Patient’s satisfaction with perioperative care: development, validation, and application of a questionnaire

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Background. Measuring patient satisfaction after anaesthesia care is complex. The existing patient satisfaction questionnaires are limited and omit aspects of patient satisfaction, such as professional competence, information provision, service, and staff–patient relationship. The aim of our study was to develop a valid and reliable self-reported multidimensional questionnaire assessing patient satisfaction that included these issues.

Methods. The development of the Leiden Perioperative care Patient Satisfaction questionnaire (LPPSq) was as follows: expert consultation, construction of the pilot questionnaire, pilot study, statistical analysis of the results of the pilot study (validity, reliability, and factor analysis), compilation of the definitive questionnaire, main study, and repeated statistical analysis (validity, reliability, and factor analysis). The overall patient satisfaction is expressed by the mean satisfaction score.

Results. Three hundred and eighty-two patients consented to participate in the study; 80.4% of the patients (n=307) completed the questionnaire. The LPPSq isolated three dimensions: information (Cronbach’s α=0.82), fear and concern (Cronbach’s α=0.69), and staff–patient relationship (Cronbach’s α=0.94). Patient satisfaction with perioperative care was not directly dependent on the outcomes of anaesthesia but how patients were approached and the amount of information they received. Age (P=0.001), gender (P=0.001), work situation (P=0.003), and specialty (P=0.017) were the characteristics most influencing patient satisfaction.

Conclusions. We developed the LPPSq questionnaire to measure patient satisfaction with perioperative care, of which anaesthesia care is an important element. In this study, information provision and the relationship between staff and patient were the major determinants of patient satisfaction.

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Patient satisfaction is a subjective and complex concept, involving physical, emotional, mental, social, and cultural factors. It is determined by the quality of the provided care and the patient’s expectations of that care. Dissatisfaction arises if the patient experiences a discrepancy between expected and provided care. Patient satisfaction with pre- and perioperative anaesthesia care is difficult to measure. A few validated anaesthesia-related questionnaires have been reported in the literature. These questionnaires are difficult to compare because of differences in aspects of patient satisfaction measured. Aspects mentioned are information, adverse anaesthesia outcomes, anxiety, organization of postponed surgery, and contact with the anaesthetist, respect, and confidence. None of the published questionnaires combines these dimensions in one questionnaire, and patient satisfaction questionnaires could be improved by combining these items. The aim of our study was to develop a valid and reliable self-reported multidimensional questionnaire assessing patient satisfaction with perioperative and anaesthesia care that included questions about information, professional competence, service, and staff–patient relationship. To this end,
we took the ‘l’échelle de vecu pérïopératoire de l’anesthésie’ (EVAN) questionnaire of Auquier and colleagues as a starting point to develop a new questionnaire.

Methods

Questionnaire development

Approval from the medical ethics committee was obtained for this study. Informed consent was obtained from all patients who participated.

The EVAN questionnaire includes six dimensions. These are anxiety, embarrassment, fear, pain-discomfort, information, and physical needs. We expanded the ‘information’ dimension of EVAN by asking questions about information given about the operation and operating theatre, and satisfaction about the amount of information given. Heidegger and colleagues concluded that a questionnaire for the assessment of patient satisfaction should include patient information, patient involvement in decision-making, and contact with the anaesthetist, confidence, and respect. We incorporated these items in our dimension staff–patient relationship.

We asked six experts (two anaesthetists, two psychologists, and two researchers) for feedback on the first version of our questionnaire which included 42 questions. We also carried out a pilot study of 50 patients to examine face and content validities and test the comprehensibility and feasibility of the questionnaire. In an open-ended question at the end of the questionnaire, patients were asked to give their supplementary comments or mention the important issues missed in the questionnaire. Questions with a response rate lower than 85% were reconsidered and rewritten to improve face validity, resulting in a final 39 questions. On the basis of the findings of the pilot study, the initial questionnaire was modified to give the Leiden Perioperative care Patient Satisfaction questionnaire (LPPSq) examined in this study.

