

**AUSTRALIAN COMMISSION  
ON SAFETY AND QUALITY IN HEALTH CARE**

**Australian Hospital Patient Experience Question Set  
(AHPEQS)**

**Summary of development and testing  
December 2017**

When someone acknowledges us, or listens to us, or comforts us, or explains things to us, it's so much better ... we just feel better because someone has cared for us.

AHPEQS focus group participant

© Australian Commission on Safety and Quality in Health Care 2017.

Unless otherwise noted, all material presented in this publication is licensed under a **Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International Licence**.



Enquiries regarding the licence and any use of this publication are welcome and can be sent to [communications@safetyandquality.gov.au](mailto:communications@safetyandquality.gov.au).

The Commission's preference is that you attribute this publication (and any material sourced from it) using the following citation:

Australian Commission on Safety and Quality in Health Care. Summary of Development and Testing of the AHPEQS – December 2017. Sydney: ACSQHC; 2017

### **Disclaimer**

This report has been prepared by the Australian Commission on Safety and Quality in Health Care. The Commonwealth of Australia does not accept any legal liability or responsibility for any injury, loss or damage incurred by the use of, or reliance on, or interpretation of, the information contained on this report.

## Contents

Introduction .....	4
Project rationale .....	4
Project scope .....	4
Governance.....	5
Ethics .....	5
Timeline.....	5
Question development process .....	6
Phase 1: Question item generation.....	6
Phase 2: Question item reduction.....	7
Phase 3: Question item refinement.....	9
Implementation and use .....	10
101 factors affecting the quality of patient experience .....	12

## **Introduction**

---

The purpose of this document is to provide a brief overview of the development and testing of the Australian Hospital Patient Experience Question Set (AHPEQS). This non-proprietary question set was developed by the Australian Commission on Safety and Quality in Health Care to facilitate nationally consistent measurement of the experiences of patients admitted to hospital or day surgery clinics. It is a short set of generic questions assessing core elements of experience which are not dependent on the patient's condition or setting of care.

## **Project rationale**

---

There were three principal drivers for the development of the AHPEQS.

1. In 2014, the Australian Health Ministers' Advisory Council (AHMAC) requested and funded the development of non-proprietary core patient experience questions for overnight admitted hospital patients, to replace existing proprietary core questions. This was considered a cost-effective alternative to ongoing annual payment of a licence fee for the use of ten of the existing questions. A non-proprietary question set will increase the accessibility of standard national questions to all providers of overnight and day stay hospital care, including the private sector.
2. National reporting obligations under the *National Health Reform Agreement 2011* and the *Performance and Accountability Framework* include indicators of patient satisfaction and experience. At present, Australian Bureau of Statistics (ABS) population survey data is used for this purpose, but such information is of limited use for quality and safety improvement purposes as results cannot be attributed to particular facilities or episodes of care.
3. At present there are no patient experience question sets which have been developed using robust qualitative research with consumers and other stakeholders from across the country. The AHPEQS are tailored to the concerns of Australian consumers and the Australian healthcare context. They will be an important resource for organisations in meeting accreditation requirements and in improving the experience of their patients.

## **Project scope**

---

The project scope, as agreed by AHMAC in 2015, is the 'specification of non-proprietary hospital patient experience core common questions,' 'for insertion into an existing survey or as a stand-alone mini survey.' The AHPEQS are designed for use by adults aged 18 or over.

An early decision was made to create the new question set in-house from first principles, using independent research, without reference to other proprietary survey questions or instruments. This is to protect the intellectual property of the AHPEQS for the Commonwealth of Australia, so that it can remain non-proprietary in future. The scope of the project therefore included question item generation, reduction, refinement, piloting and statistical testing.

It was not within the scope of the project to test the AHPEQS purposively with, or adapt them for, particular culturally and linguistically diverse populations, for Aboriginal and Torres Strait Islander communities, for those aged under 18, or for people with intellectual disability or cognitive impairment. It is anticipated that further validation and reliability testing will occur with these groups after endorsement of the AHPEQS, in collaboration with interested health services. Due to the generic nature of the questions, there has already been interest in testing them in outpatient, primary care and paediatric populations as well.

