Patient-Experience-Based Organizational Learning – Criteria for a Patient Satisfaction Measure as an Effective Indicator in Home Care Settings

1. Introduction

Organizational learning based on patient experiences can improve the process and quality of care. Especially the integration of patients’ views and experiences for quality improvement is becoming more important in the health care sector (Wensing & Elwyn, 2002). In the home care sector, in particular, the patient perspective is key. Because care-giving takes place at the patient’s home, the care process involves mainly one relationship – namely between the patient and the home care nurse.

In the Swiss home care setting, the social context of this study, quality is mainly assessed through objective indicators such as the Resident Assessment Instrument (RAI)\(^1\), thus neglecting the subjective perspective of patients (Burla, Schaffert, Mylæus, & Rüesch, 2010), even though patient satisfaction is one of the most commonly used and accurate outcome indicator in healthcare (Doyle, Graves, & Gruber, 2017; Mahon, 1996). This is why patients’ views and experiences should be integrated more strongly in home care settings.

Research suggests different approaches to collecting and learning from patients’ views. One such approach involves patient satisfaction surveys, which are, in fact, conducted by many health care organizations (Wensing & Elwyn, 2002). Patient satisfaction surveys provide important insights into patient satisfaction with the health care services received. They can deliver key information about the whole process and the potential for optimization. Moreover, this information can be integrated into training measures and educational concepts (Burla et al., 2010). Patient satisfaction can, therefore, said to be a valuable source of process optimization, enhanced care quality, and continuous development within the organization (Fancott, 2016).

\(^1\) Tool to assess the need for nursing care which covers the initial assessment phase (patient enrollment and assignment of therapy and nursing procedures) and leads to diagnosis, prioritization, and outcome evaluation.
Recent international home care research has not been focusing on the benefits of patient satisfaction as an effective measure of organizational learning. In the context of home care, few efforts appear to have been made to develop an adequate instrument to measure patient satisfaction in general. A literature search found that some instruments have been adapted from those used in other medical care services, without taking into account the unique characteristics of home care settings and with no evidence provided of their psychometric characteristics (e.g., services at patients’ home over a long period of time) (Hawthorne, 2006).

In order to address this research gap, a measurement instrument is being developed as a part of an ongoing research project entitled “Swiss Home Care Data: Patient Profiles and Quality Measures for Home Care” funded by the Swiss National Science Foundation (SNF). This paper discusses the findings of a sub-project which focuses on the integration of patients’ views in home care. Regarding the aim of the project, the focus is on elderly patients (65 and above), which make up nearly 75 percent of all home care patients in Switzerland (Swiss Federal Statistical Office, 2015). The goal is to develop an instrument that measures patient satisfaction adequately and enables organizational learning at the same time.

The following sections provide an overview of the development of a new patient satisfaction measure. After defining the constructs of patient satisfaction and organizational learning, the previous knowledge regarding the characteristics of the home care setting is discussed. Further, criteria to develop a patient satisfaction measure are discussed, with a focus on a measure that meets all the requirements as well on organizational learning. Finally, other possible approaches are discussed and a project outlook is provided.

2. Organizational Learning in Healthcare

In the industry, the ability to adapt quickly to environmental changes or other requirements is a key success factor. For example, those who have learned how to adapt to changing customer needs are perceived as innovative and competitive (Argote, 2013). This need for adaptability
increasingly applies also to healthcare. Healthcare institutions must remain competitive and innovative to survive in a changing economic environment. Organizational learning is a key ability in adapting to changing circumstances and continuous improvement (Argote, 2013; St.Pierre & Hofinger, 2014).