Patients were asked to score each question on a five-point Likert-type scale. A Likert scale consists of several declarative items that express a viewpoint on a topic. Respondents can indicate the degree to which they agree or disagree with the opinion expressed by the statement. For information provision and staff–patient relationship, the scales ranged from 1, completely dissatisfied, to 5, completely satisfied. For ‘discomfort and needs’ and ‘fear and concern’, the scales ranged from 1, not at all, to 5, extremely.

The LPPSq includes questions, divided over the dimensions: information (four questions), professional competence with discomfort and needs (seven questions), and fear and concern (seven questions), and staff–patient relationship (14 questions). Four additional questions about professional competence explored the way the professionals dealt with problems. Finally, three questions were directed at the dimension ‘service’. In total, the questionnaire comprised 39 questions. This questionnaire is given in the Appendix.

Recruitment of the patients occurred before operation on the outpatient anaesthesiology ward. Patients gave written informed consent after an explanation of the study requirements and assurance of confidentiality and anonymity. Inclusion criteria for the study were: age ≥18; a stay of >24 h on a surgical ward; understanding the Dutch language; and the ability to complete a questionnaire within 2 days of the operation. Patients unable to read and write in Dutch, sedated after operation, expected to go to the intensive care unit, or not able to complete the questionnaire by themselves were excluded from the study. The questionnaire and the reply envelope were given to the patients after the operation and completed during their stay on the ward within 2 days of surgery.

Statistical analysis

Data were analysed with SPSS 12.0 for Windows. Exploratory factor analysis was used to assess the underlying factor structure of the questionnaire. Reliability was assessed by Cronbach’s α, inter-item correlation, and item-discriminant validity. By definition, a Cronbach’s α from 0.61 to 0.80 represents a substantial correlation, and from 0.81 to 1.00 a good correlation. The inter-item correlation describes the Spearman rank correlation between items scores and their dimension score. Each item should be correlated with their own dimension at or above 0.40. A correlation below 0.30 is usually considered unacceptable. The item-discriminant validity describes the Spearman rank correlation between item scores of a given dimension with the other dimensions. Items should have a higher correlation with their own dimension than with other dimensions.

The occurrence and severity of adverse anaesthesia outcomes (postoperative pain, sore throat, back pain, vomiting, cold, hunger, and thirst) were calculated as well as their prevalences. The Kruskal–Wallis test was used to examine the association between outcomes, type of anaesthesia, and the prevalence of undesirable anaesthesia outcomes and surgical procedure. P ≤0.05 was considered statistically significant. Spearman rank correlations were calculated for the adverse anaesthesia outcomes and the dimensions of the LPPSq.

The patient satisfaction with perioperative care is represented by the mean satisfaction scores in each dimension. To compare patient satisfaction within the scale dimensions and for the total LPPSq, the percentages of the maximal possible satisfaction scores were calculated. The overall patient satisfaction score (LPPSq score) was compared with patient characteristics (gender, age, and work situation) and clinical features (surgical procedure, specialty, earlier operated, and type of anaesthesia) using independent sample t-tests or ANOVA as appropriate.
A $P$-value of $\leq 0.05$ was considered statistically significant.

**Results**

**Population characteristics**

Four hundred and seventy-one patients were asked to participate in the study, of whom 382 patients gave their consent. Finally, 307 patients completed the questionnaire within 2 days, a response rate of 80.4%.

These patients underwent a wide range of surgical procedures: 95 general surgical (30.9%), 82 gynaecological (26.7%), 73 orthopaedic (23.8%), 43 urological (14.0%), 10 obstetric (3.3%), and 4 plastic surgical (1.3%). The mean patient age was 51.7 yr (range: 18–81 yr), 103 of the patients (33.6%) were male, 256 patients (83.4%) had previous operations, 253 patients (83.5%) had general anaesthesia or general combined with regional anaesthesia, and 120 patients (39.1%) underwent a major surgical procedure. A major surgical procedure was defined as one of the following: an operation lasting more than 4 h, expected blood loss of more than 1000 ml, or a major orthopaedic, urologic, or intraperitoneal operation. Non-responders included patients who returned empty questionnaires (10.6%) or patients did not meet the inclusion criteria (8.9%) due to an unexpected stay on the intensive care unit (4.7%), a stay shorter than 24 h in the hospital (2.4%), or because the planned operation was cancelled (1.8%).

