intended to evaluate the availability of physical therapy, occupational therapy, and recreational therapy programs which were offered by both facilities. The residents immediately understood that it was these special programs which were being referred to:

> "I was getting some in the hospital, but since I got here, nothing. Just leg exercises." (Interview No. 4).
>
> "Oh yes, the therapist is good." (Interview No. 6).
>
> "They have programs for the patients. They try to entertain the patients." (Interview No. 4).

However, it is impossible to know precisely which program the resident was considering when making his/her evaluation. Should a program evaluator wish to probe more deeply and precisely into the satisfaction levels with these specific programs, it would be necessary to add a question for each program. However, the present questionnaire must be kept as short as possible, and before this element could be made meaningful, three more sets of questions would have to be added. Therefore, in the interests of keeping the questionnaire as brief and concise as possible, this element should be eliminated altogether.

11. **Explanations about treatment:**

This item was readily and consistently understood by

the respondents. Explanations could be about treatment procedures;

> "It's telling you exactly what they're going to do. Like, you know, I think the University Hospital's bad for not explaining things. They just come in and do it." (Interview No. 6).

or about the need for medication:

> "Being told why they do this or that. The only treatment I get is my pills, and I say 'What's this for?' and they tell me." (Interview No. 4).

Therefore, there is no need to change the wording of these questions, as the respondents' understanding of them is consistent with their intent.

12. **Instructions about taking care of yourself:**

These questions were designed to evaluate the health teaching services which are offered through the transitional care programs which, in turn, are intended to increase the client's responsibility for his/her own health and functioning. Overall, the clients gave high ratings for this element. However, when they were asked what "taking care of yourself" entailed, they referred to day-to-day, instrumental functions which they normally did take full responsibility for, and for which they did not feel they needed any additional instructions:

> "I can get dressed myself. I can't walk, but I've still got a head on my shoulders." (Interview No. 3).

> "It [taking care of yourself] means getting up on your feet and making yourself presentable for the day, getting up and down stairs by yourself." (Interview No. 2).

In other words, they felt they could take care of themselves:

> "I really don't need any instructions because I can take care of myself. I just need help getting out of bed and going to the bathroom." (Interview No. 6).

"I'm able to manage on my own." (Interview No. 2).

If they needed any assistance, they had made the necessary provisions to have these programs in place:

> "Here, I'm quite badly spoiled. I wash my face and all that sort of thing, but the nurse comes in and washes my back. At home, I have home care come in twice a week." (Interview No. 4).

The phrase "taking care of yourself" would therefore appear to be misleading the respondents and should be removed.

Furthermore, from the client's perspective, they did not think that they were given explicit instructions. Rather, they perceived that the staff gave them helpful suggestions:

> "They don't tell you what to do. They suggest what you should do." (Interview No. 7).

Therefore, this element should be reworded to make it more consistent with the perceptions of the clients. The performance item would thereby read, "I am given suggestions about how to manage on my own."

13. **Improvement in health:**

These questions were intended to evaluate a primary goal of these programs, the extent to which the program was maintaining or improving the functional status of the client. Generally, the respondents related this to a reversal of the health problem which had brought them into the program:

> "Well, I'm walking, which I couldn't do before." (Interview No. 4).

> "Oh, of course I'm satisfied with the improvement in my health. I'm walking again, aren't I?" (Interview No. 6).

However, the word "health" was misleading to some respondents, and frequently required some discussion before the respondents were able to focus on their immediate

situation. For example, the following comments were made by clients who had experienced fractured bones, which they obviously did not perceive to be conditions which would jeopardize their overall health:

> "I was never sick, to tell you the truth." (Interview No. 7).
>
> "My health is about the same." (Interview No. 6).

Other clients could not expect an improvement in their overall health as they were generally quite frail or disabled and had entered the program for a respite following a collapse:

> "They can't do anything about it [my health], but they make me comfortable." (Interview No. 3).

Therefore, the word "health" should be removed and replaced with a phrase which relates to the treatment of the problem which reduced the client's functional level. The satisfaction item should read, "I am satisfied with my recuperation as a result of this program."

14. **Improvement in ability to manage at home:**

These questions were intended to evaluate another primary goal of the programs: the goal to discharge the client back home with the appropriate equipment and resources to function safely and independently. Generally, it was found that the respondents expected to be able to manage at home upon their release from the program. Prior to their admissions, although they required assistance with various tasks, they were living independently with whatever formal or informal support they required. The respondents in Interview Nos. 1, 2, 3, 4, 5, and 6 used home care to assist them at home. The only exception was the lady in Interview No. 7 who lived next door to the son and daughter-in-law who did "everything" for her. The respondents would continue to manage at home, with assistance, after their discharge. Essentially, their level of functioning at home

will not change, although they will have more responsibilities than when they are in the program:

> "I imagine it'll be about the same. I'm afraid I'm getting spoilt by having everything done for me here." (Interview No. 4).

For some, the health problem they had experienced only interrupted their ability to manage at home:

> "I always did manage at home, but when I fall, I fall." (Interview No. 7).

Some clients criticized these items for being too speculative, forcing them to guess what the appropriate response would be:

> Q: "The improvement in my ability to manage at home as a result of this program is...."
>
> A: "How can I answer that? I won't know until I get home." (Interview No. 4).

Therefore, this element may not be appropriate. The improvement in the client's health condition is included as an element, and the support structures should be in place before the client even considers returning home. Furthermore, as the respondent in Interview No. 4 pointed out, clients cannot evaluate a change in their level of functioning at home until they are actually there. The only aspect of this element to which they can reply is whether they can expect to manage at home with the assurance that they have the appropriate resources in place. Therefore, this element can be deleted from the questionnaire.

15. Cost:

These questions were intended to evaluate how high (or low) the clients perceived the cost of these programs to be. However, there was some ambiguity in the questionnaire items, as the expectations and performance items contained the word "affordable," while the satisfaction and disconfirmation questions did not. A lot of discussion was

generated by the presence of the word "affordable" as the respondents seemed to want to clarify the fact that whether or not a program was affordable depended on the individual's financial resources:

> "So much depends on the individual's financial background. Some people may find the cost no problem at all. Other people would say it's a little stiff." (Interview No. 5).