Organizational learning in the healthcare context has been described as the cumulative product of learning in small groups or teams, which leads to increased organizational effectiveness and efficiency through shared knowledge and understanding (Peirce, 2000; Ratnapalan & Uleryk, 2014; St.Pierre & Hofinger, 2014). Most researchers agree with the definition of organizational learning as a change in an organization’s knowledge that occurs as a function of experience (Argote, 2013). Organizations which promote organizational learning are called “learning organizations”. The term “learning organization” was introduced by Peter Senge to describe an organization which values continuous development. Within such organizations, continuous change, optimization, and flexibility are encouraged and integrated into everyday business activities (Senge & Klostermann, 2011). In this context, five key concepts have been proposed (Davies, 2000; Senge & Klostermann, 2011):

- **Systems thinking**: Instead of a reductionist view characterized by simple cause-and-effect relationships, learning organizations adopt a view that considers dependencies, time delays, and interactions within a system.

- **Personal mastery**: Learning organizations identify and empower employees' strengths and talents, and provide opportunities for development.

- **Team learning**: Focusing solely on individual skills is not enough because patient care is teamwork. Learning organizations therefore know the power of teamwork as a key factor in their success. Beyond departmental boundaries, knowledge is exchanged in order to achieve effective, joint action as an organization.
- **Mental models**: People’s mental models underlying their action vary. This is why there is a tendency for people to want to stick to previous perspectives and thus be blind to changed circumstances. Learning organizations have adopted rules of conduct that allow them to know, explore, and question the mental models of their team members. In order to gain a clear, comprehensive picture of reality, they openly discuss mental models instead of insisting on a single perspective.

- **Shared visioning**: Learning organizations provide their members with a shared vision that enables individuals to understand their own contribution in the overall context of the organization.

Previous studies in the healthcare context have mainly focused on team learning and mental models in the context of simulation and crisis resource management (CRM) training. In these training activities, a real-life scenario is simulated and afterwards discussed with participants. The simulation scenarios are based on real medical cases. In some cases, the data was selected through the Critical Incident Reporting System (CIRS), a patient safety system that records potential and past patient exposure. The cases are intended to be used for care providers to practice critical events in a protected environment (Fanning & Gaba, 2007).

As studies have shown, team learning can be transferred to clinical settings and improve patient outcomes, including a decrease in mortality (Boet et al., 2014). Organizational research has revealed several factors that are essential in this context: a supportive learning environment, concrete learning processes and practices, and leadership behavior that provides reinforcement.

Within the concrete learning processes and practices, the systematic collection of customer information is an important factor (Garvin, Edmondson, & Gino, 2008). In view of this, organizational learning in healthcare should focus more strongly on understanding patients. Based on this improvement and optimization should be established. (Ratnapalan & Uleryk,
Understanding and analysis of patient information could result from patient experiences collected, for instance, through patient satisfaction surveys. The next section gives an overview of how patient satisfaction surveys could be integrated into the context of organizational learning.

3. Patient Satisfaction as a Driver of Organizational Learning

3.1 Potential of Patient Satisfaction Measures

Patients are becoming increasingly empowered in the healthcare system in general. On the one hand, they can be seen as co-creators of healthcare because having an understanding of current problems in care delivery and quality can lead to a continuous improvement of the service (Wensing & Elwyn, 2002). On the other hand, patients have recently begun to be viewed as key stakeholders in the healthcare context. They are a useful source of information because they are involved in the complete care process and are, therefore, able to give an overall view on the healthcare experience (Ward & Armitage, 2012).

Based on an experience-based design methodology, it has been shown that integrating patients’ experiences into the development process can improve services. A recent study conducted at a neonatal intensive care unit, for instance, showed that the integration of the families’ needs results in measurable benchmarks such as reduced noise or greater capacity (Bate & Robert, 2006; Broom, Brady, Kecskes, & Kildea, 2013). Moreover, hospitalized patients have the potential to adequately report safety outcomes (Ward & Armitage, 2012). In other words, there are various reasons why patient integration could be a crucial source of information about care quality.

