Abstract

Aim To compare the satisfaction levels of patients and carers with a community night nursing service.

Method Thirty seven patients and 23 carers completed satisfaction postal questionnaires. Respondents were further subdivided into acute, chronic and terminally ill patients and their carers.

Results Satisfaction levels with the service were generally high, although respondents from the terminally ill group showed the lowest levels of satisfaction overall. The Kruskal-Wallis test showed that results between the groups were not significantly different (Chi-square (x2) test = 3.52; df = 2; P = 0.172).

Conclusion Although the results demonstrated positive levels of satisfaction with the community night nursing service, there were some respondents who indicated a low level of satisfaction. This could be explained by patients’ and carers’ lack of autonomy and inadequate provision of psychological care.

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Keywords

Carers; Community nursing; Patient satisfaction

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Satisfaction levels with a community night nursing service


Henwood (1998) argued that daytime-only services were unable to deliver effective primary and community health care. McWalters (1999) suggested that patients often felt most vulnerable and in need of support during the out-of-hours period. Informal carers are often the main caregivers in the community. It has been shown that they appreciate the service of community night nurses (Maggs and Rapport 1994), but often have different priorities and may express different views on the service compared to patients (Ong 1991).

To establish whether the current service provided by a community night nursing service was meeting the needs of patients and carers, the present study focused on the satisfaction levels of these two groups. The patient group was then further subdivided into three groups: acute, chronic and terminally ill patients, which allowed some comparison of satisfaction levels between groups.

Literature review

A review of the literature showed that generally home care was the preferred option for most patients, although there was recognition that in some cases it failed to prevent readmission to hospital, for example, in patients with chronic obstructive pulmonary disease (Hermiz et al 2002).

A post-bereavement survey of 229 people who registered the death of a patient with cancer in an inner London health authority showed that only one fifth of patients (48, 21%) died at home. Despite expressing a preference for a home death, only 58% (132) of people achieved this (Karlsen and Addington-Hall 1999). However, it is recognised that the factors influencing the place of death for cancer patients are complex and relate to support at home, risk assessment and proper support and training for practitioners (Gomes and Higginson 2006).
Older people may also be faced with the decision of home care or supported care. Factors relating to increasing co-morbidities and dependence underpin the decision as to whether older patients will have the option to stay in their own home (Gott et al 2004).

Confidence and trust in healthcare professionals may often be crucial factors in successful home care. There is evidence that out-of-hours community nursing is appreciated (Maggs and Rapport 1994, Poulton 1996), but alternative ways of providing care in the out-of-hours period have also been successful (Marklund et al 1991, Legge 1998). However, establishing whether patients have confidence in the service provided can be difficult, as patients may often be reluctant to criticise a service on which they are reliant (King 1998).

In an overstretched, out-of-hours service, tension between organisational demands and patient needs can occur (Ong 1991). Service providers have shown a great deal of interest in alternative ways of providing care. Telephone advice has been well established in areas outside the UK for many years (Christensen and Olesen 1998) and in the UK, nurse-led telephone consultation has reduced GPs’ overall workload by 50% (Lattimer et al 1998). When planning service provision it is important that the needs of patients are at the forefront and for some telephone advice may not meet their needs.

There is little evidence in the literature of patient satisfaction relating to out-of-hours nursing care but patients in a large GP co-operative showed the highest levels of satisfaction with a home visit compared to telephone advice (Moll van Charante et al 2006). An out-of-hours telephone service can meet the needs of patients and carers in some areas, if structured appropriately, as was shown by an innovative out-of-hours telephone service led by hospice nurses. Senior palliative care nurses were provided with access to patients’ medical details and current medications with patients’ consent and were then able to offer patients and carers out-of-hours telephone advice and support (Campbell et al 2005).

The use of patient satisfaction surveys to provide healthcare professionals with information relating to out-of-hours primary care has been found to be useful (Salisbury et al 2005, Moll van Charante et al 2006).

Method

This was a retrospective study of patients and carers who had previously received care but were not currently on the community night nursing service caseload.

Postal questionnaires were selected as the most appropriate method of data collection, because a large number of patients could be contacted. The questionnaires were anonymous, which meant that patients were more likely to be critical of the service. Respondents were asked to indicate whether they were the patient or carer.

Sample

A convenience sample of patients was restricted to those who had received care from the community night nursing service during the previous 12-month period. The selection of patients who had received care before this period may have resulted in inaccuracies, because patients may have had less recall of the details of care (McKinley et al 1997). The inclusion criteria consisted of acute, chronic and terminally ill patients visited over a 12-month period and all age groups were included. Carers of any patient who had died in the previous three-month period were excluded. This exclusion criterion was based on previous research which had suggested that this was a reasonable exclusion time (Cusick 1998).

