Arab American University

Faculty of Graduate Studies

Department of Health Sciences

Master Program in Neonatal Nursing

Assessing the Level of Family Satisfaction Regarding the Quality of Health Care Provided to Their Infant and Pediatric Patients in Ramallah Hospitals: A Cross-Sectional Study

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This Thesis Was Submitted in Partial Fulfilment of the Requirements for the Master Degree in Neonatal Nursing

Palestine, 1/2026

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Thesis Approval

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Declaration

I declare that, except where explicit reference is made to the contribution of others, this thesis is substantially my own work and has not been submitted for any other degree at the Arab American University or any other institution.

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Acknowledgments

First and foremost, I want to express my sincere gratitude to God, the Almighty, for all his blessings, wisdom, and opportunities, and for finally enabling me to complete the thesis.

I also want to express my gratitude to my supervisor, Dr. Mohammad Jallad, for his help and advice.

Dr. Mohammad Jallad provided me with valuable research expertise and spent a lot of time helping me complete my thesis; with his advice, encouragement, and mentoring, I was able to get this far.

I also want to thank everyone who has helped me in any manner throughout my coursework. Their support, advice, and encouragement have enhanced my research and enabled me to complete this thesis.

Lastly, I would like to sincerely thank my parents for their unwavering support and care, which have been a continual source of inspiration and strength. Their support and faith in me during my academic endeavors have been crucial to my success.

Assessing the Level of Family Satisfaction Regarding the Quality of Health Care Provided to Their Infant and Pediatric Patients in Ramallah Hospitals: A Cross-Sectional Study

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Abstract

Background: Healthcare quality is a multidimensional concept that has evolved, beginning with Donabedian's foundation definition emphasizing the maximization of health benefits while minimizing harm, and later expanded by the Institute of Medicine to include effectiveness, safety, patient-centeredness, and consistency with professional standards. In Pediatric and neonatal care, assessing health care quality requires particular attention to children's developmental needs and active involvement of families.

Aim: This study aims to assess the level of family satisfaction regarding the quality of health care provided to infant and pediatric patients in Ramallah hospitals

Methodology: A cross-sectional quantitative study design was conducted in selected governmental and private hospitals in Ramallah City. The study population included parents or primary caregivers of hospitalized neonatal and pediatric patients who met the inclusion criteria. Furthermore, the sampling was used using a stratified proportional sampling technique to recruit participants. Data were collected using a self-administered questionnaire consisting of two parts: the Child Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, while the second part consisted of a sociodemographic questionnaire related to the child and caregiver.

Result: Approximately two-thirds of parents reported consistently positive experiences, indicating a high overall level of satisfaction with pediatric inpatient care, particularly with regard to communication and interpersonal interactions from nurses and doctors. While admission, family-centered communication, discharge planning, and adolescent involvement were somewhat lower but still satisfactory. The level of satisfaction, core care procedures, and the hospital setting were all assessed well. Mothers reported marginally higher satisfaction than other caregivers, but sociodemographic characteristics had no statistically significant association. Hospital satisfaction varied, with Istishari Arab Hospital rated best.

Conclusion: In pediatric and neonatal care, a variety of organizational, environmental, and patient-related factors influence patient satisfaction. The most significant and modifiable determinant of positive care experiences factor influencing happy experiences, is effective communication. Enhancing family satisfaction and healthcare quality requires a comprehensive, patient-centered approach that emphasizes interdisciplinary collaboration, developmentally appropriate care environments, and continuous quality monitoring.

Keywords: Family Satisfaction, Quality of Health Care, Infant patients, Pediatric Patients

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List of Definitions of Abbreviations

Abbreviations	Title
AIDET	Introduce, Duration, Explain, and Thank you
ASCH	Arab Specialized Care Hospital
ER	Emergency Room
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCP	healthcare providers
IAH	Istishari Arab Hospital
ICU	Intensive Care Unit
IOM	Institute of Medicine
IPCP	Interprofessional Collaborative Practice
KPIs	key performance indicators
PMC	Ramallah Governmental Hospital
RMNCH	reproductive, maternal, newborn, and child health
SPSS	Statistical Package for Social Sciences
US	United States
USA	United State America

Chapter One: Introduction

1.1 Background

In maternal, neonatal, and pediatric healthcare, the literature provides numerous definitions aimed at improving health outcomes; however, no single comprehensive definition of healthcare quality has been universally agreed upon. On the other hand, most definitions consistently emphasize that healthcare quality is a multidimensional concept, taking into consideration multiple perspectives from the healthcare providers (HCPs), managers, and patients' sides, as well as healthcare system dimensions, with the use of safety, effectiveness, patient-centeredness, timeliness, equity, and efficiency elements (Barhoush & Amon, 2023).

As the pediatric patients constitute a large and vulnerable group of healthcare service users, it is important to focus on innovative methods to improve their involvement in the care they receive, which enhances their engagement in care and provides a comprehensive understanding of their experiences, taking into account the variation in the intellectual and developmental aspects in the pediatric stage compared to others (Janhunen et al., 2019). Moreover, several factors were identified in the literature in relation to the barriers that affect the quality of care that pediatric patients may receive, including racial factors, maldistribution of healthcare services based on geographical basis, as well as the limited availability of subspecialties in medical and surgical pediatric care, and therefore, multiple strategies have been proposed, including the use of telehealth, which supports the under-resourced population of pediatric patients and their families to access high quality care (Curfman et al., 2021).

The use of the "quality" term in healthcare settings and scope is different but frequently used, and is mainly focused on the nature or characteristic of things. It was utilized in literature since the last century as "the application of medical science and technology in a manner that maximizes its benefit to health without correspondingly increasing risk", as defined by Donabedian (1988), which then was redefined by the Institute of Medicine (IOM) as the "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge", as cited by Mitchell (2008).

The level of quality that the patient receives in the healthcare settings, whether a hospital, a primary care clinic or home nursing facility, should be in its optimal level, but the determination of "good" or "high" level of quality must be reflected from the ethical

perspective in the first place, which includes the inclusion of all ethical aspects, including mandatory principles of beneficence and nonmaleficence, as well as patient's autonomy and justice respect, which raises the medical professionalism in the clinical setting, leading to advances in outcomes and satisfaction (Marckmann & Schildmann, 2022). Therefore, several concepts of "healthcare quality" were established and analyzed in the medical and nursing literature, and took four attributes in consideration, which are: safety, effectiveness, culture of excellence and desired outcomes, leading to more modern health care quality definition of "the assessment and provision of effective and safe care, reflected in a culture of excellence, resulting in the attainment of optimal or desired health", which was built upon the use of the most common method of concept analysis in nursing literature, i.e., Walker and Avant (Allen-Duck et al., 2017).

Clinical research has been implemented in the area of healthcare quality to improve the outcomes, and several management tools have been developed, including the Six Sigma, which was widely used in the United States (US). It was found that case studies are the most used methodological approach in this field of quality improvement (65.3%). Also, the Six Sigma approach was mostly focused on purposes of time reduction in terms of waiting list, medical consultations, tests, and emergency cases, with the focus on cost reduction in terms of the management of unnecessary processes or tests, as well as error reduction, mainly in the fields of surgical interventions and medication administration (Niñerola et al., 2020). In addition, quality improvement should not exclude the ethical side of healthcare improvement and empowerment, where the measurable property of quality of care should be integrated with the ethical property, and not neglected (Cribb et al., 2020).

Reviews of literature have investigated three major indicators of quality of care in the hospital and community healthcare settings across the globe among the reproductive, maternal, newborn, and child health (RMNCH), which are structure (including human resources), process, and outcomes. The major component of the structure indicator is the ratio of healthcare resources per 1000 people, like nurses (which ranges between 0.46 and 5.36 per 1000), physicians (2.78 to 0.16 per 1000), and hospital beds (5.34 to 1.41 per 1000) between Europe and South Asia, respectively. The process indicator is related to the percentage of children who receive specific treatments, receiving appropriate and timely treatments, which may reach 70.3% in Europe and Central Asia, and as low as 34.2% in Sub-Saharan Africa, while the main outcome indicators are in relation to immunization, contraception, and supplementation. These

indicators are particularly relevant in evaluating neonatal and pediatric hospital care, given the unique morbidity and mortality profiles of these populations (Bollinger & Kruk, 2016).

Healthcare quality in Palestine is affected by several factors, including the political situation, in which some studies referred a barrier to proper healthcare quality as the "medical apartheid in Palestine", which refers to healthcare discrimination and pervasive segregation based on race, and results in inequalities in availability, accessibility, and quality of care that Palestinians receive, as characterized by impacts on healthcare facilities, workers and transport (Barhoush & Amon, 2023). The quality in Palestinian healthcare services is determined by several indicators, including the provision of collaborative and comprehensive patient care, services that are provided during admission, stay, transition between wards and hospitals, and discharge to the community, as well as problem identification, screening, and solving, collaboration between healthcare providers, professional development and continuous education, and performance and its efficiency (Shawahna, 2020). The current study aims to address this gap by identifying key factors influencing healthcare quality from the perspective of families, which contributes foundational evidence to support future quality improvement initiatives in Palestinian pediatric healthcare settings.

1.2 Problem Statement

Several barriers to achieving high-quality healthcare have been identified in the medical literature, including the limited transparency in pricing and quality standards, which are also included in the pharmaceutical and medical devices services, and therefore, such aspects should be taken into account when trying to evaluate and improve the quality of care that pediatric and neonatal patients receive (Rao et al., 2022).

There is a scarcity in the coverage of healthcare quality and its improvement among the pediatric and neonatal category of patients in the Palestinian literature, which may be caused by limited emphasis on systematic quality measurement and monitoring, as well as the variations between different health sectors in Palestine (governmental and non-governmental) in the availability and accessibility of healthcare.

There is a lack of concrete information regarding family satisfaction with the quality of care provided to neonatal and pediatric patients in both governmental and private hospitals in Palestine. Policymakers and healthcare leaders cannot pinpoint gaps in service delivery, strengths, and areas needing improvement because of the absence of this data. Moreover, it is challenging to evaluate healthcare environments and implement targeted

quality enhancement initiatives without standardized evaluation tools such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which further limits the ability to objectively assess pediatric healthcare environments and monitor quality performance across institutions.

1.3 Significance of the Study

There is an increasing importance in the use of health services research in the field of quality improvement, which aims to identify the opportunities, interventions, and improvement capabilities to be provided to healthcare quality, which is targeted by the healthcare organizations in the first place to try to focus on eliminating the unnecessary healthcare use, as well as improving care coordination (Das et al., 2020).

Health services research plays an increasingly important role in healthcare quality improvement by identifying opportunities, interventions, and system-level strategies to enhance care delivery. Such research supports healthcare organizations in reducing unnecessary service utilization, improving care coordination, and optimizing patient-centered outcomes (Das et al., 2020).

The current study is unique in its general aim, as well as the tool used to evaluate the quality of care. Results that emerge from such studies are a cornerstone in the assessment of healthcare quality that is provided among neonatal and pediatric patients, with the ultimate aim to recommend specific actions and interventions that can be implemented by stakeholders and decision-makers in the healthcare sectors of Palestine, ultimately targeting the provision of the best healthcare services.

The current study is significant due to both its focus and methodology. It represents one of the few studies in Palestine to assess family satisfaction with pediatric and neonatal inpatient care using a standardized, internationally recognized tool. Findings from this study provide essential evidence for evaluating healthcare quality among pediatric populations and offer actionable insights for healthcare administrators, policymakers, and decision-makers. Ultimately, the study aims to inform targeted interventions that enhance the quality of pediatric healthcare services and promote optimal outcomes for children and their families.

1.4 Study Objectives

The current study aims to assess the level of family satisfaction regarding the quality of health care provided to infant and pediatric patients in hospitals in Ramallah, and aims to achieve the following objectives.

The primary aim of this study is to assess the level of family satisfaction regarding the quality of healthcare provided to infant and pediatric patients in hospitals in Ramallah. Specifically, the study seeks to:

1. To assess the level of satisfaction among parents regarding the quality of care provided to their infants and children during hospitalization.
2. To identify which dimensions (domains) of the HCAHPS survey demonstrate the highest and lowest levels of satisfaction.
3. To examine the relationship between parents' sociodemographic characteristics—including child age and gender, caregiver age, educational level, duration of hospital stay, and relationship to the child—and satisfaction levels.
4. To compare the level of satisfaction that parents have with hospital characteristics, including hospital type and accreditation status.

Study Questions

The following null hypotheses were tested

1. What is the level of satisfaction among parents regarding the quality of care provided to their infants and children during hospitalization?
2. Which dimensions (domains) of the HCAHPS survey demonstrate the greatest and lowest levels of satisfaction among parents?
3. Is there a relationship between parents' sociodemographic characteristics and their satisfaction with pediatric hospital care?
4. Are there significant differences in satisfaction levels based on hospital characteristics?

1.6 Study Hypotheses

The following study tested the following hypotheses:

- $H0_1$: There is no statistically significant level of satisfaction among parents regarding the quality of care provided to their infants and children in Ramallah hospitals.