> "You can't use that word because if I can afford $1000 per month, some other guy may only be able to afford $50. How do I know?" (Interview No. 3).

During debriefing, the cost itself was recognized by all the respondents to be important. Therefore, cost is a basic service characteristic. However, the word "affordable" was confusing to the respondents and should not be used.

The comments of the respondents also suggested that there was an additional aspect of the cost which they were considering. They frequently indicated that they were evaluating the value of the program, or the cost/benefit ratio that they had received:

> "I'm not sure what the final bill will be, but I am satisfied with all the care and everything else." (Interview No. 4).

> "As long as they do it [take care of me], it is affordable. But if they don't, it's not worthwhile." (Interview No. 7).

Interview No. 6 highlighted the importance of value when evaluating cost. This respondent was in the program because she had fallen and fractured her leg while she was visiting the hospital for her regular dialysis treatment. Consequently, the hospital was paying all her transitional care costs. This respondent reported very high satisfaction with the cost of her care, and very high positive disconfirmation, while rating the cost itself too high:

> "The cost of this program is much better [than expected] for me! (She chuckles.) Actually, I think

> the cost is pretty high for most people. I couldn't afford it if I had to pay for it." (Interview No. 6).

This respondent reported very high satisfaction because she perceived that she was receiving very high value: she was getting the service for nothing. Therefore, from this respondent's viewpoint, the value of the service was one thing, but the absolute cost of the service was another aspect of the service. This suggests that value is a distinct aspect of the cost of the program. In fact, the value of the program may be more important the cost. Furthermore, when attempting to describe cost as an element, the wording which was used led to comprehension difficulties. Therefore, a set of questions about value should replace the questions about cost. The satisfaction item for these questions would read, "I am satisfied with the value I am getting for my money while in this program."

Analysis of the "Importance" scale

The purpose of this part of the evaluation was to determine whether the elements which had been identified through the process of questionnaire development were important to the clients of these services and whether there were additional service characteristics which should be included in the questionnaire. This information would then be used to revise the questionnaire so that it would be evaluating all the elements which were important to the clients.

It was not possible to either add or eliminate any elements on the basis of this analysis. During the debriefing, most of the elements were described as either "Important" or "Very important". No elements were consistently rated "Unimportant". Although there is no doubt that the length and intensity of the interview would interfere with the participants' ability to name additional items, the respondents universally declared that there were

no additional elements which were important to them. This suggested that the elements which were selected covered, for the most part, the domain of important elements in this setting.

When respondents did rate an element as either "Unimportant" or "Neither important nor unimportant," they referred solely to their own personal experience (Interview Nos. 2, 3, 4, 5, and 6). For example, the same level of care on all shifts was not important if the respondent did not feel he/she needed as much care at night as during the day:

> "It's not important because you don't need much care at night when you're sleeping." (Interview No. 6).

Likewise, cost was not important to one individual who had a comfortable annual income of $60,000 to $69,000 (Interview No. 5), and therapeutic treatments were not important to the individual who was not scheduled to receive any (Interview No. 3). Some participants did not have any family members available to assist them and, therefore, family involvement was not important to them:

> "My family's not here. My wife has Alzheimers. They are certainly not going to consult her. It's neither important nor unimportant because it doesn't involve me." (Interview No. 5).

In most cases, however, respondents indicated that elements were "Important" or "Very important" in spite of the fact that they themselves had not experienced or needed that element. In these cases, the elements were said to be important because that would be the ideal situation;

> "So far, [in regard to personal involvement in decisions about care] I haven't been involved in any discussions, but ideally, this should be important." (Interview No. 4).

they could see that it was important for other people;

> "As far as I'm concerned, I'm getting all the care I

> need. I do worry about those who don't have any family to see that they get attention." (Interview No. 6).

or they felt that an element would be important if the circumstances were different:

> "I have no family in the city. That's something that I have no control over. A loner! I would imagine that if they were in the city, it would be important, and they would work with the staff." (Interview No. 1).

For some participants, an element was not currently needed, but they still stated that it was important because they felt that they may need it sometime:

> "Important things are things that will help when you need that help. It could be important to me, to get care in the middle of the night, although right now I don't need it. I've been lucky, I guess." (Interview No. 4).

The participants were therefore considering the needs of others and possible changes in circumstances when judging the importance of the elements. The circumstantial change that was anticipated by many participants was a change in their level of need for an element.

The responses to the "Importance" questions did not produce reliable data because, rather than referring strictly to their present circumstances, respondents frequently rationalized their responses. Subsequently, most elements were described as either "Important" or "Very important". However, as discussed in the previous section, the analysis of the wording of elements suggested that there were important aspects of the service which should be added and that two elements should be eliminated from the questionnaire. Therefore, the "Importance" scale is not a suitable methodology to examine the importance of elements. A content analysis, such as the one which was performed on the questionnaire items in this study, would be more effective in collecting this information. However, other qualitative methodologies such as focus groups and

interviews would be suitable.

Demographic data scales

The health status item (Question No. 61) used only a 4-point scale. One respondent (Interview No. 2) insisted that there was no category listed which applied to her. She stated that her health was "Fairly good". Therefore, a fifth response choice, "Fairly good", should be added between "Poor" and "Good".

The "Beliefs about personal control" scale (Question No. 62) is adequate, as a range of responses was reported. Responses ranged from "Control over few or some decisions" (1 response) to "Control over all decisions" (2 responses), with the remaining 4 responses falling into the intervening category, "Control over most decisions".

The "Annual income" scale (Question No. 63) appeared to be adequate to capture the range of incomes of the clients of these services. Responses ranged from "$10,000 to $19,000" (3 responses) to "$60,000 to $69,000" (1 response). The remaining 3 responses fell in the "$40,000 to $49,000" category (2 responses) and the "$20,000 to $29,000" category (1 response).