There are different approaches to integrating patients’ view. Some of them, such as focus groups or interviews, provide valuable information but are also very time- and resource-consuming. It is, therefore, questionable if these approaches are suitable in a health care context.
Another approach involves using devices such as surveys, written complaints, and questionnaires to obtain patient feedback. In this context, patient satisfaction surveys are often used (Coulter, Fitzpatrick, & Cornwell, 2009). As mentioned before, this approach provides important information about the care process from the patients’ perspective. Based on this data, conclusions about the direction and intensity of staff training and further education can be made to improve specific areas (Torres & Guo, 2004; Wensing & Elwyn, 2002). An additional advantage of patient surveys is that they do not take much time or many resources. Rather than adding to employees’ workload, questionnaires can be filled out by patients anytime.

Only a few organizations have so far introduced an adequate management system that allows organizational learning based on patient satisfaction surveys (Coulter et al., 2009), however. In addition, only a small number of empirical studies have explored co-creation in accordance with learning in healthcare (Hardyman, Daunt, & Kitchener, 2015). The next section will provide an overview of how patient satisfaction can enable organizational learning and the requirements for a new tool to measure patient satisfaction.

3.2 Requirements for a New Organizational Learning Measure

To use patient satisfaction surveys effectively for organizational learning, they have to fulfill validity criteria. Their validity can be limited by the fact that patient satisfaction surveys often struggle with ceiling effects; this is the effect of responses to questionnaires being positive despite varying degrees of satisfaction (Döring & Bortz, 2016). Research has confirmed that social desirability and dependency can lead to high reported patient satisfaction (Pearson, Durant, & Punton, 1989).

Social desirability is the tendency of individuals to reject socially undesirable behaviors in favor of socially desirable ones (Zerbe & Paulhus, 1987). In the context of patient satisfaction, social desirability is more likely to occur when patients fear that there might be
negative consequences if they rate their patient satisfaction as low (Drevs, Gebele, & Tscheulin, 2014).

In addition, the sense of dependency that patients often feel towards their service providers can also have an impact on expressions of satisfaction. This can be influenced by the norm of reciprocity, which can be understood as the expectation that we will repay in kind what others have done for us. In other words, people will respond favorably to each other by returning a favor for a favor (Levine & Manning, 2014).

A new measure should be able to detect distorted response behavior. This requires the integration of innovative new question formats, and scales should be considered which can detect biased response behavior and allow for statistical adjustment, thus preventing ceiling effects. In addition, the new measure must also guarantee anonymity (e.g., by means of self-reporting forms).

The validity of the new measure could also be biased by the fact, that it may not represent patient experience to its full extent. For example, as mentioned before, critical incidents represent an integral part of organizational learning such as team-learning and building mental models (Boet et al., 2014; St.Pierre & Hofinger, 2014). Yet it is unclear whether these incidents are integrated in existing measurement instruments. Currently, most common reporting systems report only critical incidents reported by employees, not the patients. In addition, only negative events are recorded. Although such a system provides valuable information, it could be optimized by integrating the patients’ views. In this way, more information could be provided as an additional basis for organizational learning. The integration of the patients’ views, such as critical incidents, could persuade patients to report more specific experiences rather than just rate the care received using common rating scales. In dealing with critical incidents, which could be defined as events that promote or inhibit the occurrence of patient satisfaction, a new measure will, therefore, have to consider how
patients view the critical incidents they experience. One possibility for collecting critical incidents is the “method of critical events”. This method collects information about events that have a positive or a negative effect on patient satisfaction. An event involves an observable behavior that has been shown and that allows conclusions to be drawn about future behavior. The goal is to identify effective and ineffective behaviors as comprehensively as possible (Flanagan, 1954; Nerdinger, Neumann, & Curth, 2015).

Besides these requirements, aspects of patient characteristics in home care are also important and should not be neglected. The next section provides an overview of needs related to patient satisfaction.

4. Patient Characteristics and Patient Satisfaction in Home Care

4.1 Patient Characteristics

Research has indicated that patient satisfaction is a cognitive evaluation of performance which is influenced by expectations and affective states and can, therefore, be classified as a subjective perception, in which interpersonal relationships are the most important determinant (Crow et al., 2002; Urden, 2002). These research results are from the general healthcare context and include diverse patient groups. In order to develop a suitable instrument for the home care sector, it is important to consider its special features.