- H0$_2$: There is no statistically significant difference in family satisfaction with healthcare quality based on patients' and parents' sociodemographic characteristics at a significance level of 0.05.
- H0$_3$: There is no statistically significant difference in family satisfaction with healthcare quality based on institutional hospital characteristics at a significance level of 0.05.

1.7 Study Variables

- **Dependent Variables**: family satisfaction
- **Independent Variables**: Sociodemographic characteristics of parents and children, child characteristics, and hospital characteristics.

1.8 Conceptual definition

- **Family satisfaction:** Family satisfaction was measured using the Pediatric Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Responses were recorded on Likert-type scales, with higher scores indicating higher levels of satisfaction. Domain scores were calculated and categorized into low, moderate, or high satisfaction levels (Westbrook et al., 2014).
- **Healthcare quality:** Healthcare quality is defined as the degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge. It includes dimensions such as equity, efficiency, timeliness, safety, effectiveness, and patient-centeredness (Institute of Medicine).

1.9 Operational Definition

- **Family satisfaction**: Family satisfaction was measured using the Pediatric Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Responses were recorded on Likert-type scales, with higher scores indicating higher levels of satisfaction. Domain scores were calculated and categorized into low, moderate, or high satisfaction levels (Westbrook et al., 2014).
- **Healthcare quality**: In this study, healthcare quality was indirectly assessed through parents' responses to HCAHPS domains, including communication with nurses and physicians, staff responsiveness, pain management, hospital environment, discharge information, and overall hospital rating (Westbrook et al., 2014).

Chapter Two: Literature review

2.1 Introduction

This chapter reviews the existing literature related to family satisfaction with the quality of care provided to infant and pediatric patients in hospital settings. It explores key concepts of healthcare quality, family-centered care, and patient satisfaction, with a particular focus on the use of standardized measurement tools such as the Child Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. By synthesizing findings from international and regional studies, this chapter identifies factors influencing family satisfaction and highlights gaps in the literature, particularly within the Palestinian context, thereby establishing the rationale for the present study.

2.2 Search Strategies

A comprehensive literature search was conducted to identify relevant studies addressing healthcare quality and family satisfaction in pediatric and neonatal settings. Three major scientific databases—Google Scholar, PubMed, and Scopus—were searched. The search included full-text, peer-reviewed articles published in English within the last five years and encompassed systematic reviews, observational studies, and interventional research.

Key search terms included healthcare quality, quality of care, family satisfaction, HCAHPS, pediatric care, and neonatal care. The initial search yielded more than 150 articles. After screening titles, abstracts, and full texts for relevance and methodological rigor, a total of 16 studies were selected for detailed review and inclusion in this chapter.

2.3 Factors affecting the quality of care as measured by HCAHPS

Systematic reviews provide a comprehensive foundation for understanding factors that influence healthcare quality as measured by HCAHPS. One of the most influential reviews was conducted by Mazurenko et al. (2017), who analyzed 41 eligible studies using a narrative synthesis approach. The review identified multiple determinants of patient satisfaction that operate at patient, hospital, and market levels.

At the patient level, satisfaction scores varied according to demographic characteristics such as age, gender, race, and ethnicity. Older patients and female patients were often found to report lower satisfaction scores. Effective pain management consistently emerged as a strong predictor of higher satisfaction, particularly when controlling for disease severity. Better pain

control was also associated with improved communication between patients and healthcare providers. Additionally, lower rates of hospital-acquired conditions and better patient perceptions of infection-control practices were linked to higher satisfaction levels.

Hospital-level factors were examined in the majority of reviewed studies. Higher HCAHPS scores were associated with non-profit hospitals, specialty hospitals, Magnet-designated institutions, and hospitals that were part of larger healthcare systems. Positive work environments, strong safety cultures, and well-structured nursing standards also contributed to improved patient satisfaction. Shorter lengths of stay were frequently linked to higher satisfaction scores.

Market-level factors were less frequently studied but included variables such as community socioeconomic status, insurance coverage, and educational attainment. These factors were associated with variations in satisfaction scores, emphasizing the complexity of interpreting HCAHPS results across different healthcare settings.

Communication has repeatedly been identified as a central determinant of patient satisfaction. Stikes et al. (2015) implemented a quality improvement initiative targeting communication skills and discharge education in a maternal-infant unit. Their intervention included reviewing health literacy levels, assessing educational materials, evaluating learning styles, and implementing ongoing staff education. Following the intervention, patient satisfaction scores related to nursing communication increased significantly, and satisfaction with discharge preparation improved markedly. These findings underscore the importance of structured communication strategies in enhancing patient experience.

Environmental factors, particularly hospital quietness, have also been linked to patient satisfaction. Hedges et al. (2019) examined the impact of structured “quiet time” interventions in pediatric wards, including designated quiet hours, noise-reducing equipment, and staff awareness strategies. Their results demonstrated substantial improvements in HCAHPS quietness scores, sleep quality, and overall patient experience, highlighting the influence of environmental conditions on perceived care quality.

Large-scale retrospective analyses have further reinforced these findings. Mann et al. (2016) analyzed HCAHPS data from 2,273 hospitals in the United States and found that higher hospital rankings, increased survey response rates, larger bed capacity, and teaching hospital status were significantly associated with improved patient satisfaction. These studies illustrate the value of benchmarking and comparative analysis in guiding quality improvement efforts.

2.4 Patient satisfaction and quality of care among pediatric and neonatal patients

Previous research has identified potential selection bias in studies assessing patient satisfaction, particularly among adult populations, where race and insurance status may influence response rates (Kekkonen et al., 2015). To address these limitations in pediatric care, Lee et al. (2019) evaluated the pediatric adaptation of the HCAHPS survey and examined demographic influences on caregiver responses. Their findings indicated higher response rates among white, non-Hispanic, and privately insured families. However, the only factor significantly associated with overall satisfaction was emergency department waiting time, with shorter waits correlating with higher satisfaction.

The Child HCAHPS survey has also been widely used in Canada. Kemp et al. (2018) analyzed data from over 3,000 pediatric inpatient surveys collected across pediatric-only and general hospitals. Results showed consistently higher satisfaction scores in pediatric-only hospitals, particularly in domains related to communication with nurses and doctors, parental involvement, privacy, discharge preparation, and overall hospital ratings. These findings suggest that specialized pediatric environments may better meet the needs of children and families.

Ahmed et al. (2020) further explored the relationship between individual Child HCAHPS items and overall hospital ratings. Their analysis revealed that communication with doctors and nurses and preparation for discharge demonstrated moderate to strong correlations with global satisfaction scores, while items related to error reporting and hospital quietness showed weaker correlations. These results emphasize the relative importance of interpersonal communication and discharge planning in shaping overall family satisfaction.

Physician characteristics have also been examined as predictors of patient satisfaction. Chen et al. (2017) analyzed data from more than 50,000 patient surveys and found that older physicians and those working in pediatric and obstetric settings received higher satisfaction scores across multiple domains. While these findings suggest experience and specialty alignment may influence patient perceptions, the authors cautioned against overinterpreting demographic differences.

The usefulness of HCAHPS data for quality improvement has also been evaluated. Quigley et al. (2021) assessed perceptions of HCAHPS utility among hospital leaders and frontline staff and found that leaders reported greater perceived usefulness, particularly for benchmarking and improving communication processes. These findings highlight the

importance of organizational engagement in translating satisfaction data into actionable improvements.

Large national surveys further support the value of Child HCAHPS. Toomey et al. (2017) analyzed data from over 17,000 pediatric inpatient surveys across 69 hospitals in the United States. Their results demonstrated higher satisfaction scores in free-standing pediatric hospitals compared with pediatric units within general hospitals, particularly in domains related to communication, discharge planning, teen involvement, and overall hospital ratings.

2.5 Specific factors that were studied to improve the quality of care among patients

Beyond descriptive assessments, several studies have focused on targeted interventions aimed at improving specific HCAHPS domains. Communication remains a central focus of these interventions. D'Agostino et al. (2017) demonstrated that structured communication skills training improved healthcare providers' confidence, knowledge, and attitudes, leading to enhanced patient satisfaction.

Allenbaugh et al. (2019) evaluated a brief communication curriculum implemented among physicians and nurses and reported significant improvements in patient satisfaction related to listening, explanation, respect, and discharge understanding. Similarly, Tiperneni et al. (2022) implemented structured communication frameworks, including the AIDET model and enhanced physician rounding, resulting in substantial improvements in HCAHPS communication scores across multiple domains.

Interprofessional collaboration has also been identified as a key quality improvement strategy. Gormley et al. (2019) examined the impact of nurse-led interprofessional rounding and found significant improvements in communication, medication education, and discharge information scores over time. These findings underscore the value of standardized, team-based approaches to patient care.

Collectively, the reviewed literature demonstrates that patient satisfaction in pediatric and neonatal care is influenced by a complex interaction of patient characteristics, provider behaviors, organizational structures, and environmental conditions. The consistent association between effective communication, specialized care environments, and higher satisfaction supports the use of standardized tools such as Child HCAHPS to guide continuous quality improvement initiatives.

Chapter Three: Methodology

3.1 Introduction

This chapter describes the methodological framework adopted for the present study. It outlines the study design, setting, population and sampling procedures, inclusion and exclusion criteria, data collection tools and processes, validity and reliability considerations, data analysis techniques, and ethical considerations. These methodological components were selected to ensure rigor, transparency, and reproducibility in assessing family satisfaction with the quality of pediatric and neonatal healthcare services.

3.2 Study Design

A cross-sectional quantitative study design was employed to assess the level of family satisfaction regarding the quality of care provided to pediatric and neonatal patients. This design was selected because it allows for the collection of data at a single point in time and enables the examination of relationships between satisfaction levels and sociodemographic and institutional variables.

The cross-sectional quantitative approach is appropriate for health services research as it is time-efficient, cost-effective, and suitable for measuring multiple variables simultaneously. Additionally, it allows for statistical comparison between groups without the need for follow-up, making it well suited for the objectives of the current study (Queirós et al., 2017; Spector, 2019).

3.3 Site and Setting

The study was conducted in selected governmental and private hospitals located in Ramallah City, West Bank, Palestine. These hospitals were chosen because they provide pediatric and/or neonatal inpatient services and admit a sufficient number of pediatric and neonatal patients to support quantitative analysis.

- **Palestinian Medical Complex (PMC)** in Ramallah, the PMC consists of 5 hospitals, 3 of which were already existing (Ramallah Public Hospital, Al-Sheikh Zayed Hospital, National Center for Blood Diseases- Hippocrates), and the other 2 hospitals to be constructed, and they are the Bahrain pediatrics Hospital and the Kuwaiti Specialized Surgery Hospital. The PMC includes 214 beds. It provides a wide range of services, including neonatal care, maternity care, internal medicine, pediatrics, general surgery,

and cardiovascular surgery. Kuwaiti Specialized Surgery Hospital: There is a great need to develop capacity in Palestine, in the area of heart surgery and the provision of specialist care for those suffering from heart diseases. A new specialist cardiology hospital, to be based in Ramallah, is therefore being developed. The Kuwait Government, through the Arab Fund for Social and Economic Development, financed the construction and equipping of the hospital. Bahrain Pediatrics Hospital: The Palestinian health service also had an inadequate capacity to deal with the particularities of providing health care to sick children. A new pediatric hospital is, therefore, to be built in Ramallah.

- **Arab Specialized Care Hospital**: In Ramallah City, Palestine, there is a private medical facility called Arab Specialized Care Hospital. The hospital serves patients from Ramallah, Al-Bireh, and the surrounding areas and offers a comprehensive variety of inpatient and outpatient medical services. With the goal of providing complete and superior healthcare services, it is outfitted with qualified medical personnel and cutting-edge diagnostic and treatment technologies. By providing specialist care across a range of medical specialties, including pediatric and neonatal services, the hospital plays a significant role in the local healthcare system and helps to satisfy the community's expanding healthcare demands.
- **H-Clinic Hospital**: H Clinic Hospital is a private Palestinian hospital operating in the West Bank. Established in 2019, it is located in Al-Bireh. The hospital includes over 40 specialized clinics and has a capacity of 44 beds. The hospital comprises several departments, including the Neonatal Intensive Care Unit, the Intensive Care Unit, the Obstetrics and Gynecology Department, the Accident and Emergency Department (which includes a pediatric emergency room), the Surgery Department, the Internal Medicine Department, operating rooms, clinics, a laboratory, radiology, and a pharmacy.
- **Istishari Arab Hospital**: Istishari Arab Hospital, one of the largest private hospitals in the West Bank - Palestine, is a 170 (expandable to 330) bed facility and is accredited with the JCI International Accreditation. The hospital, operating since 2016, aims to be recognized as a trusted leader in healthcare and advancing healthcare system and as a national leader in secondary and tertiary care services incorporating innovative and evidence - based practices with western and local board-certified physicians. Our mission is to provide high-quality medical services through clinical practices, leadership and excellence in delivering quality healthcare services, education and

research. IAH plays an active role in promoting and expanding the national healthcare system horizon. By collaborating with a wide range of partners such as Arab American University, Al Quds University, Birzeit University, Al Najah University and other local and international prestigious organizations, we strive to address the needs of the Palestinian community and comply with national and internationally recognized hospital standards. Our list of top doctors, dedicated staff, and excellent patient care is what differentiates us from any other hospital in the region. For example, our maternity department is one of a kind, with next-level privacy and luxurious services and we are also very proud of our state-of-the-art Cardiology and Neurosurgery departments, Spine and Spinal Deformities department, and most importantly, our advanced Oncology (cancer) Center, all making Istishari Arab Hospital a top health care facility in the area.

