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Women's-Perceived Quality In Postpartum Care

Maryland A. Hunter

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Women's-Perceived Quality In Postpartum Care

Abstract

Increased competition among healthcare organizations for the obstetric consumer market has led to increased interest in women's perceptions of their obstetric experience. This study explored women's perceptions of quality and women's perceptions of benefits for women who received family-centered postpartum care (FCPPC) and women who received traditional postpartum care (TPPC). The study also assessed the relationship between women's-perceived quality (WPQ) and women's-perceived benefit (WPB) for those receiving FCPPC and those receiving TPPC. Quality and beneficence are the two concepts of Larrabee's (1992) model of quality operationalized in this study. The sample consisted of 60 postpartum women, 30 receiving care on an all FCPPC unit and 30 receiving care on a TPPC unit delivering both FCPPC and TPPC. Women's quality was measured by obtaining satisfaction scores using the modified patient participation questionnaire, with responses rated on a five-point Likert scale. Women's-perceived benefit was measured by obtaining responses to benefit items rated on a five-point Likert scale score. Chi-Square and ANOVA revealed no demographic differences between groups. The study findings indicate that women receiving FCPPC have higher perceptions of quality on some dimensions of care than women receiving TPPC because FCPPC group scores were significantly higher on 8 out of 22 WPQ items. WPQ Mean scores for both FCPPC and TPPC groups were high. However, FCPPC group scores were significantly higher on 8 out of 22 WPQ items. In addition, the study findings indicate that women receiving FCPPC have higher perceptions of some benefits than women receiving TPPC because the FCPPC group scores were significantly higher on 3 out of 7 WPB items. Results also indicated that a relationship exists between quality and beneficence. These findings suggest implications that nurses working in TPPC units should incorporate FCPPC approaches to giving care, pertaining to those eight WPQ aspects of care and for the three WPB aspects of care. Results further imply that if women perceive care as beneficial they will also perceive it as quality. Health care providers should focus care activities and quality improvement activities on aspects of care women perceive as beneficial and for which quality improvement is indicated from the women's perspective.

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Women's-Perceived Quality In Postpartum Care

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of
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In Partial Fulfillment
Of the Requirements for the Degree
Master of Science in Nursing
From the University of Tennessee

by
Maryland A. Hunter
December, 1994

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DEDICATION

This work is dedicated to:

Charles L. Timms, my late father,

Ollie L. Timms, my mother,

Horace Hunter Jr., my husband,

Darrence V. Hunter, my son,

and

Antoinette L. Hunter, my daughter

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ABSTRACT

Increased competition among healthcare organizations for the obstetric consumer market has led to increased interest in women's perceptions of their obstetric experience. This study explored women's perceptions of quality and women's perceptions of benefits for women who received family-centered postpartum care (FCPPC) and women who received traditional postpartum care (TPPC). The study also assessed the relationship between women's-perceived quality (WPQ) and women's-perceived benefit (WPB) for those receiving FCPPC and those receiving TPPC. Quality and beneficence are the two concepts of Larrabee's (1992) model of quality operationalized in this study. The sample consisted of 60 postpartum women, 30 receiving care on an all FCPPC unit and 30 receiving care on a TPPC unit delivering both FCPPC and TPPC. Women's quality was measured by obtaining satisfaction scores using the modified patient participation questionnaire, with responses rated on a five-point Likert scale. Women's-perceived benefit was measured by obtaining responses to benefit items rated on a five-point Likert scale score. Chi-Square and ANOVA revealed no demographic differences between groups. The study findings indicate that women receiving FCPPC have higher perceptions of quality on some dimensions of care than women receiving TPPC because FCPPC group scores were significantly higher on 8 out of 22 WPQ items. WPQ Mean scores for both FCPPC and TPPC groups were high. However, FCPPC group scores were significantly higher on 8 out of 22 WPQ items. In addition, the study findings indicate that women receiving FCPPC have higher perceptions of some benefits than women receiving TPPC because the FCPPC group scores were significantly higher on 3 out of 7 WPB items. Results also indicated that a relationship exists between quality and beneficence. These findings suggest implications that nurses working in TPPC units should incorporate FCPPC approaches to giving care, pertaining to those eight WPQ aspects of care and for the three WPB aspects of care. Results further imply that if women perceive care as beneficial they will also perceive it as quality. Health care providers should focus care activities and quality improvement activities on aspects of care women perceive as beneficial and for which quality improvement is indicated from the women's perspective.

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LIST OF SYMBOLS

SYMBOL

1. F--Family-Centered
2. T--Traditional
3. FCPPC--Family-Centered Postpartum Care
4. TPPC--Traditional Postpartum Care
5. WPBQ--Women's-Perceived Benefits Questions
6. PPSQ--Patient Participation Satisfaction Questionnaire
7. WPQ--Women's-Perceived Quality
8. WPB--Women's-Perceived Benefits
9. PPQ--Patient-Perceived Quality
10. PPB--Patient-Perceived Benefits
11. IRB--Internal Review Board

CHAPTER 1

Introduction

Current issues, related to rising health care cost, increased competition for the health care market, and consumer movements have stimulated a resurgence of attention to customer-perceived quality (Weisbrod, 1985; Merry, 1987; Robinson, 1988; Ginsburg & Hammon, 1988; Frederick, Sharp & Atkins, 1988; Garvin, 1988; Domask & Childs, 1988; King, 1988; Taylor & Haussman, 1988; Steiber, 1989; Engle, Blackwell & Miniard, 1990; Meterko, Nelson & Rubin, 1990; Rubin, 1990; Campbell, Mason & Weiler, 1990; Yoder & Rode, 1990; Taylor, Hudson & Keeling, 1991; Kreidler & Conrad, 1992; Larrabee 1992;). Health care facilities in general are eagerly adopting a customer-centered philosophy as their primary mission. This philosophy gives patients more control over their care, and compels health care facilities to review their success at providing quality service, comparable in methodology to that of other businesses (Engle, et al., 1990). In this context, health care providers must adopt assessment of patient-perceived quality (PPQ), not just provider-perceived quality. The very survival of these health care facilities may be dependent on knowing about these perceptions. In his book "The Customer Driven Company", Whitely (1991) "contends that we are in an era of fierce competition, one in which satisfying, even delighting the customer is absolutely crucial, not only to business, but even business survival."(p. 2)

As with other health care services, agencies which deliver postpartum services are concerned about attracting and maintaining a share of the market. Changing the method of nursing care delivery is one strategy being used. The traditional model of postpartum care is being replaced by family centered postpartum care (FCPPC) in many agencies.

Traditional postpartum care (TPPC) tends to be rigid in adhering to policies that do not allow individual choices in care. First, infants, in general, are housed in a central

nursery, and are brought to the mothers at designated times. Second, visiting hours are scheduled at specific times. Third, sibling visitation is discouraged. And fourth, decisions about the care a woman receives are based almost totally on hospital policies, procedures, and protocols, with very little patient input. Consequently, women have negative perceptions about quality of care and benefits under TPPC (Young, 1992).

In contrast, the FCPPC model is designed to allow greater participation in postpartum care by women and their families (Waldenstrom & Nilsson, 1993). FCPPC offers more flexibility and individualized care than TPPC. The expected benefits of the family-centered concept are that (1) the family can begin functioning as a unit earlier, (2) there are more opportunities for visitation, (3) increased infant-family bonding, affording more opportunities to touch and hold the baby, (4) a homelike, less hospital-oriented atmosphere, (5) increased choices in care after delivery, and (6) adaptation of routines to individual wishes. This model, unlike the TPPC model permits the parents to share the childbearing experience and to have access to their baby during the postpartum period to the extent they desire (Ingalls & Salerno, 1991). Overall, the patients experiencing FCPPC should report higher perceptions of care quality and benefits than patients experiencing TPPC.

An editorial by Young (1992) suggested that aspects of the FCPPC model should be considered for use in maternity units based on research findings that demonstrate effectiveness of specific forms of care. Further, Young suggests abandoning conventional practices that are unfounded in research such as separating mothers and babies, and scheduling of breast feeding routines. In addition, the editorial relates that models of FCPPC should fit the expressed desire of the community it serves.

While, there exists a growing number of studies related to consumer satisfaction in health care, few of them explore women's satisfaction with postpartum care as a measure of care quality. Further, no studies have examined (1) women's perceptions of FCPPC

benefits or (2) the relationship between women's-perceived quality (WPQ) and women's-perceived benefit (WPB).

This relative scarcity of studies that measure quality and beneficence of postpartum care, coupled with the efforts of maternity units throughout the country to capture the flourishing childbirth market, add significantly to the need for additional research that investigates perceptions of quality and benefits. Therefore, the purpose of this study was to (1) describe and compare women's perceived quality and women's perceived benefits for a group of women receiving TPPC and receiving FCPPC, and (2) to explore the relationship between WPQ and WPB between those receiving FCPPC, and those receiving TPPC.

Theoretical framework

The theoretical framework for this study was Larrabee's (1992) new wholistic model of quality (see Figure 1) which was synthesized using concepts from Aristotle's ethical and political philosophies and a linguistic analysis of quality. Larrabee defines quality as "the presence of socially acceptable, desired attributes within the multifaceted wholistic experience of being and doing, and quality encompasses at least four interrelated concepts: value, beneficence, prudence, justice"(p. 17). Quality and beneficence are the two theoretical concepts of this model which are operationalized in this study. Beneficence is defined as "actual or potential capacity for (a) producing good and (b) promoting well-being. Beneficence encompasses harmlessness"(p. 17). Well being is of value to individuals, groups, and society (Larrabee, 1992).

One proposition of Larrabee's model is that quality and beneficence are related. If this relationship exists, then, when women view care as beneficial, they will perceive it as quality. This study (see Figure 2) will test this proposed relationship in a group of women who have received TPPC and in a group of women who have received FCPPC.

Figure 1. Larrabee's model of quality.
From "Hospital Patients and Nurses Perceptions of Quality" by J. H. Larrabee, 1992, unpublished doctoral dissertation, The University of Tennessee, Memphis. Reprinted with permission of the author.

Figure 2. The model for investigation of the relative relationship between quality and beneficence

The abstract concept of quality was operationalized by measuring the midrange concept of satisfaction. Quality cannot be measured directly, but was measured using a perception. A number of authors have used patient satisfaction as WPQ. According to Taylor, et al., (1991) consumer's perceptions should be a matter of great importance to those attempting to define and measure the construct of quality. When patients are satisfied with the service they receive, they perceive the care as quality (Brown, 1992; Beymer, et al., 1992). According to Risser (1975), satisfaction is the degree of congruency between a patient's expectations of ideal nursing care and his perception of the real nursing care he receives. Risser contends that by examining patient satisfaction, nurses can obtain a more complete picture to evaluate the quality of nursing care provided.