As mentioned before, elderly people aged 65 years or above are the main clients of Spitex, the Swiss home care services, and were, therefore, chosen as the target group for this research project. In order for a measure to adequately reflect patient satisfaction among the elderly, the needs and demands of this patient group must be known. As Table 1 shows, various studies have examined the satisfaction-related needs of the elderly.

[Table 1 here]

Beside the specific satisfaction-related needs listed above, the elderly also have several characteristics which limit their ability to participate in satisfaction surveys (Epstein, Hall,
Tognetti, Son, & Conant, 1989; Gasquet, Dehe, Gaudebout, & Falissard, 2003). First, their reading and hearing abilities may be reduced (Dagnelie, 2013; Gates & Mills, 2005). With increasing age, working memory capacity decreases, making new equipment/devices or complex procedures a major challenge. In addition, the ability to distinguish relevant from irrelevant information decreases (Wilkowska & Ziefle, 2009). Various studies have shown that these cognitive changes have an influence on the survey methodology. For example, high non-response rates could be due not only to the length of the questionnaire but also to patients’ physical limitations. The new measure should, therefore, contain an age-appropriate scale. One such possibility is a scale which is based on intuitive shapes such as emoticons or figures. Moreover, the number of questions should be limited. Age-appropriate elements such as an intuitive design and a small number of questions require less working memory, which would reduce the risk of distorted response behavior.

4.2 State of Research on Patient Satisfaction Measures in Home Care

Measurement of patient satisfaction in the home care setting differs from measurements in inpatient care. Since questionnaires used in inpatient care can only be transferred to homecare settings to a limited extent, they were excluded. The following section gives an overview of existing knowledge regarding the measuring of patient satisfaction in home care, in particular patient satisfaction in a) elderly patients and b) concerning the home care they receive.

In order to find a suitable instrument to use with elderly patients in home care, a literature search was conducted which resulted in a total of over 200 articles. Articles that do not include or refer to a patient satisfaction measure in home care were excluded. Also excluded were scales referring to specific diseases (e.g., mental disorders) or target groups and articles which did not include the elderly or focused on non-nursing services. This reduced the number of appropriate instruments considerably.
The literature search finally yielded $n = 17$ home care patient satisfaction scales that were published or referenced in published studies. Table 2 below provides an overview of existing instruments.

[Table 2 here]

Overall, little homogeneity was found to exist among the various dimensions, which reflects the fact that there is no standard instrument. Some of the instruments focus on health service delivery and neglect aspects of interpersonal relationships (e.g., Bear et al., 2000), although interpersonal relationship is the most important determinant of patient satisfaction across the various settings, and for the elderly, in particular (see Table 1) (Crow et al., 2002). This was confirmed at the item level; most items refer to cognitive aspects of patient satisfaction and do not include affective components. The number of items ranges from 12 to 60 items. In research, instruments with a high number of items are often required for construct definition. Moreover, a high number of items could exceed the cognitive capacity of the elderly. Further, no instrument was found to include questions about critical incidents. This was considered a serious deficiency because as mentioned before, critical incidents could be an important indicator in organizational learning. Also, no statements were found about the vulnerability of the measures in terms of ceiling effects and how to prevent or control them.

To sum up, previous research has not proposed any instrument which can be relied on to help with a) the adequate measurement of patient satisfaction of elderly patient and b) organizational learning.

The next section discusses two possible solutions to solve the challenges mentioned in previous sections.
5. **Promising Approaches for the Development of an Effective Patient Satisfaction Measure**

It is suggested that a new instrument to measure patient satisfaction with home care in the elderly has to fulfill several requirements. To meet the needs of organizational learning, ceiling effects have to be limited. Also, it must not focus solely on evaluating perceived care. A new measure should represent patient experience to its full extent (Coulter et al., 2009), with a focus on events that have an influence on patient satisfaction, such as critical incidents. In addition, age-specific aspects should not be neglected. In the light of these requirements, two promising approaches are discussed below.