3.4 Sample population and sampling

The study population included parents or primary caregivers of pediatric and neonatal patients admitted to the selected hospitals during the study period. Eligible participants were those whose children met the inclusion criteria and who were present during the hospitalization period.

A stratified proportional random sampling technique was used to ensure fair representation of both pediatric and neonatal patients across the participating hospitals. Initially, the study population was stratified into two groups based on the type of admission: pediatric and neonatal.

Official monthly admission records were obtained from each hospital to determine the number of eligible pediatric and neonatal admissions. Based on these figures, the required sample size for each stratum and hospital was calculated proportionally.

Within each stratum, daily admission lists were used as sampling frames. Eligible parents were assigned unique identification numbers, and simple random sampling was performed using random number generation to select participants until the required sample size was achieved. Selected parents were approached sequentially and invited to participate in the study.

This stratified randomization process minimized selection bias, enhanced representativeness, and ensured that each eligible participant had an equal opportunity to be included.

Hospital name	Pediatric admissions	Proportion	Sample size	Neonatal admissions	Proportion	Sample size
PMC	35	0.4	35	32	0.3	62
IAH	30	0.3	24	30	0.3	30
H-Clinic	15	0.2	12	18	0.2	15
ASCH	12	0.1	15	15	0.2	0
Total	92	1	75	95	1	77

Hospital name	Pediatric Sample size	Neonatal sample size
PMC	22	46
IAH	0	42
ASCH	0	32
Total	22	120
Total	142	

PMC = Palestine Medical Complex, IAH = Istishari Arab Hospital, ASCH = Arab Specialized Care Hospital

3.5 Inclusion criteria

The following criteria were applied to recruit the sample, which were based on the Agency for Healthcare Research and Quality (AHRQ, 2014) criteria:

1. Parents or primary caregivers of children younger than 18 years
2. Child admitted for at least one overnight hospital stay
3. Child alive at the time of discharge
4. Child discharged to home (not transferred to rehabilitation or hospice care)

3.6 Exclusion criteria

1. Parents of children admitted for less than one night
2. Parents of children transferred to other facilities
3. Parents unwilling to provide informed consent

3.7 Data collection tool and process

Data were collected using a self-administered questionnaire consisting of two main parts. The first part included the Pediatric Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which assesses parents' experiences with pediatric inpatient care. The second part included sociodemographic information related to the child and caregiver, such as age, gender, educational level, relationship to the child, and duration of hospital stay.

The Child HCAHPS survey comprises 62 items and generates multiple composite and single-item measures addressing communication, safety, comfort, hospital environment, discharge processes, and overall hospital rating. The tool is widely used to assess patient-centeredness in pediatric inpatient settings.

An Arabic validated version of the Child HCAHPS survey was used. Parents were approached individually during the hospitalization period, informed about the study purpose, and invited to participate voluntarily. After obtaining written informed consent, participants completed the questionnaire independently, with the researcher available to clarify questions when needed.

Completed questionnaires were collected immediately, placed in sealed envelopes, and stored securely until data entry and analysis.

3.8 Validity and reliability

The Child HCAHPS survey is a well-established, validated instrument used internationally to assess family satisfaction with pediatric inpatient care (Westbrook et al., 2014). It has been translated and validated in multiple languages, including Arabic (Dockins et al., 2015).

For the current study, the Arabic version of the survey underwent translation and back-translation by two independent certified medical translators to ensure linguistic accuracy and cultural appropriateness. Content validity was further assessed by a panel of five experts in healthcare quality and patient experience, including quality specialists, nursing leadership, and academic faculty members.

A pilot study was conducted with approximately 10% of the target sample to assess clarity, comprehension, and internal consistency. Feedback from the pilot participants was used to

refine the final questionnaire. Internal consistency reliability was evaluated using Cronbach's alpha, with a value of 0.70 or higher considered acceptable.

3.9 Data analysis

Data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 27. Descriptive statistics were used to summarize sociodemographic variables and survey responses, including frequencies, percentages, means, and standard deviations.

Normality of continuous variables was assessed using the Shapiro–Wilk and Kolmogorov–Smirnov tests to determine the appropriate use of parametric or non-parametric tests. Inferential statistics included independent sample t-tests, one-way analysis of variance (ANOVA), and correlation analyses, depending on the level and distribution of variables.

HCAHPS domain scores were calculated by recoding item responses to a standardized 1–4 scale, with higher scores indicating greater satisfaction. A significance level of $p < 0.05$ was used for all statistical tests.

3.10 Ethical Considerations

Ethical approval for the study was obtained from the Arab American University research ethics committee, the Ministry of Health, and the participating hospitals before data collection. Participation was voluntary, and informed consent was obtained from all participants.

No identifying information was collected, and confidentiality was ensured through the use of coded questionnaires. Participants were informed of their right to withdraw from the study at any time without penalty. The study involved no clinical interventions and posed minimal risk to participants.

Chapter Four: Results

4.1 Introduction

This chapter presents the findings of the study and addresses the research questions through descriptive and inferential statistical analyses. The results are organized to move from a description of participants' sociodemographic characteristics to detailed reporting of parents' experiences and satisfaction across Child HCAHPS domains. The chapter concludes with comparisons of satisfaction levels according to sociodemographic variables and hospital characteristics.

4.2 Sociodemographic characteristics of the participants

The demographic and background characteristics were presented in (Table 4.1) of the 142 parents/caregivers and their hospitalized children who participated in the study. These variables describe who completed the Child HCAHPS survey (relationship, age, education, and language), as well as key child-related and hospital-related factors (child age and sex, hospital attended, sector, and accreditation status). Describing this profile is important to understand the context of the reported satisfaction levels and to judge how representative the sample is of parents of pediatric inpatients in the included hospitals.

Table 4.1: Demographic and Background Characteristics (N = 142)

Variable	Category	n	%
Relationship to child	Mother	120	84.5
	Father	15	10.6
	Other	7	4.9
Parent age (years)	25 – 34	131	92.3
	18 – 24	4	2.8
	45 – 54	4	2.8
	35 – 44	2	1.4
	55 – 64	1	0.7
Educational level	Grade 8 or less	30	21.1
	Higher than 4-year college	29	20.4
	Completed high school	23	16.2
	Completed 4-year college	22	15.5
	Diploma / 2-year college	22	15.5

	High school, not graduated	16	11.3
Child sex	Female	73	51.4
	Male	69	48.6
Child age	>1 year	43	30.3
	1–2 years	20	14.1
	3–5 years	17	12.0
	6–12 years	24	16.9
	13–17 years (teens)	38	26.8
Hospital	PMC	68	47.9
	IAH	42	29.6
	ASCH	32	22.5
Hospital type	Governmental	68	47.9
	Private	74	52.1
International accreditation0	No	100	70.4
	Yes	42	29.6

The sample was predominantly composed of mothers (84.5%), which is expected in pediatric settings where mothers are usually the primary caregivers during hospitalization. Most respondents were in the 25–34-year age range (92.3%), indicating a relatively young parent group, consistent with the age at which parents are caring for young and school-aged children. Educational levels were mixed: while 21.1% had Grade 8 or less, a considerable proportion (about one fifth) reported education higher than a 4-year college (20.4%), suggesting heterogeneity in socioeconomic and educational backgrounds.

Regarding the children, sex was almost equally distributed (51.4% female vs. 48.6% male). The age distribution shows that the largest single category was children aged 1 year (30.3%), but a notable 26.8% were adolescents (13–17 years), which supports later analyses that look specifically at teen experience. Most children were admitted to PMC (47.9%), followed by IAH (29.6%) and ASCH (22.5%), and the sample was fairly balanced between private (52.1%) and governmental (47.9%) hospitals. Finally, about one-third of the admissions (29.6%) were in internationally accredited hospitals, while the majority (70.4%) were not, which will allow comparison of satisfaction by accreditation status.

4.3 Merging items into domains and recoding to 1–4

The original HCAHPS questionnaire contains several items that assess very similar aspects of the same construct (for example, nurse listening, nurse explaining, and nurse treating the

family with respect are all indicators of "communication with nurses"). In international HCAHPS reporting, such items are usually combined and reported as composite (domain) **scores** rather than as completely separate outcomes. To follow this logic, and to make the results easier to interpret, the items in this study were grouped into 12 conceptually coherent domains (admission/ER information, communication with nurses, communication with doctors, family-centred communication, responsiveness, safety/pain, environment, discharge, teen involvement, and global rating).

Because the questionnaire uses different response formats (4-point frequency, 3-option agreement, and yes/no), a direct comparison of raw responses across items is not possible. Therefore, and only for the purpose of computing domain-level descriptive statistics (mean ± SD) and later comparing domains across sociodemographic groups, the item responses were harmonized to a common 1–4 metric as follows:

- 4-point items (Never / Sometimes / Usually / Always) were kept as 1–4.
- 3-option items (Yes definitely / Yes somewhat / No) were recoded to 4, 3, and 1, respectively, to preserve the ordinal meaning and to keep the "best" answer at the highest value.
- Dichotomous items (Yes / No) were recoded to 4 and 1, respectively, so that a positive experience contributed positively to the domain score.

This recoding does not change the descriptive reporting of the original options: frequencies and percentages for the real categories (Yes/No, or 3 options) can still be presented in the tables. The recoding was applied only to enable calculation of an overall domain mean that summarizes several closely related items into one indicator, which is a common approach in research that uses HCAHPS-based tools but needs to run statistical tests (t-test/ANOVA/correlations) on domain scores rather than on dozens of single items.

So, this analytic structuring (grouping similar items into domains and harmonizing response categories) was done to improve interpretability and to align the instrument with the composite-score approach used in HCAHPS reporting, while still allowing inferential statistical analysis.

4.4 Child HCAHPS Descriptions

4.4.1 Domine No. 1: Child Admission to This Hospital

The findings are shown in (Table 4.2) for Domain 1, "Child Admission to This Hospital," which covers the first contact with the hospital and the quality of communication and medication reconciliation during the first day of stay (items Q1–Q6). These items describe how the child was admitted (through ER or not), whether the parent was present, and—most importantly—whether parents were kept informed and asked to review the child's home medicines, vitamins, and over-the-counter (OTC) products. This domain reflects the hospital's ability to start care safely and transparently from the moment the child arrives.

Table 4.2: When Your Child Was Admitted to this Hospital (n=142) (Q1-Q6)

Item	No n(%)	Yes n(%)	Mean (SD)
Q1 Born during stay	122 (85.9)	20 (14.1)	1.86 ± 0.35
Q2 ER admission	50 (35.2)	92 (64.8)	2.94 ± 1.43
Q3 Parent in ER	54 (38.0)	88 (62.0)	2.76 ± 1.55

Item	No n(%)	Yes, somewhat n(%)	Yes, definitely n(%)	Mean (SD)
Q4 Kept informed in ER	16 (11.3)	30 (21.1)	96 (67.6)	3.44 ± 0.83
Q5 Review prescription meds	20 (14.1)	28 (19.7)	94 (66.2)	3.38 ± 0.90
Q6 Review vitamins/OTC	22 (15.5)	30 (21.1)	90 (63.4)	3.32 ± 0.93

Most of the children were not born during this hospital stay (85.9%), so the remaining admission questions apply to the majority of the sample. About two-thirds of the children (64.8%) were admitted through the Emergency Room, and in 62% of these cases, a parent was present in the ER, which is desirable in pediatric admissions. Communication scores at admission were generally high: two-thirds of parents (67.6%) reported that they were "kept informed" in the ER, and similar proportions said staff "definitely" reviewed prescription medicines (66.2%) and vitamins/OTC products (63.4%). The means for Q4–Q6 (3.32–3.44) also indicate performance in the upper range of the scale. The slightly lower percentages in medication/vitamin review suggest a small opportunity to strengthen full medication

reconciliation for all admitted children. Still, overall, the hospital admission process was reported positively by most respondents.

4.4.2 Domine 2: Your Child's Experience with Nurses and Doctors

Domain 2 explores the child's direct interaction with the clinical team, focusing first on whether the child was actually able to communicate with nurses and doctors (Q7), and then on the quality of those encounters with nurses (Q8–Q10) and with doctors (Q11–Q13). Because pediatric patients differ in age and developmental level, it is important to know how many of them could speak for themselves, and, for those who could, whether staff listened, explained information in a child-friendly way, and encouraged questions.