Chapter 5: Conclusions

Usefulness of the Questionnaire

The consistency between the overall response scores and the confirmation/disconfirmation model's predictions, consistencies between the respondents' commentary and the questions, and the ability of the respondents to verbally describe and differentiate among the constructs, indicate that most respondents can comprehend the constructs encompassed by this model. This suggests that it is a valid model within which to conceptualize and operationalize satisfaction for transitional care programs.

Using the interaction framework for a service encounter (Klaus, 1985) to select the service characteristics for the questionnaire has successfully situated this questionnaire within a theoretical framework which is consistent with the assumptions of a client-centred system. All of the elements so identified were declared to be either "Important" or "Very important" by the respondents.

Analysis of the commentary identified very few additional elements, or aspects of elements, which were important to the respondents. Therefore, using the methodology adopted in this study to develop the questionnaire has successfully identified the characteristics of this service which are important to clients. The revised questionnaire provides a client-centred approach to evaluating transitional care programs.

Limitations of this Study

There were two major limitations to this study. First, the sample size was small. This was largely due to the high level of disability and illness in this population, compounded with a high refusal rate.

Secondly, there were numerous instances of inconsistent comments and inconsistent response patterns, indicating the

influence of several factors on both the validity and reliability of responses. In this study, these factors included adaptation, positive bias on the part of some of the respondents, physical and cognitive limitations of respondents, and external distractions.

Sources of Limitations and Solutions

Through an analysis of these limitations in relation to the structure and presentation of the questionnaire, structural and administrative improvements can be made to the questionnaire. Thereby, both the validity and reliability of this instrument can be improved.

It can be assumed that there will always be a high refusal rate from clients of these services. The clients of transitional care programs have suffered a recent health crisis, and are seriously ill. In fact, it should be assumed that the refusal rate can be as high as 40%. In the present study, however, the high refusal rate was magnified by the demanding nature of the study. The pilot test required that the respondents commit themselves to an hour-long interview. This discouraged several potential respondents, who were cognitively competent, from undergoing the interviewing process.

Furthermore, the selection criteria for this study was higher than it would be for a simple questionnaire administration. Individuals who had no severe visual, auditory, or cognitive deficiencies were deliberately selected. As many of the clients of these programs are experiencing these impairments, this resulted in a small, systematically biased sample which was not representative of the population that utilizes these programs. However, it would not be necessary to have such high selection criteria for future standard administration of the questionnaire. This, in turn, would reduce the systematic differences between participants and non-participants, and increase the

validity and generalizability of the results.

During both the pre-test and the pilot test, the questionnaire took more than 20 minutes to complete, in spite of the administrative changes that were made after the pre-test. During the pilot test, the average length of the interviews was one hour, twenty minutes. Of course, the debriefing took up most of this time (an average of 45 minutes) and a debriefing will not be included in future administrations of the questionnaire. Nevertheless, the actual questionnaire administration took an average of 35 minutes, making it a very demanding exercise. Because of the high level of frailty and illness, as well as the high refusal rate within this population, the questionnaire should be made as short as possible. This would make the tool more manageable for this population and thereby improve both the instrument's reliability and the response rate.

The length of the questionnaire is determined by four factors: the wording of the questions, the number of service characteristics, the number of constructs measured for each characteristic, and the presentation format. Modifying all of these factors, within the context of other limiting factors that were identified in the results, would both shorten the questionnaire and improve its validity and reliability.

One of the primary sources for the discussions that extended the length of each interview was misleading phrases or words in the questions. Therefore, the time it takes to administer the questionnaire can be minimized by making each statement as clear and unambiguous as possible. Accordingly, the questions have been revised so that they can be easily comprehended by the respondents, and so that each service characteristic is phrased in the clients' own terminology. See the revised questionnaire in Appendix D.

In the interests of keeping the questionnaire as short as possible, the number of service characteristics to be

evaluated should be kept to a minimum. This means that only the most important service characteristics should be included in the questionnaire. However, the results suggested that there are frequently several aspects of a characteristic that the client is considering. For example, the therapeutic treatments which are offered by these programs include physiotherapy, occupational therapy, and recreational therapy. For this particular population, attempting to delineate the satisfaction response along these separate aspects will only serve to make the questionnaire longer, and threaten the reliability of the responses. Service providers should be aware that there are sometimes several distinct aspects to a service characteristic and that the respondents could be evaluating either one of them. If it is in the service providers' interests, they may choose to probe deeper into the distinct aspects of a characteristic. An alternative approach was taken to the element of cost by including only the most important aspect of the service characteristic.

The results indicated that adaptation affected the validity of the responses on the "expectations" scale. In order to avoid these effects, the "expectations" portion of the questionnaire should be administered at the time of the client's admission to the program. Administering part of the questionnaire at admission will reduce the amount of time that the respondent must spend at one sitting for the questionnaire's completion and reduce the number of constructs that the client is required to evaluate at one time. Furthermore, administering some of the questionnaire at this time would have the added benefit of avoiding bias on the part of the respondents, for this portion of the questionnaire at least, as the respondents would not yet have formed any attachments to staff members and so would not be motivated to "pity the poor girls [the nurses]," (Interview No. 4).

The randomized presentation of the questions made it very difficult for some of the respondents to give reliable responses. The randomized presentation required that the respondent attend carefully to each word. Each respondent would therefore be heavily dependent on both their hearing acuity and their short-term memory, two of the very factors which provide limitations to this particular population.

In the revised questionnaire, the structure of the questionnaire has been changed so that all the disconfirmation, performance, and satisfaction questions are presented together. This presentation should permit each respondent to focus on one construct at a time, while minimizing the risk of the respondent forming a patterned response set.

An alternative presentation format would be to present the three constructs for each characteristic (disconfirmation, performance, and satisfaction) together. Presenting the questions in this way would permit each respondent to rationally process the relationships between the constructs. However, this presentation may also lead the respondent through this process, setting up a response set. In the confirmation/disconfirmation model, these three constructs are conceptualized as three distinct constructs which should be measured separately.