### 5.1 SAM Scale

The self-assessment manikin (SAM) scale is a nonverbal, visual assessment technique that measures direct affective response to a wide variety of stimuli. The scale consists of three dimensions which reflect the affective response. The dimension of valence (see Figure 1, top panel) describes positive or negative feelings caused by a situation or an event. The arousal dimension (see Figure 1, middle panel) alludes to the individual’s level of affective arousal. The dimension of dominance, finally, describes how much a person feels in control of a situation (see Figure 1, bottom panel) (Bradley & Lang, 1994). The scale has been successfully used in previous studies. For example, the SAM scale can reliably measure people’s emotional reaction to pictures (Backs, da Silva, & Han, 2005) and self-reported emotions (Betella & Verschure, 2016).

![Figure 1 here](image)

The SAM scale has several advantages regarding the measurement of patient satisfaction by elderly in home care. First, the evaluations are carried out on three different dimensions. An ideal level of patient satisfaction should reflected by a high rating on the valence dimension (see Figure 1, right side), a low rating on the arousal dimension (see Figure 1, left side), and a
high rating on the dominance dimension (see Figure 11, right side), which includes aspects of autonomy, also a need of elderly patients (see Table 1).

Potentially, however, ratings on the valence dimension could be distorted by social desirability because these ratings could be manipulated easily. By contrast, the other two scales (arousal and dominance) represent affective components that are less vulnerable to this bias. It would be conceivable, for example, for an elderly person, who was treated without respect, to give a high value in the valence scale and a low one for dominance, as a negative consequence. As a result of the different dimensions, social desirability response behavior could, therefore, be limited.

Based on previous research, the SAM scale can be used with different age groups (Backs et al., 2005; Bradley & Lang, 1994). It might, therefore, be an adequate alternative to common rating scales (e.g., Likert) to reduce the cognitive demands on elderly patients.

5.2 Critical Event Methods

To gain more insight into where patient satisfaction arises or where it might potentially change, critical incidents should be integrated more strongly. To do so, there are different approaches. First, previous and current CIRS cases should be analyzed. The disadvantage of this approach is that these cases are reported anonymously and only represent the employees’ view. To complement these findings, critical incidents as reported by patients will have to be added, using, for example, the Critical Incident Technique (CIT). With CIT, events are identified by the patient which are critical for increasing or decreasing his or her satisfaction. The method deals only with cases where extremely positive or negative events have been observed. By using this method, critical events can be recorded from the patient's perspective. As opposed to the CIRS, which only records negative events, with CIT positive events can also be recorded (Flanagan, 1954; Nerdinger et al., 2015).
Another option for gaining more insight into where patient satisfaction arises is the sequential event method. This method focuses not only on extreme events (in terms of critical incidents) but takes into account all employees (Stauss & Weinlich, 1996). Within the framework of this method, each contact point is considered and evaluated. This method prevents recall bias from occurring, for example, through primacy and recency effects (Nerdinger et al., 2015). Through these methods, more insight will be gained on how patient experiences can be captured fully.

6. Conclusion

Patient satisfaction is an important success factor for a wide range of aspects in healthcare. Research has indicated that quality of care could be improved through patient satisfaction and that it is also a driver of organizational learning. In the home care context, however, few attempts have been made, generally, to integrate patient satisfaction. In fact, there are only a few suitable instruments used to measure patient satisfaction, and these tend to pay little attention to the specific needs of elderly patients. The aspect of organizational learning has also been largely neglected. The aim of this research project was, therefore, the development of a suitable measure with which to evaluate patient satisfaction among elderly patients in the home care context which would also make use of organizational learning.

