Measuring Client Satisfaction in Residential Aged Care Settings: A Narrative Review of Instruments

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Citation

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Abstract

Background: The aim of this paper is to provide a narrative review of validated instruments measuring client satisfaction in residential aged care facilities, including key attributes of the identified instruments. Methods: A systematic literature search was conducted using scientific journal databases (Medline, ProQuest Health and Medical, ProQuest Social Science and CINAHL), specialist journals and websites, and Google. The search was limited to peer-reviewed and research or instrument development articles published between January 1990 and November 2009. 'Snowballing' and hand searching of the references of the selected articles were also used to ensure all relevant articles were examined.Results: Ten instruments were identified as relevant for the in-depth review. The review suggested instrument development to date has tended to include the development of new domains, many of which broadly draw on the literature but are honed to the specific objectives of the study or the organization being evaluated. This has led to a diverse range of domains with broadly congruent characteristics but often with different nomenclature. Seven domains were thematically identified based on the most commonly captured aspects of the satisfaction measures reviewed; Interpersonal manner of the provider, Technical quality of care providers, Physical environment, Meals/dining, Socializing opportunities/activities/relationships with others, Spiritual services, and Organization/policy/administration. Conclusion: Further work is required to develop an instrument which addresses the gap caused by the inherently different goals of the service provider, staff and the individual client, and the differences which exist among individual clients. To assess truly person-centered approaches of care, satisfaction instruments should reflect individual client's perceived importance and expectation on different domains of care/services.

INTRODUCTION

The past several decades have seen a rapid increase in the volume of health care research focusing on the measurement of patient (or consumer) satisfaction as an indicator of quality care (1). Patient satisfaction refers to the patient's subjective view of various aspects of health care and service provided, such as the availability of personal and technical resources, interpersonal characteristics of care providers, and the care environment (2), and often depends on their level of expectation toward such care (1, 3, 4). In his seminal work on the assessment of quality care, Donabedian aptly asserts that "… information about patient satisfaction should be as indispensible to assessments of quality as to the design and management of health care systems" (5, p. 1746). Much of the existing research on the measurement of patient satisfaction as a quality care outcome indicator has taken place in the hospital (both in-patient and out-patient) and primary care settings (2, 3). However, coinciding with a growing ageing population and ever expanding consumer expectations in society, measuring the satisfaction of care recipients in residential aged care (or long-term care) is gaining more interest in the health care literature (6).

There has also been an increase in the popularity and recognition of the importance of person-centered care for older people, in particular those with dementia, as a means to ensure and improve care quality (7, 8). Within a person-centered approach to care, respecting clients' needs and wishes and involving them in care and decision making is vital, and has been linked to more positive encounters with health care services and potentially better health outcomes (9-11). However, with a few exceptions (12, 13), there has been little debate as to how the quality of aged care, underpinned by the philosophy of person-centeredness, can be reliably assessed by residents and their relatives/families ('clients' hereafter). Notably, the meanings attached to 'health care' and 'care quality' in residential aged care differ from that of hospital or acute care. Acute care is mostly transient, focusing on a speedy recuperation while residential

aged care usually means a permanent placement, focusing on managing individuals' routines. Hence, the notion of a home-like environment plays a major role when choosing a residential aged care facility. The ultimate goal of care is also different; acute care typically aims to treat or cure an illness, or manage/control acute health problems so that people can continue living in their own home after discharge through self-care, while residential aged care aims to provide personal care, support for daily activities and on-going management of chronic conditions that require long-term care by skilled care staff. Other distinctive characteristics of residential aged care include the staff skill mix (i.e. a low proportion of registered nurses and no medical doctors) and care recipients' illness features (i.e. a high proportion of people with dementia or other cognitive impairment), requiring greater involvement of families/relatives in care-related decision making (14, 15).

Assessing client satisfaction with care and services is a first step in ensuring quality care, as well as providing evidence that guides service planning and evaluation. It is critical that outcome measures for the assessment of client satisfaction are designed and chosen so that information obtained is meaningful to the clients, as well as for health care providers, policy makers and service planners. When assessing client satisfaction for the purposes of quality improvement, service planning and evaluation, it is therefore imperative to use an instrument that considers the unique characteristics of residential aged care facilities.