**Reliability**

Table 1 shows the reliability estimates for the dimensions information, fear and concern, staff–patient relationship, and the total LPPSq. Cronbach’s $\alpha$ for the scale dimensions ranged from 0.69 to 0.94 and was 0.90 for the total LPPSq. Correlations between the items and their dimensions, the inter-item correlation, ranged from 0.53 to 0.83.

Deleting the items: ‘To which degree were you afraid of not awaking after the operation? Are you afraid of mistakes by the surgeon? Are you afraid of mistakes by the anaesthetist?’ and the item: ‘To which degree did staff of the Operating Theatre Centre take into account your cultural background’ increased the reliability, and therefore these were excluded from the final questionnaire.

The internal consistency for the dimension discomfort and needs was low (Cronbach’s $\alpha = 0.33$). The items of the dimension discomfort and needs are not related to each other, but measure undesirable outcomes of anaesthesia care. Therefore, these items were measured as individual aspects.

**Validity**

An exploratory factor analysis was conducted, loading on the dimensions using principal components extraction with Varimax rotation. The analysis revealed a solution with three factors explaining 60% of the total variance (Table 2). These factors were named according to the aspects of patient satisfaction, they reflected: information (four items), fear and concern (four items), and staff–patient relationship (13 items). On the basis of these findings, our final questionnaire includes 21 items within the dimensions information, fear and concern, staff–patient relationship, and the questions are grouped under these headings on the questionnaire in the Appendix. An additional seven items that register undesirable outcomes of anaesthesia care are included in the questionnaire under the heading ‘Service’. This final questionnaire is given in bold in the Appendix.

**Patient satisfaction: experiences of surgical patients**

Patient satisfaction with perioperative care was expressed by the mean satisfaction scores and the percentage of the maximum possible scores for each dimension and total LPPSq score (Table 1). The lowest percentage patient satisfaction score was for information (85.6%) and the

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Number of items within the dimension</th>
<th>Cronbach’s $\alpha$ coefficient for dimension</th>
<th>Mean dimension score (SD)</th>
<th>Maximum possible dimension score</th>
<th>% Satisfaction score</th>
<th>Inter-item correlation (IIC)</th>
<th>Item-discriminant validity (IDV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>4</td>
<td>0.82</td>
<td>17.1 (2.13)</td>
<td>20</td>
<td>85.6</td>
<td>0.70–0.80*</td>
<td>0.06–0.51*</td>
</tr>
<tr>
<td>Fear and concern</td>
<td>4</td>
<td>0.69</td>
<td>18.7 (2.15)</td>
<td>20</td>
<td>93.3</td>
<td>0.53–0.72*</td>
<td>0.05–0.50*</td>
</tr>
<tr>
<td>Staff–patient relationship</td>
<td>13</td>
<td>0.94</td>
<td>60.7 (5.60)</td>
<td>65</td>
<td>93.4</td>
<td>0.64–0.83*</td>
<td>0.05–0.42*</td>
</tr>
<tr>
<td>LPPSq</td>
<td>21</td>
<td>0.90</td>
<td>96.8 (7.29)</td>
<td>105</td>
<td>92.1</td>
<td>†</td>
<td>†</td>
</tr>
</tbody>
</table>
highest was for staff–patient relationship (93.4%), resulting in a good rating of the overall patient satisfaction of the perioperative care with an LPPSq score of 92.1%.

Of the different items of the original discomfort and needs scale, the median score was 2 for postoperative pain and thirst (Table 3). Patients had few complaints of sore throat, back pain, vomiting, cold, and hunger after the operation. Postoperative pain was reported by 69.4% of the patients; 28.8% reporting quite a bit to extreme pain. There was a significant difference in postoperative pain between types of anaesthesia (P < 0.001). Quite a bit to extreme pain was experienced by more patients who had general anaesthesia compared with regional anaesthesia and the combination of general and regional anaesthesia (37.7% vs 8.6% vs 23.0%).