Table 4.3: Was your child able to talk with nurses and doctors? (Q7)

Item	**No n(%)**	**Yes n(%)**	**Mean (SD)**
Q7 Child able to talk	99 (69.7)	43 (30.3)	1.30 ± 0.46

Table 4.4 Child's experience with nurses (Q8–Q10)

Item	Never n(%)	Sometimes n(%)	Usually n(%)	Always n(%)	Mean (SD)
Q8 Nurses listened carefully to your child	4 (2.8)	10 (7.0)	38 (26.8)	90 (63.4)	3.51 ± 0.77
Q9 Nurses explained in an easy way	3 (2.1)	12 (8.5)	36 (25.4)	91 (64.1)	3.52 ± 0.74
Q10 Nurses encouraged child to ask questions	6 (4.2)	12 (8.5)	37 (26.1)	87 (61.3)	3.44 ± 0.84

Table 4.5: Child's experience with doctors (Q11–Q13)

Item	Never n(%)	Sometimes n(%)	Usually n(%)	Always n(%)	Mean (SD)
Q11 Doctors listened carefully to child	3 (2.1)	9 (6.3)	40 (28.2)	90 (63.4)	3.53 ± 0.71

Q12 Doctors explained in an easy way	4 (2.8)	10 (7.0)	39 (27.5)	89 (62.7)	3.50 ± 0.75
Q13 Doctors encouraged child to ask questions	5 (3.5)	12 (8.5)	36 (25.4)	89 (62.7)	3.47 ± 0.80

Only about one third of the children (30.3%) were able to talk with nurses and doctors, while the majority (69.7%) were not. This is consistent with the age distribution in the sample, where many children were toddlers or young school-age, and therefore, parental reporting becomes essential.

Despite this, ratings of nurse–child and doctor–child communication were very positive. For nurses (Table 3.2), around two-thirds of parents said nurses "always" listened carefully (63.4%), easily explained things (64.1%), and encouraged the child to ask questions (61.3%). Very few parents selected "never" or "sometimes," and the means ranged from 3.44 to 3.52, indicating performance near the top of the 4-point scale. For doctors (Table 3.3), the pattern was almost identical: 62–63% reported "always" for listening, explaining, and encouraging questions, with slightly higher means (3.47–3.53). This suggests that, even though many children could not speak directly with providers, staff communication practices—as perceived by parents—were strong for both nurses and doctors, with doctors scoring marginally higher on listening. Overall, Domain 2 reflects good child-centred communication in the participating hospitals, with room mainly in helping more children participate directly when age-appropriate.

4.4.3 Domine 3: Your Experience with Nurses and doctors

Domain 3 shifts the focus from the child's interaction with staff to the parent's own experience with the healthcare team. Because parents are the main decision-makers and stay with the child throughout hospitalization, their perceptions of how well nurses and doctors listened, explained, and showed respect are critical indicators of family-centred care. This domain includes three items about nurses (Q14–Q16) and three about doctors (Q17–Q19), all using the same 4-point response scale, which allows direct comparison between the two professional groups.

Table 4.6: Your experience with nurses (Q14–Q16)

Item	Never n (%)	Sometimes n (%)	Usually n (%)	Always n (%)	Mean (SD)
Q14 Nurses listened to you	5 (3.5)	13 (9.2)	33 (23.2)	91 (64.1)	3.48 ± 0.81
Q15 Nurses explained clearly	2 (1.4)	15 (10.6)	37 (26.1)	88 (62.0)	3.49 ± 0.74
Q16 Nurses treated you with courtesy/respect	4 (2.8)	6 (4.2)	39 (27.5)	93 (65.5)	3.56 ± 0.69

Table 4.7: Your experience with doctors (Q17–Q19)

Item	Never n (%)	Sometimes n (%)	Usually n (%)	Always n (%)	Mean (SD)
Q17 Doctors listened to you	4 (2.8)	6 (4.2)	39 (27.5)	93 (65.5)	3.56 ± 0.71
Q18 Doctors explained clearly	3 (2.1)	14 (9.9)	38 (26.8)	87 (61.3)	3.47 ± 0.77
Q19 Doctors treated you with courtesy/respect	4 (2.8)	9 (6.3)	33 (23.2)	96 (67.6)	3.56 ± 0.74

Parents reported consistently high satisfaction with both nurses and doctors. For nurses, about two-thirds of respondents said nurses “always” listened (64.1%), explained things clearly (62.0%), and treated them with courtesy and respect (65.5%). Very few chose “never,” and the means ranged from 3.48 to 3.56, placing nurse–parent interaction in the upper part of the scale. Doctors’ scores were almost identical: 65.5% said doctors “always” listened, 61.3% said they “always” explained clearly, and 67.6% said doctors “always” treated them with courtesy and respect. The highest single ratings in this domain were for respectful treatment by both nurses and doctors (around two-thirds “always”), which suggests that interpersonal behavior was a strength in these hospitals. Slightly lower, but still strong, were the “explained clearly” items, indicating a small area for further enhancement in information-giving. Overall, Domain 3 shows that parents felt heard, informed, and respected by the clinical team, reinforcing the positive picture seen in the earlier domains.

4.4.4 Domine 4: Your Experience with Providers (family-centered communication/provider–family interaction)

Domain 4 examines how well providers involved, informed, and respected the family during the child's hospitalization. Unlike the previous domains that focused on listening and explanation by specific professionals, this section captures broader family-centred behaviors such as protecting privacy, checking what the family already knows, acting in ways appropriate to the child's age, and keeping parents updated—especially when tests were done. Because parents are partners in pediatric care, these items (Q20–Q25) are key indicators of whether the hospital is practicing shared, family-centred communication.

Table 4.8: Provider / family-centered communication (Q20- Q25)

Item	Never n(%)	Sometimes n(%)	Usually n(%)	Always n(%)	Mean (SD)
Q20 Given as much privacy as wanted	3 (2.1)	18 (12.7)	40 (28.2)	81 (57.0)	3.40 ± 0.79
Q22 Providers acted right for child's age	9 (6.3)	6 (4.2)	43 (30.3)	84 (59.2)	3.42 ± 0.84
Q23 Kept you informed	3 (2.1)	11 (7.7)	41 (28.9)	87 (61.3)	3.49 ± 0.73

Table 4.9: Providers asked what your family already knew Q21

Item	No n(%)	Yes, somewhat n(%)	Yes, definitely n(%)	Mean (SD)
Q21 Asked what family knows	14 (9.9)	46 (32.4)	82 (57.7)	3.38 ± 0.82

Table 4.10: Child had tests Q24

Item	No n(%)	Yes n(%)	Mean (SD)
Q24 Child had tests	32 (22.5)	110 (77.5)	3.10 ± 1.33

Table 4.1: Information about test results (n=110) Q25

Item	Never n(%)	Sometimes n(%)	Usually n(%)	Always n(%)	Mean (SD)
Q25 Info about test results	3 (2.7)	10 (9.1)	32 (29.1)	65 (59.1)	3.45 ± 0.80

Overall, parents reported good levels of family-centred communication. More than half (57.0%) said they "always" received as much privacy as they wanted (Q20), and nearly 60% said providers "always" acted in a way that was right for their child's age (Q22), which is essential in pediatric settings. The strongest item in this domain was being kept informed (Q23): 61.3% reported "always," and only 2.1% said "never," giving it one of the highest means in the domain (3.49 ± 0.73). Providers also made an effort to start from the family's existing knowledge: 57.7% said staff "definitely" asked what the family already knew (Q21), though about one in ten said this did not happen, indicating some room to make this a more consistent practice.

Most children (77.5%) had tests during their stay (Q24). Among those 110 cases, parents again rated communication positively: 59.1% said they "always" received information about test results, and almost 30% said "usually," yielding a mean of 3.45 ± 0.80. This suggests that once a test was done, information flow was generally good, but a small minority did not get timely or clear updates. Taken together, Domain 4 shows that the hospitals are largely succeeding in engaging families, protecting privacy, and keeping them informed, with the clearest opportunities being to ask every family what they already know and to standardize communication after tests.

4.4.5 Domine 5: Your Child's Care in this Hospital (call button, medicines, pain, safety) (26-32)

Domain 5 focuses on core aspects of the child's care and safety during hospitalization, including response to call bells, medication administration, information about reporting errors, and pain assessment and management (Q26–Q32). These items capture how reliably nursing care was delivered at the bedside and whether parents perceived care as timely, safe, and attentive to the child's comfort. Because most pediatric inpatients need medicines and many experience pain, this domain is an important indicator of day-to-day quality of care.

Table 4.2: Pressed call button Q26

Item	No n(%)	Yes n(%)	Mean (SD)
Q26 Pressed call button	24 (16.9)	118 (83.1)	3.49 ± 1.16

Table 4.3: Help was given as soon as wanted (n=118) Q27

Item	Never n(%)	Sometimes n(%)	Usually n(%)	Always n(%)	Mean (SD)
Q27 Help after call	3 (2.5)	9 (7.6)	29 (24.6)	77 (65.3)	3.53 ± 0.78

Table 4.4: Child was given medicine Q28

Item	No n(%)	Yes n(%)	Mean (SD)
Q28 Child was given medicine	16 (11.3)	126 (88.7)	3.67 ± 0.96

Table 4.5: ID checked before giving medicine (n=126) Q29

Item	Never n(%)	Sometimes n(%)	Usually n(%)	Always n(%)	Mean (SD)
Q29 ID checked	4 (3.2)	7 (5.6)	34 (27.0)	81 (64.3)	3.53 ± 0.74

Table 4.6: Told how to report a mistake Q30

Item	No n(%)	Yes, somewhat n(%)	Yes, definitely n(%)	Mean (SD)
Q30 Told how to report mistakes	21 (14.8)	21 (14.8)	100 (70.4)	3.47 ± 0.87

Table 4.7: Child had pain needing treatment Q31

Item	No n(%)	Yes n(%)	Mean (SD)
Q31 Pain needing treatment	48 (33.8)	94 (66.2)	3.00 ± 1.49

Table 4.8: Asked about child's pain often enough (n=94) Q32

Item	No n(%)	Yes, somewhat n(%)	Yes, definitely n(%)	Mean (SD)
Q32 Pain assessed often	11 (11.7)	20 (21.3)	63 (67.0)	3.44 ± 0.86

Most families actually used the call system: 83.1% reported pressing the call button (Q26), and among those, nearly two-thirds (65.3%) said help "always" came as soon as they wanted (Q27), with another 24.6% saying "usually." This shows good responsiveness from nursing staff, with only a small group (about 10%) experiencing delays ("never" or "sometimes").

Medication processes were also common and generally safe. Almost all children (88.7%) received medicines during their stay (Q28). Among these, 64.3% of parents said staff "always" checked the child's ID before giving medicine, and 27% said "usually" (Q29), which means more than 9 in 10 parents observed ID checking most of the time—an encouraging finding for medication safety. Moreover, 70.4% said they were "definitely" told how to report a mistake (Q30), reflecting good transparency and a culture of safety, though about 15% said this was not explained.

Two-thirds of the children (66.2%) had pain that needed treatment (Q31), so pain management was a real issue in this sample. Among those 94 cases, parents reported that pain was checked often enough in most situations: 67.0% said "yes, definitely" and 21.3% said "yes, somewhat" (Q32), giving a solid mean of 3.44. Still, about 1 in 9 parents (11.7%) felt staff did not ask about pain often enough—this is a small but important group, since unassessed pain can remain undertreated. Overall, Domain 5 paints a positive picture of bedside care: timely responses, safe medication practices, clear information about error reporting, and generally adequate pain assessment, with modest room for making pain checks even more consistent.

4.4.6 Domine 6. The Hospital Environment (cleanliness, quiet, age-appropriate activities)

Table 4.9: Hospital environment (Q33–Q35)

Item	Never n(%)	Sometimes n(%)	Usually n(%)	Always / Yes definitely n(%)	Mean (SD)
Q33 Room/bathroom kept clean	6 (4.2)	7 (4.9)	41 (28.9)	88 (62.0)	3.49 ± 0.78
Q34 Area around room quiet at night	4 (2.8)	6 (4.2)	35 (24.6)	97 (68.3)	3.58 ± 0.71
Q35 Child-friendly things available	14 (9.9)	43 (30.3)		85 (59.9)	3.40 ± 0.83

4.4.7 Domie 7. When Your Child Leaves This Hospital (discharge planning and instructions)

Domain 7 evaluates how well the hospital prepared parents and children for going home. Discharge is a critical transition point in pediatric care, and clear instructions can prevent complications, unnecessary readmissions, and parental anxiety. Items Q36–Q43 ask whether staff checked readiness to leave, explained home care, medicines, and side effects, when the child could resume normal activities, what warning signs to watch for, and whether written information was provided. Together, these items show how complete and family-friendly the discharge process was.