Additional Revisions to the Questionnaire

Unreliable responses were also produced by distractions and interruptions. These tended to occur when a site other than the designated day room was selected for the interview. It is therefore recommended that, in future studies, a quiet room that is free from distractions be chosen for interviewing purposes, and that it be used consistently. The two exceptions which were made in this study were made with deference to the respondents' preferences: one preferred to talk outside, where he could smoke, and the

other preferred to stay in her room, as she didn't want to bother getting "dressed up." In view of the difficulties experienced in getting respondents in this and similar studies, exceptions may sometimes have to be made in order to facilitate participation. It is important to note, however, that when exceptions are made, the reliability of the responses may be jeopardized.

Three "Strongly agree/Strongly disagree" scales were used for the original questionnaire. This may have been another factor which contributed to the homogeneity of the responses for the three constructs for which this scale was used: expectations, performance, and satisfaction. The respondents may have consciously endeavoured to make their responses for each service characteristic consistent. The reliability of the responses should be improved upon by using a different scale for the "satisfaction" items. In the revised questionnaire, the 5-point "satisfaction" scale runs from "Very satisfied" to "Very dissatisfied", with a neutral zone in the middle labelled, "Neither satisfied nor dissatisfied." There will still be two "Strongly agree/ Strongly disagree" scales in the questionnaire. However, since expectations and performance measures will now be taken at different times, it is less likely that the respondents will be able to remember what their responses to the expectations items were.

Furthermore, the satisfaction items should contain a reference to how the respondent **feels** about the element in question. Since satisfaction is conceptualized as an emotional response, this should help the respondent focus on his/her feelings about the element. Thereby, satisfaction responses may be more readily conceptualized as distinct from the objective evaluation which the respondent is expected to give for the performance item. For example, the satisfaction item for the element of food should read, "The food provided here makes me feel..."

The word "neutral" had different meanings for different people. Some examples are: "I don't care one way or the other," (Interview No. 2); "kind of inbetween," (Interview No. 1); "neither pro nor con," (Interview No. 3); "not of much concern one way or the other," (Interview No. 5); and "it could be a lot better but it could be a lot worse," (Interview No. 6). These self-described definitions suggest that the respondents did see positive and negative sides to the constructs. Therefore, bipolar scales which range from a high positive anchor point to a low negative anchor point, such as the ones used in the questionnaire, should be appropriate for the measurement of these constructs. However, using the word "neutral" allows the respondents to put their own meaning to this response category. Therefore, in order to specify the meaning of this category, it should be labelled "Neither agree nor disagree" on the "Strongly agree/Strongly disagree" scale.

In addition, there was no response choice available for respondents when they encountered an item which was not applicable to them. Therefore, some respondents frequently chose the "neutral" category when the item simply did not apply to them:

> "I have no family in the city. I can't answer one way or the other, so I guess I'll say neutral." (Interview No. 1).

In this case, the respondent is indicating that the item is not important to her, rather than evaluating the level of her family's involvement on an interval scale. Some respondents refused to answer the question when it did not apply to them (Interview No. 5). The respondents are either unable to answer a question or are being forced to make an invalid response. Therefore, the option to reply "not applicable" should be available to respondents on all scales.

Finally, since the questionnaires were read aloud by

the researcher, rather than directly by the respondent, the use of the first person was sometimes confusing:

> Q: "I expected that my room would always be clean."
>
> A: "You expected?"
>
> Q: "No, you expected. I'm reading the statements as if you yourself were saying them." (Interview No. 2).

Therefore, if the questionnaires are intended to be administered in this way, the items should be phrased in the second person.

In view of the respondents' tendency to rationalize their responses, which was most apparent in the "Importance" scale results, the disconfirmation scales should be made more personalized. This is accomplished in the revised questionnaire by the addition of the word, "you". The anchor points on this scale are now, "Much better than you expected," and "Much worse than you expected."

Implications of this Project:

Developing a reliable and valid instrument such as this provides transitional care operators with a tool with which to measure satisfaction with the relevant elements of their programs. Previous surveys with health care services have attempted to operationalize satisfaction. However, this study utilized the confirmation/disconfirmation paradigm as an empirically validated conceptual framework for these satisfaction measures. The application of this model permitted the measurement not only of satisfaction, but of three constructs which determine the satisfaction response: expectations, disconfirmation, and performance. Measuring the sources of satisfaction/dissatisfaction provides the agency with more information than a single satisfaction scale would impart. These measures go beyond simply determining if the client is satisfied; they indicate why

the client is satisfied or dissatisfied. Therefore, they accommodate a shift by the agency to "action" questions, such as, "What can be done to improve the client's satisfaction with the service?" Because different sources of satisfaction are measured, it would be possible to direct remedial action at the appropriate source.

Expectations form a vital component in a client's satisfaction evaluation, as they are conceptualized as the standard against which judgments are made. Measuring expectations gives the researcher an indication of what each client expects to receive. For example, clients may have unrealistic expectations about a service. These expectations will very likely be negatively disconfirmed, producing dissatisfaction evaluations. Measuring expectations enable the agency to detect these high expectations as the source of the dissatisfaction and may help delineate appropriate client education programs.

Measuring performance gives the researcher an indication of each client's assessment of what he/she actually received. Measuring performance gives the agency immediate feedback about any deficiencies in the delivery of the service, as well as reinforcing any positive features.

Finally, the measurement of disconfirmation will provide an indication of the client's perception of how the performance of that aspect of the service actually compared to his/her expectations. Since perceptions of disconfirmation are dependent on both the client's expectations and the actual performance, this construct provides an additional piece of information about how expectations and performance are related, and their subsequent effects on satisfaction measures. For example, even if the overall performance is found to be mediocre, if overall expectations for the service are found to be low, satisfaction measures may still be quite high because of the effects of this positive disconfirmation. This is an

indication that there is still room for improvement in the delivery of the service, in spite of good satisfaction evaluations.