Engle, et al., 1990 defined satisfaction as "a post-consumption evaluation that a chosen alternative at least meets or exceeds expectations, and dissatisfaction is the outcome of negatively confirmed expectations." Oliver (1980), when discussing the expectancy disconfirmation model, relates that "consumers enter into purchase with expectations of how the product will actually perform once it is used." The emphasis on consumer expectations in the expectancy model is an example of the influence that meeting expectations can have on perceived satisfaction. Customer expectations is a term closely related to the concept of quality analyzed in this study, since the characteristics of quality includes meeting customer expectations (Boothe, 1990).

Other experts offer further support for operationalizing quality by measuring satisfaction. Linder-Pelz (1982) defined patient satisfaction as an individual's attitude based on reference to their values; satisfaction is the positive evaluation of distinct dimensions of health care. Prehn, Mayo & Weisman (1989) pointed out that patients may be dissatisfied with procedures that are uncomfortable or distasteful, even when quality is high. Further, according to Doering, (1983); Steiber, (1989); Cleary, Keroy, Karapanos, & McMullen (1989); and Abramowitz, Cote & Berry (1987), perceived quality or

satisfaction reflects one outcome of the nursing process, and nursing has been found to be an important determinant of hospital patient satisfaction. In studies to measure patient satisfaction, Abramowitz, et al., (1987), and Doering, (1983) related that satisfaction with nursing care has been found to be one of the most important predictors of overall patient satisfaction with hospital care.

Beneficence was operationalized at WPB. Health care benefits are examples of Larrabee's definition of beneficence (Larrabee,1992), because of their potential to produce good and promote well-being. Both the TPPC model and FCPPC model offer some benefits to women. It was anticipated that women's-perceived benefit would be higher under the FCPPC model than under the TPPC model.

Relevance to nursing

As one of the most powerful groups of contributors to patient care, (Risser, 1975) nurses in the 90's must participate in the movement to become business oriented in the health care setting, by focusing on evaluation of care from the consumer's perspective (Taylor, et al, 1991). This study, and others like it, afford an opportunity to operationalize a basic concept of the nursing process, assessment, the solid foundation that promotes the delivery of quality individualized care (Iyer & Taptich, 1991). For instance, decisions about what constitutes quality for women and their families in obstetrics, as well as other fields, should be determined by first assessing what constitutes quality from the consumers view point (Engle, et al, 1990). Insight into women's perceptions of quality and benefits of their care, will enable care-givers to better plan care. In many instances, the standards used to measure quality are implemented clinically without input from the clients being served (Kreidler & Conrad, 1992).

The results of this study have implications for quality assessment and improvement programs. For instance, the nursing interventions that result in higher satisfaction scores, and are beneficial can be used as quality improvement indicators for continuous

monitoring. Also, on-going surveys provide timely input about changing consumer perceptions.

Operational Definitions

Women's-perceived quality: Women's-perceived quality was measured by obtaining women's satisfaction scores using the modified patient participation questionnaire (PPSQ). Responses were rated on a five-point Likert scale encompassing Items 1-22 of the modified PPSQ (Littlefield , 1986). (see appendix B).

Women's-perceived benefit: Women's-perceived benefit was measured using items 24-30 on the modified PPSQ. Responses were scored on a five-point Likert scale. (see appendix B).

Research questions

1. Are there differences in women's perceptions of quality of care between those choosing FCPPC and those choosing TPPC care?
2. Are there differences in women's perceptions of benefits between those receiving FCPPC and TPPC?
3. What is the relationship between WPQ and WPB?

Assumptions

The following assumptions apply to this study:

1. Women seek satisfactory experiences from childbirth.
2. Women who are satisfied with the birth experience in a give institution and who considered it quality, will likely return to that institution for future deliveries.
3. Nurses are the major contributors to women's satisfaction with hospitalization during the postpartum period.
4. When expectations are met women experience satisfaction

5. Women expect to benefit from the postpartum experience.
6. Women expect quality in postpartum care.
7. When women are satisfied with the care received, it is perceived as quality.

Limitations

The limitations to this study are:

1. Results can only be applied to the sample population or other urban hospitals with similar patient demographics.
2. Negative antepartal and intrapartal experiences may influence women's perceptions of postpartum care.

CHAPTER 2

Literature Review

Provider concern to deliver quality in health care from the consumers' perspective has resulted in a plethora of studies related to patient satisfaction, some of which will be discussed in this literature review. An article by Brown (1992) noted the increased attention perceived quality has received in the health literature in general, and under the auspices of patient satisfaction. In addition, there are a number of studies related to PPQ in nursing, (Burgess, 1932; Abdellah & Levine, 1957; Lambertson, 1965; Hegvary & Haussman, 1976; Schroeder, 1984; Lang & Clinton, 1984; Taylor & Haussman 1988; Bader, 1988; Brown, 1992; Rubin, 1990; Taylor, Hudson & Keeling, 1991; Schroeder, 1991; Larrabee, 1992; Kreidler & Conrad, 1992). However, in postpartum, literature support for the concepts quality and beneficence is mainly implied.

This literature review will include: (1) patient satisfaction: general health care, (2) patient satisfaction with nursing care, (3) women's satisfaction with postpartum care, (4) women's preferences in postpartum nursing care, and (5) benefits in postpartum care. The relative absence of literature on patient benefits supports the premise that there is a need for more research on the concept.

Patient Satisfaction: General Health Care

Three studies (Weiss & Senf, 1990; Corrigan, 1990; O'Malley & Thompson, 1992) demonstrated that patient satisfaction with health care in general is a concern of providers. First, Weiss & Senf, (1990) investigated predictors of patient disenrollment from health care plans. Results indicated that among the reasons for changing their health care plans were perceived inadequacy of the quality of health, cost, or perception that services were inadequate. This study underscored the market incentive for attending to consumer satisfaction.

Second, Corrigan, (1990) demonstrated that involving patients in their care planning pays off. Their findings revealed that psychiatric patients involved in care planning in both institutional and community care reported being satisfied with their care.

Third, O'Malley & Thompson (1992) demonstrated the influence of a hospitality representative service on consumer satisfaction. In conducting program evaluation, they found that patient and staff perceptions of quality care fostered a climate of excellence that prevailed over complex operations and market pressures. This study emphasized the benefits of designing health care that is patient or consumer centered.

These three studies (Weiss, 1990; Corrigan, 1990; and O'Malley & Thompson, 1992) serve as examples of the vast body of literature on patient satisfaction with health care in general. They demonstrate that providers are actively investigating quality and improving care from the patient's perspective.

Patient Satisfaction: Nursing Care

Nurses have been concerned with patient satisfaction for many years (Burgess, 1932; Abdellah & Levine 1957; Risser, 1975; Ventura et al, 1982; Lang & Clinton, 1984; Erikson, 1987; Taylor & Haussman, 1988; Marker, 1989; Yoder & Rode, 1990; Taylor et al, 1991 and Twardon & Gartner, 1991). These studies have examined patient perceptions of nursing care in a sample of hospitalized patients (Ventura et al, 1982; Yoder & Rode, 1990; Taylor et al, 1991; Larrabee, 1992; Megivern et al, 1992), ambulatory care patients, (Risser, 1975) and home health care (Reeder & Chen, 1990; Twardon & Gartner, 1991). These studies described patient satisfaction (Risser, 1975; Ventura et al, 1982; Yoder & Rode, 1990; Reeder & Chen, 1990; Twardon & Gartner, Megivern et al; 1992), identified dimensions of care patients can evaluate; (Taylor et al, 1991), and identified predictors of patient satisfaction (Larrabee; 1992).

The studies by Risser (1975), Ventura et al (1982), Yoder & Rode (1990), Reeder & Chen (1990), Twardon & Gartner and Megivern et al (1992), described patient

satisfaction. Risser (1975) developed an instrument to measure patient satisfaction with nurses and nursing in primary care. Alpha coefficients obtained in two trials for antepartum, intrapartum and postpartum subscales were: .80, .86, and .89, for trial 1 and .63, .82, and .81 for trial 2. Results reflected that respondents reported greater satisfaction with behavior of nurses in professional technical areas and less in the area of trust; and education. This study demonstrates the importance of patient perceptions of nursing care for individual patient populations and patient care settings. However, results can only be directly applied to the study population.

Ventura et al, (1982) used the Risser scale to evaluate the effectiveness of primary nursing in an orthopedic nursing unit. Results revealed no significant difference in satisfaction scores between primary nursing care units and the team functional nursing unit participants. This study provided support for the need to include patient's perceptions prior to implementing changes in health care delivery.

Yoder & Rode (1990) examined patient satisfaction with nursing actions, using a questionnaire of 50 nursing actions. Internal consistency for the scale was $\alpha = .93$. They found that regardless of diagnosis, most patients were most satisfied with positive feedback from the staff and increased independence with self-care.

Reeder & Chen (1990) conducted a study to determine the client's satisfaction with care as an important factor in determining success of home health programs. Their results revealed that clients were most satisfied with how well nurses listened and were least satisfied with attention to their needs. Reliability for the survey was .93. These findings were important in illustrating the significance of studying individual populations such as these elderly clients in a rural home health setting. Also, Reeder & Chen viewed client satisfaction as a measure of quality.

Twardon & Gartner (1991) explored patient satisfaction with primary health care to determine patient satisfaction with nursing care as an indicator of quality. Results revealed that patients were overall satisfied with nursing in the areas of attention to concern,

communication with physician, and ability to contact care givers. Content validity of the survey tool was evaluated and established by a nursing administrator and nursing instructor.

Megivern, et al., (1992) conducted a quality assurance study of patients and families in critical care to evaluate the degree of patient and family satisfaction with care provided by critical care nurses. Results revealed that patients and families were overall satisfied with care, but responded with low ratings for (a) control of unnecessary noise, (b) providing private time for the family; (c) waiting room facilities, and (d) lack of communication with nurses and physicians. Content validity was established with a 90% agreement for data categories. Revisions of the patient satisfaction survey used was reviewed by head nurses and clinical nurse specialist. These results pointed out the need for nurses to incorporate more patient and family preferences into their plans for remodeling a facility that will be functional as well as satisfying and beneficial.