Table 4.20: Discharge communication/ When Your Child Left this Hospital (Q36–Q43)

Item	No n(%)	Yes, somewhat n(%)	Yes, definitely n(%)	Mean (SD)
Q36 Asked about readiness to leave	20 (14.1)	33 (23.2)	89 (62.7)	3.36 ± 0.90
Q37 Talked about care at home	19 (13.4)	30 (21.1)	93 (65.5)	3.39 ± 0.88
Q39 How to take new medicine	12 (11.5)	23 (22.1)	69 (66.3)	3.39 ± 0.88

Q40 Side effects explained	14 (13.5)	27 (26.0)	63 (60.6)	3.34 ± 0.92
Q41 Return to activities	17 (12.0)	28 (19.7)	97 (68.3)	3.44 ± 0.86
Q42 Warning signs explained	18 (12.7)	25 (17.6)	99 (69.7)	3.45 ± 0.87
Q43 Written information	17 (12.0)	23 (16.2)	102 (71.8)	3.48 ± 0.85

Table 4.10: When Your Child Left This Hospital (n= 38)

Item	No n(%)	Yes n(%)	Mean (SD)
Q38 Told about new medicine	38 (26.8)	104 (73.2)	3.19 ± 1.42

Overall, parents reported a good level of discharge communication. Around two thirds said staff "definitely" asked if the child was ready to leave (62.7%, Q36) and "definitely" talked about care at home (65.5%, Q37), which means most families did not feel rushed out without discussion. Most children (73.2%) were started on a new medicine at discharge (Q38); for these families, two thirds (66.3%) said they were clearly told how to give the medicine (Q39), and 60.6% said side effects were explained (Q40). These are positive figures, but side-effect counseling was slightly lower than instruction on how to take the medicine—an area that could be reinforced.

Very strong performance was seen in the anticipatory guidance items: 68.3% said they were "definitely" told when their child could return to normal activities (Q41), and 69.7% said warning signs were clearly explained (Q42). The strongest single item in this domain was receiving written information (71.8%, Q43), which is important because written materials help families remember instructions after leaving the hospital. Despite these good results, about 12–14% of parents in most items said "No," meaning a small but consistent group left without full discharge counseling. Standardizing discharge education for every family, especially around new medicines and side effect, would close this gap and make the process even more family-centred.

4.4.8 Domine 8. Your Teen's Care in This Hospital (for children 13–17 years)

Domain 8 applies only to the subgroup of adolescents (13–17 years) and assesses whether the hospital involved the teen directly in care and discharge discussions. Because adolescents are usually capable of understanding their condition and participating in decisions, teen-centred communication is an important quality marker in pediatric services. Items Q44–Q47 first identify how many respondents actually had a teen (Q44), then ask whether the teen was involved in care (Q45), and whether staff spoke with the teen about readiness to leave and home care (Q46–Q47).

Table 4.11: Your Teen's Care in this Hospital (44-47)

Item	No n(%)	Yes n(%)	Mean (SD)
Q44 Child ≥13	104 (73.2)	38 (26.8)	1.73 ± 0.44

Item	Never n(%)	Sometimes n(%)	Usually n(%)	Always n(%)	Mean (SD)
Q45 Teen involved (n=38)	2 (5.3)	4 (10.5)	11 (28.9)	21 (55.3)	3.34 ± 0.86

Item	No n(%)	Yes, somewhat n(%)	Yes, definitely n(%)	Mean (SD)
Q46 Asked teen about readiness (n=38)	8 (21.1)	11 (28.9)	19 (50.0)	3.16 ± 0.99
Q47 Talked with teen about home care (n=38)	7 (18.4)	10 (26.3)	21 (55.3)	3.26 ± 0.94

Only 38 out of 142 children (26.8%) were adolescents, so findings in this domain are based on a smaller group, which is typical in mixed-age pediatric samples. Within this subgroup, results were generally positive but not as uniformly high as in earlier domains. Just over half of parents (55.3%) said staff "always" involved the teen in care (Q45), and another 28.9% said "usually," giving a good mean of 3.34. This indicates that most teens were included in discussions, but a small portion (about 16%) were only sometimes or never involved—suggesting practice is good but not universal.

For discharge-related communication, half of the teens were "definitely" asked about readiness to leave (50.0%, Q46) and 55.3% were "definitely" talked to about care at home (Q47). About one fifth, however, reported no such discussion (18–21%), and roughly one quarter said it happened only "somewhat." This pattern suggests that, compared with communication with parents, communication directly with teens was a bit less standardized. Strengthening policies to always address the adolescent patient—especially at discharge—would help make the service more developmentally appropriate and consistent across all 13–17-year-olds.

4.4.9 Domine 9. Overall Rating of This Hospital (0–10 rating and recommendation)

Domain 9 summarizes parents' global evaluation of the hospital using two key Child HCAHPS items: the 0–10 overall rating (Q48) and whether they would recommend the hospital to others (Q49). Unlike the previous domains that focused on specific aspects of care, these two items capture the parent's overall impression after the entire admission. The data are presented separately for the three participating hospitals (ASCH, PMC, and IAH) to show how parents' overall satisfaction varied by facility.

Table 4.12: Overall rating of hospital (Q48- Q49) Rating (0-10)

Item	ASCH Mean (SD)	IAH Mean (SD)	PMC Mean (SD)
Q48 Overall rating (0–10)	5.8± 1.30	8.0 ± 1.00	6.0 ± 1.20

Table 4.13 Recommend this hospital Q49

Item	Definitely no n(%)	Probably no n(%)	Probably yes n(%)	Definitely yes n(%)	Mean (SD)
Q49 Recommend hospital – ASCH	3 (9.4%)	6 (18.8%)	11 (34.4%)	12 (37.5%)	3.00 ± 0.95
Q49 Recommend hospital – PMC	2 (4.8%)	4 (9.5%)	11 (26.2%)	25 (59.5%)	3.41 ± 0.78
Q49 Recommend hospital – IAH	2 (2.9%)	2 (2.9%)	10 (14.7%)	54 (79.4%)	3.71 ± 0.55

The 0–10 overall rating (Q48) shows clear differences between hospitals. Parents of children admitted to IAH gave the highest overall score (mean 8.0 ± 1.00), indicating very good

global satisfaction. PMC received a moderate rating (mean 6.0 ± 1.20), while ASCH had the lowest mean score (5.8 ± 1.30), suggesting that parents there perceived more room for improvement.

The recommendation item (Q49) follows the same pattern but makes the contrast even clearer. At IAH, almost 80% of parents said they would "definitely" recommend the hospital (79.4%), and the mean was the highest (3.71 ± 0.55), reflecting a very strong likelihood to recommend. PMC performed reasonably well, with 59.5% "definitely yes" and a mean of 3.41 ± 0.78, indicating a generally positive but less enthusiastic endorsement. ASCH had the weakest recommendation profile: only 37.5% selected "definitely yes," and more than a quarter chose "definitely no" or "probably no," giving the lowest mean (3.00 ± 0.95). Taken together, Domain 9 shows that while families were broadly satisfied, IAH achieved the highest global satisfaction, PMC was in the middle, and ASCH lagged, pointing to hospital-level differences in perceived quality.

4.4.10 Domine 10. About Your Child and You

Domain 10 provides contextual information about the child and the responding parent/caregiver. These items (Q50–Q54, Q55, Q59) are not satisfaction items but descriptive variables that help interpret the earlier domains. They capture the child's general health status, age, and sex, as well as who completed the survey and how much time that person actually spent in the hospital. Together, they show whether the responses reflect parents who were truly present at the bedside and how healthy or complex the children were.

Table 4.14: Child's overall health (Q50)

Item	Excellent n(%)	Very good n(%)	Good n(%)	Fair n(%)	Poor n(%)	Mean (SD)
Q50 Child health	47 (33.1)	44 (31.0)	31 (21.8)	15 (10.6)	5 (3.5)	2.21 ± 1.17

Table 4.15: Child age (Q51)

Item / Child age	1 year n(%)	1–2 years n(%)	3–5 years n(%)	6–12 years n(%)	13–17 years (teens) n(%)
Child age	43 (30.3)	20 (14.1)	17 (12.0)	24 (16.9)	38 (26.8)

Table 4.16: Child sex (Q52)

Item	Female n(%)	Male n(%)
Q52 Child sex	73(51.4)	69 (48.6)

Table 4.17: Relationship to child (Q55)

Item	**Mother n(%)**	**Father n(%)**	**Other n(%)**
Q55 Relationship	120 (84.5)	15 (10.6)	7 (4.9)

Table 4.18: Time spent in hospital Q59

Item	None/little n(%)	Some n(%)	Most n(%)	All/nearly all n(%)	Mean (SD)
Q59 Time in hospital	6 (4.2)	20 (14.1)	34 (23.9)	82 (57.7)	3.35 ± 0.86

Parents rated their children's overall health quite favorably: about one third said the child's health was excellent (33.1%) and another third said very good (31.0%), while only 10.6% rated it as fair and 3.5% as poor (Q50). The mean (2.21 ± 1.17) indicates that most children were perceived as generally healthy, though a small group had more health problems. The age and sex distributions here mirror what was shown earlier: the sample included all pediatric age groups, with the largest single group being 1-year-olds (30.3%) and a substantial proportion of adolescents (26.8%), and an almost equal split between girls (51.4%) and boys (48.6%) (Q51–Q52).

As in previous tables, the vast majority of respondents were mothers (84.5%), with fathers representing only about 1 in 10 respondents (10.6%) (Q55). This confirms that the satisfaction data largely reflect the mother's viewpoint. Importantly, most respondents were very present during the admission: 57.7% said they spent "all or nearly all" of the time in the hospital with the child, and another 23.9% said "most" of the time (Q59). This high level of parental presence supports the credibility of their reports in earlier domains, since they directly observed care processes. Overall, Domain 10 shows that the survey tapped a typical pediatric inpatient population, with engaged caregivers and mostly good baseline child health, which strengthens the interpretation of the satisfaction results in Chapters 4 and 5.

4.5 Mean satisfaction across Child HCAHPS domains

The mean satisfaction scores across all Child HCAHPS domains included in the study. Instead of looking at single items, this table groups conceptually related questions (e.g., admission, nurses, doctors, family-centred communication, discharge) and shows both the range of item means within each domain and the overall average for that domain. This provides a quick snapshot of where parents reported the highest satisfaction and where experiences were relatively weaker, and it helps compare performance across different parts of the pediatric hospitalization.

Table 4.30: Mean satisfaction scores across Child HCAHPS domains

Domain	Items included	Range of means	Overall domain mean
When your child was admitted	Q1–Q6	1.86 – 3.44	2.95
Your child’s care after admission	Q7	1.30 – 1.30	1.30
Your child’s experience with nurses	Q8–Q10	3.44 – 3.52	3.49
Your child’s experience with doctors	Q11–Q13	3.47 – 3.53	3.50
Your experience with nurses	Q14–Q16	3.48 – 3.56	3.51
Your experience with doctors	Q17–Q19	3.47 – 3.56	3.53
Provider / family-centred communication	Q20–Q25	3.10 – 3.49	3.37
Your child’s care in this hospital	Q26–Q32	3.00 – 3.67	3.45
Hospital environment	Q33–Q35	3.40 – 3.58	3.49
Discharge / when your child left hospital	Q36–Q43	3.19 – 3.48	3.38
Your teen’s care in Hospital	Q45–Q47*	3.16 – 3.34	3.25
About your child general health	Q50	2.21 – 2.21	2.21
Time in hospital	Q59	3.35 – 3.35	3.35

Overall, most domains scored in the upper part of the 4-point scale, indicating generally positive parent experiences. The strongest areas were those reflecting direct interaction with staff: “Your experience with doctors” (overall mean 3.53) and “Your experience with nurses” (3.51) were among the highest, showing that parents felt listened to, respected, and clearly informed. Closely behind were “Your child’s experience with doctors” (3.50), “Hospital environment” (3.49), and “Your child’s experience with nurses” (3.49), suggesting that communication with the child and the basic environment (clean, quiet) were also well rated.

Domains covering broader, more process-oriented aspects scored slightly lower but still favorable. Provider / family-centred communication (3.37) and Discharge / when your child

left hospital (3.38) were good but not at the very top, which matches the earlier item-level findings that some families did not always get every element (e.g., test results, side effects, or being asked what they already knew). Your child's care in this hospital (3.45) was solid, reflecting good responsiveness, medication safety, and pain assessment.

Two lines in the table need special interpretation. First, "Your child's care after admission" shows a low mean (1.30) because it is based on a single item (Q7) about whether the child was able to talk with staff; most of the younger children could not, so the low score reflects child age/development rather than poor quality of care. Second, "Your teen's care in hospital" (3.25) is based only on adolescents (13–17 years) and is naturally a bit lower, indicating that teen-centred communication is good but less consistent than parent-centred communication. Finally, "About your child general health" (2.21) is descriptive, not a satisfaction score, so it should not be compared to the other domains. In summary, the table shows a generally high level of parent-reported satisfaction, with the clearest strengths in interpersonal care (nurses/doctors) and the main opportunities in standardizing family-centred and discharge communications.

4.6 Study questions

Q1 What is the level of satisfaction among parents regarding the quality of care provided to their infants and children in hospitals?

The overall level of parental satisfaction with the quality of care was generally high**."** This is shown by the fact that most care-related domains had mean scores above 3 on a 4-point scale. The highest satisfaction was reported in **"**Your experience with doctors**"** (mean = 3.53) and "Your experience with nurses" (mean = 3.51), indicating that parents felt listened to, respected, and clearly informed by healthcare staff. Similarly, domains reflecting the child's direct experience—**"**Your child's experience with doctors" (3.50), "Your child's experience with nurses" (3.49), "Hospital environment**"** (3.49), and "Your child's care in this hospital" (3.45)—also fell in the satisfied range, suggesting that day-to-day clinical care and the ward setting met parents' expectations.

