The goal of any patient survey instrument must be to help improve the quality of the patient's experience of care. But what is quality as perceived by patients?

Is quality the clinical ability of a nurse to administer an IV? Or is it communicating with compassion about the IV - what is it - what does it do - how long will it be in place - or what will happen if it runs out?

Is quality administering the right pain medication? Or is it communicating with compassion about pain management - what is pain - what dose - what to expect - what potential side effects - or when to finish?

The answer is that patients expect that their care providers know what they are doing clinically. The patient makes a judgement combining both perceptions of clinical skill, communication and most importantly emotional interaction.

How to improve patient satisfaction?

There are many tactics and strategies that improve patient satisfaction. This article provides advice on getting the groundwork covered first: understanding the patient's most important points of interaction: Their "Moments of Truth”

It provides an example of a homecare experience, and maps the key moments of truth as a patient makes the journey through a complex health care system.

More importantly, it profiles the patient expectations and requirements at each moment of truth.

The first step to improving patient satisfaction is to ensure that our staff deliver excellent clinical care – but also behave in a manner that provides emotive care - together making the moments of truth flawless in the eyes of the patient.
Recently, there’s been some talk about the supposed difference between surveys that measure the “experience of care” versus surveys that measure “patient satisfaction.” Those who espouse the “experience of care” survey claim that an “experience of care” survey asks patients to objectively report on actual events during their hospital stay. Thus, they claim this survey reveals what “really” happened. In contrast, a “patient satisfaction” survey asks patients to subjectively rate their care. “Rating” involves perception and evaluation.

In reality, all patients experience care. What we’re dealing with here is a rhetorical distinction with significant implications. We’re examining the difference between surveys that narrowly define and measure only the “experience of care,” and surveys that measure “patient satisfaction with the experience of care”. The two are constructed quite differently and examine care very differently. An “experience of care” survey typically asks patients to report very specifically on the occurrence of events, or the frequency of occurrence, or the timing of an event.

- Did something happen?
- Did the staff do XYZ?
- How often did doctors, nurses or other hospital staff do XYZ?

Here, the patients are asked to recall if a process occurred or the frequency of an action. It is assumed that patients have clear and accurate recollections of this, days, weeks or months after the interaction.

More important than what’s being asked, is what isn’t. Patients are not being asked how well staff interacted or behaved with them.

Survey research literature is overwhelmingly critical of so-called “frequency of occurrence” surveys that are characteristic of “experience of care” instruments.

A key limitation of frequency scaling is that it lacks a subjective evaluative component, which is the essence of satisfaction ratings.

**Indicating how often something occurred is not the same as saying how it is perceived.**

The relationship between patient satisfaction and the frequency of a performed service is not always linear. What seems like immediate care to one patient seems like an eternity to another.

Common sense and our own personal experience and research over 27 years tell us that quality of care involves far more than speed and frequency of an action. The content of the action is important. The mode of delivery is important. Information delivered about the care is important. Information given to the patient about the care must be appropriate. The empathy and explanations that accompany care must be appropriate.

Even staff discussions with family members must be appropriate, as communication can subtly affect the family’s interaction and their subsequent tolerance.

All of these elements contribute to the patient’s experience of care. The experience of care is not a multitude of distinct or isolated events that can be clocked and then recalled with accuracy some time after discharge. The experience of care necessarily includes a host of factors that are sensed by the patient and that surround delivery of each element of care.
A survey that measures patient satisfaction with the experience of care recognises that care and its impact on the patient is complex. It affirms that the experience of care is always perceived, interpreted and evaluated in a personal and subjective manner.

For example, if a patient feels dissatisfied with pain control, it doesn't matter whether it “really” was handled speedily or according to the hospital's established protocol. It means that the patient feels pain control was inadequate. Period.

The real experience of care is always personal and always subjective. Pretending that the patient’s experience of care can be objectively reported distracts attention away from the root causes of care problems - behaviour.

Satisfaction surveys recognise the subjective nature of the experience of care. Satisfaction surveys recognise, with realism and common sense, that the subjective evaluation of the hospital experience is all that's available from the patient.

The “experience of care” survey purports to capture what “really” happens with respect to specific aspects of the official care protocol. Such an approach is facility-centred, not patient-centred.

The “real” experience of care is always in the eye of the patient and is subjectively sensed and evaluated. As such, any measure of the care experience must accommodate its broad and subjective nature.

The first step to improving patient satisfaction is to ensure that our staff deliver excellent clinical care – but also behave in a manner that provides emotive care at our patient’s moments of truth.

What is a Moment of Truth?