The use of the confirmation/disconfirmation paradigm (Oliver, 1980) in conjunction with the interaction framework for a service (Klaus, 1985) is an appropriate choice of a model with which to measure consumers' reactions to client-centred services. The model establishes the consumer's expectations as the frame of reference about which the consumer makes satisfaction judgments. Expectations are influenced by the consumer's individual characteristics, such as their health status, or level of need for health care services. Therefore, the survey results are grounded in the consumer's experience and will indicate the consumer's evaluation of the service relative to a baseline which reflects his/her individual needs.

The revisions that have been made to the questionnaire will make it more manageable for residents who are more frail and disabled than the respondents in the pilot test. This will reduce any systematic differences between respondents and nonrespondents, but will not eliminate them. It is probable that the most ill and disabled clients will be the least likely to participate in any survey. Furthermore, until more data with a larger sample is obtained, there is no evidence to suggest that the expectations of the more disabled and ill differ from those of the less disabled and ill. Until this analysis is done, it is not clear whether satisfaction measures obtained with this instrument are valid for the whole population. However, until this is known, there are other appropriate uses for this questionnaire.

As transitional care programs are still in a demonstration, trial phase, one of the primary interests of the administrators of these programs is to determine if the goals and objectives of these programs are being met. The

questionnaire could be used to track both the destinations of clients and satisfaction with the 14 elements over time. For example, since the primary goal of these programs is to rehabilitate the client in a cost effective manner, tracking satisfaction along the four constructs with the two elements relating to the client's recuperation and the value the client received for his/her money from the program, would provide indicators of whether these goals are being met. In addition, tracking the elements along the four constructs would enable the researcher to detect any characteristics that were producing dissatisfaction because of poor performance. This would serve as evidence of the need to direct more resources at these specific elements to improve satisfaction. The questionnaire could be administered at the time of each client's release, permitting the agency to complete monthly or bimonthly summaries of the four constructs for each characteristic, as evaluated at the completion of the service.

Family members may also be involved in decisions about the care of frail or ill seniors. If they seek formal services to provide the care that is required by their elderly family member, they are as much a client of the service as the actual recipient of the care. This questionnaire could be modified so that satisfaction with the characteristics of the service which are important to the family members could be measured. In view of the difficulty in getting reliable evaluations from very ill and disabled care recipients, this may be another approach for agencies to consider.

The questionnaire developed in this study has the potential to play an integral part in the planning and evaluation of local, client-centred programs which are currently being developed in Alberta. This questionnaire supports the assumption of client-centredness which underlies the planning and implementation of programs in

Alberta's reformed health care system. With appropriate modifications, this tool could be adapted to evaluate any specific program in Alberta and thereby ensure the input and participation of consumers in the continued development of these programs.

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Appendix A

CONSENT FORM

TITLE OF RESEARCH PROJECT: Developing a Consumer Satisfaction Scale Modelled on the Confirmation/Disconfirmation Paradigm

INVESTIGATORS: **Elizabeth White** **478–3713**
Janet Fast **492–5768**
Norah Keating **492–4191**

INFORMATION:

The purpose of this study is to create a questionnaire which will tell us how people like you who use the "Almost Home Program" feel about the service you receive.

We would like you to help us with the first stage in the development of the questionnaire. We need to know how clear and understandable each question is. First, we would like you to complete the questionnaire. This should take between 15 and 30 minutes. Then, we would like to have a conversation with you about the questions. This should take an additional 15 to 30 minutes. During this time, you will be asked to indicate how important each item was to you, and to tell us about any questions that you didn't fully understand. To make sure that we don't miss any of your comments, the whole session will

INFORMATION (Continued):

be recorded on audio tape. With your permission, we would like to obtain information on your age, diagnosis, length of stay, and destination from your medical file.

All information gathered from this session will be kept confidential. No names are put on the forms; the questionnaires are only numbered and dated. The audio tapes will only be heard by the investigator, who will use them when she is writing her report.

CONSENT:

The purpose and procedures of the research have been explained to me, and my questions have been answered to my satisfaction. In addition, I know that I may contact Elizabeth White, if I have further questions. I have been assured that personal information relating to this study will be kept confidential. I understand that I am free to withdraw from the study at any time without consequence to myself or my care.

The person who may be contacted about the research is:

Elizabeth White
Department of Human Ecology
University of Alberta
478-3713

_____
(Please print participant's name)

_____
(Signature of participant)

_____
(Signature of witness)

_____
(Date)

_____
(Signature of investigator)

Appendix B

Satisfaction Questionnaire 1

THE ALMOST HOME PROGRAM
CONSUMER SATISFACTION QUESTIONNAIRE ©

Thank you for agreeing to participate in the pre-test of this questionnaire. We need your help to see if the questions are relevant and the wording is clear. Your responses will be used only for the development of this questionnaire, and will be kept strictly confidential.

For each item, please indicate the response which most closely describes your experience while in the "Almost Home Program."

Dimensions of the Program:

	Imprt	Cmpr	Word
1. I expected that my room would always be clean.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
2. I like the food provided here.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
3. I am satisfied with the privacy I have in my room.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
4. The hominess of these surroundings is:			
[] Much better than expected			
[] Better than expected			
[] About the same as expected			
[] Worse than expected			
[] Much worse than expected			

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	Imprt	Cmpr	Word
5. I am satisfied with the professional skills of the staff.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
6. I expected that the staff would involve me in decisions about my care.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
7. I have privacy in my room when I want it.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
8. The staff involves my family in decisions about my care.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
9. The way the staff on all the shifts work together to care for me is:			
[] Much better than expected			
[] Better than expected			
[] About the same as expected			
[] Worse than expected			
[] Much worse than expected			
10. The staff is attentive to my needs.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			

	Imprt	Cmpr	Word
11. I expected to receive therapeutic treatments for my particular problem.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
12. I am satisfied with the explanations that are given to me about my treatment.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
13. I am given instructions about how to take care of myself.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
14. The improvement in my health as a result of this program is:			
[] Much better than expected			
[] Better than expected			
[] About the same as expected			
[] Worse than expected			
[] Much worse than expected			
15. I expected that my ability to manage at home would improve as a result of this program.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
16. I am satisfied with the cost of this program.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			