Patients’ addresses were obtained from the community night nurses caseload and consisted of the last 100 patients visited by the community night nursing service. Thirty three questionnaires were sent to the acute and chronic group and 34 questionnaires were sent to the terminally ill group.

Patients in the acute group included all those who had received between one and three visits from the community night nursing service, which was based on criteria used in the community nursing statistical returns. Patients in the chronic group had received more than three visits from the night nursing service. Terminally ill patients included all patients who had received a diagnosis of terminal illness. Patients in the terminally ill group may have received between one and many visits from the community night nursing service.

Questionnaire design

The use of satisfaction surveys to establish levels of satisfaction with community nursing has been successful in many areas, with response rates from patients generally high (Maggs and Rapport 1994, McColl et al 1996). The use of stamped addressed envelopes and designing questionnaires that were likely to be of interest to respondents were aids to achieving higher response rates (Edwards et al 2002).

A questionnaire was designed which included a 14-item satisfaction scale adapted from a design by McKinley et al (1997) (Figure 1). The study examined satisfaction levels with out-of-hours care provided by GPs. It demonstrated internal reliability with Cronbach’s alpha coefficients greater than 0.60 for all scales and the test and retest scores were also highly correlated.
There did not appear to be any out-of-hours, nursing-based satisfaction questionnaires in the literature and it was believed that McKinley et al’s (1997) questionnaire could be adapted to capture some of the essential elements of patient satisfaction required for the study. McKinley et al (1997) used a bank of questions to produce multi-item scales as part of their questionnaire design. The use of multi-item scales has been shown to be more reliable than single questions (Ware et al 1978).

As one of the aims of the study was to compare satisfaction levels between all the groups surveyed, it was felt that a closed format questionnaire would be most appropriate in terms of analysis. Some space was left, however, to allow respondents to comment on issues relating to their care. The use of qualitative comments helped to test the validity of the psychometric measures of satisfaction.

Pilot study A small pilot study was conducted with three patients and two carers and although overall the questionnaire appeared satisfactory, there was some confusion over the term ‘community nurses’. The questionnaire was changed to ensure clarity and ‘community night nurses’ was the term used on all subsequent questionnaires.

Sampling procedure There was an absence of a central database to provide the sampling frame. Each questionnaire was therefore coded manually: acute = a, chronic = c, and terminal = t.

Reminder letters were sent out if the questionnaires had not been returned within four weeks of the initial posting.

Data analysis Patients’ and carers’ responses in

<table>
<thead>
<tr>
<th>Patient and carer questionnaire</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly agree</th>
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<tbody>
<tr>
<td>1. There is generally no difficulty in contacting the night nursing service via the telephone</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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<td>2. The person who answered the telephone at night gave all the necessary advice</td>
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<td>3. I am totally satisfied with the information the night nurse gave me regarding my care</td>
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<td>4. The arrangements for contacting the community night nursing service could be improved</td>
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<td>5. The night nurse gave me clear advice about where to get more help if required</td>
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<td>6. The nurse appeared reluctant to visit on certain occasions during the night</td>
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<td>7. I would have liked the night nurse to tell me a little more about my care</td>
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<td>8. It was easy to get advice from the nurse on the telephone during the night</td>
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<td>9. Overall, I was happy with the care I received from the night nursing service</td>
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<td>10. My needs were completely met by the night nursing service</td>
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<tr>
<td>11. The night nurse appeared happy to call when I needed her</td>
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<td>12. I was generally happy with the time the nurse arrived</td>
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<tr>
<td>13. I would have preferred the nurse to come at the appointed time during the night</td>
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<tr>
<td>14. I think the nurse was a little rushed at times</td>
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</tbody>
</table>

Thank you for completing this questionnaire. If there are any comments you would like to include, please do so in the following space (continue on the back if necessary).

(Questionnaire reproduced and adapted with kind permission of BMJ Publishing Group Ltd)
the three groups were calculated separately, to establish whether there was a difference between the levels of satisfaction in the groups. A reverse item technique was used, which included a mix of negative and positive statements, and contributed to the validity of the responses and reduced the risk of acquiescent response sets. Stencil scoring was felt to be the most appropriate method of analysis for this type of technique. To analyse the data in this way, a stencil is placed over the completed questionnaires, which enables the analyst to check whether a strongly agree response in a positive statement would equate with a strongly disagree response in a negative statement.