Moments of Truth was coined by Jan Carlzon's while president and CEO of Scandinavian Airlines System (SAS). SAS experienced low profitability, negative customer feedback and poor market position.

SAS was able to become a high performing, customer-oriented company, organised for change. Carlzon's strategies focused on the customer, encouraging risk-taking, delegating more authority to front-line employees, and eliminating vertical levels of hierarchy for a more horizontal organisation. He achieved this by instilling a culture that identified the key moments of truth between SAS customers and SAS employees, then ensuring that each interaction was flawless.

Carlzon's work has a universal message for health care.

Why Map Moments of Truth?

In the healthcare industry, there are a minimum of twenty or thirty moments of truth in the provision of care and service. A moment of truth is when an interaction occurs between a patient/resident or family member and the healthcare service provider that can leave a lasting, positive or negative impression on a patient.
Moments of truth in a hotel, for example, will undoubtedly include, but not be limited to, booking the room, check-in, check-out, dinner reservations, in-room dining, and response to requests.

Understanding the moments of truth that are important to a health care organisation's patients is the key to understanding what IS patient care.

Mapping Moments of Truth

Understanding good care from a patient’s viewpoint begins with mapping a generic patient's experience and determining their moments of truth. It is insufficient, however, to only have a generic organisational view of the map. To make use of the map to improve patient care, the view of each significant patient grouping must be understood to ensure that appropriate care is given at appropriate moments. For example, the journey of an inpatient is significantly different to a patient experiencing a day surgery procedure, the experience of a mother having a child is significantly different to a person experiencing outpatient oncology treatment.

Determining each moment of truth, for each patient group, and what impacts on the patient's perception and memory of the service is the key to providing good patient care.

In identifying the moments of truth a number of good practices can be used:

• Conducting psychometric tests on survey data identifies which issues are important to patients.

• Conducting ‘mystery shopping’ where employees assume roles of patients and/or families, without the knowledge of staff.

• Patient complaints are a source of extra material but given that only a small percentage of customers who are dissatisfied actually fill them out, they cannot be the sole source of information.

• The organisation’s employees are also a good source of information to determine the moments of truth. Employees see first hand the body language, the tone and pace of voice and the circumstances.

What impacts on each Moment of Truth?

Research by Liljander and Mattson (2002), revealed three personal factors (and the general environment) impact on perceptions of service. The personal factors are:

• The level of concern shown for the individual customer

• The level of friendliness shown towards the customer

• The level of civility shown towards the customer

Having someone wait in an emergency department can cause a negative impression. Showing genuine concern at the length of their wait and helping to make the next interaction easy in a friendly and helpful manner can reduce that negative impact to zero.

By understanding what each patient group requires at their moments of truth enables organisations to develop and execute plans to improve the perception and the memory of the interactions that are important.

Patients are then more likely to be genuinely satisfied with the care and service provided.

The following pages provide an example of a homecare experience, and maps the key moments of truth as a patient makes the journey through a complex health care delivery system.

The key to patient satisfaction is to ask ourselves 'how do we perform in matching these patient expectations?’ Once we have identified the gaps, we can then commence implementing improvement strategies.

By Terry Grundy, Managing Director
Press Ganey Associates - Australia and New Zealand

Edited Extracts from 'Experience of Care vs Satisfaction With Experience of Care’, by Irwin Press Ph.D.
## HOME HEALTH CARE SERVICES - MOMENTS OF TRUTH