Taylor, et al., (1991) identified dimensions of care patients could evaluate by having patients define quality nursing care. Results indicated that families viewed holistic care as total patient care, family involvement, and patient and family education. Reliability was reported as established by consensus of three nurse researchers. Nurse attributes, identified were nurses as kind, nice, friendly, flexible, efficient, helpful, gentle, caring, courteous, and confident. Soliciting patient input is a valuable method of identifying their perspective of quality nursing care.

Larrabee (1992) identified predictors of PPQ (n=199). She found empirical support for relationships between PPQ and patient-perceived value because patient goal achievement was a predictor of PPQ. She also found empirical support for the relationship between PPQ and PPB because low pain was a predictor of high PPQ scores. Because of the dynamic, subjective nature of constructs measured, reliability was not established for the VAS (visual analogue scale) used in Larrabee's study. However, Larrabee's sample was limited to patients hospitalized on two medical surgical nursing units in one hospital.

These eight studies identified the dimensions of nursing care patients can evaluate and identified predictors of patient satisfaction. However, they did not investigate the relationship between quality and beneficence for two or more groups of patients.

Women's satisfaction with postpartum nursing care

Three studies were located that have examined women's satisfaction with postpartum nursing (Sullivan & Beeman, 1981; Littlefield & Adams, 1987; Waldenstrom et al., 1993). First, Sullivan & Beeman (1981) examined the relationship between satisfaction of postpartum women and infant bonding. Only 57% were very satisfied. The less than optimal reports of satisfaction were closely related to lack of opportunities for parent-infant bonding, a concept closely linked to family centered care. The strengths of this study were a large sample size (n=1900) consisting of racially and ethnically diverse individuals. However, a major limitation was that the psychometric properties of the instrument were not reported.

Littlefield & Adams (1987) found that the alternative birth experience increased women's sense of participation and positively correlated with women's satisfaction on both the intrapartum and postpartum scales (n=99). However, women in both groups were dissatisfied with their intrapartum care; a finding requiring further investigation. Two limitations of the Littlefield and Adams study were that (1) results were applicable to primipara who enrolled in prepared childbirth classes but not the general postpartum population, and (2) women were not paired between the two groups and the group sizes were quite different. A major strength was the inclusion of all aspects of the women's experience: Antepartum, intrapartum and postpartum. The Littlefield and Adams study is related to this study because of the similarity between the two concepts FCPPC and alternative birth. Both concepts advocate family involvement and respect for women's preferences for care. However, Littlefield did not use satisfaction as a measure of quality or explore the relationship between quality and beneficence. The most relevant relationship

between Littlefield & Adam's study and this one is the use of the Patient Participation and Satisfaction Questionnaire (PPSQ), although this study used a modified version of the PPSQ (Appendix B).

Waldenstrom, et al., (1993) found that women were more satisfied with birth center care than with TPPC in the area of physical and psychological aspects of postpartum care. Birth center care and family centered care are closely related in concept characteristics. The major strengths of the study were the use of (1) a randomized controlled trial and (2) a large sample size (n=1230). The major weakness of the study was the time frame between discharge and receipt of the questionnaire for the postpartum scale, questionnaires were mailed two months after expected date of delivery. The time frame of two months could influence results either positively or negatively.

These three studies demonstrated that women are more highly satisfied with care that has the characteristics of FCPPC. However, neither of these studies looked at differences in WPB between women receiving FCPPC and TPPC.

Women's Preferences in Postpartum Nursing Care

Several studies have investigated women's preferences and expectations regarding many dimensions of postpartum care (Scaer & Korte, 1978; Moore, et al , 1986; Tribotti, et al.,1988; Weiss and Armstrong, 1990). Scaer & Korte (1978) found that among 49 options for maternity care, women, chosen at random from La Leche groups and from prepared childbirth classes, were all similar in their preferences for maintaining family closeness and obtaining help from hospital staff. Allowing women to select options for maternity care is closely associated with the FCPPC concept, particularly as it relates to the term family-centered. The major strength of this study is the large sample size (n= 645). The limitation was that two of the three groups could be considered to have selection bias. Being a LaLeche member and attending childbirth classes suggest similarities in what these woman expect in postpartum care.

Weiss and Armstrong, (1990) found that, regardless of their decision to use the dyad delivery system (FCPPC) or the TPPC, women preferred to have their infants in the room with them at night, with the option of sending them back to the nursery if they needed uninterrupted sleep. However, there was a significant difference between the two groups in terms of night time care of the neonate. The dyad group experienced more satisfaction with, and preference for having their infants with them all night. This study points out the significance of group differences in terms of what would be satisfying in postpartum care for populations under study. Limitations of the study were (1) that results can only be applied to the population being studied, and (2) disproportion in sample size between the groups (n=28, n=77). The strength of the study is that it provided stimulus for further exploration of the differences in these groups regarding their preferences.

Tribotti, Lyons, Blackburn, Stein, & Withers, (1988) found that the most frequent nursing diagnoses selected by patients were: alteration in comfort, impaired mobility, sleep pattern disturbance, and altered bowel elimination. The results of this study provided nurses with a focus for planning nursing care for postpartum women, but could not be generalized to other groups because a convenience sample was used consisting of predominantly caucasian women who had vaginal or cesarean births. In addition, definitions of the nursing diagnoses were modified to be meaningful specifically for postpartum women. The results of this study are related to present study concepts because the most frequently selected options have similar characteristics to those of FCPPC.

Moore, et al., (1986) found that women wanted more emphasis on education, comfort, coping with stress and getting to know baby (bonding). A major strength of this study was that the sample included various ages, socioeconomic status, and ethnicity. Therefore, study findings may be useful in clinic or hospital settings. Further research on the tool used needed because there was no evidence of psychometric analysis provided. The findings of this study also indicated that women selected aspects of care closely associated with FCPPC.

The literature on women's preferences is significant because women's preferences are at the center of the FCPPC concept. If women prefer the aspects of care the FCPPC model addresses, then shouldn't they be more satisfied with FCPPC than with TPPC?

Benefits in postpartum care

Only one study was located which investigated women's-perceived benefit in postpartum care. Waters and Kristiansen (1989) used questionnaires to measure patients' and nurse's perceptions of nursing measures for postnatal nursing care and to evaluate the benefits of combined mother-infant versus traditional separate staffing patterns. Patients' responses reflected that they would benefit from increased teaching opportunities and psychosocial care activities. Researchers concluded that the scales demonstrated construct and content validity, however additional studies were recommended to be conducted for the measures using a variety of population characteristics. This study was relevant, because those nursing measures patients perceived as beneficial are also characteristics of the FCPPC model of care. The major strength of the study was that it examined an important contributor to WPQ and WPB.

Summary

The interest in consumer satisfaction is evident in this relatively brief review of literature. Health care organizations have come to realize the importance of identifying factors that relate to consumers' perceptions of quality and satisfaction in health care. The review indicates the significant deficit in postpartum studies related to WPQ. While there is much literature related to quality, most is only vaguely related to postpartum care. The literature on quality justifies, (1) the use of the term satisfaction as a measure of WPQ, (2) relates how other authors have used satisfaction as a measure of quality in areas other than obstetrics, and (3) provides support for the interest generated in nursing and possible impact on health care in general. The literature review also demonstrated gaps related to the

concepts of WPQ and WPB. For instance, none of these studies explored the relationship between quality and beneficence for women receiving FCPPC, and those receiving TPPC. Only one study was found related to WPB in postpartum care, and none explored the differences in women's perception of benefits between the two models of care.

CHAPTER 3

Methodology

Research design

This exploratory study used a two-group design to describe and compare women's-perceived quality and women's-perceived benefit. One group of women received TPPC, and the other group received FCPPC. The study used a modified version of Littlefield's PPSQ (Littlefield, 1986). See Appendix B.

Study site

The site for this study was a 476 bed private not for profit urban care facility. This hospital provides health care for the majority of the uninsured and underinsured persons in Shelby County (The Med, 1991). The hospital has over 23,000 admissions per year, and more than 225,000 out-patient visits. The units selected for the study were housed in the high risk perinatal center of that hospital. The center delivers more than 7,000 babies per year and averages 1800 admissions to the high risk neonatal unit annually.

Two postpartum units were selected for this study. The first unit represented a typical postpartum unit of the hospital, that is, TPPC, with some women receiving FCPPC. On this unit only patients receiving TPPC were included in the study. The second unit was considered to be totally FCPPC as described in chapter 1 (p.2). Nurses in the traditional unit were either assigned FCPPC, where they provided couplet care or TPPC, where they cared for babies and mothers as separate units. In the FCPPC unit, the nurses were expected to care for both mom and baby as a unit (dyad).

Sample

A convenience sample of postpartum women (N=60), 30 receiving TPPC and 30 receiving FCPPC were included in the study.

Inclusion criteria were:

1. 18 years and older
2. Vaginal delivery
3. Second day postpartum
4. Considered low risk with low risk infants

Procedure

Initially, the investigator examined charts on each of the two units to identify women that were at least 16 hours postpartum, and met the criteria for inclusion in the study. The nursing care coordinator on each unit was then informed of the intent to interview the participants and was consulted about the most appropriate times to conduct uninterrupted interviews. Participants were then approached by the investigator who explained the purpose of the study and obtained their written consent to participate (Appendices A&D). Once the participants consented, they were given a consent form to sign (Appendix D). Specific instructions concerning the questionnaire were given to participants, including definitions of the concepts under study. The items in the questionnaire were read to the women by the investigator to insure understanding and to increase chances of retrieval. Demographics were the last items solicited from the study participants because experience of expert researchers has indicated that participants are more receptive to completing the form under those circumstances (Shelley, 1984; Burns & Grove, 1987). The average time for completion of the questionnaire was 15 minutes.

Measurement of the concepts

Women's-perceived quality was measured using a modified version of the PPSQ, limited only to postpartum care, using items 1-22. Women's-perceived benefit was measured using items 24-30 of the PPSQ. Additionally, six open-ended questions (31-36) were used to identify how women perceived the care they received in their own words.