Since no adequate, reliable measure was found to exist that takes account of elderly patients’ characteristics and enables organizational learning, a new instrument is needed that meets the following requirements: In order to solely evaluate the care received, it has to limit ceiling effects caused by social desirability response behavior. In addition, the factors that have a positive or a negative effect on patient satisfaction must be understood more fully. Finally, the specific needs of the elderly should be considered, for instance by the use of an age-appropriate rating scale.
The integration of the SAM scale in future measures could minimize or at least identify social desirable response behavior and, consequently, prevent ceiling effects. An unbiased measure will allow home care providers to draw more accurate conclusions concerning patient satisfaction among patients receiving home care. This, in turn, will make it possible to identify potential for optimization and improvement and to develop training concepts.

By integrating critical event methods that take account of patients’ views, more insight could be gained into the influence of critical incidents. This is an important factor for organizational learning. For instance, based on specific events or aspects that promote or inhibit the occurrence of patient satisfaction, scenarios could be created that could promote team learning and team building in training courses. The knowledge gained from such activities could improve the home care organization as a whole in the long term.

Within this research project, the approaches proposed to measure patient satisfaction will be tested empirically in a pilot test with patients of a larger home care organization in Switzerland. One goal is to test whether the SAM scale is a reliable and valid self-reporting measure for patient satisfaction among the elderly in home care. In this context, convergent validity with overall satisfaction ratings will be tested. The results will be compared with insights gained from applying critical event methods (e.g., CIT). These data will be collected by repeated measures and interviews within a small sample.

The findings of the pilot test with regard to the SAM scale and the critical event data will be incorporated into the further development of the instrument.
References


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## Table 1. Special satisfaction-related needs of elderly patients

<table>
<thead>
<tr>
<th>Need</th>
<th>Reference</th>
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<tbody>
<tr>
<td>Interpersonal relationships: Elderly patients want to be treated kindly and with respect. They want to be able to have a relationship with the nurse.</td>
<td>Dempsey et al., 2016; Geron et al., 2000; Huang, 2015; Karlsson, Edberg, Jakobsson, &amp; Hallberg, 2013</td>
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<tr>
<td>Autonomy, participation, and empowerment of the patient: Patients want to be able to act as independently as possible and be actively involved in making decisions.</td>
<td>Berglund, 2007; Caris-Verhallen, de Gruijter, Kerkstra, &amp; Bensing, 1999; Dempsey et al., 2016; Geron et al., 2000; Gillear &amp; Reed, 1998; Sixma, 2000; Triemstra, Winters, Kool, &amp; Wiegers, 2010</td>
</tr>
<tr>
<td>Nursing competence and continuity of care</td>
<td>Geron et al., 2000; Karlsson, Edberg, Jakobsson, &amp; Hallberg, 2013</td>
</tr>
<tr>
<td>Information and time management: Elderly patients want to be kept informed about the course of their illness, the long-term prognosis, and the accessibility and punctuality of home care.</td>
<td>Dempsey et al., 2016; Huang, 2015; Karlsson et al., 2013; Triemstra et al., 2010</td>
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</table>
Table 2. Existing instruments to measure home care patient satisfaction