Communication-related aspects, captured in “Provider/family-centred communication” (mean = 3.37) and “Discharge / when your child left hospital” (mean = 3.38), were slightly lower but still above 3, which indicates satisfactory but improvable performance, especially in giving information about tests, medicines, and home care. The time in hospital item also showed good satisfaction (3.35).

Two values are clearly lower and should be interpreted differently: “Your child’s care after admission” (Q7, mean = 1.30) reflects a filter-type item (child’s ability to talk to staff) rather than satisfaction, and “About your child general health” (mean = 2.21) describes the child’s health status, not satisfaction with services. These should not be taken as low satisfaction with hospital care.

Conclusion: Parents reported a high level of satisfaction with most aspects of pediatric hospital care, especially interpersonal care from doctors and nurses (means 3.49–3.53), with moderately high satisfaction for communication and discharge processes (means ~3.3–3.4). Areas related to the communication of tests/medications could be targeted for further improvement.

Q2 Which dimensions (domains) of the HCAHPS survey showed the greatest and lowest levels of satisfaction among parents?

“The domains with the highest satisfaction were those related to direct interactions with healthcare staff.” Specifically, “Your experience with doctors” had the highest overall mean (3.53), followed very closely by “Your experience with nurses” (3.51), “Your child’s experience with doctors” (3.50), “Your child’s experience with nurses” (3.49), and “Hospital environment” (3.49). This pattern shows that parents were most satisfied with interpersonal care, respect, listening, explanation, and the unit environment.

The lowest scores appeared in domains that are not pure satisfaction constructs**:**

- "Your child's care after admission" (1 item, mean = 1.30) is actually a filter-type item (whether the child could talk to staff), so it should not be interpreted as dissatisfaction with care.
- "About your child general health" (mean = 2.21) reflects the child's health status, not the parents' satisfaction with hospital services.

And for the "real" satisfaction/service domains, the lower-performing areas were:

- "Your teen's care in hospital" (mean = 3.25) – slightly below the other care domains, suggesting adolescent involvement could be improved.
- "Provider / family-centred communication" (mean = 3.37) and "Discharge / when your child left hospital" (mean = 3.38) – both in the satisfactory range but lower than doctor/nurse interaction domains, indicating that information-giving, test explanations, and discharge instructions are weaker than interpersonal care.
- "When your child was admitted" was also lower (mean = 2.95) compared with the main care domains, suggesting the admission/ER phase is less satisfactory than inpatient care.

Conclusion: The greatest satisfaction was observed in domains reflecting direct interactions with doctors and nurses (overall means 3.49–3.53), and in the hospital environment domain (3.49). The relatively lower satisfaction was found in communication- and process-related domains, particularly provider/family-centred communication (3.37), discharge (3.38), and admission (2.95), as well as in teen-specific care (3.25). The very low means for the "child able to talk" item (1.30) and for "general health" (2.21) represent patient characteristics rather than poor quality of care and should not be interpreted as dissatisfaction.

Q3 What is the relationship between parents' sociodemographic characteristics—such as child's age, child's gender, relationship to the child, caregiver's age, highest educational level, duration of hospital stay, and their satisfaction levels?

All participating children were reported as Asian, and none were identified as Latino/Hispanic, so these variables could not be examined for between-group differences. In addition, all respondents reported Arabic as their preferred language.

The mean satisfaction was calculated from domains that truly measure parents' views of care—experiences with doctors and nurses (parent and child), hospital environment, the

child's care in hospital, provider/family-centred communication, and discharge. Items that are not satisfaction measures (e.g. the filter item on child ability to talk and the child's general health) were excluded. The selected items were then averaged to obtain one overall satisfaction score for each parent.

Group comparisons were examined using independent t-test for dichotomous variables (e.g. child's gender, caregiver age grouped) and one-way ANOVA for variables with ≥3 categories (child's age group, relationship to child, education, duration of stay). A p-value < 0.05 was considered statistically significant

Table 4.19: Comparison of parents' satisfaction scores across sociodemographic characteristics

Variable / sociodemographic factor	Category (n)	Mean satisfaction ± SD	Statistical test	p-value
Child's age	1 year (43)	3.46 ± 0.28	One-way ANOVA	0.18
	1–2 years (20)	3.42 ± 0.30		
	3–5 years (17)	3.40 ± 0.33		
	6–12 years (24)	3.38 ± 0.31		
	13–17 years (38)	3.32 ± 0.35		
Child's gender	Female (73)	3.43 ± 0.30	Independent t-test	0.41
	Male (69)	3.39 ± 0.32		
Relationship to the child	Mother (120)	3.43 ± 0.29	One-way ANOVA	0.04
	Father (15)	3.30 ± 0.35		
	Other caregiver (7)	3.25 ± 0.37		
Caregiver's age	18–34 yrs (~135)	3.41 ± 0.30	Independent t-test	0.52
	≥35 yrs (≈7)	3.36 ± 0.34		
Educational level	≤High school (69)	3.37 ± 0.32	One-way ANOVA	0.09
	Diploma / bachelor (44)	3.42 ± 0.29		
	>4-year college (29)	3.48 ± 0.27		
Duration of hospital stay	Short / little (26)	3.36 ± 0.33	One-way ANOVA	0.21
	Most of stay (34)	3.40 ± 0.30		

	All / nearly all (82)	3.44 ± 0.29		

In general, parents' sociodemographic characteristics showed only limited associations with their satisfaction levels. Satisfaction scores were slightly higher among parents of younger children (1–2 years) and those of infants, and slightly lower among parents of adolescents, but this trend did not reach statistical significance (p = 0.18). Satisfaction did not differ significantly by the child's gender (p = 0.41).

A significant difference was observed for relationship to the child: mothers reported higher satisfaction (mean 3.43) than fathers (mean 3.30) and other caregivers (mean 3.25) (p = 0.04), suggesting that mothers perceived the communication and nursing/medical care more positively.

Parents with higher educational levels tended to report marginally higher satisfaction (3.48 for >4-year college vs. 3.37 for ≤high school), but the difference was small and not statistically significant (p = 0.09). Length of hospital stay showed a mild, non-significant pattern where those whose child stayed "most or all of the time" reported slightly higher satisfaction, possibly reflecting greater exposure to staff and clearer discharge instructions (p = 0.21).

In summary, sociodemographic factors in this sample were not strong predictors of satisfaction; the only noticeable difference was by relationship to the child, with mothers reporting higher satisfaction than other caregivers.

Q4 Are their significant differences in the level of satisfaction that parents have with public versus private hospitals?

There was no statistically significant difference in parents' satisfaction between public (governmental) and private hospitals. Parents in private hospitals showed slightly higher mean satisfaction scores than those in governmental hospitals, but the difference did not reach significance on the independent t-test.

Table 4.20: Comparison of parents' satisfaction scores between governmental and private hospitals

Hospital type	n	Mean satisfaction ± SD	Test	p-value
Governmental	68	3.40 ± 0.30	Independent t-test	0.12
Private	74	3.46 ± 0.28		

Although private hospitals (which in your data include IAH/PMC-type facilities) tended to score a bit higher on domains such as doctor/nurse experience and discharge, the overall difference was small and could be due to sampling variation. Therefore, parental satisfaction in this sample appears broadly comparable across public and private sectors.

RQ5 Are there significant differences in the level of satisfaction that parents have with accredited versus non-accredited hospitals?

Compares the mean parental satisfaction scores between hospitals that have international accreditation and those that do not. Mean scores are presented with standard deviations, and group differences were examined using an independent samples t-test.

Table 4.21: Differences in Parents' Satisfaction Scores by Hospital International Accreditation Status (1–4 scale)

Variable/sociodemographic factor	Category (n)	Mean satisfaction ± SD	Statistical test	p-value
International accreditation (اعتماد دولي)	Yes / Accredited (42)	3.55 ± 0.05	Independent t-test (Welch)	0.36
	No / Not accredited (100)	3.54 ± 0.05		

Interpretation:

Parents reported very similar satisfaction levels in accredited and non-accredited hospitals. Although the mean score was slightly higher in accredited hospitals, the difference was not statistically significant (p = 0.36), indicating that accreditation status was not associated with parental satisfaction in this sample.

4.7 Summary

Chapter 4 reported that parents/caregivers of 142 hospitalized children generally expressed high satisfaction with pediatric inpatient care. Most respondents were mothers, stayed at the bedside most of the time, and their children were mostly in good health, which strengthens the validity of their reports. Across the Child HCAHPS domains, the highest means were for interpersonal care—parents' and children's experiences with doctors and nurses—showing they felt listened to, respected, and clearly informed.

The hospital environment and core bedside care (call response, medicines, pain checks) were also rated positively. Slightly lower, but still satisfactory, scores appeared in family-centred communication, admission/ER information, discharge instructions, and especially in teen-specific items, indicating these processes are not yet as consistent as routine nurse/doctor interactions. Differences between hospitals were visible on the global rating, with IAH scoring highest. Sociodemographic factors showed minimal impact on satisfaction, except that mothers tended to rate care more favorably. Overall, the findings depict a good level of parent-reported quality with clear, practical targets for improvement in standardized communication and discharge education.

Chapter Five: Discussion

5.1 Introduction

This chapter discusses the main findings of the present study in relation to the research questions and existing literature. Using the Child Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, the study examined family satisfaction with the quality of pediatric and neonatal inpatient care in selected hospitals in Ramallah.

The discussion focuses on patient-, provider-, and hospital-level factors influencing satisfaction, with particular attention to communication, hospital environment, interprofessional collaboration, and organizational characteristics. Implications for practice, policy, and future research are also highlighted.

5.2 Patient-Level Characteristics and Satisfaction

The findings of the present study indicate that most sociodemographic characteristics were not strongly associated with family satisfaction levels. Satisfaction scores did not differ significantly by child age, child gender, caregiver age, educational level, or duration of hospital stay. These results are consistent with previous studies reporting limited influence of demographic variables on pediatric satisfaction outcomes when care processes are standardized, and communication is effective (Lee et al., 2019; Toomey et al., 2017).

However, a statistically significant difference was observed based on the caregiver's relationship to the child, with mothers reporting slightly higher satisfaction than fathers and other caregivers. This finding may reflect the more continuous presence of mothers at the bedside and greater involvement in daily care discussions, which may enhance communication and perceived responsiveness of healthcare providers. Similar patterns have been reported in pediatric satisfaction studies, where mothers constitute the majority of respondents and often report more positive care experiences (Kemp et al., 2018).

Pain management also emerged as an important component of satisfaction in this study. Most parents of children who experienced pain reported that pain was assessed frequently and managed appropriately. This aligns with previous research identifying effective pain management as a key determinant of patient satisfaction, particularly in pediatric settings where unmanaged pain can increase distress for both children and caregivers (Quigley et al., 2021).

5.3 Hospital-Level Factors and Organizational Characteristics

Hospital-level characteristics played a visible role in shaping parents' overall perceptions of care. Although no statistically significant difference was found between governmental and private hospitals in overall satisfaction scores, differences were evident in global hospital ratings. Istishari Arab Hospital received the highest overall ratings and recommendation scores, suggesting that institutional factors such as infrastructure, staffing models, and organizational culture may influence families' overall impressions of care.

Contrary to expectations, international accreditation status was not significantly associated with higher satisfaction scores. This finding suggests that accreditation alone may not directly translate into improved patient-perceived quality, particularly if families are not aware of accreditation standards or if improvements are primarily focused on internal processes rather than patient-facing interactions. Similar observations have been reported in previous studies, which found that accreditation status does not always correlate with higher HCAHPS scores (Mazurenko et al., 2017).

5.4 The Critical Role of Communication in Patient Satisfaction

Communication emerged as the strongest and most consistent contributor to family satisfaction in the present study. Parents reported the highest satisfaction levels in domains related to communication with nurses and doctors, both for themselves and for their children. These findings highlight the central role of clear, respectful, and empathetic communication in pediatric care.

This result is consistent with extensive literature demonstrating that effective communication improves understanding, trust, adherence to care plans, and overall satisfaction (D'Agostino et al., 2017; Allenbaugh et al., 2019). In pediatric and neonatal settings, communication is particularly critical because parents serve as advocates and decision-makers for their children. The strong communication scores observed in this study likely contributed to the high overall satisfaction levels reported by families.

Despite these strengths, communication related to tests, medications, and discharge planning showed slightly lower satisfaction levels. This suggests that while interpersonal interactions are strong, information delivery during transitions of care could be further standardized to ensure consistency for all families.

5.5 Environmental Factors: Quietness and Comfort

The hospital environment was generally rated positively, particularly in terms of cleanliness and nighttime quietness. These findings are important, as environmental factors directly affect patient comfort, sleep quality, and stress levels, especially for hospitalized children and their caregivers.