Acquiescent responses can account for upward bias in satisfaction scores computed from favourably worded questions, that is, positive statements, and downward bias in satisfaction scores computed from unfavourably worded questions, that is, negative statements. Total scores for each group were analysed by use of the Kruskal-Wallis test to determine if there were any statistical differences between the groups.

**Ethical permission**

Ethical permission was granted by the local research ethics committee. The committee concluded that the study was a form of audit and no ethical permission was required. Permission to conduct the survey was granted by the researcher’s line manager. A letter was sent to all respondents detailing the study. Respondents were reassured that all information received was anonymous and that completion of the questionnaires was voluntary. Demographic data were not included in the questionnaire design.

**Results**

The main findings showed positive levels of satisfaction with the community night nursing service in both the patient and carer groups (Figure 2). A total of 60 questionnaires was returned, giving a response rate of 90%. Table 1 shows the individual responses for all groups.

Patients in the terminally ill group showed the lowest level of satisfaction with the service. This was in contrast to the carers of terminally ill patients who showed high levels of satisfaction for all items.

Areas that showed the lowest level of satisfaction were related to nurses not arriving within an agreed or usual time period. In contrast, high levels of satisfaction were shown for the time nurses spent with patients, although some comments appeared to contradict these findings. Cronbach’s alpha was conducted on the total satisfaction score showing moderately high internal reliability (alpha = 0.56), but it did not have enough internal coherence to analyse the survey as a whole, so the survey was broken down into subscales.

There was a difference in the mean satisfaction scores for the three different groups, although it was small (Table 2).

Results for each specific area provide more detailed information on the items that individual groups responded to and are divided into four main areas:

- Access to out-of-hours’ care and telephone advice.
- Communication and management.
- Perception of nurses’ attitude and delay until visit.
- Overall satisfaction with the community night nursing service.

**Access to out-of-hours’ care and telephone advice** Satisfaction with accessing out-of-hours care was higher among the carers when compared to the patients, especially in the chronic and terminally ill groups. There was a significant difference in the mean satisfaction scores for out-of-hours care between the three groups, with the terminally ill group showing the lowest level of satisfaction.

**Communication and management** Satisfaction with communication between nurses and patients was generally high, with patients and carers reporting that nurses communicated effectively and provided clear information. However, there was a slight decrease in satisfaction among the terminally ill group, particularly in the area of timely response to questions and concerns.

**Perception of nurses’ attitude and delay until visit** Patients and carers generally reported that nurses were supportive and understanding, with the chronic and terminally ill groups showing slightly higher levels of satisfaction. There was a significant difference in the mean satisfaction scores for nurses’ attitude and delay until visit between the three groups, with the terminally ill group showing the lowest level of satisfaction.

**Overall satisfaction with the community night nursing service** Overall satisfaction was highest among the chronic group, followed by the acute and terminally ill groups. The mean satisfaction scores for the three groups are shown in Table 2.

![FIGURE 2](image-url)
care and telephone advice was generally positive (Table 3). However, it was disappointing that patients in the terminally ill group showed negative levels of satisfaction, particularly with the telephone advice given by nurses. Comments also suggested a lengthy process before patients were able to gain access to healthcare professionals:

‘The phone could be ringing for ten minutes before anyone answered’ (carer of patient in chronically ill group aged 78 years).

‘Once you had given all the information to one person, you had to wait for the nurse to ring you back and that could take ages’ (patient in acutely ill group aged 54 years).

**Communication and management** This area of satisfaction related to the information-giving process. All respondents demonstrated high satisfaction scores, except patients in the terminally ill group. This was in marked contrast to the carers of this group who showed high satisfaction.

Comments from the patient group suggested that:

‘Nurses did not always have time to talk’ (patient in terminally ill group aged 79 years), whereas carers commented that: ‘It was very helpful to have someone to talk to, especially in the middle of the night’ (carer of patient in terminally ill group aged 52 years).

**Perception of nurses’ attitudes and delay until visit** Perception of the nurse’s attitude related to whether the nurse appeared reluctant to visit and whether she appeared ‘rushed’ during the visit. Satisfaction levels in this area for all groups were generally positive (Figure 3).

Patients in the terminally ill group were, however, least satisfied with the nurse’s attitude. Although both patients in the chronically ill group and their carers had shown high satisfaction levels with nurses’ attitudes, some comments suggested that there was less satisfaction. One patient in the chronically ill group stated that:

‘I was made to feel guilty for calling out the community nurses’ (patient in chronically ill group aged 77 years).