17. I expected that I would like the food provided here.

[] Strongly Agree
[] Agree
[] Neutral
[] Disagree
[] Strongly Disagree

18. The privacy I have in my room is:

[] Much better than expected
[] Better than expected
[] About the same as expected
[] Worse than expected
[] Much worse than expected

19. My room is always clean.

[] Strongly Agree
[] Agree
[] Neutral
[] Disagree
[] Strongly Disagree

20. The way the staff involves my family in decisions about my care is:

[] Much better than expected
[] Better than expected
[] About the same as expected
[] Worse than expected
[] Much worse than expected

21. These surroundings are homey.

[] Strongly Agree
[] Agree
[] Neutral
[] Disagree
[] Strongly Disagree

22. The professional skills of the staff are:

[] Much better than expected
[] Better than expected
[] About the same as expected
[] Worse than expected
[] Much worse than expected

Imprt	Cmpr	Word

	Imprt	Cmpr	Word
23. I am satisfied with the way the staff involves me in decisions about my care. [] Strongly Agree [] Agree [] Neutral [] Disagree [] Strongly Disagree			
24. The staff on all the shifts work together to care for me. [] Strongly Agree [] Agree [] Neutral [] Disagree [] Strongly Disagree			
25. The staff involves me in decisions about my care. [] Strongly Agree [] Agree [] Neutral [] Disagree [] Strongly Disagree			
26. I am satisfied with the therapeutic treatments that I receive for my problem. [] Strongly Agree [] Agree [] Neutral [] Disagree [] Strongly Disagree			
27. The explanations that are given to me about my treatment are: [] Much better than expected [] Better than expected [] About the same as expected [] Worse than expected [] Much worse than expected			
28. I expected that I would be given instructions about how to take care of myself. [] Strongly Agree [] Agree [] Neutral [] Disagree [] Strongly Disagree			

	Imprt	Cmpr	Word
29. My health improved as a result of this program. [] Strongly Agree [] Agree [] Neutral [] Disagree [] Strongly Disagree			
30. The cost of this program is: [] Much better than expected [] Better than expected [] About the same as expected [] Worse than expected [] Much worse than expected			
31. My ability to manage at home improved as a result of this program. [] Strongly Agree [] Agree [] Neutral [] Disagree [] Strongly Disagree			
32. I am satisfied with the cleanliness of my room. [] Strongly Agree [] Agree [] Neutral [] Disagree [] Strongly Disagree			
33. The food provided here is: [] Much better than expected [] Better than expected [] About the same as expected [] Worse than expected [] Much worse than expected			
34. I expected that I would have privacy in my room whenever I wanted it. [] Strongly Agree [] Agree [] Neutral [] Disagree [] Strongly Disagree			

	Imprt	Cmpr	Word
35. I am satisfied with the hominess of these surroundings.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
36. The staff is professionally skilled.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
37. I expected that the staff would involve my family in decisions about my care.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
38. I am satisfied with the attentiveness of the staff to my needs.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
39. I am satisfied with the way the staff on all the shifts work together to care for me.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
40. I expected that the staff would be attentive to my needs.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			

	Imprt	Cmpr	Word
41. The therapeutic treatments that I receive for my problem are:			
[] Much better than expected			
[] Better than expected			
[] About the same as expected			
[] Worse than expected			
[] Much worse than expected			
42. I am given explanations about my treatment.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
43. I am satisfied with the improvement in my health as a result of this program.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
44. The instructions that I am given about how to take care of myself are:			
[] Much better than expected			
[] Better than expected			
[] About the same as expected			
[] Worse than expected			
[] Much worse than expected			
45. The improvement in my ability to manage at home as a result of this program is:			
[] Much better than expected			
[] Better than expected			
[] About the same as expected			
[] Worse than expected			
[] Much worse than expected			
46. I expected that the cost of this program would be affordable.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			

	Imprt	Cmpr	Word
47. I expected that my health would improve as a result of this program.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
48. The cost of this program is affordable.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
49. I am satisfied with the food provided here.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
50. I am satisfied with the way the staff involves my family in decisions about my care.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			
51. The attentiveness of the staff to my needs is:			
[] Much better than expected			
[] Better than expected			
[] About the same as expected			
[] Worse than expected			
[] Much worse than expected			
52. I expected that the staff on all the shifts would work together to care for me.			
[] Strongly Agree			
[] Agree			
[] Neutral			
[] Disagree			
[] Strongly Disagree			

	Imprt	Cmpr	Word

53. I expected that I would be given explanations about my treatment.

[] Strongly Agree
[] Agree
[] Neutral
[] Disagree
[] Strongly Disagree

54. I am satisfied with the instructions that I am given about how to take care of myself.

[] Strongly Agree
[] Agree
[] Neutral
[] Disagree
[] Strongly Disagree

55. I am satisfied with the improvement in my ability to manage at home as a result of this program.

[] Strongly Agree
[] Agree
[] Neutral
[] Disagree
[] Strongly Disagree

56. The cleanliness of my room is:

[] Much better than expected
[] Better than expected
[] About the same as expected
[] Worse than expected
[] Much worse than expected

57. I expected that the staff would be professionally skilled.

[] Strongly Agree
[] Agree
[] Neutral
[] Disagree
[] Strongly Disagree

58. I expected that these surroundings would be homey.

[] Strongly Agree
[] Agree
[] Neutral
[] Disagree
[] Strongly Disagree

59. The way the staff involves me in decisions about my care is:

[] Much better than expected
[] Better than expected
[] About the same as expected
[] Worse than expected
[] Much worse than expected

60. I receive therapeutic treatments for my particular problem.

[] Strongly Agree
[] Agree
[] Neutral
[] Disagree
[] Strongly Disagree

Imprt	Cmpr	Word

Personal Characteristics:

61. How would you rate your health prior to receiving this service:

[] Very Good
[] Good
[] Poor
[] Very Poor

62. How much control do you feel you have in making decisions that affect your everyday life:

[] No control
[] Control over few or some decisions
[] Control over most decisions
[] Control over all decisions
[] Don't know

63. What is your annual income:

[] Less than $10,000
[] $10,000 to $19,000
[] $20,000 to $29,000
[] $30,000 to $39,000
[] $40,000 to $49,000
[] $50,000 to $59,000
[] $60,000 to $69,000
[] $70,000 to $79,000
[] $80,000 or more

Investigator's Notes:

Date: _____

Gender of respondent: _____

Noteworthy Problems:

_____

_____

_____

_____

_____

File Information:

Age: _____

Origin of Client:

[] Home
[] Other _____

Diagnosis: _____

Length of Residence to Date: _____

Destination Upon Discharge: _____

Mini mental assessment: _____

Scores:

		Importance	Exp	Disc	Perf	Sat
1.	Food	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2.	Cleanliness of room	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3.	Privacy in room when wanted	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
4.	Family involvement in decisions about care	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
5.	"Homey" surroundings	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
6.	Professional skills of staff	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
7.	Personal involvement in decisions about care	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
8.	Attentiveness of staff to needs	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
9.	Same level of care on all shifts	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
10.	Therapeutic treatments	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
11.	Explanations about treatment	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
12.	Instructions about taking care of yourself	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
13.	Improvement in health	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
14.	Improvement in ability to manage at home	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
15.	Cost	VI I N U VU	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1

Additional Items:

_____

_____

_____

Appendix C

The following probes evolved throughout the debriefing sessions. They were used to explore the respondent's comprehension of the constructs, the meaning of words and phrases to the respondents, the importance of items, and the need for additional items.

Comprehension of the constructs:

* How are the following statements different [Read only two at a time]:
  a) "I expected that my room would always be clean."
  b) "I am satisfied with the cleanliness of my room."
  c) "My room is always clean."

* What does the statement "I expected that the staff would be attentive to my needs," mean to you?

Importance of items:

* What aspect of the food is important to you?
* Was your family's involvement an important aspect of your experience here?
* Besides being affordable, what aspects of the cost do you consider to be important?

Meaning of words and phrases:

* What does "privacy" mean to you?
* What does "homey" mean to you?
* What do you think "explanations about treatment" would involve?
* What does the phrase "my personal involvement in decisions about care" mean to you?
* What does "professional skills of the staff" mean to you?
* What behaviors/actions does "taking care of yourself" include?
* What would indicate to you that your health had improved?
* What does "neutral" mean to you?
* What does "affordable" mean to you?
* What makes that aspect important to you?

Additional items:

* Are there any additional aspects of the service which were important to you which we have not covered in the questionnaire?

Appendix D

TRANSITIONAL CARE PROGRAMS
CONSUMER SATISFACTION QUESTIONNAIRE ©

Thank you for agreeing to participate in the ongoing assessment of transitional care programs. Please be assured that your responses will be kept strictly confidential.

For each item, please indicate the response which most closely describes your expectations for/experiences with this program.

Expectations Questions (To be administered upon admission)

E1. You expect that you will like the food provided here.
- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree
- [ ] Not applicable

E2. You expect that your room will be clean.
- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree
- [ ] Not applicable

E3. You expect that you will have privacy in your room.
- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree
- [ ] Not applicable

E4. While in this program, you expect to be as involved with your family as you were before you came here.
- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree
- [ ] Not applicable

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E5. You expect that these surroundings will be homey.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

E6. You expect that the staff will be professionally trained.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

E7. You expect that the staff will treat you in a professional manner.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

E8. You expect to be involved in non-medical, day-to-day decisions about your care.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

E9. You expect that the staff will be attentive to your needs.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

E10. You expect that the number of staff members on all shifts will be adequate to meet your needs.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

E11. You expect to be given explanations about your treatment.

[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

E12. You expect to be given suggestions about how to manage on your own.

[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

E13. You expect to recuperate as a result of this program.

[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

E14. You expect to get value for your money from this program.

[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

Disconfirmation Questions

D1. The food provided here is:
- [] Much better than you expected
- [] Better than you expected
- [] About the same as you expected
- [] Worse than you expected
- [] Much worse than you expected
- [] Not applicable

D2. The cleanliness of your room is:
- [] Much better than you expected
- [] Better than you expected
- [] About the same as you expected
- [] Worse than you expected
- [] Much worse than you expected
- [] Not applicable

D3. The privacy you have in your room is:
- [] Much better than you expected
- [] Better than you expected
- [] About the same as you expected
- [] Worse than you expected
- [] Much worse than you expected
- [] Not applicable

D4. Since coming here, the extent to which you have maintained the same level of involvement with your family as before is:
- [] Much better than you expected
- [] Better than you expected
- [] About the same as you expected
- [] Worse than you expected
- [] Much worse than you expected
- [] Not applicable

D5. The hominess of these surroundings is:
- [] Much better than you expected
- [] Better than you expected
- [] About the same as you expected
- [] Worse than you expected
- [] Much worse than you expected
- [] Not applicable

D6. The professional training of the staff is:
- [] Much better than you expected
- [] Better than you expected
- [] About the same as you expected
- [] Worse than you expected
- [] Much worse than you expected
- [] Not applicable

D7. The professional manner with which the staff treats you is:
- [] Much better than you expected
- [] Better than you expected
- [] About the same as you expected
- [] Worse than you expected
- [] Much worse than you expected
- [] Not applicable

D8. The extent to which you are involved in non-medical, day-to-day decisions about your care is:
- [] Much better than you expected
- [] Better than you expected
- [] About the same as you expected
- [] Worse than you expected
- [] Much worse than you expected
- [] Not applicable

D9. The attentiveness of the staff to your needs is:
- [] Much better than you expected
- [] Better than you expected
- [] About the same as you expected
- [] Worse than you expected
- [] Much worse than you expected
- [] Not applicable