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<th>Moment of Truth</th>
<th>What are the patient/client expectations, needs and behaviours? What will they experience?</th>
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<tr>
<td>Hearing news from GP or specialist about their health issue requiring a home health service</td>
<td>High anxiety&lt;br&gt;Question - <em>What will this mean to me:</em>&lt;br&gt;• my ability to live&lt;br&gt;• ability to function&lt;br&gt;• how will it impact on my family, my home&lt;br&gt;• my job&lt;br&gt;• my income&lt;br&gt;What will I be going through&lt;br&gt;What are my options&lt;br&gt;Want the family to be involved in any decisions&lt;br&gt;Is this home health service the right one for me</td>
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<td>Asking friends and relatives and looking up the internet about their condition</td>
<td>Want to know about other people’s experiences&lt;br&gt;Want to know about the issues they will face, the possible outcomes&lt;br&gt;May check on the information provided by their doctor or specialist (mostly via the internet) – what if it conflicts</td>
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<td>Phone call to the home health care organisation</td>
<td>High anxiety, particularly if first time&lt;br&gt;Want a quick answer to the call&lt;br&gt;Want to speak to the correct person&lt;br&gt;Want to receive call back in acceptable time (if this is required)&lt;br&gt;Want to be treated with dignity and respect&lt;br&gt;Want to be treated with courtesy and compassion</td>
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<td>Discussions and agreement regarding the care plan</td>
<td>Home health clients evaluate the efficacy of the original home healthcare plan to meet their needs. Clients have spoken and unspoken needs that need to be ascertained and incorporated into communication strategies by home healthcare staff.&lt;br&gt;Clients usually have the initial assessment for home health services conducted by their doctor, nurse, discharge planner, or case manager. If numerous agencies are involved, clients expect that the coordination of care between those initiating the plan (typically the referrer) and the home health care agency executing the plan is flawless.&lt;br&gt;They want to know what is going to happen&lt;br&gt;They want to know how the goals and how they will be measured&lt;br&gt;They want to know when first visits will take place&lt;br&gt;They want to know how many visits and at what interval&lt;br&gt;They want to know how long each visit will take&lt;br&gt;They want to know who will be visiting and providing the services&lt;br&gt;Want to know what they will need to do or prepare for the visit</td>
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<tr>
<td>Arranging a time or schedule for home visits with the agency</td>
<td>The act of arranging an appointment involves a series of experiences, including: the phone system, phone personnel, availability of times, convenience of agency operating hours, and the amount of coordination the client has to do on his or her own.&lt;br&gt;For many home care clients – there is one of two situations at play. Either the client will need only a short duration of visits, making the timing important so that they can complete their scheduled care and resume a more “normal” life; or, they will need continuous care over many months or longer, making the timing of the visits crucial to ensure that they have a schedule to which they can become accustomed.&lt;br&gt;Obviously, not all scheduling requests can be fulfilled all the time. It then becomes the job of the agency to come to an agreeable compromise, at the same time that they reconcile the needs of the client with the requirements of the client’s doctor and the capabilities of the client’s financial situation.&lt;br&gt;Wants to know that special needs will be met&lt;br&gt;Wants any promises to be carried through&lt;br&gt;Wants to feel they have been listened to and understood&lt;br&gt;Wants to feel they are treated with respect&lt;br&gt;Once the arrangements have been made, a clock starts in the client’s mind.</td>
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<tr>
<td>Preparing for the first visit from a home health professional or other person</td>
<td>Want a phone call if the person is running late, and the ability to change the time if delay is perceived to be too long.&lt;br&gt;High anxiety, particularly if first time, do not know the staff</td>
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### Home Health Care Services - Moments of Truth