A significant difference in feeling cold after surgery was reported between minor and major surgical procedures (39.1% vs 49.1%; Mann–Whitney U-test P = 0.05). There were no significant differences between the other aspects of discomfort and needs and surgical procedure.

No correlation existed between the occurrence of undesirable outcomes of anaesthesia care and the LPPSq. Spearman rank correlation (r

<table>
<thead>
<tr>
<th>Discomfort and needs</th>
<th>n</th>
<th>Prevalence of outcomes ranging from a little bit to extremely</th>
<th>Prevalence of the outcomes quite a bit and extremely</th>
<th>Severity, median (range)</th>
<th>Prevalence of the outcomes quite a bit and extremely by type of anaesthesia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>General anaesthesia</td>
</tr>
</tbody>
</table>

Table 2 Principal component analysis (Varimax rotation) of the 21-item LPPSq. Loadings <0.35 are not reported in the table

Table 3 Prevalence of undesirable anaesthesia outcomes. Severity of the outcomes was graded as 1, not at all; 2, a little bit; 3, moderately; 4, quite a bit; 5, extremely. P-values were determined by the Kruskal–Wallis test
and is predominantly influenced by staff–patient relationship \((r_s=0.47;\ P<0.001)\) and provision of information \((r_s=0.35;\ P<0.001)\). Information and staff–patient relationship were significantly correlated \((r=0.50;\ P<0.001)\).

The minimum LPPSq score is 21 points and maximum 105 points. Women were somewhat less satisfied than men. A mean satisfaction score of 95.7 vs 98.8 \((t\text{-}test;\ P=0.001)\). Patients aged below 50 yr had lower satisfaction scores than older patients (95.1 vs 98.5; \(t\text{-}test;\ P=0.001)\). Also work situation influenced the overall patient satisfaction score (ANOVA; \(P=0.003)\). Patients with paid employment were less satisfied (95.8) vs household duties (96.9) and retired (100.4).

Type of surgery did not influence overall patient satisfaction, but patients undergoing a major surgical procedure were more satisfied with the information supplied (minimum 4–maximum 20) than patients undergoing a minor surgical procedure (17.5 vs 16.9; \(t\text{-}test;\ P=0.025)\). Surgical specialty had an effect on the LPPSq score (ANOVA; \(P=0.017)\). Satisfaction scores ranged from 99.0 for urology to 82.5 for plastic surgery. No significant effects were identified of anaesthesia and information, fear and concern, and staff–patient relationship on LPPSq.

### Discussion

The aim of our study was to develop a valid and reliable questionnaire assessing patient satisfaction with perioperative care, of which anaesthesia care is an important element. Patient satisfaction is frequently studied using rating scales for the global assessment of patient satisfaction. It is difficult for patients to judge the technical quality of care, the outcomes of the technical quality did not influence patient satisfaction scores. Measuring the patient’s experience of care is more complex than seeking an isolated measure of the degree of patient satisfaction.

In the present study, we have developed a patient satisfaction questionnaire that addresses both the patient’s experience of care and patient satisfaction about information, discomfort and needs, fear and concern, and staff–patient relationship.

The items within a questionnaire do not stand by themselves but are related to concepts behind the questionnaires, the so-called scales or dimensions. The validity of the questionnaire is determined by the issues: face validity, content validity, and construct validity. Content validity refers to the degree to which items in an instrument adequately represent the content for the concept being measured. Face and content validities were ensured by expert opinion and the pilot study. Both the opinions of experts and patients are thus important for the development of a patient satisfaction questionnaire. The interaction between the professional and patient influences the expectations of care and thereby patient satisfaction.

Construct validity refers to the degree to which an instrument measures the topic under investigation, that is, does the instrument adequately measure the abstract concept of interest? Construct validity was analysed with principal component analysis to structure the questions in dimensions. Within the LPPSq, three dimensions could be identified: information, fear and concern, and staff–patient relationship.

The reliability of a scale is often expressed by Cronbach’s \(\alpha\), a widely used reliability index that estimates the internal consistency or homogeneity of a measure composed of several subparts. A low coefficient does not necessarily confirm that expected relationships between items do not exist.