The aim of this paper is to provide a narrative review of validated instruments measuring client satisfaction in residential aged care facilities, including key attributes of the identified instruments.

METHODS

A literature search of Medline, ProQuest Health and Medical, ProQuest Social Science and CINAHL was conducted using the following terms: aged care, nursing homes, long term care, residential care, OR dementia care; combined with (using 'AND') consumer, client, patient, carer, relative, OR family satisfaction. The search was limited to peer-reviewed and research or instrument development articles published between January 1990 and November 2009. 'Snowballing' and hand searching of the references of the selected articles were also used to ensure all relevant articles were examined. Google, Google Scholar and key websites associated with residential aged care quality, such as the www.nhqualitycampaign.org, were also examined to ensure a comprehensive search process. Instruments were included in the review if they were: 1) reported explicitly as measuring 'satisfaction'; 2) developed exclusively for a residential aged care setting (e.g., nursing home, assisted living, hostels or low-care residential care and long-term care facilities); 3) used to survey residents, family members/relatives, or both; 4) consisted of multiple aspects/domain to assess satisfaction (a global measure), rather than a single-item satisfaction measure/score or covering only one domain such as food service (16, 17); and 5) tested for validity and reliability (Cronbach's alpha of >0.70 and stated validity or face validity). Instruments that measured quality of life or quality of care determined by staff or service provider were excluded. An additional step was taken to identify studies that had utilized the final selected instruments measuring resident satisfaction in aged care settings. Citing articles were identified through the same search engines described above using the 'citing articles' functionality or the title of the original study, as relevant, in a search that was limited to peer-reviewed articles published between January 1990 and June 2010.

RESULTS

Thirty-six satisfaction instruments were identified in the initial search, ten of which reported both reliability and validity results and met all other inclusion criteria. Eleven examined instrument reliability but not validity, and 15 reported no reliability or validity measurements. Of the final ten instruments, eight were developed and tested in the USA. One instrument was developed in Australia (12) and one in Hong Kong (18). The predominant basis for instrument development was a literature review, often combined with feedback from their target resident, relative and other stakeholder populations such as administrators and experts, using interviews, advisory panels or focus groups. The majority described detailed pilot testing processes (n=7). All ten instruments reviewed were developed primarily with quality assurance or improvement purposes in mind. They were generally associated with either a desire, or an imposed imperative on the part of providers, to validate their practices or policies by assessing the views of their clients.

The review suggested the absence of a standardized set of domains (or constructs) for, or approaches to, evaluating satisfaction in long-term care (19, 20). As a result, instrument development to date has tended to include the development of new domains, many of which broadly draw on the literature but are honed to the specific objectives of the study or the organization being evaluated. This has led to

a diverse range of domains with broadly congruent characteristics but often with different nomenclature. For example, all ten instruments included a reference to food-related measures, but were categorized under a variety of different domain headings, including 'Food service' (21), 'Respect for resident's values and preferences' (22), 'Cleanliness' (18) and 'Relationships with Staff' (23). In addition, many domains were multi-faceted, with instruments focusing on different elements of experience within that domain or subdomains. Satisfaction with food has been measured with respect to the dining environment, standard of service, cleanliness and choice, as well as the quality of the food itself. The following seven domains have been thematically identified based on the most commonly captured aspects of the satisfaction measures reviewed (see Tables 1 &2 for relevant domains of each of the instruments reviewed).