## Governance

The development process was overseen by an Expert Advisory Group. This Group was established to ensure equal input from interested stakeholder groups, including clinicians and consumers. Expert Advisory Group members were drawn from the following stakeholder groups:

- Healthcare consumers (2), nominated by the Consumers' Health Forum
- Health professionals (4), nominated by the Australian College of Nursing, Royal Australasian College of Physicians, Allied Health Professions Australia, and Royal Australian College of Medical Administrators
- State health departments (2), Commonwealth agencies with an interest in patient experience measurement (3)
- Private sector healthcare providers (2)
- Independent experts in patient experience and its measurement (2).

## Ethics

All phases of the project were subject to ethics applications and approvals with the relevant Human Research Ethics Committees.

## Timeline

The development and testing process begin in mid-2015 and concluded in mid-2017. The phases of the project and their timing are shown below.

		2015		2016				2017	
		Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
<b>Preparation phase</b>									
0.1	Project design, ethics								
<b>Conceptual framework development phase</b>									
1.1	Consumer focus groups								
1.2	Literature review								
<b>Candidate question item reduction phase</b>									
2.1	Consumer priorities survey								
2.2	Expert consensus round 1								
2.3	Clinician & policymaker interviews								
2.4	Feasibility testing								
<b>Candidate question refinement</b>									
3.1	Expert consensus round 2								
3.2	Survey methodologist review								
3.3	Consumer cognitive testing								
3.4	Field testing & statistical analysis								

## Question development process

The AHPEQS development process was divided into three phases: (1) candidate question item generation; (2) question item reduction; and (3) iterative item refinement. Each phase comprises several research steps, each of which is outlined below.

### Phase 1: Question item generation

#### 1.1 Consumer focus groups

Fifteen focus group discussions were held during August-September 2015 with people who had a recent experience of hospital or day stay care. Eighty-six participants joined the groups in eight locations across Australia (Canberra, Sydney, Melbourne, Adelaide, Perth, Brisbane, Townsville and Launceston); two virtual groups were held by teleconference with people living in rural/remote parts of Northern Territory and Western Australia. All participants were recruited using the local email networks of healthcare consumers' associations, where they exist, in each state and territory. The three groups held in Melbourne were with members of culturally and linguistically diverse communities.

A conceptual framework was developed from iterative coding of the transcripts of group discussions, using a hybrid inductive-deductive thematic analysis method. The framework was structured around 20 dimensions of patient experience which emerged from the focus groups (figure 1 shows the dimensions). This framework accounted for 101 factors mentioned by consumers as influencing the quality of their experience of hospital or day procedure services. See Appendix 1 for the framework.

The 101 factors were each considered to form a conceptual basis for a potential question item and progressed to Phase 2 of the research (item reduction).