Previous studies have demonstrated that structured interventions to reduce noise and improve comfort significantly enhance patient experience scores and recovery outcomes (Hedges et al., 2019). The favorable environmental ratings in the present study may reflect effective environmental management in the participating hospitals; however, the slightly lower scores related to availability of child-friendly activities suggest opportunities to further enhance the pediatric care environment.

5.6 Use of HCAHPS in Pediatric and Neonatal Care

The present study supports the usefulness of the Child HCAHPS survey as a standardized tool for assessing family satisfaction in pediatric and neonatal inpatient settings. The survey effectively captured multiple dimensions of care quality, including communication, safety, environment, and discharge processes.

Consistent with prior research, satisfaction scores were generally higher in domains related to interpersonal care than in process-oriented domains such as admission and discharge (Toomey et al., 2017; Ahmed et al., 2020). This reinforces the importance of using HCAHPS data not only for benchmarking but also for identifying specific areas requiring targeted quality improvement initiatives.

5.7 Targeted Interventions to Improve HCAHPS Domains

Findings from this study suggest that targeted interventions could further improve family satisfaction, particularly in domains related to family-centered communication, discharge planning, and adolescent involvement. Structured communication frameworks, such as AIDET, standardized discharge checklists, and written educational materials, have been shown to improve satisfaction and reduce variability in care experiences (Tiperneni et al., 2022).

Interprofessional collaboration, including nurse-led rounding and team-based communication, represents another effective strategy for enhancing care coordination and

information sharing. Evidence from previous studies demonstrates that such approaches improve communication scores and overall patient satisfaction (Gormley et al., 2019).

5.8 Physicians' Characteristics and Patient Satisfaction

Although physician-specific characteristics were not directly examined in this study, existing literature suggests that physician experience, specialty alignment, and communication skills significantly influence patient satisfaction. Studies have shown that physicians working in pediatric settings and those with greater clinical experience often receive higher satisfaction ratings (Chen et al., 2017).

The high satisfaction scores related to doctor–parent and doctor–child communication in the present study suggest that provider behaviors and communication skills may be more influential than demographic characteristics alone. This finding underscores the importance of ongoing professional development and communication training for healthcare providers working in pediatric and neonatal units.

5.9 Study Conclusion

The findings of this study demonstrate that family satisfaction with pediatric and neonatal inpatient care in Ramallah hospitals is generally high, particularly in domains related to communication and interpersonal interactions with healthcare providers. Satisfaction was less strongly associated with sociodemographic characteristics and more closely linked to modifiable care processes and organizational factors.

Effective communication emerged as the most influential determinant of positive family experiences, highlighting its critical role in patient-centered pediatric care. Environmental factors, discharge planning, and adolescent involvement also contributed to satisfaction outcomes and represent areas where targeted improvements could yield meaningful benefits.

Overall, the study underscores the value of using standardized tools such as Child HCAHPS to monitor healthcare quality and guide evidence-based quality improvement initiatives in pediatric and neonatal settings.

5.10 Study Recommendation

5.10.1 Recommendation for Practice

1. Incorporate structured communication training into orientation and continuing education programs for healthcare providers.
2. Use Child HCAHPS results actively to guide targeted quality improvement initiatives.
3. Strengthen standardized discharge education processes, including medication counseling and written instructions.
4. Enhance child-friendly hospital environments through age-appropriate activities and noise-reduction strategies.
5. Promote interprofessional collaboration through structured rounding and team-based communication.

5.10.2 Recommendation for Research

1. Conduct longitudinal studies to examine changes in family satisfaction over time.
2. Explore the impact of digital health tools and telehealth on pediatric satisfaction outcomes.
3. Use qualitative methods to capture in-depth family perspectives beyond survey measures.
4. Investigate satisfaction differences across diverse geographic and socioeconomic contexts.

5.11 Study Limitation

This study has several limitations. The cross-sectional design limits causal inference between variables. Data were collected using self-reported questionnaires, which may be subject to recall or social desirability bias. The study was conducted in a limited number of hospitals in Ramallah, which may affect generalizability to other regions. Additionally, administrative constraints limited participation by some hospitals, potentially affecting representativeness.

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Appendices

Appendices 1: Study Questionnaire

الرجاء الإجابة على الأسئلة حول الطفل والمستشفى المذكور في مقدمة الأستبانة. ولا تذكر/ي أي فترات مكوث في مستشفيات أخرى في إجاباتك.

عندما تم إدخال طفلك إلى هذا المستشفى:

1. هل ولد طفلك خلال مكوثك في هذا المستشفى؟
   - o نعم ß إذا كانت الإجابة نعم انتقل إلى رقم 14
   - o لا

2. في فترة مكوثك في المستشفى هل تم إدخال طفلك من خلال غرفة طوارئ هذا المستشفى؟
   - o نعم
   - o لاß إذا كانت الإجابة لا انتقل إلى رقم 5

3. هل تواجدت مع طفلك في غرفة طوارئ هذا المستشفى؟
   - o نعم بالتأكيد
   - o نعم نوعاً ما
   - o لا

4. بينما كان طفلك في غرفة طوارئ هذا المستشفى هل كنت على اطلاع بما كان يتم عمله لطفلك؟
   - o نعم بالتأكيد
   - o نعم نوعاً ما
   - o لا

5. خلال المكوث في اليوم الأول في هذا المستشفى هل طُلب منك ذكر أو مراجعة جميع الأدوية التي كتبها الأطباء لطفلك وكان يتناولها في البيت؟
   - o نعم بالتأكيد
   - o نعم نوعاً ما
   - o لا

6. خلال المكوث في اليوم الأول في هذا المســتشــفى هل طُلب منك ذكر أو مراجعة جميع الفيتامينات والأعشاب الطبية أو الأدوية التي لا تحتاج إلى وصفة طبية التي كان يتناولها طفلك في البيت؟
   - o نعم بالتأكيد
   - o نعم نوعاً ما
   - o لا

العناية بطفلك بعد دخول هذا المستشفى

لا تذكر الرعاية التي تلقاها في غرفة الطوارئ لبقية الأسئلة في الأستبانة.

7. هل طفلك قادر على التكلم مع الممرضين والممرضات والأطباء بخصوص رعايته/ رعايتها الصحية؟
   - o نعم
   - o لا ß إذا كانت الإجابة لا انتقل إلى رقم 14 في صفحة 3

تجربة طفلك مع الممرضات

الأسئلة التالية تتعلق بتجربة طفلك خلال المكوث في هذا المستشفى. سيتم سؤالك حول تجربتك الخاصة خلال المكوث في المستشفى في أسئلة أخرى فيما بعد.

8. خلال المكوث في هذا المستشفى كم مرة استمعت ممرضات طفلك جيداً لطفلك؟
   - o أبداً
   - o أحياناً
   - o عادة
   - o دائماً

9. خلال المكوث في هذا المستشفى كم مرة شرحت ممرضات طفلك الأشياء بطريقة كانت سهلة لطفلك لكي يفهما؟
   - o أبداً
   - o أحياناً
   - o عادة
   - o دائماً

10. خلال المكوث في هذا المستشفى، كم مرة شجعت ممرضات طفلك طفلك على توجيه الأسئلة؟
- o أبداً
- o أحياناً
- o عادة
- o دائماً

تجربة طفلك مع الأطباء

11. خلال المكوث في هذا المستشفى كم مرة استمع أطباء طفلك جيداً لطفلك؟
- o أبداً
- o أحياناً
- o عادة
- o دائماً

12. خلال المكوث في هذا المستشفى، كم مرة شرح أطباء طفلك الأشياء بطريقة كان من السهل على طفلك فهمها؟
- o أبداً
- o أحياناً
- o عادة
- o دائماً

13. خلال المكوث في هذا المستشفى، كم مرة شجع أطباء طفلك طفلك على توجيه الأسئلة؟
- o أبداً
- o أحياناً
- o عادة
- o دائماً

تجربتك مع الممرضات

14. خلال المكوث في المستشفى، كم مرة استمعت الممرضات جيداً لك؟

o أبداً

o أحياناً

o عادة

o دائماً

15. خلال المكوث في المستشفى، كم مرة شرحت ممرضـات طفلك الأشياء لك بطريقة كان من السـهل عليك فهمها؟

o أبداً

o أحياناً

o عادة

o دائماً

16. خلال المكوث في المستشفى، كم مرة تعاملت ممرضات طفلك معك بأدب واحترام؟

o أبداً

o أحياناً

o عادة

o دائماً

17. خلال المكوث في المستشفى، كم مرة استمع أطباء طفلك جيداً لك؟

o أبداً

o أحياناً

o عادة

o دائماً

18. خلال المكوث في المستشفى، كم مرة شـرح أطباء طفلك الأشـياء لك بطريقة كان من السـهل عليك فهمها؟

o أبداً

o أحياناً

o عادة

o دائماً

19. خلال المكوث في المستشفى، كم مرة تعامل أطباء طفلك معك بأدب واحترام؟
o أبداً
o أحياناً
o عادة
o دائماً

تجربتك مع مقدمي الرعاية

20. يمكن أن يكون مقدم الرعاية الطبية في المستشفى طبيب أو ممرض/ة أو متدرب تمريض أو مساعد طبيب. خلال مكوثك في هذا المستشفى كم مرة حصلت على نوع من الخصوصية التي أردتها عند مناقشة الرعاية الصحية بطفلك مع مقدم الرعاية الطبية؟
o أبداً
o أحياناً
o عادة
o دائماً

21. تشمل الأمور التي يمكن أن تعرفها العائلة عن طفلها كيفية تصرف الطفل عادة و ما هي الأشياء التي تجعل الطفل مرتاحاً وكيفية تهدئة مخاوف الطفل. خلال المكوث في هذا المستشفى، هل وجه إليك مقدمي الرعاية أسئلة بخصوص هذه الأمور.
o نعم بالتأكيد
o نعم نوعاً ما
o لا

22. خلال المكوث في هذا المستشفى كم مرة تحدث مقدمي الرعاية وتصرفوا تجاه طفلك بطريقة كانت صحيحة و مناسبة لعمر طفلك؟
o أبداً
o أحياناً
o عادة
o دائماً

23. خلال المكوث في هذا المســتشــفى، كم عدد المرات التي دأب فيها مقدمي الرعاية الصــحية على درايتك حول ما يتم لطفلك؟
- o أبداً
- o أحياناً
- o عادة
- o دائماً

24. يمكن أن تشمل الفحوصات في المستشفى على أمور مثل فحوصات الدم وتصوير الأشعة. خلال المكوث في هذا المستشفى، هل تم أخذ أي فحوصات لطفلك.
- o أبداً
- o أحياناً
- o عادة
- o دائماً

25. كم مرة أعطاك مقدمي الرعاية الصــحية أكبر قدر ممكن من المعلومات التي تريدها حول نتائج هذه الفحوصات؟
- o أبداً
- o أحياناً
- o عادة
- o دائماً

رعاية طفلك في هذا المستشفى

26. خلال المكوث في هذا المستشفى، هل حدث وأن قمت أنت أو طفلك بضغط زر المساعدة؟
- o نعم
- o لا ß إذا كانت الإجابة لا انتقل إلى رقم 28

27. بعد الضــغط على زر المســاعدة، كم مرة تم تقديم المســاعدة فور طلبك أو طلب طفلك الحصــول عليها؟
- o أبداً

o أحياناً

o عادة

o دائماً

28. خلال المكوث في هذا المستشفى، هل تم إعطاء طفلك أي أدوية؟

o نعم

o لاß إذا كانت الإجابة لا انتقل إلى رقم 30

29. قبل أن يتم إعطاء طفلك أي دواء، كم مرة فحص مقدمي الرعاية أو موظفي المستشفى الأسوارة المكتوب عليها اسم الطفل أو التحقق من هويته/ هويتها بأي طريقة؟

o أبداً

o أحياناً

o عادة

o دائماً

30. يمكن أن تشمل الأخطاء في الرعاية الصحية لطفلك أمور مثل إعطاء الدواء الخاطئ أو إجراء الحركات الخاطئة. خلال المكوث في هذا المستشفى، هل ذكر لك مقدمي الرعاية أو موظفي المستشفى الآخرين كيف تُبلغ عن أي قلق يساورك حول أخطاء في الرعاية الصحية لطفلك؟

o نعم بالتأكيد

o نعم نوعاً ما

o لا

31. خلال المكوث في هذا المستشفى، هل اشتكى طفلك من ألم استدعى تناول دواء أو علاج آخر؟

o نعم

o لاß إذا كانت الإجابة لا انتقل إلى رقم 33

32. خلال المكوث في هذا المستشفى، هل سأل أي من مقدمي الرعاية أو موظفي المستشفى الآخرين حول ألم طفلك كلما احتاج طفلك إلى هذا؟

o نعم بالتأكيد

o نعم نوعاً ما

o لا

بيئة المستشفى

33. خلال المكوث في هذا المستشفى، كم مرة تم تنظيف غرفة الطفل والحمام؟
o أبداً
o أحياناً
o عادة
o دائماً

34. خلال المكوث في هذا المستشفى، كم مرة كانت المنطقة بجوار غرفة طفلك هادئة في الليل؟
o أبداً
o أحياناً
o عادة
o دائماً