Figure 1

TABLE 1 Resident-only instruments

Instrument	Country & care setting	Domains used*	Score range	Time required	Reliability/validity	Uses & citations
Resident Satisfaction Questionnaire (RSQ) (Boldy & Bartlett, 1998)	Australia Residential	I, T, P, M, SO, SP, O	50 items. 3- or 4-point Likert scales	40-45 minutes (max. 1 hour)	**Reliability:** coefficients for each composite variable = .81-.90. Test-retest reliability = .74-.90 **Validity**: content validity confirmed with stakeholders & through respondent feedback. Discriminant validity factor correlations >.85	6 uses; 6 citations Chou et al., 2001 & Chou et al., 2003 developed a short-form version (33, 34)
Scale on Domains of Resident Satisfaction (SDRS) (Chong & Chi, 2001)	China (Hong Kong) Residential aged care homes	I, T, P, M, SO, SP	28 items. Scale not reported	Not reported	**Reliability:** α for entire scale = .81. For the 6 subscales with > 1 measure, α = .30 - .67. **Validity:** convergent validity estimated by correlating scale to Resident Satisfaction Scale (McCaffree & Harkin, 1976) – correlation = 0.47 (p<.01)	1 use; 4 citations Results of pilot study used in later research article by Chong, 2003 (referred to as the Residential Care Satisfaction Scale) (35)
Nursing home customer satisfaction survey (Mostyn et al., 2000)	USA Nursing homes	I, T, P, M, SO	57 items. Scale: 5-point scale:	Not reported	**Reliability:** internal reliability = .77 - .92 for 4 scales. **Validity:** criterion-related validity accounted for 64% variance in overall quality ratings.	0 uses; 9 citations
Satisfaction with Nursing Home Instrument (SNHI) (Ryden et al., 2000)	USA Long-stay nursing homes	I, T, P, M, SO	29 items. Yes/no.	5-10 minutes	**Reliability:** α for the scale = .81. **Validity:** content & construct validity established	11 uses; 21 citations Other versions of scale developed
Resident Satisfaction Index (RSI) (Sikorska-Simmons, 2001)	USA Assisted living	I, T, P, M, SO	27 items. 4-point scale: 0-3	Average 45 mins reported during piloting	**Reliability:** α=.92 for entire scale; .77-.86 for sub-scales. **Validity:** factorial, correlational, discriminant & construct validity reported	2 uses; 9 citations Simmons et al., 1997, is first reference to RSI but no detail reported
Ohio Nursing Home Resident Satisfaction Survey (Straker et al., 2007)	USA Nursing homes	I, T, P, M, SO, SP, O	45 items (long-stay), 48 items (short-stay). 4-point scale	Not reported	**Reliability:** subscale α range = .69 - .95 **Validity:** reported	0 uses; 8 citations Conducted regularly by the Ohio Department of Aging.

Figure 2

TABLE 2 Resident and relative/proxy instruments

Instrument	Country & care setting	Domains used*	Score range	Time required	Reliability/validity	Uses & citations
PACE Satisfaction Survey (Atherly, Kane & Smith, 2004)	USA Long-term community-based care	I, T	24 items. 5-point Likert scale: 1-5	Not reported	**Reliability**: for 2 scales, perceived access = 0.88 & perceived interpersonal quality = .74. Decision-making scale had poor consistency (.54) **Validity:** internal validity reported for all resident & 2 of 3 relative factors	0 uses; 6 citations Reference to satisfaction scales used within PACE facilities found, but none specifically using this scale
Assisted Living Satisfaction Scale (Edelman et al., 2006)	USA Assisted living	I, T, SO	18 items. Response range: 1-4	20-30 minutes	**Reliability:** reported for residents & relative members (>.60 for all 9 facets) **Validity:** convergent validity reported for residents & relative	0 uses; 3 citations
Satisfaction with Assisted Living (Gesell, 2001)	USA Assisted living homes	I, T, P, M, SO, O	45 items. 5-point Likert scale: 1-5	Not reported	**Reliability:** all-item scale α= .97; subscale reliabilities range = .85 - .94. **Validity:** convergent, discriminant & predictive validity reported	2 uses; 17 citations
Customer Satisfaction in Nursing Homes (Kleinsorge & Koenig, 1991)	USA Nursing homes	I, T, P, M, SO, SP, O	Resident survey = 31 items. Proxy survey = 35 items. Likert scale: 1-5	Not reported	**Reliability** = .36 - .82 (may be explained by small number of items on each scale). **Validity:** convergent validity examined. Discriminant validity correlations = .58 - .595	2 uses; 13 citations

*Domain key:
I = Interpersonal manner of the provider
T = Technical quality of care providers
P = Physical environment
M = Meals/dining
SO = Socializing opportunities/activities/relationships with others
SP = Spiritual services
O = Organization/policies/administration

TECHNICAL QUALITY OF CARE PROVIDERS

Technical quality of care providers approximates most closely to the accepted clinical definition of 'quality of care'. In this review, it was defined as the specific medical and nursing care addressed by staff technical skills and knowledge, competencies and professionalism. As such, it is a domain for which all instruments included in this study provided satisfaction measures. This domain was handled variably across the instruments, with some using generic phrasing such as 'staff care' while others asked residents to comment on the more technical aspects of care delivery and whether staff "know what they are doing" (21, p. 58). Several instruments framed this construct in terms of perceived adequacy of care received (22, 24, 25), skills (12, 23), knowledge (13), quality (12, 25) or training (24) of staff.