The poor Cronbach’s \(\alpha\) of 0.33 for the dimension discomfort and needs indicates that the scale is not homogeneous and may not represent one dimension. The items of discomfort and needs are measuring the existence of undesirable outcomes of anaesthesia care and are relevant to the study. We therefore decided that these items should be measured as individual items. Contrary to our expectations and the study of Auquier and colleagues, we found no relationship between these side-effects of anaesthesia care and the overall patient satisfaction score.

The findings in our study are similar to those on postoperative pain also reported in The Netherlands by Kalkman and colleagues. They found an incidence of 25.8% of severe pain in surgical patients, measured within 1 h after surgery. In our study, the prevalence of severe pain was 28.8% in the recovery room. Kalkman and colleagues observed that the severity of pain was significantly influenced by factors such as age, type of surgery, anxiety level, and need for information, which also influenced patient satisfaction in our study.

To reduce the interference between the patient’s experience between care on the medical ward and perioperative care in the operating theatre centre, the LPPSq was completed within 2 days of operation. Whether the patient is actually able to completely separate the care provided on the ward from the care in the operating room is debatable. In many aspects of care, such as information provision throughout the perioperative process, many factors play a role and complement each other. Thus, ratings of provided perioperative care must be interpreted within the context of all participating parties around the operation.

Our data confirm the findings in the literature that gender, age, and specialty influence patient satisfaction. Older patients, above the age of 50, were more satisfied than younger patients. Men are more satisfied than women with the care provided. Patients who had major surgical procedures were more satisfied with the information supplied. As expected also specialty influences patient satisfaction. Further research is recommended to confirm these differences and investigate the influence of confounding variables on patient satisfaction.
Healthcare professionals may differ to some extent in rating by patients of the services provided.\textsuperscript{15,20} We assume that professionals attach a greater value to technical aspects of the provided care and to outcomes of that care than to the rating of their services. In the present study, patient satisfaction was not directly determined by the immediate outcomes of anaesthesia, such as absence of discomfort and minimal postoperative pain and vomiting. More importantly, the way the health professional acted on these problems influenced their degree of satisfaction. From a patient’s perspective of healthcare, quality is not only determined by the outcome of treatment, but also by the extent to which patients are supported during their hospital stay.\textsuperscript{21,22}

Asking for indications of discomfort and needs after a surgical procedure is important, but the results are not reliable indicators of measuring patient satisfaction as the patient may have other, psychological needs that have to be addressed. The literature underscores the importance of issues representing information and communication in relation to patient satisfaction.\textsuperscript{15,20,22,23} In this study, we found that better informed patients also ranked staff–patient relationship higher. Combining these observations, we conclude that information provision and staff–patient relationship are the major determinants for patient satisfaction with perioperative care. Our findings are in agreement with those of Heidegger and colleagues,\textsuperscript{4} who concluded that a questionnaire for the assessment of patient satisfaction should contain areas such as patient information, patient approach in decision-making, and contact with the anaesthetist, confidence, and respect. Kuprat and colleagues\textsuperscript{24} found that the discrepancy between patient and practitioner beliefs about care is an important determinant of trust and satisfaction. Involving patients in the decision-making process results in higher satisfaction with care.\textsuperscript{23}

Integrating patients’ satisfaction in the decision-making process should be an integral part of continuous quality improvement in anaesthesia care.\textsuperscript{1} Our study confirms that quality of anaesthesia care is not only composed of good information and communication skills but also how the health professional acts or behaves towards the patient. We believe that once the patient has good reason to assume that the best possible care is provided, that patient satisfaction is largely based on good patient information and the staff–patient relationship.

### Appendix

The Leiden Perioperative care Patient Satisfaction questionnaire (LPPSq). Translated from Dutch to English. The questions as described in this appendix were asked to the patients in the Dutch language. The questions in bold are included in the final questionnaire after reliability and validity analysis.