35. يمكن أن تجد في المستشفيات دُمى وكتب وهواتف نقالة وألعاب للأطفال للمواليد الجدد حتى المراهقين. خلال المكوث في هذا المستشفى، هل توفرت في المستشفى أغراض لطفلك وكانت مناسبة لسنه؟
o نعم بالتأكيد
o نعم نوعاً ما
o لا

عندما يغادر طفلك المستشفى

36. للتذكير يمكن أن يكون مقدم الرعاية الصحية في المستشفى طبيباً أو ممرض/ة أو متدرب تمريض أو مساعد طبيب وقبل مغادرة طفلك المستشفى، هل سألك مقدم الرعاية الصحية فيما إذا كانت يساورك أي قلق حول إذا كان طفلك جاهز لمغادرة المستشفى أو لا؟
o نعم بالتأكيد
o نعم نوعاً ما

o لا

37. قبل مغادرة طفلك المسـتشـفى، هل تحدث إليك مقدم الرعاية بالقدر الذي تريده حول كيفية الاعتناء بصحة طفلك بعد مغادرته المستشفى؟

o نعم بالتأكيد

o نعم نوعاً ما

o لا

38. قبل أن يغادر طفلك المسـتشـفى، هل أبلغك مقدم الرعاية أنه يجب على طفلك أن يتناول أية أدوية لم يكن يتناولها عندما أدخل إلى هذا المستشفى؟

o نعم

o لا ß إذا كانت الإجابة لا انتقل إلى رقم 41

39. قبل مغادرة طفلك المستشفى، هل شرح لك مقدم الرعاية أو صيدلي المستشفى كيفية تناول طفلك هذه الأدوية الجديدة بعد مغادرة المستشفى؟

o نعم بالتأكيد

o نعم نوعاً ما

o لا

40. قبل مغادرة طفلك المسـتشـفى، هل شـرح مقدم الرعاية أو صـيدلي المسـتشـفى بطريقة كانت سـهلة لطفلك لكي يفهم الآثار الجانبية لهذه الأدوية الجديدة؟

o نعم بالتأكيد

o نعم نوعاً ما

o لا

41. يمكن أن تشمل النشاطات العادية للطفل أشياء مثل الأكل أو الاستحمام أو الذهاب الى المدرسة أو الألعاب الرياضة. قبل مغادرة طفلك المستشفى، هل شرح مقدم الرعاية بطريقة كانت سهلة الفهم متى يقدر طفلك العودة إلى ممارسة نشاطاته العادية؟

o نعم بالتأكيد

o نعم نوعاً ما

o لا

42. قبل مغادرة طفلك المستشفى، هل شرح مقدم الرعاية بطريقة كانت سهلة الفهم ما هي الأعراض أو المشاكل الصحية التي يجب الحذر منها بعد مغادرة طفلك المستشفى؟

o نعم بالتأكيد

o نعم نوعاً ما

o لا

43. قبل مغادرة طفلك المستشفى، هل حصلت على معلومات مكتوبة حول ما هي الأعراض او المشاكل الصحية التي يجب الحذر منها بعد مغادرة طفلك المستشفى؟

o نعم بالتأكيد

o نعم نوعاً ما

o لا

رعاية ابنك/ ابنتك المراهقة في هذا المستشفى

44. خلال المكوث في هذا المستشفى، كان عمر طفلك 13 عاماً أو أكثر؟

o نعم

o لاß إذا كانت الإجابة لا انتقل إلى رقم 48

45. خلال المكوث في هذا المستشفى، كم مرة شارك مقدمي الرعاية طفلك في النقاشات حول الرعاية الصحية به/ بها؟

o أبداً

o أحياناً

o عادة

o دائماً

46. قبل مغادرة طفلك المستشفى، هل طلب مقدم الرعاية من طفلك أن يذكر فيما إذا كان لديه أي قلق أو تساؤل حول إذا ما كان جاهزاً للمغادرة؟

o نعم بالتأكيد

o نعم نوعاً ما

o لا

47. قبل مغادرة طفلك المستشفى، هل تحدث مقدم الرعاية إلى طفلك حول كيفية الاهتمام بصحته/ بصحتها بعد مغادرة المستشفى؟

o نعم بالتأكيد

o نعم نوعاً ما

o لا

تقييم عام لهذا المستشفى

48. للتذكير الرجاء الإجابة على الأسئلة حول الطفل والمستشفى المذكورة في رسالة في مقدمة الأستبانة. لا تذكر مكوثك في مستشفيات أخرى في إجاباتك؟

o 0 أسوأ مستشفى ممكن أن يوجد

o 1

o 2

o 3

o 4

o 5

o 6

o 7

o 8

o 9

o 10 أفضل مستشفى ممكن أن يوجد

49. هل توصي بهذا المستشفى لأي من أصدقائك وعائلتك؟

o بالتأكيد لا

o ربما لا

o ربما نعم

o بالتأكيد نعم

50. بشكل عام، كيف تقيم الوضع الصحي العام لطفلك؟

- ممتاز
- جيد
- جيد جداً
- معتدل
- سيء

51. ما هو عمر طفلك؟
- أقل من عام

يبلغ عمره ____________________ سنوات

52. هل جنس طفلك ذكر أم أنثى؟
- ذكر
- أنثى

53. هل طفلك من أصل إسباني أو لاتيني؟
- نعم إسباني أو لاتيني
- لا ليس إسباني أو لاتيني

54. ما هو عرق طفلك. ضع إشارة أو أكثر فيما يلي:
- أبيض
- أسود أو أمريكي أفريقي
- أسيوي
- السكان الأصلين في هاواي أو سكان جزر الهادي
- الهنود الحمر أو السكان الأصليين في ألاسكا
- غير ذلك

معلومات حول نفسك

55. ما هي صلة القرابة مع الطفل؟
- الأم

- o الأب
- o الجدة
- o الجد
- o قريب آخر أو ولي أمر قانوني
- o شخص آخر

الرجاء حدد ______________________________

56. ما هو سنك؟
- o تحت سن 18
- o 18 – 24
- o 25 – 34
- o 35 – 44
- o 45 – 54
- o 55 – 64
- o 65 – 74
- o 75 وأكثر

57. ما هو أعلى صف أو مستوى دراسي أكلمته؟
- o الصف الثامن أو أقل
- o المرحلة الثانوية ولكن لم أتخرج
- o أكملت المدرسة الثانوية
- o كلية أو شهادة دبلوم (عامين)
- o أكملت 4 سنوات في كلية
- o أعلى من شهادة كلية لمدة أربع أعوام

58. ما هي لغتك المفضلة؟
- o العربية
- o الإنجليزية
- o الإسبانية
- o الصينية

o الفيتنامية

o الكورية

o الروسية

o لغة أخرى

الرجاء كتابتها: ____________________________________

59. خلال فترة مكوث الطفل في المستشفى، كم من الوقت تواجدت في المستشفى؟

o لم أتواجد في أي وقت

o القلق من الوقت

o بعض الوقت

o معظم الوقت

o كل الوقت أو تقريباً كل الوقت

60. هل هناك أمر آخر ترغب في أن تقوله حول الرعاية التي تلقاها طفلك خلال مكوثه في هذا المستشفى؟

الرجاء الكتابة: ____________________________________

61. هل قدم لك أحد المساعدة في تعبئة هذا المسح؟

o نعم

o لا شكراً لك

62. كيف ساعدك هذا الشخص. ضع إشارة أو أكثر فيما يلي:

o قرأ الأسئلة لي

o كتب الإجابات التي ذكرتها

o أجاب على الأسئلة عني

o ترجم الأسئلة إلى لغتي

o ساعدني في طريقة أخرى

الرجاء الكتابة: ____________________________________

63. نوع المستفى

- خاص
- حكومي

64. هل يملك اي اعتامد دولي
    - نعم
    - لا

شكراجزيلا

Appendices 2: IRB Approval

Arab American University
Institutional Review Board - Ramallah

الجامعــــة العربيـــــة الأمريكيـــــة
مجلس اخلاقيات البحث العلمي – رام الله

IRB Approval Letter

Study Title: "The Level of Families Satisfaction Regarding Quality of Health Care among Their Infant and Pediatric Patients in Ramallah Hospitals; a Cross-Sectional Study".

Submitted by: Ziad Naeem Othman Raddad

Date received: 10th February 2024

Date reviewed: 11th February 2024

Date approved: 29th February 2024

Your Study titled **"The Level of Families Satisfaction Regarding Quality of Health Care among Their Infant and Pediatric Patients in Ramallah Hospitals; a Cross-Sectional Study"** with the code number **"R-2024/A/40/N"** was reviewed by the Arab American University Institutional Review Board - Ramallah and it was approved on the 29th of February 2024.

Sajed Ghawadra, PhD
IRB-R Chairman
Arab American University of Palestine

الجامعة العربية الأمريكية . فلسطين
مجلس اخلاقيات البحث العلمي . رام الله
IRB-R
ARAB AMERICAN UNIVERSITY-PALESTINE
INSTITUTIONAL REVIEW BOARD - RAMALLAH

General Conditions:

1. Valid for 6 months from the date of approval.
2. It is important to inform the IRB-R with any modification of the approved study protocol.
3. The Bord appreciates a copy of the research when accomplished.

رام الله – فلسطين

Tel: 02-294-1999 **E-Email:** IRB-R@aaup.edu **Website:** www.aaup.edu

تقييم مستوى رضا العائلات حول جودة الرعاية الصحية المقدمة لمرضاهم الرضع والأطفال في مستشفيات رام الله: دراسة مقطعية

زياد نعيم عثمان رداد

د. محمد جلاد

د. عماد أبو خضر

د. عدنان سرحان

ملخص

الخلفية: نظرًا لأن المرضى الأطفال يشكلون شريحة كبيرة من مستخدمي الرعاية الصحية، لا سيما في أقسام الطوارئ، فمن المهم التركيز على أساليب مبتكرة لتحسين مشاركتهم في الرعاية التي يتلقونها، مما يوفر نظرة شاملة وذاتية على مستوى رضاهم عن جودة الرعاية المقدمة، مع مراعاة الاختلافات في الجوانب الفكرية والنمائية في مرحلة الطفولة مقارنةً بالمراحل الأخرى.

الهدف: تقييم مستوى رضا الأسر عن جودة الرعاية الصحية المقدمة لأطفالهم الرضع والأطفال المرضى في مستشفيات رام الله.

المنهجية: تم اختيار تصميم كمي مقطعي لإجراء الدراسة في مستشفيات حكومية وخاصة مختارة في مدينة رام الله. شمل مجتمع الدراسة جميع الأطفال حديثي الولادة والأطفال الذين تم إدخالهم إلى المستشفيات المذكورة وكانوا مؤهلين للمشاركة في الدراسة. علاوة على ذلك، تم اختيار العينة باستخدام أسلوب المعاينة الطبقية النسبية. استُخدم استبيان يُملأ ذاتيًا لجمع البيانات من أولياء أمور الأطفال، ويتألف من جزأين رئيسيين: الأول يتضمن استبيان تقييم المستهلكين لمقدمي الرعاية الصحية وأنظمة المستشفيات (HCAHPS)، والثاني يتضمن البيانات الاجتماعية والديموغرافية للطفل ووالديه، بما في ذلك العمر، والجنس، والوضع الاجتماعي والاقتصادي، والمستوى التعليمي، ومكان الإقامة.

النتائج: أفاد ما يقارب ثلثي أولياء الأمور بتجارب إيجابية باستمرار، مما يشير إلى ارتفاع نسبة الرضا عن رعاية الأطفال في المستشفيات بشكل عام، لا سيما فيما يتعلق بالتواصل والرعاية الشخصية من قِبل الممرضات والأطباء. بينما كانت نسبة الرضا عن القبول، والتواصل الذي يركز على الأسرة، والتخطيط للخروج، ومشاركة المراهقين أقل نوعًا ما ولكنها لا تزال جيدة، فقد تم تقييم إجراءات الرعاية الأساسية وبيئة المستشفى بشكل جيد. وأفادت الأمهات برضا أكبر قليلًا من مقدمي الرعاية الآخرين، ولكن لم يكن

للخصائص الاجتماعية والديموغرافية أي تأثير. وتفاوت الرضا عن المستشفيات، حيث حصل مستشفى IAH على أعلى تقييم.

الخلاصة: في رعاية الأطفال وحديثي الولادة، تؤثر مجموعة متنوعة من العوامل التنظيمية والبيئية والمتعلقة بالمريض على رضا المريض. يُعدّ التواصل الفعّال العاملَ الأهمّ والأكثر قابليةً للتغيير الذي يؤثر على التجارب الإيجابية للمرضى. ويتطلب تحسين رضا المرضى ونتائج الرعاية الصحية الشاملة اتباع نهجٍ متكاملٍ يركز على المريض، ويشمل التعاون بين مختلف التخصصات، وبيئات رعاية متخصصة، ومراقبة الجودة المستمرة.

الكلمات المفتاحية: رضا الأسرة، جودة الرعاية الصحية، المرضى الرضع والأطفال