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<th>Moment of Truth</th>
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| Initial interaction with the first clinical home health professional | Want a friendly face  
Want to be treated with dignity and respect  
Want the person to respect the home and personal belongings and furniture  
Want to be involved in decisions about their care or treatment plan  
Want to be treated with courtesy and compassion  
Want to be assured of the knowledge and skill of the clinical staff member  
Want to know what is going to happen  
Want to know what any tests are to be done – why and when  
Want the clinical staff member to spend appropriate time with them  
Want to know how soon before they go to the next phase of care, if applicable  
Want to know about any medications  
Want to know how any pain will be controlled  
Want to know when the clinical staff member will be back |
| Confidence in the Staff                     | Clients do not judge clinical competence relative to professional standards, but, rather, just as one does not have to be an automotive engineer to judge the quality of a car, various cues exist which indicate to the lay person the level of professional expertise a clinician brings to the table:  
Clients expect professional appearance (e.g. attire, grooming, cleanliness, free of perfume or smoke odors, etc.)  
Clients expect adherence to safety guidelines (e.g. wearing gloves when touching clients'wounds)  
Clients expect communication skills and understandability of his/her speech  
Clients expect effectiveness of collaboration, communication, and coordination across disciplines and throughout the care organisation  
Clients expect information to be professional (e.g. are self-care instructions an old photo-copy or a clean, glossy sheet with illustrations?) |
| Involvement in decisions                    | Clients want to feel awareness, understanding, and participation in decisions regarding their care and treatment.  
The client might not need to actually make the decision in order to feel like he or she was included in decisions.  
Because the agency staff member is caring for the client in the home, the client feels that they are on their "turf", the nurse (or therapist, etc.) must maintain a careful balance between being the authority and being a partner with the client.  
Clients want to feel that their ideas are considered and respected, even if they cannot be acted upon. |
| Receiving care or treatment                 | Clients want the staff member to show concern for their comfort and well-being throughout any care or treatment being administered.  
"Concern" is a subjective feeling of caring or regard for the welfare of another. It can only be detected if manifested in behaviour. |
| Preparing for any test or treatment         | Want privacy if needing to change clothes or undress  
Anxious at hearing the noise of any machines  
 Watches the skill of person preparing for the test  
Want to know about the equipment used  
Want to know what is happening throughout the test or treatment  
Want to know what to expect |
| Administering of test, treatment or medications | Want to be comfortable and put at ease  
Anticipates outcome while being examined  
Concerned about infection and hygiene |
| Conclusion of test or treatment             | Want to know what is going to happen next  
Want to know how long it will take before any test results come through  
Want to know what the results may mean  
Want to know - if results cannot be shared now - why not |
| Knowing what to do after visit              | Patients want to be confident that they know what to do between visits, or after their visit has ended  
The agency needs to prepare the patient to do this by providing good information and instructions on self-care. |
| Experiencing pain                           | The issue of pain management is a complex one, since each person experiences pain in their own unique way (different thresholds for what is manageable, different ways of handling pain).  
Perception of the quality of pain management and the exact pain experienced are two different things.  
Clients consider the actual pain experienced and match it to the advice or information provided by their professional carers.  
A degree of tolerance will be accepted if the match is there. |
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<td>Patient does not feel comfortable with the staff member</td>
<td>Home care providers are sometimes regarded with gratitude for coming to provide needed care, or with resentment for intruding in the client’s environment or for serving as a reminder of the client’s dependent state. With the latter reaction, the visiting staff member becomes key in reversing the client’s emotional reaction to home care. If there is not a good “fit”, the client can begin to resent the visits even more, making progress difficult if not impossible. Clients want to feel that if a trusting and compassionate relationship does not exist or breaks down, they are able to ask, (without making the staff member feel bad), if a change can be made. It then falls onto the agency to rectify any situation in which the visiting staff member does not work well with the client. Clients want these feelings listened to and responded to without negative verbalizing or the need to overly justify the request. How well the agency handles the request takes into account not only whether or not the change was made, but how much work the client had to do in order to make the request, how friendly the agency was in accommodating the request, and how much explanation went into the process. For an individual requiring home health care, especially on a long term basis, it is very important that they feel comfortable with the individuals that are visiting.</td>
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<tr>
<td>Consistency and reliability of staff and visits</td>
<td>Clients judge consistency and reliability on a number of factors: Clients, especially those that are long-term customers of the home health agency, often have a very set schedule of visits. They have needs that dictate when they are visited, and can feel that a missed or late visit will adversely affect their health. They may have plans that are being put on hold until the visit can be completed, in which case a late or missed appointment can affect their personal activities.</td>
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<tr>
<td>Ongoing communication and progress</td>
<td>Illness impacts not only the client, but also the entire social fabric of which the client is a part. Clients and their families place mutual priority to get and receive information about their condition and treatment in a safe and confidential manner. The ability of the family to support the client during their illness and recovery can have an enormous impact on the client’s recovery and well-being. In many situations, the family member is also the primary caregiver when the nurse, therapist, etc. is not in the home. The client wants family members who are care providers to receive relevant information.</td>
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<td>Concerns about privacy</td>
<td>There are two elements that clients consider when they expect privacy to be maintained – physical privacy and confidentiality. The client experienced inappropriate nakedness, where parts of the body might be exposed to others uninvolved with the client’s care. Staff did not respect the client’s home, e.g. did not knock before entering, did not announce themselves, handled client’s belongings inappropriately, picked up something without permission, etc. Staff relay information volunteered by the client to inappropriate parties, or relayed information to the client about other clients.</td>
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<tr>
<td>Dealing with the family</td>
<td>Members of a client’s family want to be treated with dignity and respect. Members of a client’s family want to feel OK that they can ask for help whenever needed. Members of a client’s family want to know how to make contact with the organisation, and the staff member who visited. Members of a client’s family want to know how soon before they will go home and come back next time.</td>
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<tr>
<td>Voicing a concern or making a complaint</td>
<td>A complaint occurs because actions do not meet expectations. It may reflect anxiety, fear and uncertainty. The client hopes that the caregivers in the organisation will do something to handle the disquiet or dissatisfaction that has been voiced. When the client mentions something that troubled or worried him/her or when the client expressed dissatisfaction with something that happened (or didn’t happen) they expect appropriate actions, such as acknowledging the event or concern, answering the issues, or if not giving a timeframe that a response will be made. In many instances a simple apology is all that is required.</td>
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<tr>
<td>Stopping visits</td>
<td>In many instances the staff need to prepare the client to stop receiving services from the organisation. The client or a carer may need to continue the treatment or care after the conclusion of home health services, however, for financial or other reasons the services from the agency must conclude. Staff must instil client and carers with the capacity and confidence to manage (either on their own or with the help of family).</td>
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