<table>
<thead>
<tr>
<th>Information</th>
<th>Completely dissatisfied</th>
<th>Dissatisfied</th>
<th>Not satisfied, nor dissatisfied</th>
<th>Satisfied</th>
<th>Completely satisfied</th>
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</thead>
<tbody>
<tr>
<td>To what degree were you satisfied about . . .</td>
<td></td>
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</tr>
<tr>
<td>1. The explanation about the operation?</td>
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<td></td>
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<tr>
<td>2. The amount of information about the operation?</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The explanation about your stay at the operating theatre centre?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The amount of information about your stay at the operating theatre centre?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discomfort and needs</td>
<td>Not at all</td>
<td>A little bit</td>
<td>Moderately</td>
<td>Quite a bit</td>
<td>Extremely</td>
</tr>
<tr>
<td>To what degree did you after the operation have . . .</td>
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<tr>
<td>1. Postoperative pain?</td>
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<tr>
<td>2. A sore throat?</td>
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<tr>
<td>3. Back pain?</td>
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<tr>
<td>4. Vomiting?</td>
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<tr>
<td>5. Cold?</td>
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<td></td>
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<tr>
<td>6. Hunger?</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Thirst?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear and concern</td>
<td>Not at all</td>
<td>A little bit</td>
<td>Moderately</td>
<td>Quite a bit</td>
<td>Extremely</td>
</tr>
<tr>
<td>To what degree were you afraid of . . .</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1. Not awaking after the operation?</td>
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<tr>
<td>2. Awaking during the operation?</td>
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<tr>
<td>3. Seeing the operating room?</td>
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<td></td>
<td></td>
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<tr>
<td>4. Pain due to the surgeon?</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Mistakes by the surgeon?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Pain due to the anaesthetist?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Mistakes by the anaesthetist?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Was the staff attentive to your needs?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Did they act according to your needs?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Satisfaction with perioperative care

3. Did they consult another health professional?
1. To what degree did you experience professional competence?
- Yes
- No

Staff–patient relationship

To what degree...
1. Did the staff of the operating theatre centre take into account your privacy?
2. Did you have confidence in the staff of the operating theatre centre?
3. Had the staff of the operating theatre centre an open attitude?
4. Were staff of the operating theatre centre respectful?
5. Did staff of the operating theatre centre show understanding for your situation?
6. Were staff of the operating theatre centre polite?
7. Did you find the staff of the operating theatre centre professional?
8. Did staff of the operating theatre centre pay attention to your complaints like pain and nausea?
9. Did staff of the operating theatre centre pay attention to your professional opinion?
10. Did staff of the operating theatre centre pay attention to your personnel preferences?
11. Did you find the staff of the operating theatre centre knowledgeable?
12. Did staff of the operating theatre centre pay attention to you as an individual?
13. Did staff of the operating theatre centre pay attention to your cultural background?
14. Were you treated kindly by the staff of the operating theatre centre?

Service
1. Were you operated on the agreed date and time?
2. How did you experience the waiting time between your arrival at the operating theatre centre and the operation?
3. How did you experience the waiting time between your time spent in the recovery room and your leaving of the operating theatre centre?
4. Were you operated on the agreed date and time?
5. How did you experience the waiting time between your arrival at the operating theatre centre and the operation?
6. How did you experience the waiting time between your time spent in the recovery room and your leaving of the operating theatre centre?
7. Were you operated on the agreed date and time?
8. How did you experience the waiting time between your arrival at the operating theatre centre and the operation?
9. How did you experience the waiting time between your time spent in the recovery room and your leaving of the operating theatre centre?
10. Were you operated on the agreed date and time?
11. How did you experience the waiting time between your arrival at the operating theatre centre and the operation?
12. How did you experience the waiting time between your time spent in the recovery room and your leaving of the operating theatre centre?
13. Were you treated kindly by the staff of the operating theatre centre?
14. Did staff of the operating theatre centre take into account your cultural background?
15. Did staff of the operating theatre centre show understanding for your situation?
16. Did staff of the operating theatre centre take into account your personnel preferences?
17. Did staff of the operating theatre centre pay attention to you as an individual?
18. Did staff of the operating theatre centre pay attention to your professional opinion?
19. Did staff of the operating theatre centre take into account your privacy?
20. Did staff of the operating theatre centre take into account your personnel preferences?

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