Another aspect of technical quality of care providers covered by the majority of instruments was communication and the provision of medical information. In particular, residents were asked about the quality of the explanations for or information about care and treatment given by staff (13, 21, 22, 24, 25). Ryden et al. (22) dedicated an entire domain to 'Communication' and referred to the quantity of information, its accuracy and the extent to which it enabled choice. The provision of choice in care and/or advance care directive was also examined by a number of instruments (18, 19, 22, 24, 25), and was a key domain for the Ohio

satisfaction survey (25). Resident involvement and choice in care decision-making was a particular focus for the PACE Satisfaction Survey (19) and for Boldy and Bartlett (12) who examined staff/practitioners' understanding of the importance of actively involving both residents and relatives in care decisions, and in selecting and evaluating health care options (12).

Linked to technical quality of care providers is the concept of resident autonomy, that is, respect for the rights of residents to determine their own care choices and decisions in general. This entails a recognition and assessment of an individual's level of care needs, initiated and followed up by staff (13). A number of instruments considered the degree to which the care setting allowed for choice, in terms of resident independence (13, 25), staff understanding of individuals' privacy preferences (12, 22) and residents' need for control over their own privacy, for example, "Does the staff tell you when to keep your door open or closed?" (25, p. 94). Most instruments also included questions relating to staff access or responsiveness (23), in terms of frequency and timeliness of care (13, 19, 21), and speed of response (13, 18, 21, 23, 25, 26). Availability of staff has been included (25) and Atherly et al. (19) specifically referred to access to emergency care.

INTERPERSONAL MANNER OF THE PROVIDER

Interpersonal qualities are the prism through which a patient views the technical elements of care and therefore is critical to its success (5). Interpersonal manner of the provider captures the psychosocial, or empathetic, elements of care-giving and staff interaction with residents. In this review, interpersonal manner of the provider was defined as the aspects of care pertaining or contributing to the nature of relationships between staff and residents or relatives. Summarized by Gesell as "emotional assistance" (26, p. 22), this construct encompasses staff attitudes and behavior towards residents, and expressions of personality in interaction with residents.

Nine of the ten instruments reviewed used domains relating to staff interpersonal qualities such as courtesy or respect. Two instruments examined the respect shown by a range of caregivers and nursing home staff, including nursing staff, cleaning staff, social workers and activities staff (diversional care staff) (23, 25). Other staff interpersonal qualities examined included general inter-personal approaches or manner of care (22, 24, 25), interest (19), understanding (19, 24), and trust related issues such as honesty of communication (22). A common categorization across the instruments assessing the interpersonal manner of the provider was residents' access to staff. This encompassed the attention (13, 19) and amount of time given by staff to residents, their approachability (12, 19), and the ease of interaction with staff (22).

Attempts to provide a person-centered approach to care were reflected in items relating to the ability of staff to show interest in the individual and ways in which they individualized care (18, 19, 22, 25, 26). Other instruments provided for a more generic or less technical assessment of interpersonal qualities, asking residents if staff were nice (18, 23, 24), pleasant (24) and friendly (23, 25). Typical questions in this domain related to the ease of transition to life in a long-term care setting, either in terms of the initial welcome to the home (12, 22, 24) or the perceived degree of transition amongst residents (24). Two instruments included an assessment of staff attitudes to their work. Staff attitudes were framed either in terms of how staff were perceived to enjoy their work (24) or the level of teamwork, for example, "All the people in my care work well together" (19, p. 353).

PHYSICAL ENVIRONMENT

A key feature of residential aged care reflected in the instruments was that of the resident's external surroundings, conditions and living space. This domain brings together elements which impact on the physical and psychological well-being of residents and their ability to consider their setting a home, as well as a care environment. In determining this, distinctions were made in a number of the instruments between communal living areas and the resident's personal environment (i.e. room or apartment).