Two carers in the chronically ill group also commented on the large area the community night nurses needed to work.

One patient in the chronically ill group stated:

‘I worry when the nurses are late because of [the] danger of working in the dark in this area’ (carer of patient in chronically ill group aged 76 years).

**Overall satisfaction with community night nursing service** This area related to overall satisfaction with the community night nursing service. Again patients from the terminally ill group indicated the lowest score, although results showed that all groups demonstrated positive levels of satisfaction overall. Comments provided some further insight into the feelings of patients and carers. One respondent from the acute group did not think the community night nursing team was the most appropriate service to meet her needs. She had been unhappy that she had not received a visit from the GP, despite stating that the nurse had dealt with her problem adequately.

It appeared that respondents valued the familiarity and the relationship they had developed with nurses, as particularly in the

### TABLE 3

<table>
<thead>
<tr>
<th></th>
<th>Acute</th>
<th>Chronic</th>
<th>Terminal</th>
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<tbody>
<tr>
<td>Patients</td>
<td>77</td>
<td>11.4</td>
<td>5.8</td>
</tr>
<tr>
<td>Carers</td>
<td>75</td>
<td>6.4</td>
<td>8.2</td>
</tr>
</tbody>
</table>

(Neutral score 6)

![Graph showing satisfaction levels regarding perception of nurses' attitude](image)

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chronic group, patients and carers had stated they were unhappy with the use of unfamiliar nurses. Two of the patients from the chronic group stated that they could not cope without the service and two carers from this group also stated that visits from the community night nursing team ensured that their dependants could be nursed at home. Two responses from carers of patients in the terminally ill group suggested that without the support of the night nursing team they would not have been able to cope.

Response of the patient to the service.

‘We had so much support during the day but it was very frightening during the night, as my husband was in so much pain. If it had not been for the girls visiting during the night, I could not have coped’ (carer of patient in terminally ill group aged 54 years).

Discussion

The survey was relatively small. Satisfaction survey scales were moderately reliable but correlation between items was not high. This was possibly as a result of the relatively small number of items included in the scale. A larger scale may have provided a wider picture of elements of satisfaction and dissatisfaction.

There was an unequal group division between patients and carers in all groups. For example, there were five carers in the chronic group compared to 14 patients in the same group. A problem was also noted in group selection. In the acute and chronic groups selection was relatively simple, as acute patients had received between one and three visits from the community night nursing service and patients in the chronic group had received more than three visits from the service. However, there was difficulty in the categorisation of the terminally ill group where the diagnosis of terminal illness was used as a category. The number of visits was not categorised and this may have affected their satisfaction scores.

As this was a retrospective study all data collected were based on recall and could not be guaranteed to provide an accurate representation of the satisfaction levels of all groups. An attempt was made to minimise this limitation, by only including patients and carers who had been service users in the previous 12-month period.

There are also many other factors that affected the results. The study included patients who were in various stages of illness and it is therefore difficult to make an accurate comparison between groups. Patients with a terminal illness were much less likely to be satisfied than, for example, a patient from the acute group who may have been visited for a simple wound dressing.

The main aim of this study was to examine whether users of the community night nursing service were satisfied with the service received.

Patients’ and carers’ overall satisfaction with nursing care was generally high. However, examining individual items on the satisfaction scale made it possible to identify those aspects of nursing that patients and carers were most or least satisfied with. Some comments suggested that without the provision of a community night nursing service, it would have been more difficult for patients to stay at home. This is a view shared by others as home care is often only a viable option for patients and carers if they are given 24-hour support (Murashima et al 1998).

Access to out-of-hours care showed varying levels of satisfaction and patients and carers commented on the delay sometimes experienced before they could access a nurse. Patients and carers often have difficulty deciding whether to call out-of-hours services, as a result of legitimacy of need (Worth et al 2006), which will be compounded by problems with access and may result in patients and carers not receiving the service to which they are entitled. During the period of this study, there had been many changes to the telephone control centre and problems had been experienced with messages not being relayed or a delay between the control centre receiving the message and the time it took to pass this message to the nurse. Incident reporting and meetings with the control centre personnel eventually resolved initial problems and communication improved.

Timing of calls, particularly for the carers of patients in the acutely ill group, was another area of dissatisfaction. It was interesting to note that although some respondents were unhappy with the uncertainty of visiting times, rather than suggest that the nurse was at fault, other factors were identified as causing the problem. For example, the large distances the nurses needed to travel.