The PPSQ was selected as the measurement instrument for the study because it had been used to measure the concepts under study. Developed in 1986 by Littlefield, the original tool consisted of 97 items divided into 3 subscales: Antepartum, Intrapartum, and Postpartum care. The tool was modified with permission of the author to 36 items related to FCPPC for the postpartum scale, with two subscales: 23 items that assessed women's satisfaction to measure quality using a 5-point Likert scale, and 7 items related to FCPPC that measured beneficence using a 5-point Likert scale. In addition, the tool included 6 open-ended questions, two of which assessed (1) women's definition of quality, and (2) women's overall perceptions of quality. The advantages of the modified tool was that it was specifically constructed to measure the study variables in postpartum settings. Items used for the postpartum scale had content and construct validity from previous studies. Cronbach's alpha coefficient for internal consistency on the postpartum scales were .57 and .63 (Littlefield, 1986). Content validity of the PPSQ had been judged adequate, because experienced clinicians had developed the instrument from two previously tested questionnaires (Littlefield, 1986). Construct validity was judged acceptable because a separate questionnaire on satisfaction with birth showed similar results.

Instructions for use of the PPSQ included the use of a Likert scale format for all subscales. The investigator assisted the participants in completion of the questionnaire, and thus, was available to clarify interpretation of the items contained in the questionnaire.

For analysis, demographic data & PPSQ scores were entered into an EXCEL spread sheet (Microsoft Corporation, 1990). The two groups were coded separately using "F" for women receiving FCPPC, and "T" for women receiving TPPC. Blocks of data were copied into files in the StatView for Students software on a MacIntosh (Abacus Concepts, 1991).

Analysis of the data

All numerical data were analyzed using the StatView Student software system for Macintosh computers (Abacus Concepts, 1991). Descriptive and inferential statistical evaluation were performed. Demographic characteristics of the groups are presented in tables displaying means and standard deviations. The demographic data for the two groups were analyzed for differences using Chi-square for categorical variables and one-way ANOVA for continuous variables. Descriptive statistics for women's-perceived quality and benefit scores were also obtained. Research questions were analyzed using t-test and correlation coefficients.

Research question 1: Are there differences in women's perceptions of quality care between those choosing FCPPC and those receiving TPPC?

Analysis was conducted by computing a t-test to examine the difference between Likert scores of the two groups for items 1-22 measuring perceived quality.

Research question 2: Are there differences in women's perceptions of benefits between those receiving FCPPC and those receiving TPPC postpartum care?

Analysis was conducted by computing a t-test to examine the difference between Likert scores of the two groups for items 24-30 measuring benefits.

Research Question 3: What is the relationship between women's-perceived quality and women's-perceived benefit?

Analysis was conducted by computing a correlation coefficient test.

Protection of human participants

The researcher secured Institutional Review Board approval from The University of Tennessee Memphis and approval from the Regional Medical Center at Memphis. Participants were provided with an informed consent explaining in simple details the purpose of the study. The researcher informed participants that participation was voluntary. Participants were assured confidentiality and anonymity on all documents and collected data, which were maintained in a locked file in a secured area with access limited to the investigator.

CHAPTER 4

Results

Demographic Statistics

The sample included 60 hospitalized postpartum women, 30 who received TPPC, and 30 who received FCPPC. All 60 eligible women participated for a response rate of 100% (n=60). The mean age of the 60 participants was 24, mean education 11.6, and hours postpartum 25.8 (Table 1). Black participants comprised 80% of the sample, and white 20%. The majority of the women were single (73%).

Analysis was conducted to determine if the two groups were demographically different. A one-way ANOVA was conducted for differences in hours postpartum, age, and grade level. No differences in those variables were found the two groups. Table 1 presents means, standard deviations f-ratios and *p*-values for the groups on hours postpartum, age, and education. A Chi-square was performed for difference in groups TPPC and FCPPC for race and marital status. Results revealed no significant differences (Table 2).

Descriptive statistics

Descriptive statistics of WPQ scores for women who received TPPC and women who received FCPPC are presented in Table 3. The mean Likert score for WPQ out of a possible 4 for the family-centered group was 3.86 and for the traditional care group 3.54, both of which represent high satisfaction scores.

Descriptive statistics for WPB for women who received TPPC and women who received FCPPC are presented in table 4. The mean Likert score for WPB out of a possible 4 for the family-centered group was 3.93, and for the traditional group 3.82, both of which represent high benefit scores.

Table 1

ANOVA for Difference in Hours Postpartum, Age, Grade Between a Group of Women Receiving TPPC (n=30), and Women Receiving FCPPC (n=30)

Variable	FCPPC (M±SD)	TPPC (M±SD)	Difference	F-ratio	p -value
Age	24.6±5.9	23.5±5.6	1.1	0.54	.47
Education	11.7±0.88	11.5±1.20	0.2	0.38	.54
HPP	25.9±9.6	25.8±7.6	0.1	<0.001	.98

Note: HPP= Hours Postpartum

FCPPC= Family-Centered Postpartum Care

TPPC= Traditional Postpartum Care

Table 2

Race and Marital Status for Women Receiving TPPC (n=30) and Women Receiving FCPPC (n=30)

Variable	Delivery Model	n	%	<i>p</i> - value
Race				
Black	TPPC	23	76.6%	.52
	FCPPC	25	83.33%	
White	TPPC	7	23.33%	
	FCPPC	5	16.67%	
MStatus				
Married	TPPC	6	20%	.24
	FCPPC	10	33.33%	
Single	TPPC	24	80%	
	FCPPC	20	66.67%	

Note. FCPPC= Family-Centered Postpartum Care

TPPC= Traditional Postpartum Care

MStatus= Marital Status

Table 3

Descriptive Statistics for Women's-Perceived Quality: Women Who Received Traditional Postpartum Care and Women Who Received Family-Centered Postpartum Care (n=30)

Variable	Mean	SD	SE
TPPC	3.54	.41	.08
FCPPC	3.86	.21	.04

Table 4

Descriptive Statistics for Women's-Perceived Beneficence for Women Who Received Traditional Postpartum Care (n=30) and Women Who Received Family-Centered Postpartum Care (n=30)

Variable	Mean	SD	SE
TPPC	3.82	.25	.04
FCPPC	3.93	.14	.03

Note. FCPPC= Family-Centered Postpartum Care

TPPC= Traditional Postpartum Care

Analysis of Questions

Research Question 1: Are there differences in women's perceptions of quality care between those choosing FCPPC and those choosing TPPC ?

The results of the *t*-test displayed in Table 5 identified that there were differences between the two groups on eight out of 22 WPQ items. The Family-Centered group reported higher scores for how nurses responded to their need for pain medications ($p = .00$), provided of adequate food and fluids ($p = .01$), women's wishes regarding rest ($p = .01$), involved family participation in their care ($p = .01$), nursing staff helped them feel physically comfortable ($p = .01$), nursing staff adapted routines to their wishes ($p = .03$), provided diet preferences ($p = .04$, and provided useful information on an individual basis ($p = .05$). Although not statistically significant, *t*-tests revealed that women with FCPPC tended to report higher scores than women receiving TPPC on the following four items: receiving help with care and feeding of your baby ($p = .07$), protection of privacy ($p = .08$), explanation of needs and wishes to others ($p = .07$), and emotional support and reassurance ($p = .08$).

Research Question 2: Are there differences in women's'-perceptions of benefits between those receiving FCPPC and those receiving TPPC?

The results of the *t*-test displayed in table 6 identify three out of seven WPB items that were different between women who received FCPPC and women who received TPPC. Women in the FCPPC group reported higher scores on the following: a home like atmosphere at ($p = .01$), adapting routines to your individual wishes ($p = .03$), and inclusion of your family in your care as much as you wanted ($p = .03$). Although not statistically significant, *t*-test also revealed that women receiving FCPPC tended to report higher scores than women receiving TPPC on the following item: the chance to have your choices in care honored ($p = .08$). On the remaining 3 items there were no significant differences between the groups with *p* values ranging from .4 to .6.

Table 5

Means, Standard Deviations, and Group Differences in Mean Women's-Perceived Quality Score for Each item in the Modified PPSQ for Women Who Received TPPC (n=30) and Women Who Received FCPPC (n=30)

Item	TCPPC M $\pm$ SD	FCPPC M $\pm$ SD	Difference in Means	t -test	p-value
Nursing Staff After Birth					
Gave you emotional support and reassurance	3.7 $\pm$ 0.7	3.9 $\pm$ 0.3	0.2	1.8	.08
Showed a warm and caring attitude	3.8 $\pm$ 0.5	3.9 $\pm$ 0.3	0.1	0.7	.51
Explained procedures	3.8 $\pm$ 0.4	3.9 $\pm$ 0.5	0.1	0.8	.40
Provided adequate food and fluids	3.0 $\pm$ 1.2	3.8 $\pm$ 0.6	0.8	2.9	.01
Helped you feel physically comfortable	3.6 $\pm$ 0.8	4.0 $\pm$ 0.2	0.4	2.6	.00
Adapted routines to your individual wishes	3.3 $\pm$ 1.0	3.8 $\pm$ 0.6	0.5	2.2	.03
Helped you with feeding and other care of your baby	3.2 $\pm$ 0.9	3.6 $\pm$ 0.8	0.4	1.9	.07
Provided useful information on an individual basis	3.4 $\pm$ 1.0	3.8 $\pm$ 0.5	0.4	2.0	.05
Provided useful information in classes	3.0 $\pm$ 0.7	4.0 $\pm$ 0.0	1.0	1.9	.12
Had technical knowledge and skills	3.9 $\pm$ 0.3	3.9 $\pm$ 0.4	0	0.4	.68
Protected your privacy	3.9 $\pm$ 0.3	4.0 $\pm$ 0	0.1	1.8	.08

Note. TPPC= Traditional Postpartum Care
FCPPC= Family-Centered Postpartum Care

Table 5 continued

Item	TPPC M±SD	FCPPC M±SD	Difference in Means	t-test	p- value
Treated you with respect	3.9±0.3	4.0±0	0.1	1.4	.16
Explained the actions and statements of others to you	3.9±0.3	4.0±0.2	0.1	1.4	.17
Explained your needs and wishes to Doctors and others	3.7±0.3	3.9±0.4	0.2	1.8	.07
Answered your questions honestly and completely	3.9±0.3	4.0±0.2	0.1	1.4	.17
Personal participation					
Time with your baby	3.4±1.0	3.7±0.8	0.3	1.5	.12
Visitors	3.8±0.5	3.9±0.4	0.1	1.2	.23
Rest	3.8±0.4	4.0±0	0.2	2.7	.01
Pain medication	2.7±1.0	3.8±0.6	1.1	3.8	.00
Procedures(for example IV's sitz baths)	3.7±0.8	3.9±0.3	0.2	1.4	.16
Family involvement	3.5±0.9	3.9±0.2	0.4	2.7	.01
Diet	2.5±0.2	3.3±1.0	0.8	2.1	.04

Note. TPPC= Traditional Postpartum Care
FCPPC= Family-Centered Postpartum Care

Table 6

Means, Standard Deviations, and Group Differences in Mean Women's-Perceived Benefit Score for Each Item on the WPBQ for Women Who Received TPPC (n=30) and Women Who Received FCPPC (n=30)

Item	TCPPC M $\pm$ SD	FCPPC M $\pm$ SD	Difference in Means	t--test	p-value
The opportunity to remain together as a family	3.9 $\pm$ 0.3	3.8 $\pm$ 0.6	0.1	.76	.45
Being able to touch and hold your baby immediately after birth	3.8 $\pm$ 0.6	3.9 $\pm$ 0.4	0.1	.74	.46
A home-like atmosphere less hospital like	3.7 $\pm$ 0.5	4.0 $\pm$ 0.2	0.3	2.6	.01
Adapting routines to your individual wishes	3.6 $\pm$ 0.8	4.0 $\pm$ 0.2	0.4	2.2	.03
Inclusion of your family in your care as much as you wanted	3.6 $\pm$ 0.8	4.0 $\pm$ 0.2	0.4	2.2	.03
The chance to have your choices in care honored	3.9 $\pm$ 0.3	4.0 $\pm$ 0	0.1	1.8	.08
The chance to be with and care for your baby when you wanted	4.0 $\pm$ 0.2	3.9 $\pm$ 0.4	0.1	.4	.67

Note. TPPC = Traditional Postpartum Care

FCPPC= Family-Centered Postpartum Care

Research Question 3: What is the relationship between WPQ and WPB?