The most cited subdomain in this category was the cleanliness of the environment, be it facility-wide (22, 23, 25), specifically relating to the resident's room (18, 21, 26) or the common areas of the facility (18, 21, 24, 26). Related items were the quality of housekeeping (12, 24), the comfort of the facility (21, 23, 24, 26), its physical attractiveness and the level of noise (22, 26). These subdomains were deemed to contribute to the sense of living in a home-like environment, a stand-alone item in three instruments (18, 22, 23). This is an important aspect given that for many residents this will be their final home (22). Equally, a number of instruments discussed the extent of residents' ability to personalize their surroundings (21, 22).

The use of communal space was examined by a number of instruments, in terms of the amount of recreational space

(12, 18, 23, 26) or its diversity, including the extent to which communal space is relevant to the needs of its elderly residents (18, 22). The majority of instruments included items relating to the safety and security of residents and/or their belongings (12, 13, 18, 21, 22, 24, 25, 26), reflecting the priority this issue has and the level of concern around it in an aged care setting. Other environmental domains related to privacy (12, 13, 25, 26) and the extent to which resident autonomy was facilitated by conducive physical environment (13, 22, 26).

MEALS/DINING

Satisfaction around food-related topics was of key interest to all stakeholders in satisfaction instruments, both to those measuring satisfaction with long-term care and to the recipients of the food service. Intuitively, food is central to a care recipient's enjoyment of their way of life. It is also an area over which, in an aged care setting, much individual control is inevitably lost. As such, it is potentially one of the most visible changes in lifestyle for residents upon moving to an aged care facility. The 'Meals/Dining' domain captured all aspects of the food experience, from logistics, to environmental concerns and service, to the choice and quality of the food itself. Whilst one of the inclusion criteria for this review was assessment of multiple layers/elements of satisfaction, it is worth noting that a number of satisfaction instruments focused exclusively and in detail on food-related issues (16), an indication of its importance to the overall residential care experience.

The importance of food was also reflected by the fact that eight instruments included items relating to this domain. As well as a single item relating to food service in general, the instruments covered a diverse range of subdomains relating to meals/food, reflecting the complexity of ensuring a positive and healthy mealtime experience (16, 27). The majority of instruments discussed the quality of the food (12, 18, 21, 26) and specifically its taste (24, 25). Individual choice of dishes at mealtimes (12, 18, 21, 22), meeting individual's special dietary needs (26) or giving preferred choice of foods (25), and the variety of food served over a period of time (24) were also examined. Other instruments posed questions around the temperature of the food (12, 21, 25) and its quantity; the latter phrased as "Are there times you don't get enough to eat?" (12, 25). A separate facet of the mealtime experience is that of logistics and food service. Service standards were addressed by four of the ten instruments. Items within this subdomain included interpersonal qualities such as the courtesy of serving staff (21, 23), their attentiveness to individual needs (26) and presentation of a "pleasant" demeanor (24). From a more logistical perspective, Gesell (26) examined the wait time for food service.

SOCIALIZING OPPORTUNITIES/ACTIVITIES/RELATIONSHIPS WITH OTHERS

Another common domain of satisfaction related to the social elements of life in an aged care facility, including recreational activities, opportunities for recreation, and interaction with fellow residents. As with many satisfaction domains, the focus was on the significance of the broader facets of day to day residential aged care life with others, beyond those of nursing and medical management, which contribute to an overall satisfaction with the resident's quality of life. Nine instruments included items relating to the provision of leisure and recreational activities within the care setting or perceptions of how worthwhile they were overall, their availability and quality. More specific items related to the importance of cognitively challenging activities (24) and physical activity (22), whilst some instruments distinguished between indoor and outdoor leisure opportunities (13, 22, 26) and opportunities for retaining links with the broader community (12, 23). In a number of cases, items pinpointed the consequence of an absence of adequate leisure activities, namely boredom (13, 18, 25). In this domain, satisfaction was also measured in terms of residents' relationships with others in the facility (12), recognizing that the move to an aged care setting can involve significant losses in a resident's established social groups and the need to make new friends (18). Similarly, access to communal areas which facilitate socializing was identified as important (26).