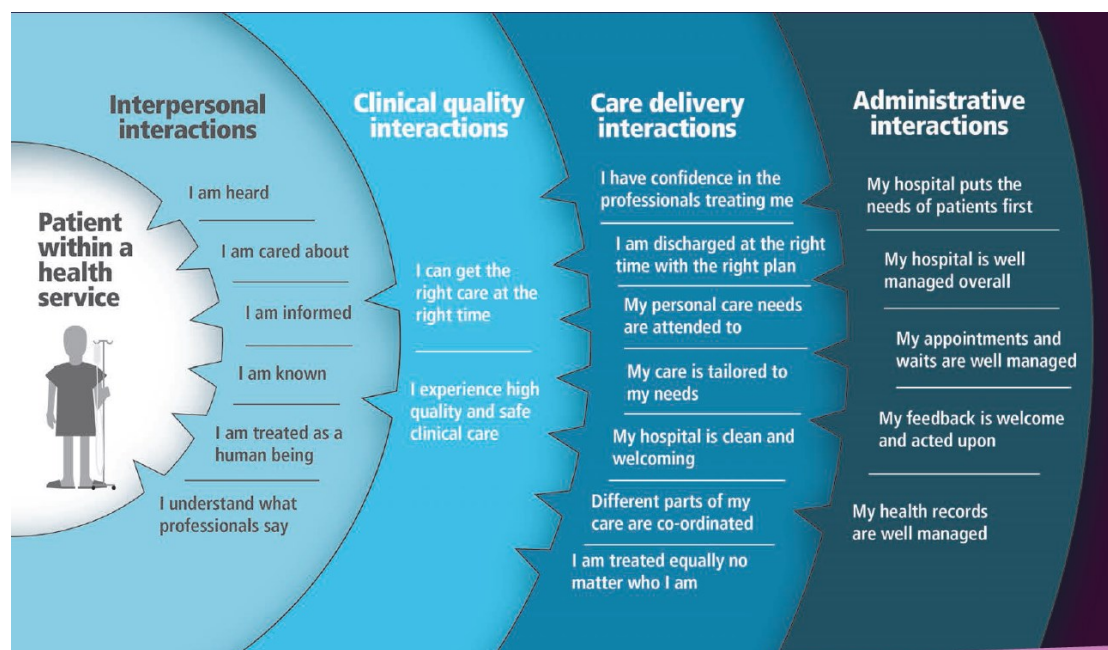


Figure 1: 20 dimensions of patient experience

## **1.2. Literature review**

To provide a point of comparison with, and ensure the comprehensiveness of, the focus group findings, a literature review was carried out. Because of the need to ensure our instrument is developed independently of other instruments, we restricted the scope of the literature review to primary qualitative research with consumers and carers in Australia about their experiences of health care since 1995. Thirty-nine studies were included in the review, and were analysed using the meta-narrative method. All elements of the literature review findings were covered by our conceptual framework, and indeed some of the findings from our focus groups were infrequently or not mentioned in previous studies.

## **Phase 2: Question item reduction**

### **2.1. Consumer prioritisation survey**

The first step in item reduction was to assess which factors were most important to consumers on each dimension. A prioritisation survey was constructed and administered in SurveyMonkey. A link to the survey was sent to those who had participated in the focus groups, as well as a group of more than 50 consumer representatives from existing Commission committees. During this exercise, participants nominated the two factors which they considered most important on each dimension, and then nominated the five dimensions they believed to be the most important. Analysis of results, using weightings, yielded an overall ranking of the 101 factors.

### **2.2. EAG consensus meetings - round 1**

Consultation with the Expert Advisory Group and collation of members' written comments on each item resulted in the selection of 35 items from the long list of 101 items. These 35 were chosen in a stepped process as follows.

- First, the 35 top-ranked items from the consumer prioritisation exercise were selected.
- Second, items suitable for combination without loss of meaning were combined.
- Third, items not included in the top 35 ranked items but which were as prominent themes in focus group discussions were added.
- Fourth, a dimension check was carried out to ensure that there were no major gaps in terms of dimension coverage.

### **2.3. Feasibility interviews**

Focus groups and interviews were carried out with frontline health professionals and with policymakers and senior administrators. Three focus groups were held with health professionals (with a total of 13 participants), eight interviews with representatives of jurisdictional governments (with a total of 15 participants; all jurisdictions except the Commonwealth participated), and four interviews with private sector representatives (two providers and two insurance funds nominated by the Commission's Private Hospital Sector Committee).

As part of the focus groups and interviews, participants were asked to assess each of the 35 shortlisted factors (which had been reworded as indicators: ‘patient reports that ...’) from their own professional perspective on three criteria, as follows.

- Is it realistic to expect improvement on this factor?
- Is it possible to demonstrate improvement on this factor (is it potentially measurable)?
- Would regular information about this factor be useful for quality and safety improvement (either at the ‘frontline’ or at jurisdiction/ private hospital group level)?

Each of the focus groups and interviews yielded a detailed discussion of participants’ reactions to and assessments of the five factors which had been ranked highest by consumers. Participants were then asked to complete a written assessment of each factor and return this. Each focus group completed this task as a joint exercise; all jurisdictions’ interviewees and two private sector representatives each completed the task individually. Overall, 15 assessments of all 35 indicators were completed. All comments made about the indicators were synthesised, and the overarching themes emerging through participants’ interviews and written assessments were analysed.

#### 2.4. Application of feasibility and quality criteria

Based on the comments received on each indicator by professionals and policymakers, recommendations were made by the Commission to the Expert Advisory Group on each of the 35 indicators.

Each recommendation was based on a detailed assessment of each indicator against 16 quality criteria including aspects of relevance, appropriateness, usefulness, and question construction. The quality criteria were derived from the discussions with professional participants and from a published list of quality criteria given in a paper about a similar process in the context of PROM development.<sup>1</sup> The criteria are shown in Table 1.