D10. When it comes to meeting your needs, the adequacy of the number of staff members on all shifts is:
- [] Much better than you expected
- [] Better than you expected
- [] About the same as you expected
- [] Worse than you expected
- [] Much worse than you expected
- [] Not applicable

D11. The extent to which explanations are given to you about your treatment is:
- [] Much better than you expected
- [] Better than you expected
- [] About the same as you expected
- [] Worse than you expected
- [] Much worse than you expected
- [] Not applicable

D12. The extent to which you are given instructions about how to manage on your own is:
- [] Much better than you expected
- [] Better than you expected
- [] About the same as you expected
- [] Worse than you expected
- [] Much worse than you expected
- [] Not applicable

D13. Your recuperation as a result of this program has been:
[] Much better than you expected
[] Better than you expected
[] About the same as you expected
[] Worse than you expected
[] Much worse than you expected
[] Not applicable

D14. The value you are getting for your money from this program is:
[] Much better than you expected
[] Better than you expected
[] About the same as you expected
[] Worse than you expected
[] Much worse than you expected
[] Not applicable

Performance Questions

P1. You like the food provided here.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

P2. Your room is clean.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

P3. You have privacy in your room.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

P4. Since coming here, you are as involved with your family as you were before.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

P5. These surroundings are homey.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

P6. The staff is professionally trained.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

P7. The staff treats you in a professional manner.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

P8. You are involved in non-medical, day-to-day decisions about your care.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

P9. The staff is attentive to your needs.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

P10. The number of staff members on all shifts is adequate to meet your needs.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

P11. You are given explanations about your treatment.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

P12. You are given suggestions about how to manage on your own.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

P13. You have recuperated as a result of this program.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

P14. You are getting value for your money from this program.
[] Strongly agree
[] Agree
[] Neither agree nor disagree
[] Disagree
[] Strongly disagree
[] Not applicable

Satisfaction Questions

S1. The food provided here makes you feel:
[] Very satisfied
[] Satisfied
[] Neither satisfied nor dissatisfied
[] Dissatisfied
[] Very dissatisfied
[] Not applicable

S2. The cleanliness of your room makes you feel:
[] Very satisfied
[] Satisfied
[] Neither satisfied nor dissatisfied
[] Dissatisfied
[] Very dissatisfied
[] Not applicable

S3. The privacy you have in your room makes you feel:
[] Very satisfied
[] Satisfied
[] Neither satisfied nor dissatisfied
[] Dissatisfied
[] Very dissatisfied
[] Not applicable

S4. Since coming here, the extent to which you are involved with your family makes you feel:
[] Very satisfied
[] Satisfied
[] Neither satisfied nor dissatisfied
[] Dissatisfied
[] Very dissatisfied
[] Not applicable

S5. The hominess of these surroundings makes you feel:
[] Very satisfied
[] Satisfied
[] Neither satisfied nor dissatisfied
[] Dissatisfied
[] Very dissatisfied
[] Not applicable

S6. The professional training of the staff make you feel:
[] Very satisfied
[] Satisfied
[] Neither satisfied nor dissatisfied
[] Dissatisfied
[] Very dissatisfied
[] Not applicable

S7. The extent to which the staff treats you in a professional manner makes you feel:
[] Very satisfied
[] Satisfied
[] Neither satisfied nor dissatisfied
[] Dissatisfied
[] Very dissatisfied
[] Not applicable

S8. The extent to which you are involved in non-medical, day-to-day decisions about your care makes you feel:
[] Very satisfied
[] Satisfied
[] Neither satisfied nor dissatisfied
[] Dissatisfied
[] Very dissatisfied
[] Not applicable

S9. The attentiveness of the staff to your needs makes you feel:
- [] Very satisfied
- [] Satisfied
- [] Neither satisfied nor dissatisfied
- [] Dissatisfied
- [] Very dissatisfied
- [] Not applicable

S10. When it comes to meeting your needs, the adequacy of the number of staff members on all shifts makes you feel:
- [] Very satisfied
- [] Satisfied
- [] Neither satisfied nor dissatisfied
- [] Dissatisfied
- [] Very dissatisfied
- [] Not applicable

S11. The extent to which explanations are given to you about your treatment makes you feel:
- [] Very satisfied
- [] Satisfied
- [] Neither satisfied nor dissatisfied
- [] Dissatisfied
- [] Very dissatisfied
- [] Not applicable

S12. The suggestions that you are given about how to manage on your own make you feel:
- [] Very satisfied
- [] Satisfied
- [] Neither satisfied nor dissatisfied
- [] Dissatisfied
- [] Very dissatisfied
- [] Not applicable

S13. Your recuperation as a result of this program makes you feel:
- [] Very satisfied
- [] Satisfied
- [] Neither satisfied nor dissatisfied
- [] Dissatisfied
- [] Very dissatisfied
- [] Not applicable

S14. The value that you are getting for your money from this program makes you feel:
- [] Very satisfied
- [] Satisfied
- [] Neither satisfied nor dissatisfied
- [] Dissatisfied
- [] Very dissatisfied
- [] Not applicable

Notes: Date: _____

Gender of respondent: _____

Noteworthy Problems:

_____

_____

File Information:

Age: _____

Origin of client:
[] Home
[] Other _____

Diagnosis: _____

Length of residence to date: _____

Destination upon discharge: _____

Mini mental assessment: _____

Personal Characteristics:

C1. How would you rate your health prior to receiving this service:
[] Very good
[] Good
[] Fairly good
[] Poor
[] Very poor

C2. How much control do you feel you have in making decisions that affect your everyday life:
[] No control
[] Control over few or some decisions
[] Control over most decisions
[] Control over all decisions
[] Don't know

C3. What is your annual income:
[] Less than $10,000
[] $10,000 to $19,000
[] $20,000 to $29,000
[] $30,000 to $39,000
[] $40,000 to $49,000
[] $50,000 to $59,000
[] $60,000 to $69,000
[] $70,000 to $79,000
[] $80,000 or more