SPIRITUAL SERVICES

The Spiritual services domain reflects items assessing the degree to which the care setting facilitates spiritual engagement through activities connected with religious beliefs, whether formal (e.g. church services) or informal (e.g., discussion with staff about spirituality). The domain acknowledges the importance of allowing residents to express their faith regardless of type of religion. Three instruments contained items asking about the extent to which residents were satisfied with the spiritual activities offered (12, 25), residents having opportunity to engage in their own religious activities (18), and adequacy of chapel services (24).

ORGANIZATION/POLICY/ADMINISTRATION

The Organization domain encapsulates all aspects of satisfaction concerning the administration and administrators of the care facility. It includes the day-to-day operational decision making, often in practice personified in the staff who manage the home (administration), the tangible output of the administration's activities or how well-organized they are perceived as being (organization), and the strategic decision making relating to the management of the home (policy). Despite the importance of the people and policies managing the home to the execution of the other domains, this domain was accorded relatively little weight in the instruments reviewed, again possibly reflecting the greater priority of interpersonal over logistical domains in satisfaction for aged care residents. Within 'administration', a number of instruments posed questions around access to administrative staff , including the handling of complaints and responsiveness to resident feedback (26), and the respect with which staff treat residents (25). Gesell (26) who placed the greatest emphasis on administrative issues, incorporated a general set of items including how "well-run" the facility was (26) and examined financial issues relating to how well staff communicate processes concerning payment and the uses to which fees are put. Kleinsorge and Koenig's instrument also addressed the broad issue of value for money, by asking residents to provide an opinion on whether "the administration spends money wisely" (24, p. 6).

MISCELLANEOUS DOMAINS

A number of underlying themes featured across the domains of the instruments examined, which included the concepts of access and availability. Quality of technical care and interpersonal skills are of little practical impact if the resident does not perceive (s)he has sufficient access to staff. Whilst access and availability were often raised in terms of convenience, it also related to particular concerns (22), concerns out of normal office hours (25), or in critical scenarios such as medical emergencies, where it is an issue in both resident and relative surveys (19).

Financial considerations were not raised with sufficient frequency to warrant a domain in their own right but nevertheless appeared in both relative (19) and resident surveys (24, 26). One instrument (25) included an item relating to laundry services, however this has been seen to be more relevant and of interest to laundry service providers rather than featuring highly in factors impacting on resident satisfaction (6). The Straker et al. instrument (25) also included a focus on safety of, and damage to, possessions.

RELATIVE/PROXY VS. RESIDENT SURVEYS

Four of the instruments included items for measuring satisfaction amongst proxies, mostly relatives. The surveying of proxies is generally a response to the inability of the residents themselves to take part in a satisfaction survey because of cognitive impairment or in recognition of relatives/family members as another key consumer group in their own right as surrogate consumers (28). Proxies' views and/or requirements of care do not always equate to those of residents and generally, proxies tend to express higher levels of satisfaction than residents (29). The four instruments took account of areas specific to their populations and handled the interface between resident and relative satisfaction in very different ways. While the relative survey in Gesell (26) was substantially identical to the resident survey, Edelman et al. (13) used two separate scales for residents and relatives, focusing on relatives as a separate consumer group rather than a proxy for residents. The relative survey added two additional domains: transportation and the impact on the relative of the resident's move to assisted living. The authors considered that this both allowed for cross-referencing between the surveys and reflected the different priorities and perspectives of the two groups.

In Kleinsorge and Koenig (24), the resident and relative surveys only differed in adding four items to the relative survey about the nursing home administration's effectiveness in meeting the relative's needs. Relatives were viewed primarily as surrogate consumers (24), or as a proxy for decision making in cases where residents were unable to complete the survey. In the PACE Satisfaction Survey (19), relatives were only engaged if their relative was not able to undertake the survey, and the questionnaires differed in order to reflect the respective priorities of the two groups. This instrument also explored staff interpersonal qualities in detail, including the appropriateness of staff expectations around the amount of relative input into care (19). Atherly et al. (19, p. 355) included a number of items relating to family pressure, be it "pressure…to buy services", or inadequacy of care, such as "skimping on services". Atherly et al. (19) and Gesell (26) addressed interpersonal elements, such as staff showing a genuine interest and respect and giving emotional assistance, respectively.