*Table 1: Feasibility and quality criteria for item reduction*

<b>Relevance</b>	R1	Item reflects the concept as originally described by consumers
	R2	Item can apply to experiences of both overnight and day patients
	R3	Item can apply to experiences in both public and private sectors
	R4	Item is consistent with broad policy goals
	R5	Item can apply to most consumers’ healthcare episodes
<b>Appropriateness</b>	A1	Item is within the control of the hospital/service to change
	A2	Item can apply to a single discrete episode of care
	A3	Item is ethically acceptable to ask patients without follow-up
	A4	Item is appropriate to all levels of health literacy
<b>Utility</b>	U1	Item could be used to pinpoint improvement action/s
	U2	Item could be used as a red flag for further investigation
	U3	Patient perspective on item will add value to existing data
<b>Construction</b>	C1	Item is self-contained, requiring no sub-questions or free text

<sup>1</sup> Patrick, D. L., Burke, L. B., Gwaltney, C. J., Leidy, N. K., Martin, M. L., Molsen, E., & Ring, L. (2011). Content validity—establishing and reporting the evidence in newly developed patient-reported outcomes (PRO) instruments for medical product evaluation: ISPOR PRO Good Research Practices Task Force report: part 2—assessing respondent understanding. *Value in Health, 14*(8), 978-988.



	C2	Item uses language and syntax which are easy to understand
	C3	Item expresses concept in unambiguous concrete terms
	C4	Item assesses a single concept, not multiple concepts

### **Phase 3: Question item refinement**

#### **3.1. EAG consensus meetings - round 2**

Two meetings were held with members of the Expert Advisory Group to reach a consensus on whether to remove, amend, or retain the remaining 35 question items for each question set. If the agreement was to retain an item but with amendments, the Commission collected written feedback from EAG members to inform re-drafting.

At this stage, the items were converted into question format, with proposed response options for discussion. Twenty-two question items were then presented to members during a second meeting, and the wording of particularly difficult/contentious items discussed in detail. The question sets were then reduced further based on these discussions.

#### **3.2. Methodology expert assessments**

Ten experts in survey methodology will be sent the draft questions by email and asked to comment on and score each proposed question item according to how important they feel it is to include that item in each of the final question sets, based on an overview of the purpose of the question sets and a description of each dimension of experience initially described by consumers (i.e. 4=essential; 3=very important but needs redrafting etc.). They will also be asked to nominate preferred sets of response options.

If there is divergent opinion (as assessed using an established method such as the content validity ratio), the experts will be sent the collated feedback on each item and asked to rethink their responses. If necessary, a teleconference discussion will be convened.

#### **3.3. Cognitive testing**

There will be two phases of cognitive testing. The first will involve interviews with 10 recent patients to assess comprehensibility of questions and response options. The interviewer employed the 'think-aloud' technique to detect differences of interpretation and ambiguity and to ensure the intended concepts are reflected in participants' understanding. Some rewording of questions and response options resulted.

In the second phase, 25 recent overnight hospital patients and 25 recent day stay patients in South Australia were interviewed using Computer Assisted Telephone Interviewing to test survey flow between questions and to identify any remaining comprehension difficulties. Interviewers will report back on problems with particular question items or response options. Small amendments to response options resulted.

### 3.4. Field testing and statistical testing

Field testing of 19 candidate AHPEQS was designed to cover a wide range of modes of administration as well as to meet the initial project requirement to design a question set capable of use both as a bolt-on module to an existing survey, or as a standalone mini-survey. Patients were surveyed two months after discharge, and a retest survey will be administered two weeks after that.

A total of 1460 patients in Tasmania, Victoria, New South Wales and Victoria participated in the field testing. Three modes of administration were tested – Computer Assisted Telephone Interviewing, Pen and Paper by Post, and Online self-administration. Overnight hospital patients in public and private hospitals, as well as day stay patients in four private clinics were surveyed.

The following tests were performed for validity and reliability.

#### Validity

- Content validity
- Construct validity (factor analysis)
- Convergent validity, using an additional question:  
*Would you recommend this hospital to family or friends?*

#### Reliability

- Cohen's kappa
- PBA kappa (adjusting for skewed response distributions)

The results of statistical testing, as well as several other criteria including prominence in the early consumer focus group discussions, were used to 'score' each question and to decide which questions should not be included in the final question set. This process resulted in the final set of 12 questions which can be accessed by completing a form at <https://www.surveymonkey.com/r/ahpeqs>.

### Implementation and use

---

The Commission is unable to mandate the use of particular instruments. The AHPEQS are therefore being developed as a resource for jurisdictions and providers of health services in both public and private sectors. In 2018, the Commission will begin work with state and territory governments and with the private sector to develop of detailed specifications for the purposes of nationally consistent administration of the survey. This may be supported by the newly developed Australian Health Performance Framework, a single monitoring framework for nationally consistent measurement, which prioritises the reporting of indicators derived from patient-reported experience and outcome measures.