For the combined sample, WPQ and WPB were moderately correlated ($r=.33$, $p=.01$). WPQ and WPB correlation results for TPPC were ($r=.25$, $p=.18$), and WPQ and WPB for FCPPC was ($r=.17$, $p=.38$).

Table 7

Correlation Coefficients and p -values for WPQ and WPB for the Combined Sample TPPC and FCPPC (n=60), WPQ and WPB for TPPC (n=30), and WPQ and WPB for FCPPC (n=30).

n		WPQ	p - value
<hr/>			
Combined(n=60)			
	WPB	.33	.01
TPPC (n=30)			
	WPB	.25	.18
FCPPC (n=30)			
	WPB	.17	.38
<hr/>			

Note: TPPC= Traditional Postpartum Care

FCPPC= Family-Centered Postpartum Care

WPQ= Women's-Perceived Quality

WPB= Women's-Perceived Benefit

CHAPTER 5

Discussion

Research Question 1: Are there differences in women's' perceptions of quality between those choosing FCPPC and those Choosing TPPC ?

Apparently the women in this study did not have negative antepartal or intrapartal experiences because both groups reported high perceptions of postpartum care. As expected, women in the FCPPC group had a higher mean score for WPQ than did the women in the TPPC group. In comparison to this study, Littlefield and Adams also found FCPPC women reported higher scores overall than TPPC women. In this study, women who received FCPPC and those who received TPPC did not differ on 11 out of 22 items on the PPSQ, suggesting that these two methods of care delivery are equally able to satisfy women related to those aspects of care. However, women who received FCPPC reported higher scores on quality of care resulting in significant differences between the groups on 8 out of 22 items. Each of the items will be discussed in turn.

Two items for which the FCPPC group reported significantly higher patient satisfaction scores related to pain and comfort. Pain management is a basic need for most hospitalized patients, including postpartum women. Women receiving FCPPC had higher perceptions of pain management quality than those receiving TPPC. Several explanations may account for differences between the two groups in the areas of pain relief and comfort. First, the FCPPC model was developed to encompass attention to women's needs; this does not imply that the traditional care model was not concerned with pain or comfort, but the findings may indicate that the FCPPC model may be better designed to promote comfort. Secondly, the increased attention from nursing staff and focus on family involvement in FCPPC may contribute to successful pain and comfort management and resulting increased perceptions of quality. Larrabee (1992) found that pain severity on exit

interview was a predictor of PPQ global. Third, differences in how nurses function in each model may account for the difference in pain management and women's perception of quality. The FCPPC model was designed to require less nursing staff to care for mother and baby as a unit, resulting in more efficient use of nursing time to provide measures related to comfort and pain relief (NAACOG, 1989). Hinshaw and Atwood (1979) found that staffing characteristics can affect patients satisfaction related to comfort.

The third and fourth items for which women with FCPPC reported significantly higher perceptions of quality were: consideration of wishes related to diet and provision of adequate food and fluids. The explanation as to why women in the two models differed on these items is unclear but may be related to an overall perception of quality and satisfaction with the FCPPC model. If nursing staff with the FCPPC model were more efficient in delivery of care, this efficiency may have included serving food, warmth of food, consistency with which water and other fluids were made available, and increased choices related to their diet.

Fifth, women in the FCPPC model reported significantly higher perceptions of quality than women in TPPC on the item pertaining to adequate rest. This finding might be surprising because the FCPPC model promotes more involvement by women in their personal care as well as the care of their baby (Waldenstrom & Nilsson, 1993). The TPPC model actually involves more dependence by women on nursing staff and mothers spend less time with their infants who are housed in a central nursery (NAACOG, 1989). Weiss and Armstrong found that although women in Dyad care (FCPPC) reported more night time disturbances, they still preferred the choice of having their infants with them throughout their postpartum experience. Why then do women receiving FCPPC perceive themselves more rested? Perhaps this phenomena is related to an increase in acquired skills for women receiving FCPPC in caring for self and baby. It is possible that women receiving care in the FCPPC model may experience increased feelings of security and less

anxiety related to having their infants and family with them and associate this with feeling more rested.

The sixth and seventh items for which women differed between the groups were family involvement and adaptation of routines to their wishes; because both of these items are also strongly characteristic of FCPPC, the higher quality scores for the family-centered group was anticipated. Sullivan and Beeman (1981) also found that flexibility in routines resulted in higher satisfaction scores for postpartum women. In addition, they reported that over seventy percent of respondents wanted more involvement from significant others.

The eighth item for which women in the two models were significantly different related to providing useful information on an individual basis. Because FCPPC requires more involvement by women in their own care and care of their baby, it was not surprising that they reported higher scores on this item. However, individualized instructions are essential for all postpartum women regardless of the care model and women typically request more information. In the study by Watters and Kristiansen(1989) women's responses indicated that they would benefit from increased teaching. Moore, et al.(1986) also found that women wanted more emphasis on education.

In addition to the eight items just discussed, women in the FCPPC group showed trends ($p<.10$) with higher patient satisfaction scores than women in the TPPC group on four items. Although not statistically significant, these differences may be clinically significant, especially given the small sample size of this study. Those four items related to emotional support and reassurance, help with feeding and care of baby, protection of privacy, and explanation of needs to doctors and others. Although characteristic of postpartum care in general, the items were more reflective of FCPPC, accounting perhaps for the slight though not significant variances between the groups.

For the 11 remaining postpartum WPQ items there was little or no difference between the scores of the groups. The lack of difference may imply that some aspects of the models overlap. Item sixteen, for instance, related to consideration of women's wishes

regarding time with their baby. Although it was expected that the FCPPC group would have reported higher WPQ scores than the TPPC group, there was no difference in the groups on this item. The most logical explanation for the similarities in scores may be related to availability of choices. For women in both the TPPC and the FCPPC models, care options were available, although limited and less flexible in the TPPC model.

As previously mentioned, Littlefield's study (1987) also found that women who received alternative birth (similar to FCPPC) experienced greater satisfaction (WPQ) than those women who received conventional care (TPPC). However, the two studies were different in relation to sample size and participant demographics. The Littlefield study had 21 women in the alternative birth and 78 for conventional care (N=97). In addition, participants in Littlefield's study were older for alternative birth with a mean age of 29.6, and were married. In this study, sample size was smaller (n=30 in each group), younger (mean age = 23.5 for TPPC, 24.6 for FCPPC group), and the majority of participants were unmarried (80% of the TPPC group and 67% of the FCPPC group). In addition, all participants for Littlefield's study were enrolled in childbirth classes compared to only one woman in this study who reported limited attendance. The two studies both found higher Likert scores overall in support of FCPPC, but in Littlefield's study, the tool consisted of 97 items; in this study only the postpartum scale was used with a total of 36 items.

The results of this study have significant clinical implications for nursing on TPPC units. Because the FCPPC group had higher quality scores than the TPPC group, nurses expected to function in the TPPC model should consider modifications in care delivery that would incorporate characteristics of FCPPC.

Initial consideration should be given to those items that were significantly different between groups. Items related to pain medication and physical comfort were significantly different between the groups, with the FCPPC group reporting much higher mean scores, especially for pain medications. These results send a strong message to nurses who care for women in the TPPC model, and imply that those nurses need to focus more attention to

women's need for pain management, especially because postpartum women may experience pain or discomfort from several sources. Episiotomies, afterbirth pains and hemorrhoids are examples of common discomforts of the postpartum period that must be managed before women can turn their attention to the task of caring for themselves and their infants. Simple actions such as fluffing or providing extra pillows and assisting women into more comfortable positions for either breast or bottle feeding may make the difference in a satisfying or dissatisfying experience. In addition, nurses should anticipate women's needs for pain medication and solicit their input regarding measures that work best for them.

Secondly, although women in FCPPC reported higher quality scores related to diet and fluids, both groups had lower mean scores when compared to the mean scores of the other quality items. In addition to being a basic need for any patient, adequate diet for postpartum women provides a variety of benefits for mothers and their babies. In the postpartum period women are essentially recovering from the extremely demanding chores of labor that characterize the intrapartum period. In most instances, breathing exercises, sweating, postpartum bleeding and diuresis are common causes of fluid loss for postpartum women. Nurses should be aware of these factors, and assure that water, milk, juices or other preferred fluids are made available at all times. Also, diet is extremely important to women and should not only consist of the necessary nutrients, but include food items that are satisfying to the individual desires of postpartum women.

Third, FCPPC women also had significantly higher quality scores related to optimal opportunities for rest. Again, the postpartum period should be a time when women can recuperate from demands of labor with as many opportunities for rest as possible. Nurses who function in the TPPC model should assess individually the needs of the postpartum women and solicit her input before attempting to implement self care activities.

Fourth, women in the FCPPC model reported higher scores related to information needs. This finding implies that nurses, particularly those caring for women in the TPPC

model, need to focus on providing as many opportunities for individualized instruction as possible.

Fifth, because of the significant difference in scores related to family involvement, nurses in the TPPC model should try to involve the family as much as possible. More flexibility in visiting routines require that nurses be empowered to make decision based on individual circumstances that may arise for postpartum women and their families.