The technical quality of care providers was a focal point of relative surveys, and items were similar to those in the resident surveys. The issue of staff communication with relatives was key, in terms of receiving adequate explanations (13, 19), being kept informed (26), and the ease

and timeliness of relative access to staff (13, 19). In Kleinsorge and Koenig's relative survey (24), three of the four items related to communication between staff and relatives. A separate subdomain concerned staff's understanding of individual family circumstances (19, 24) and of involving relatives in decision making (19).

Instruments differed in how they covered relatives' views of staff interaction with residents, addressing adequacy of help and time given to residents (19), staff attentiveness (13) and anticipation of needs (19, 26), autonomy and choice issues (13, 26) and teamwork (19, 26). Atherly et al. included a more generic satisfaction item, for example, "The people who provide my health care are the kind of people I would like for myself" (19, p.355). In a survey designed for assisted living clients, Edelman et al. (13) focused on transport availability and autonomy of the resident in taking medication, healthy eating and finding recreational activities while asking relatives about concerns relating to the adequacy of activities.

DISCUSSION AND CONCLUSION

Much has been discussed about the need for health care industry- and setting-specific satisfaction instruments, and this integrated review has identified ten reliable and valid measures of client satisfaction in residential aged care. There are seven common domains that constitute client satisfaction for this particular population: Interpersonal manner of the provider, Technical quality of care providers, Physical environment, Meals/dining, Socializing opportunities/activities/relationships with others, Spiritual services, and Organization/policy/ administration. However, as shown in Tables 1 and 2, the review confirmed the notion that "there is no universally accepted conceptual model for patient satisfaction" (19, p. 350), as the concept of satisfaction has been approached in different ways and with varying degrees of specificity to the particular residential aged care setting being assessed.

The review also suggested there are inconsistencies in the extent to which the meaning of satisfaction has been examined and described. For instance, satisfaction was referred to as the consumer's fulfillment response (18, p. 224), consumer feedback (25), or "a health care recipient's reaction to salient aspects of the context, process, and results of their…experience" (21, p. 55). As the literature is divided on what constitutes 'satisfaction', so are the constructs being evaluated. Quality of service, care and life are used inconsistently and often interchangeably, and the reviewed instruments were often unclear as to whether satisfaction measured service quality, quality of care or quality of life, and the extent to which these concepts overlapped.

Few studies were found to demonstrate how those instruments had been used to influence and improve quality of care and quality of life of care recipients. Only one study reported concrete improvements implemented in the surveyed aged care setting as a result of their findings. This was the Ohio study, which reported a comparison of data from subsequent years' implementations of the satisfaction instrument, and noted state and federal government initiatives to improve quality (31). Sampling and recruitment processes, as well as response rates, were often poorly described. The instruments often failed to demonstrate how they addressed potential for clients to always respond positively, which may have been imposed during the implementation of the instrument. Finally, most of instruments reviewed targeted Caucasian or did not specify ethnic and cultural backgrounds of clients who had participated in the instrument development. It is therefore difficult to determine cultural sensitivity and appropriateness of the instruments to wider populations. This is a particular concern when adopting such tools in places with high levels of immigration and multiethnic populations. In most developed countries, the aged care workforce provides services to a growing culturally and linguistically diverse client group, and cultural differences have shown to create difficulties in health care delivery and care quality (32).

This review has provided a narrative overview and critique of validated instruments designed to assess clients' satisfaction in residential aged care. The most notable absence in all of the instruments examined was the consideration of the importance of the domain items relating to client expectations and overall satisfaction, an issue raised almost a decade ago (30). Only one instrument considered clients' perception of relative importance in domains for determining satisfaction (26), and none of the instruments explored how clients' perceived importance of and expectations of the included domains relate to overall satisfaction. It is critical that further work is carried out to develop an instrument that addresses the gap caused by the inherently different goals for the service provider, staff and the individual client, and the differences which exist among individual clients. To assess truly person-centered approaches of care, satisfaction instruments should reflect individual client's perceived importance and expectation on different domains of care/services.

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