For governments, organisations or even individual departments or wards which wish to use the questions for their own safety and quality improvement purposes, the AHPEQS are available in a basic form from December 2017 (by going to <https://www.surveymonkey.com/r/ahpeqs>) and in 2018 will be formally launched together with a Patient Experience Portal containing supporting resources. These will include information for patients about why patient experience information is collected and for health services on how to administer the survey and interpret the results. There will be a strong emphasis in the Portal on embedding the AHPEQS in broader

efforts to implement patient-centred care, with the clear message that administration of a survey is just the starting point for improving patient experience, rather than an end in itself.

## 101 factors affecting the quality of patient experience

The table below shows the list of 101 factors from which the questions were derived over the course of the AHPEQS development process. These factors emerged from thematic analysis of consumer focus group discussions which began the project. They are divided into 20 dimensions of experience (in blue shaded rows) which in turn below to four categories (care delivery factors, clinical practice factors, interpersonal factors, and system/administrative factors).

This list, and the various iterations of the candidate question set as it was narrowed down from this long-list in consultation with a number of stakeholder groups, will be available as part of a User Resource. This will give health services a valuable evidence base about the aspects of patient experience that are most relevant and meaningful to patients themselves, and could form the basis for further survey question development tailored to the needs of specific organisations.

Factor	Definition
<b>Care delivery factors</b>	
<b>1. Access</b>	
1A. Timely access	Being able to access care or treatment at the right time
1B. Expertise access	Being able to see a professional with the right knowledge and skills
1C. Treatment-care access	Being able to access the right treatment and care for illness/condition
1D. System navigation	Finding it easy to find out what health services are available locally
1E. Barriers to access	Assistance with overcoming access barriers (e.g. cost; transport,)
<b>2. Discharge</b>	
2A. Timely discharge	Being discharged when patient feels ready
2B. Discharge home situation	Staff taking patient's home situation into account when making discharge decisions
2C. Post-discharge support	Staff ensuring that any required support is arranged for after patient's discharge
2D. Discharge warning	Knowing as early as possible when discharge will be
<b>3. Environment</b>	
3A. Welcoming environment	The hospital or health service feeling welcoming
3B. Quiet environment	The room or ward being quiet
3C. Privacy provision	The room or ward offering enough privacy
3D. Disability design	The hospital or health service being designed appropriately for people with a disability
3E. Equipment functioning	Equipment and facilities in the hospital being in good working order
3F. Comfortable environment	The room or ward being comfortable
<b>4. Food and personal hygiene</b>	

## Appendix 1

4A. Accessing meals	Being able to physically access the food and drink provided, or being offered assistance to do so
4B. Appetising food	Food being pleasant to eat
4C. Dietary needs	Food being appropriate to patient's dietary needs
4D. Toilet help	Being able to get prompt help with toilet needs if required
4E. Keeping clean	Getting help with keeping clean when needed
<b>5. Organisation of different parts of care</b>	
5A. Written overall plan	Having a written plan showing the steps involved in care and treatment
5B. Staff share info	Different staff or services involved in patient's care communicating with one another about this care
5C. Care co-ordination	Having one person or team co-ordinating all the different parts of a patient's care
5D. Continuity of relationship	Being able to see the same staff for treatment and care over time
<b>6. Care tailored to needs</b>	
6A. Responsiveness and flexibility	Staff being flexible in their approach in response to patient's needs and preferences
6B. Whole person approach	Staff take 'whole of life' needs into account (e.g. social, psychological, work and quality of life needs)
6C. Comorbidities	Staff taking other health conditions or illnesses into account (other than the reason for admission)
<b>7. Consistency in quality of care</b>	
7A. Geographical consistency	Being able to get the same quality of care in regional/rural/remote health services as in city health services
7B. Day of week consistency	Being able to get the same quality of care in weekday services and weekend services in hospital
7C. Time of day consistency	Being able to get the same quality of care in daytime and in night time services in hospital
7D. Sector consistency	Being able to get the same quality of care in private and public health services
7E. Clinical quality consistency	Patient being able to get the same quality of care no matter who they are
<b>Clinical practice factors</b>	
<b>8. Clinical treatment</b>	
8A. Care-treatment addressed problem	Patient feeling that the problem they attended service for has been properly addressed
8B. Waiting in pain	Not waiting unnecessarily long for pain relief
8C. Appropriateness of pain relief	Receiving appropriate pain relief
8D. Iatrogenic harm	Not experiencing physical or psychological harm as a result of treatment or care
8E. Error or unsafe practice	Not experiencing any unsafe practices or mistakes in the processes of care and treatment
8F. Medication management	Medicines being managed safely