The last item for which women were significantly different, was adapting routines to individual wishes. The mean scores for the TPPC group was significantly lower than those for the FCPPC group. Nurses providing care for women in the TPPC group must adjust rigid routines to accommodate women whenever possible.

The finding of this study also suggest clinical implications pertaining to the items on which the TPPC and FCPPC groups did not differ. Nurses working on the FCPPC units need to consider directing quality improvement activities toward those aspects of care. For instance, scores for those items for which women did not differ were equally high for both groups, with the exception of diet. Even though both groups had lower scores related to diet than on other items, the TPPC group's score was lower. Thus, nurses in both models could do more pertaining to diet to positively influence women's perception of quality.

Research Question 2: Are there differences in women's perceptions of benefits between those who received TPPC those receiving FCPPC?

The seven items used to measure women's-perceived benefit were deliberately designed benefits of FCPPC. As expected, the FCPPC group had higher WPB scores than did the TPPC group. Specifically, women in the FCPPC group reported significantly higher perceptions of benefits than women in the TPPC group on three of the seven items. Each of these will be discussed in turn. First, women differed between the groups on their perceptions of the benefits of a homelike less hospital like atmosphere ($p=.012$). Because both groups shared similar physical surroundings, the most plausible explanation for

differences in group scores may be related to the management of care. This implies that the characteristics of the care women received, not the actual physical surroundings, were responsible for the FCPPC groups higher perceptions of benefits on this item.

Specifically, FCPPC was designed to keep the family together in a more homelike atmosphere and nurses were expected to promote that aspect of the model.

Second, women in the FCPPC group reported statistically higher perceived benefit scores on inclusion of the family in care as much as possible ($p = .03$). This result was expected because family involvement is an important characteristic of the FCPPC model. According to Ingalls and Salerno (1991) the model encourages parents or significant others to get to know the baby and begin functioning as a unit as early as possible. This finding suggests that nurses were successfully implementing the FCPPC model.

Third, women in the FCPPC group had statistically higher perceptions of benefits than the TPPC group related to adaptation of routines to their individual wishes ($p = .032$). This finding supports the premise that flexibility in scheduling activities had been incorporated as part of the FCPPC model (NAACOG, 1989). The traditional model in contrast is more rigid and based on the premise that health care providers know what care is best and how best to deliver that care. Based on WPB scores, the women in TPPC perceived adaptation of routines to their wishes at a lower level, less beneficial. Quite possibly those women could have found TPPC acceptable if they did not perceive the proposed benefits of FCPPC to be expectations for their postpartum experience.

Interestingly, adapting routines to individual wishes and the chance to have choices in care honored may be interrelated items. However, for the second item only a trend ($p = .07$) difference was noted between groups. The most plausible explanation for lack of significant difference is probably that some of the TPPC women perceived "having choices in care honored" as being beneficial. A second explanation may be that the staff on the unit caring for both groups incorporated elements of the FCPPC model into care provided to

women in TPPC. This may represent a limitation of this study since the TPPC patients were cared for by nurses who gave TPPC to some patients and FCPPC to others.

On the three remaining items, there were no differences in scores between the two groups related to perceived benefits. Both groups perceived being able to touch and hold baby immediately after birth as beneficial. In the institution where the study was conducted, this option was available to all women unless medically contraindicated for mother or baby. The women did not differ on being able to remain together as a family, which was probably related to the flexible visiting policy of the institution for postpartum women regardless of the care model. Women in both groups perceived the ability to care for baby when they wanted as beneficial.

No other studies were found in the literature that measured women's perceived benefits between those receiving TPPC and those receiving FCPPC. The results of the one study that related to benefits of postpartum care (Watters & Kristiansin, 1989) indicated that women and nurses benefited from combined mother infant care because of greater success with breastfeeding and other infant care.

Clinical implications of this study related to beneficence are that because the FCPPC group had higher benefit scores overall, and the beneficence scale items are based on FCPPC, nurses who provide care for women in the TPPC model or the FCPPC should incorporate concepts of FCPPC. Nurses should also continue to survey women for their input into what is beneficial in postpartum care.

Although these results are promising, many gaps remain related to WPB in postpartum care. The scale consisting of 7 items characteristic of FCPPC has not been used in other studies. Women's-perceived benefit should be further explored to include all aspects of Littlefield's postpartum scale. In addition, studies should explore the correlation between WPB and outcomes, studied by Watters and Kristensin (1989) such as women's ability to care for self and infants. Also, additional research needs to be conducted to examine the psychometric properties of the benefits scale.

Question 3: What is the relationship between WPQ and WPB?

This study supported the proposed relationship between quality and beneficence in Larrabee's model of quality, because WPQ and WPB were related ($r = .33$; $p = .01$) in the combined sample ($n=60$). Larrabee's findings (1992) provided initial support for the relationship between quality and beneficence, because pain on exit interview was a predictor of PPQ. Separate examination of the proposed relationship between WPQ and WPB within the FCPPC and the TPPC groups revealed weak to moderate correlations that were not statistically significant.

Several factors should be taken into account in analyzing the results of this study. According to Neiswiadomy (1993), "when determining the significance of correlation coefficients, It's important to examine sample size" p. 293. Neiswiadomy (1993) also contended that a small sample size with small correlation results may be less statistically significant than a larger sample with coefficients as small or smaller. In other words, a sample size of 60 with a correlation coefficient of .33 and $p=.01$ is considered significant. This implies that women from both groups with higher perceptions of quality, also had higher perceptions of benefits. If this is true, why didn't FCPPC yield a higher correlation to benefits than TPPC?

There may be two plausible explanations for these results. First, sample size may have accounted for the lower correlation coefficients for the separate groups. According to Kerlinger (1973) sampling error decreases as the sample size increases, implying that the smaller the sample size the higher the chances are for error. Sample size for the individual groups was 50% lower than that for the combined groups. Even though results indicated that WPQ and WPB were lower for individual groups, the correlations may be clinically significant and require further analysis with larger samples of similar population characteristics to examine statistical significance.

Secondly, nurse providers for TPPC may have been the source of treatment contamination. Nurses who cared for women receiving TPPC were also consistently

assigned to care for women receiving FCPPC. Quite possibly, those nurses were unable to separate aspects of care between models. For, instance, on one of the most important aspects of the FCPPC model, "time with your baby" (NAACOG,1989; Ingalls &Salerno,1991), scores were not significantly different between groups ($p=.12$). There was also no significant difference between the groups related to the chance to be with and care for your baby when you wanted ($p =.67$). This finding indicates that both groups may have benefited from aspects of the FCPPC model, and again emphasizes that individual perceptions and choices are more important than the actual model of care. Weiss and Armstrong (1990) also found that choices was important to women regardless of the care model. For instance, in their study, postpartum women preferred the option of having their baby with them when they wanted.

Clinical implications of this relationship are that nurses should focus care on behaviors and activities women perceive as more beneficial to them. This does not imply that nurses should abandon those care activities that are necessary to meet accepted standards policies and protocols, but should consider women's perceptions in defining care. Additionally, regardless of the care model, nurses should place more emphasis on women's perceptions of what is beneficial to them.

Gaps in this research are related to the need to also study the benefits of the quality items of the PPSQ, to gain further insight into women's perceptions of their benefits. Also, additional studies with larger sample sizes and diverse patient demographics should be conducted to provide additional support for the proposed relationship between WPQ and WPB in postpartum care.

Strengths

The strengths of the study relate to: (1) demographic similarities of the FCPPC group and the TPPC group, (2) the equal number of participants for each group, (3) theoretical and prior empirical support for the relationship between quality and beneficence,

(4) uniqueness of this study related to WPB in postpartum care, and (5) the use of a tool with previous construct and content validity in the area of postpartum care specifically measuring women's perceptions of FCPPC and TPPC.

Limitations

The sample demographics of a predominantly black, unmarried, urban population limit the generalizability of the study. However, study findings may be applicable in other urban hospitals with similar patient demographics, such as other safety net hospitals (Gage, 1991). In addition, other area hospitals may now have less dissimilar patient populations because TennCare has given Medicaid recipients the option of going to those hospitals for care.

A second limitation is that the TPPC women were not housed on a unit providing TPPC only. Therefore, the nurses may have been giving the TPPC patients more choices in their care than typical of the TPPC model. If this is the case, one would anticipate even greater differences in perceived quality and perceived benefit in a study where TPPC patients were housed on a unit that only provided TPPC and no nurses floated from the FCPPC unit to that unit.

A third limitation is related to the size of the sample. Because of the discrepancy between combined group correlation results and separate group results, there is a need to explore the relationship between WPQ and WPB with larger sample sizes. Larger sample sizes should reduce sampling error and a stronger relationship between WPQ and WPB would be anticipated.

A fourth limitation is that in addition to the modified PPSQ comprised of 22 items on the quality scale, this study used 7 items on the beneficence scale (WPBQ). The WPBQ had not been tested prior to this study, and additional studies need to be conducted for construct and content validity. Also, future research should focus on validating the relationship between quality and beneficence using other sample sizes.

Future Research

Areas of study should be expanded to include other concepts of Larrabee's model of quality. For instance, future research should explore the possible relationship between quality and value, and value and beneficence in the postpartum setting. Confirmation of these relationships will provide further support for the concepts as defined from the woman's perspective. Also, a more in-depth exploration of women's definitions of quality, beneficence, and value are needed.

Conclusion

The study findings indicate that women receiving FCPPC have higher perceptions of quality on some dimensions of care than women receiving TPPC. In addition, the study findings indicate that women receiving FCPPC have higher perceptions of some benefits than women receiving TPPC. Results also indicated that a relationship exists between quality and beneficence. This relationship suggests that rather than viewing the two models as separate, providers should seek to deliver the aspects of care that women perceived as high quality and benefit. Also, regardless of the model of care, the relationship between quality and beneficence implies that if care is perceived of benefit to women they will also perceive that care of high quality.

Based on the results of this study, health care providers should continuously involve themselves in activities aimed at identifying women's perception of quality and benefits in postpartum care. The results of this study may also have implications for health care in general. The FCPPC model may contain aspects of care that may be useful in other areas of care. Perhaps critically ill patients could benefit from increased involvement of their families, and perhaps the medical surgical units could become unique family units structured for more family involvement. In today's competitive health care arena, it is time we dared to listen to our customers in all areas of health care. Continued research in this

area, will provide caregivers with relevant, and timely information about the constantly changing expectations of the community.