<table>
<thead>
<tr>
<th>Name of Instrument</th>
<th>Reference</th>
<th>Dimensions</th>
<th>Number of Items</th>
<th>Validity</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Coordinator Satisfaction Measure (SCSM)</td>
<td>Bear, Sauer, &amp; Norton, 2000</td>
<td>Service delivery</td>
<td>19</td>
<td>α = .86</td>
<td>Likert</td>
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<td></td>
<td></td>
<td>Service sufficiency</td>
<td></td>
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<tr>
<td>The Reid-Gundlach Satisfaction with Services Instrument</td>
<td>Brumley et al., 2007; Reid &amp; Gundlach, 1984</td>
<td>Relevance</td>
<td>12</td>
<td>α = .95</td>
<td>Scale</td>
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<td>Impact</td>
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<td></td>
<td>Gratification</td>
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<tr>
<td>Quality of home aid service scale</td>
<td>Chiou, Lee, &amp; Chang, 2014</td>
<td>Positive opinions</td>
<td>14</td>
<td>Yes</td>
<td>Likert, analog scale</td>
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<tr>
<td></td>
<td></td>
<td>Negative opinions</td>
<td></td>
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<tr>
<td>Human Resource Management Practices and Patient Satisfaction Scale (HRPPSS)</td>
<td>Dansky, Brannon, &amp; Wangsness, 1994</td>
<td>Three overall measures</td>
<td>N/A</td>
<td>N/A</td>
<td>Likert</td>
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<td></td>
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<td>Scheduling &amp; arrangements</td>
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<td>Nursing care</td>
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<td>Home health aide services</td>
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<td>Discharge arrangements</td>
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<td>General measures of satisfaction</td>
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<tr>
<td>Gray’s Home Care Satisfaction Scale (GHCSS)</td>
<td>Gray &amp; Sedhom, 1997</td>
<td>Caring</td>
<td>27</td>
<td>α = .78</td>
<td>Likert &amp; mixed, self-report</td>
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<td></td>
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<td>Efficiency</td>
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<td></td>
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<td>Amount of care/time spent</td>
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<td></td>
<td></td>
<td>Autonomy/socialization</td>
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<tr>
<td>The Home Care Satisfaction Measure (HCSM)</td>
<td>Geron et al., 2000</td>
<td>Competency</td>
<td>35</td>
<td>α = .79</td>
<td>Likert</td>
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<td>Service choice</td>
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<td></td>
<td>Positive interpersonal</td>
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<td></td>
<td></td>
<td>Negative interpersonal</td>
<td></td>
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</tbody>
</table>
| N/A                                      | Holmqvist, Koch, & Pedro-Cuesta, 2000 | Art of care  
Technical quality of care  
Accessibility/convenience  
Finance  
Availability  
Continuity  
Efficacy/outcome of care | 18 | N/A | Scale |
| N/A                                      | Jones, Netten, Francis, & Bebbington, 2007 | ‘Carer’ quality  
Service quality  
Outcomes | 60 | α = .84 | multiple-choice |
| The Home Care Client Satisfaction Instrument-Revised | Kouli et al., 2013 | N/A | 15 | N/A | Likert |
| Client Satisfaction Survey (CSS)         | Laferriere, 1993 | Technical quality of care  
Communication  
Personal relationships between client and provider  
Delivery of services | 35 | α = .99 | Scale |
| The Press Ganey Home Care Patient Satisfaction Questionnaire | Mylod & Kaldenberg, 2000 | Arranging home healthcare  
Dealing with the home care office  
Nurses  
Home health aides  
Medical equipment  
Overall ratings | 35 | α = .98 | Likert |
| N/A                                      | Nakatani & Shimanouchi, 2004 | Client focus  
Accessibility  
Continuity of care  
Coordination of services  
Integration of services  
Effectiveness and efficiency | 46 | α = .89 | Scale |
| Patient Satisfaction Care Specific Survey | Seibert et al., 1999 | Care process  
Patient involvement education  
Orientation to homecare  
Perceived medical outcome | 27 | N/A | forced-choice |
|------------------------------------------|----------------------|---------------------------------------------------|---|---|---|
| Standardized Outcome and Assessment Information Set for Home Health Care – OASIS-B | Struyk, Alexandrova, Belyakov, & Chagin, 2006 | Services delivered  
Services quality  
Specific service satisfaction  
General service satisfaction | 35 | N/A | Likert |
| Quality of Care from the Patient’s Perspective (QPP) | Törnkvist, Gardulf, & Strender, 2000 | Medical-technical competence of the care giver  
The physical-technical conditions of the care organization  
The degree of identity orientation in the attitudes & actions of the care givers  
The socio-cultural atmosphere of the care organization | 34 | N/A | Likert |
| The Home Care Client Satisfaction Instrument (HCCSI-R) | Westra et al., 1995 | Uni-dimensional scale | 12 | $\alpha = .93$ | Likert |
| N/A | Wilson, Wynn, & Parker, 2002 | N/A | 14 | N/A | Scale |
Figure 1. The 9-point SAM scale. (5- and 7-point scales also exist.)