Respondents appeared to show concern that nurses were working in adverse weather conditions and that night-time working could be potentially dangerous. These responses were mainly from the patients and carers of the chronically ill group, suggesting that nurses may have developed a relationship with this group over time and were confident to discuss their reasons for delay.

Although patients and carers generally indicated high satisfaction levels in relation to the time nurses spent with patients, some comments suggested otherwise. Responses from patients suggested that they were ‘made to feel guilty’ if they needed extra time and the nurse appeared ‘rushed’. An explanation for this may
be the task-orientated approach nurses may need to adopt to adhere to the Patient’s Charter (Department of Health 1996). One of the core recommendations of the charter is that patients are promised visits within one hour of appointment time. This could be particularly difficult for community night nurses, as a result of the large catchment areas. A task-orientated approach enables nurses to achieve this outcome but does not necessarily allow the best service for patients and may damage the elements of holistic care valued by patients.

In this study it was found that terminally ill patients showed the least satisfaction overall with the community nursing service. This appears to contradict earlier work showing that terminally ill patients rate nurses highly (Ong 1991, Poulton 1996). One possible explanation for these results is that nurses may often concentrate on the physical aspects of terminal care to the detriment of psychological aspects (Mcilfatrick and Curran 2001).

Communication skills are a vital aspect of nursing care but it appears that for some patients, nurses had not demonstrated a high degree of skill in this area. Lack of communication skills in the community nursing service generally may result from a lack of specialist training (Atkinson et al 1996).

The terminally ill patients in this study commented that nurses did not seem to have time to talk, but conversely the carers of terminally ill patients rated the community night nursing service highly. The apparent disparity between these results may be as a result of the amount of support required from the nursing service for carers of terminally ill patients during out of hours, as generally there is little support available elsewhere. Often the only contact the carer will have during this period is with the community night nursing service. Conversations are often sensitive and related to the diagnosis and prognosis of the patient. These interactions with carers provide them with the opportunity to talk without interruptions but may take place away from the patient’s bedside. This can further heighten the patient’s sense of isolation. More research is needed on how best to adopt strategies that allow patients and carers in the community opportunities to discuss issues and worries relating to their diagnosis and prognosis.

Low satisfaction scores by the acutely ill group relating to timing of calls were difficult to explain. Poor hospital discharges may have contributed to this as it is possible that many of the patients in this group would have been discharged recently, although no data were available to substantiate this theory. Poor hospital discharge has been proven to accentuate feelings of fear and isolation (Faugier and Greenwood 1993). It is also possible that nursing teams may be delayed if it was necessary to collect equipment that had not been provided on discharge.

Overall, satisfaction levels in the carer group were higher than the patient group. This contradicts earlier work that suggested carers may show lower levels of satisfaction than patients as they may feel more comfortable being critical of a service on which they are less dependent (King 1998). Items of dissatisfaction mainly related to the use of unfamiliar nurses and the delay in visiting times. These issues may be outside the individual nurse’s control, but would need to be highlighted as areas of concern to managers and those involved in the provision of community nursing services.

Communication showed the least satisfaction overall and problems relating to poor communication skills were highlighted many times throughout the study, especially in the area of telephone advice. Telephone advice requires particular skills to allow for accurate assessment (South Wiltshire Out of Hours Project (SWOOP) Group 1997).

Many (n=49) of the respondents were aged over 65 years. Evidence demonstrates that with increasing age there is a strong and significant bias toward higher levels of expressed satisfaction with health care (Steptoe et al 1991). This may explain the high level of satisfaction shown towards the community night nursing service. Traditionally there has been a tendency for older people to have an increased reliance on the community nursing service, as they are more likely to experience ill health than a younger age group (Bigot 1974).

Conclusion

Although overall, results demonstrated positive satisfaction with the community night nursing service, it is important to remember that there was a marked difference in the levels of satisfaction shown. Terminally ill patients in particular indicated the lowest level of satisfaction. Lack of autonomy and inadequate provision of psychological care were possible reasons for this lack of satisfaction. Caring for the physical aspects of a patient with a terminal illness should never be undervalued but it is important that community nurses work together with palliative care specialists and other professionals to provide a multidisciplinary approach to terminal care. This should encompass improvement in communication skills, as problems relating to communication skill were a continuing theme throughout the study.
Further work concentrating on reasons for dissatisfaction, particularly in the group of terminally ill patients, may provide solutions to improve the service for this particular group of patients NS

Acknowledgement
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References


McWalters M (1999) All day, and all of the night. Nursing Times. 95, 21, 28-29.