REFERENCES

References

- Abacus Concepts, (1991). *StatView Student*. Berkeley, California, Abacus Concepts.
- Abdellah, F. G. & Levine, E. (1957). Polling patients and personnel: Part 11. What factors affect patients' opinions of their nursing care. *Hospitals*, 31 (Nov. 16), 61-62,64.
- Abramowitz, S., Cote, A. A., & Berry, E. (1987). "Analyzing patient satisfaction: A multianalytic approach." *Quality Review Bulletin*, April, 122-130.
- Bader, M. M. M. (1988). Nursing care behaviors that predict patient satisfaction. *Journal of Nursing Quality Assurance*, 2 (3), 11-17.
- Beymer, P. L., Rhyan, C. J., Johnson, N.J., Hennessy, K.A., Gattuso, M.C., Epsom, R., & Czurylo, K.T. (1993). Using patient perceptions to improve quality care. *Journal of Nursing Care Quality*, 7 (2), 42-51.
- Boothe, R. (1990). Who defines quality in service industries? *Quality Progress*, February, 65.
- Brown, D. S. (1992). A conceptual framework of nursing service quality. *Journal of Nursing Care Quality*, 6 (4), 66-74.
- Burgess, M. A. (1932). Quality nursing. *American Journal of Nursing*, 32 (10), 1045-1053.
- Burns, N. & Grove, S.K. (1987). *The practice of nursing research: Conduct, critique and utilization*. Philadelphia: Saunders.
- Campbell, C. F., Mason, J. B., & Weiler, J. M. (1990). Patient perception of hospitalization as an avenue to change. *Journal of Quality Assurance*, 5 (1), 8-15.
- Cleary, P. D., Keroy, L., Karapanos, G., & McMullen, W. (1989). Patient assessments of hospital care. *Quality Review Bulletin*, 15(6), 172-179.
- Corrigan, (1990). Consumer satisfaction with institutional care. *Community Mental Health Journal*, 26(2), 151-163.
- Domask, M. E., & Childs, S. (1988). The patient and nurses perceptions of analgesic administration times. *Journal of Nursing Quality Assurance*, 2(3), 64-69
- Doering, E. R. (1983). Factors influencing inpatient satisfaction with care. *Quality Review Bulletin*, 9, 291-299.
- Engle, J. F., Blackwell, R. D., & Miniard, P. W. (1990). *Consumer Behavior* (6th ed.). Chicago: The Dryden Press.

- Erikson, L. R. (1987). Patient satisfaction: An indicator of nursing care quality. *Nursing Management*, 18, 31-35.
- Frederick, B. J., Sharp, J. Q., & Atkins, N. (1988). Quality of patient care: Whose decision? *Journal of Nursing Quality Assurance*, 2 (3), 1-10.
- Gage, L.S., Weslowski, V.B., Andrulis, D.P., Hintz, E., & Camper, A.B. (1991). *America's safety net hospitals: The foundation of our nations' health system*. Washington, D.C.: National Association of Public Hospitals.
- Garvin, D. A. (1988). *Managing quality: The strategic and competitive edge*. New York: The Free Press.
- Ginsburg, P. B., & Hammons, G.T. (1988). Competition and the quality of care: The importance of information. *Inquiry*, 25, spring, 108-115.
- Hegyvary, S. T., & Haussmann, R. K. D. (1976). Monitoring nursing care quality. *Journal of Nursing Administration*, 6 (9), 3-9.
- Hinshaw, A. S. & Atwood, J. R. (1982). A patient satisfaction instrument: Precision by replication. *Nursing Research*, 31, 170-191.
- Ingalls, A. J., & Salerno, M. C. (1991). *Alternative childbirth arrangements. in Maternal and Child Nursing* (7th ed.). St. Louis Mo: Mosby yearbook Inc.
- Iyer, P. W., & Taptich, B. J., (1991). *Nursing Process and Nursing Diagnosis* (2nd ed.) Philadelphia, London, Toronto, Montreal, Sydney, Tokyo: W.B. Saunders Company.
- Kerlinger, F. (1973). *Foundations of behavioral research* (2nd ed.). New York: Holt, Rinehart & Winston.
- King, I. (1988). *Measuring the goal attainment in patients*: In C.F. Waltz and O.L. Strickland (Eds.) *Measurement of nursing outcomes: measuring client outcomes*, volume I. New York: Springer Publishing Company, 108-117.
- Kreidler, M. C., & Conrad, M. A., (1992). A study of clients perceived needs in a nursing center. *Journal of Nursing Care Quality*, 7 (1) 57-63.
- Lang, N. M., & Clinton, J. F. (1984). Assessment of quality of nursing care. *Annual Review of Nursing Research*, 2, 135-163.
- Lambertsen, E. C. (1965). Evaluating the quality of nursing care. *Hospitals*, 39, 61-62, 64, 66.
- Larrabee, J. H., (1992). *Hospital patients' and nurse's perception of quality*, an unpublished doctoral dissertation. College of Nursing, University of Tennessee, Memphis, TN.
- Linder-Peltz, S. (1982). Toward a theory patient satisfaction: Some suggestions for research. *Social Science and Medicine*, 16, 577-582.
- Littlefield, V. M., (1986). *Patient participation satisfaction questionnaire*. New York University of Rochester School Nursing.

- Littlefield, V. M. , & Adams, B. N., (1987). Patient participation in alternative perinatal care: Impact on satisfaction and health locus of control. *Research In Nursing & Health* , 10, 139-148.
- Marker, J. (1989). Integrating patient satisfaction into your QA/RM program - Or pleased patients seldom sue. *Journal of Quality Assurance*, 8-10, 39.
- Megivern, K., Halm, M. A. , & Jones, G. (1992). Measuring patient satisfaction as an outcome of nursing care. *Journal of Nursing Care Quality Assurance*, 5 (1), 16-24.
- Merry, M. D. (1987). What is quality care? A model for measuring health care excellence. *Quality Review Bulletin*, 298-301.
- Meterko, M., Nelson, E. C., & Rubin, H. R. (1990). Patient judgment of hospital quality: report of a pilot study. *Medical Care* (suppl.), 28 (9), S1-S44.
- Microsoft Corporation. (1990). *Microsoft Excel: User's guide*. Redmond, Washington: Author.
- Moore, L., Burns, A., Thomas, L., & Karia, M. (1986). Self assessment: A personalized approach to nursing during pregnancy. *JOGNN*, July/August, 311-318.
- Neiswiadomy, R.M., (1993). *Foundations of nursing research*. Connecticut: Appleton & Lange, 292-293.
- Organization for Obstetric, Gynecologic & Neonatal Nurses, (1989). *OGN Nursing practice resource: Mother-baby care*. Washington, DC: Author.
- Oliver, R. (1980). A cognitive model of antecedents and consequences of satisfaction decisions. *Journal of Marketing Research*, November, 460-469.
- O'Malley, J., & Thompson, D. S. (1992). Redesigning roles for patient centered care *Journal of Nursing Administration*, 22 (7), 30-34.
- Prehn, R. A., Mayo, H., & Weisman, E. (1989). Determining the validity of patient perceptions of quality care. *Quality Review Bulletin*, 15 (3), 74-76.
- Reeder, P. J. , & Chen, S. C. (1990). A client satisfaction survey in home health care. *Journal Of Nursing Care Quality Assurance*, 5 (1), 16-24.
- Regional Medical Center At Memphis (The Med,1991). *Annual report*. Memphis, TN.: Auth.
- Risser, N. L. (1975) . Development of an instrument to measure satisfaction with nurses and nursing care in primary care settings. *Nursing Research*, 24 (1), 45-51.
- Robinson, J. C. (1988). Hospital quality competition and economics of imperfect information. *The Milbank Quarterly*, 66 (3), 465-481.
- Rubin, H. R. (1990). Can patients evaluate the quality of hospital care? *Medical Care Review*, 47 (3), 267-326.

- Scaer, R., & Korte, D. (1978). Maternity options for mother- what do women want in maternity care? *Birth and The Family Journal*, 5_(1), 20-26.
- Schroeder, P. S., & Maibusch, R. M. (1984). *Nursing quality assurance: A unit-based approach*. Rockville, M.D: Aspen Publishers, Inc.
- Schroeder, P. S. (1991). Improving health care quality in the nineties. In P.S. Schroeder (Ed.) *The encyclopedia of nursing care quality volume 1: Issues and strategies for nursing care quality* (1-6). Gaithersburg, M: Aspen Publishers, Inc.
- Shelley, S. (1984). *Research methods in nursing and health*. Boston: Little, Brown.
- Steiber, S. R. (1989). Social issues: How consumers perceive health care quality. *Hospitals*, 84.
- Sullivan, D.A., & Beeman, R. (1981). Satisfaction with postpartum care: Opportunities for bonding, reconstructing the birth and instruction. *Birth and the Family Journal* 8 (3), 153-159.
- Taylor, A. G. & Haussmann, G.M. (1988). Meaning and measurement of quality nursing care. *Applied Nursing Research*, 1 (2), 84-88.
- Taylor, A. G. ,Hudson, K. , & Keeling, A. (1991). Quality nursing care: The consumers perspective revisited. *Journal Of Nursing Quality Assurance*, 5 (2), 23-31.
- Tribotti, S. , Lyons, N. , Blackburn, S. , Stein, M. , & Withers, J.(1988).Nursing diagnoses for postpartum women. *JOGNN*, 31 (4), 226-230.
- Twarden, C. A. , & Gartner, M. B. (1991). Patient satisfaction with primary nursing in home health. *Journal Of Nursing Administration* 21(11), 39-43.
- Ventura, M. R. , Fox, R. N. , Corley, M. C. , & Mercurio, S. M. (19). A patient satisfaction measure as a criterion to evaluate primary nursing. *Nursing Research*, 31(4), 226-230.
- Waldenstrom, U. & Nilsson, C. (1993). Women's satisfaction with birth center care: A randomized study. *Birth*, 20 (1), 3-13.
- Watters, N.E. & Kristiansen, C.M. (1989). Evaluating hospital postnatal nursing care: Development of the instruments. *Research in Nursing & Health*, 12, 229-305.
- Weisbrod, B. A. (1985). America's health care dilemma. *Challenge*, September/October, 30-34.
- Weiss, B. D. , & Senf, J. H. (1990). Patient satisfaction survey instrument for use in health maintenance organizations. *Medical Care*, 28(5), 434-445.
- Weiss, M. E. , & Armstrong, M. (1990). Postpartum mother's preferences for nighttime care of the neonate. *JOGNN*, 20 (4), 290-295.
- Whitely, R. C. (1991). *The customer driven company*. Addison-Wesley.

Yoder, S. D. & Rode, M. W. (1990). How are you doing: Patient evaluation of nursing actions. *Journal Of Psychosocial Nursing*, 28(10), 26-30.

Young, D. (1992). Family-centered maternity care: Is the central nursery obsolete? *Birth*, 19 (4), 183-184.

APPENDICES

APPENDIX A

Purpose for Participants

The purpose of this study is to determine what aspects of care available to postpartum mothers are satisfying, beneficial and considered quality. As nurses it is important for us to know your preferences for care, and your feelings about your care after the birth of your baby, as well as your satisfaction with the current care. The information obtained in this study will help us improve care to pregnant women and their families. For each question, tell how satisfied you are with the following aspects of your postpartum experience.

APPENDIX B

Modified Patient Participation Satisfaction Questionnaire

PPSQ

Include here, your evaluation of your experience after the delivery of your baby. This period includes the time immediately after the birth of your baby until you leave the hospital.

Codes for rating scale:

NA =not applicable

FS= fairly satisfied

VDS= very dissatisfied

VS = very satisfied

FDS=fairly dissatisfied

NS nor DS= Neither satisfied nor dissatisfied

Nursing Staff After The Birth of your Baby

(include all nurses caring for you after the delivery of your infant)

How satisfied were you that they:

	NA	VS	FS	NS DS	nor FDS	VDS
1. Gave you emotional support and reassurance		4	3	2	1	0
2. Showed a warm and caring attitude toward you		4	3	2	1	0
3. Explained procedures (for example, sitz bath, IV's, meds)		4	3	2	1	0
4. Provided adequate food and fluids		4	3	2	1	0
5. Helped you feel physically comfortable		4	3	2	1	0
6. Adapted routines to your individual wishes		4	3	2	1	0
7. Helped you with feeding and other care of your baby		4	3	2	1	0
8. Provided useful information on an individual basis		4	3	2	1	0
9. Provided useful information in the classes		4	3	2	1	0

		NA	VS	FS	NS ^{nor} DS	FDS	VDS
10.	Had technical knowledge and skill		4	3	2	1	0
11.	Protected your privacy		4	3	2	1	0
12.	Treated you with respect		4	3	2	1	0
13.	Explained the actions and statements of others to you		4	3	2	1	0
14.	Explained your needs and wishes to doctors and others		4	3	2	1	0
15.	Answered your questions honestly and completely		4	3	2	1	0

Personal Participation

How satisfied were you after the delivery of your baby that your wishes were taken into consideration with regard to:

16.	Time with your baby		4	3	2	1	0
17.	Visitors		4	3	2	1	0
18.	Rest		4	3	2	1	0
19.	Pain medications		4	3	2	1	0
20.	Procedures (for example, IV's sitz baths)		4	3	2	1	0
21.	Family involvement		4	3	2	1	0
22.	Diet		4	3	2	1	0
23.	Other(specify)_____		4	3	2	1	0

Women's-perceived benefit Questionnaire **WPBQ**

Have the following aspects of nursing care been made available to you? If so how beneficial did you consider them.

Codes for rating scale: VB= Very beneficial FB= Fairly beneficial

NBNUB= Neither beneficial nor unbeneficial FUB= Fairly unbeneficial

VUB= Very unbeneficial

Options Characteristic of FCPPC

How beneficial would / was:	NA	VB	NB FB	NUB	FUB	VUB
24. The opportunity to remain together as a family		4	3	2	1	0
25. Being able to touch and hold your baby immediately after birth		4	3	2	1	0
26. A home like atmosphere (less hospital like)		4	3	2	1	0
27. Adapting routines to your individual wishes		4	3	2	1	0
28. Inclusion of your family in your care is much as you wanted		4	3	2	1	0
29. The chance to have your choices in care honored		4	3	2	1	0
30. The chance to be with and care for your baby when you wanted		4	3	2	1	0

This section allows you to tell us in your own words about your experience while in this hospital.

31. What do you consider quality care?

32. Do you consider the care you received as quality
yes_____ no_____

33. What changes would have improved your experience after delivery?

34. Please briefly describe the aspects of this experience that most pleased you and most displeased you.

Most pleased by:

Most displeased by:

35 Would you recommend delivering at this hospital to your friends or relatives?

_____yes _____no Why?

36. If you decide to have another child, would you like to deliver in exactly the same way?

_____yes _____no Why?:

Thank you for taking the time to determine if the care we are providing satisfies you, is of benefit to you, and what you consider as quality

APPENDIX C

Demographic Data

Date collected_____ MR#_____

Study #_____ Hours Postpartum_____ Age_____ Highest grade completed in high school_____

Race:

(1)Black__

(2)White__

(3)other__

Care Type:

(1)Traditional__

(2) Family-Centered__

Marital Status:

(1)Married__

(2)Single__

(3)Divorced__

(4)Widowed__

(5)Cohabitation__

Employment Status:

Employed

(1) Yes__

(2) No__

Income_____

Living arrangements:

(1)With parents__

(2)On your own__

(3)Other__

Delivery data

1)G__ (2)T__ (3)Pt__ (4) A__ (5) L__

Type of delivery:

(1)Vaginal with episiotomy__

(2)Vaginal without__

(3) Vertex

(4) Breech

Weeks gestation at birth of baby__

APPENDIX D

Consent Form

Women's Perceived Quality In Postpartum Care

I have agreed to participate in a research study about what women consider quality in postpartum care. I understand that 60 patients will be participating in this study.

I understand that once I have agreed to be a part of the study, I will be asked questions about how satisfied I am with the care I received. The interview may take 20 minutes or more depending on me and my individual responses.

I understand that my answers will not be shared in any way and will only be reported as group information. So, my answers will not cause me to be treated differently by the hospital staff than I would be if I were not in this study. My answers will be written down and stored without use of my name.

This study may not help me at this particular time , but the information may help improve future postpartum experiences for me and other women.

I understand that I am not waiving any legal rights or releasing the Regional Medical Center at Memphis, University of Tennessee, or their agents from liability for negligence. I understand that in the event of physical injury resulting from the research procedures, neither the hospital or the University have funds budgeted for compensation either for lost wages or for medical treatment. Therefore, neither the hospital or the University provides for treatment or reimbursement for such injuries.

I have read the description of this study and have freely agreed to take part in it. I have had any possible side effects explained to me. I have had the opportunity to ask questions of the investigator and have received acceptable answers. I understand that I may choose to withdraw from this study at any time and still receive the usual care for my situation provided by this hospital. If I have questions concerning the research or my rights as a subject, I can contact Maryland Hunter R.N., at 5757375.

Participant's Signature

Date

Witness

Date

Researcher

Date

APPENDIX E

Permission to Use Copyrighted Material

THE UNIVERSITY OF TENNESSEE
MEMPHIS
The Health Science Center

College of Nursing
877 Madison Avenue
Memphis, Tennessee 38163
Fax (901) 577-4121

March 9, 1994

Maryland A. Hunter, RN, BSN
4704 WildPlum Court
Memphis, TN 38118

Dear Ms. Hunter:

You have my permission to use the copyrighted figure and definitions of quality and beneficence, taken from my dissertation "Hospital Patients' and Nurses' Perceptions of Quality," in your thesis (Women's-Perceived Quality in Postpartum Care), as you have described in your March 8, 1994 letter.

You must acknowledge within your thesis the original source of that copyrighted information .

Sincerely,

A handwritten signature in cursive script that reads "June H. Larrabee".

June H. Larrabee, Ph.D., R.N.
Assistant Professor

APPENDIX F

Permission to Use Copyrighted Material

School of Nursing
University of Wisconsin-Madison

Office of the Dean
Telephone: 608/263-5155
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Center for Health Sciences
Clinical Science Center
600 Highland Avenue
Madison, Wisconsin 53792

February 18, 1994

Ms. Maryland Hunter
4704 Wildplum Court
Memphis, TN 38118

Dear Ms. Hunter:

I appreciate your interest in my questionnaire on patient satisfaction. It is enclosed as is a reprint of the article describing its psychometric properties.

Please note that not all the items on this draft were used in the analysis. You should run your own reliability prior to using the data. You may want to shorten or revise the instrument to meet your particular needs.

If I can answer questions, please do not hesitate to call me at 608/263-5155.

Sincerely,

Vivian M. Littlefield, Ph.D., R.N.
Dean and Professor

VML/cal/1

APPENDIX G

IRB Approval Letter

THE UNIVERSITY OF TENNESSEE
MEMPHIS
The Health Science Center

July 6, 1994

Institutional Review Board
62 South Dunlap, Suite 320
Memphis, TN 38163
(901) 448-4824

Maryland Hunter
4704 WildPlum Court
Memphis, Tn. 38118

Re: IRB # 5145 "Women's Perceived Quality in
Postpartum Care"

Dear Ms. Hunter:

We are in receipt of your written acceptance of the proviso outlined in my letter of May 4, 1994 concerning the above referenced Institutional Review Board protocol. We have reviewed these materials and find that they do comply with the proper consideration for the rights and welfare of human subjects, the risk involved and the potential benefits of the study. Therefore, this letter constitutes full approval from the Institutional Review Board for the above referenced study and consent form.

However, any further alterations in the protocol must be promptly reported to and approved by the Institutional Review Board. In addition, annual reapproval is required by the IRB, and it is the responsibility of the Principal Investigator to initiate the request for reapproval regardless of the time the activity has been approved by the sponsoring agency.

You have individual responsibility for reporting to the board in the event of adverse reactions.

Sincerely yours,

Clair E. Cox, M.D.
Chairman
Institutional Review Board

VITA

Maryland Augusta Hunter was born in Memphis, Tennessee. She attended City of Memphis Hospital School of Nursing in Memphis, Tennessee and graduated in September 1967 with a diploma in nursing. In May 1981 she graduated from the University of Memphis with a Bachelor of Science degree in Nursing. She is a candidate for the Master of Science degree in Nursing from the University of Tennessee, Memphis and is scheduled to graduate in December, 1994. Her major concentration of study is women's health.

Mrs. Hunter has been a member of the Organization for Obstetric, Gynecologic and Neonatal Nurses and became certified in high risk perinatal nursing in 1986. She is also a Basic Life Support and Advanced Cardiac Life Support instructor.

Mrs. Hunter was employed as staff nurse and head nurse in a high risk labor and delivery for a number of years and presently is an instructor in women's health for a major regional hospital.