<b>9. Clinical knowledge and skills</b>	
9A. Staff clinical knowledge	Patient feeling that staff have good knowledge of illness/condition
9B. Staff clinical skills	Patient finding that staff have good clinical skills (e.g. surgery; needle insertion)
9C. Trust in professionals	Patient having confidence in the abilities of the professionals involved in care and treatment
<b>Interpersonal factors</b>	
<b>10. Being heard</b>	
10A. Distress acknowledgement	Having any distress or discomfort acknowledged by staff
10B. Emotional support	Receiving emotional support from staff when needed
10C. Patient knowledge	Patient's knowledge of their body and condition taken seriously by staff
10D. Invited to be involved in decisions about care and treatment	Patient being invited to contribute their knowledge, needs, preferences and views to care and treatment decisions
10E. Carer's knowledge	Carer's knowledge and input being valued by staff
10F. Being listened to	Being listened to
10G. Having enough time	Having enough time to talk to staff
<b>11. Being kept informed</b>	
11A. Knowing what's going on	Knowing what is happening with treatment and care
11B. Knowing what to expect	Knowing what to expect with treatment and care
11C. Knowing reason	Knowing why things are being done
11D. Knowing how it went	Knowing how treatments or procedures have gone
11E. Knowing who staff are and why they're involved	Knowing the roles of staff and why they are involved in care
<b>12. Staff-patient communication</b>	
12A. Interpreter access	Being able to access an interpreter for conversations with staff (where needed)
12B. Information communicated was easy to understand	Being able to easily understand what staff say
12C. Making sure of understanding	Staff making sure that patient has understood important information
12D. Communicated respectfully	Staff talking to patient in a respectful way
12E. Clear written info	Receiving important information in written form
12F. Carer information	Carers receiving important information
12G. Information choice	Being able to choose how much information is received
<b>13. Feeling known by staff</b>	
13A. Knowing history	Staff finding out about important aspects of patient's past medical history before seeing them, whenever possible
13B. Knowing current condition	Staff finding out about patient's current condition before seeing them, whenever possible
13C. Knowing life circumstances	Staff knowing something about patient's life

## Appendix 1

	circumstances (e.g. home situation) before seeing them, whenever possible
<b>14. Being treated as a human being</b>	
14A. Fellow human being	Being treated as a fellow human being by staff
14B. Cultural sensitivity	Staff respecting cultural or religious needs
14C. Talking about without	Patient being involved in conversations about them which take place in their presence
14D. Sensitivity - dignity and respect	Staff being sensitive to your feelings
14E. Disability awareness	Staff being aware of the specific needs of people with disabilities
14F. Confidentiality	Staff maintaining patient confidentiality
<b>15. Feeling cared about by staff</b>	
15A. Staff availability	Feeling that staff are available if you need them
15B. Staff responsiveness	Feeling that staff will respond to any concerns or questions
15C. Left to cope alone	Not being left to manage alone when you need support or help
15D. Genuine caring, attempt to understand, empathy	Feeling that staff genuinely care about you
15E. Thoughtfulness and personal touch	Being treated in a kind and thoughtful way
15F. Staff positivity, reassurance	Staff having a positive and reassuring manner
<b>System and administration factors</b>	
<b>16. Giving feedback</b>	
16A. Feedback mechanism awareness	Being made aware of how to give feedback
16B. Welcoming feedback	Feeling that the health service or staff would welcome feedback
16C. Complaint assistance	Being assisted by the health service or staff to make a formal complaint
16D. Complaint responsiveness	Having a complaint taken seriously and followed up
16E. Receiving apology	Receiving an apology from the service if a mistake is made
16F. Learning organisation	Improvements to services being made as a result of feedback
16G. Patient advocate	Having access to a patient/peer advocate
<b>17. Appointments and waiting lists</b>	
17A. Unexpected delay	Appointments or admissions happening when expected
17B. Wait information	Being told how long a wait is likely to be
17C. Wait reason	Being told the reason for the length of a wait
17D. Wait acceptability	Waiting an acceptable amount of time for an appointment or treatment
17E. Appointment convenience	Appointments/admissions being arranged around patient's needs and preferences
17F. Wait list management	Not being lost off the list
<b>18. Health records and documents</b>	
18A. Accurate records	Written records about patient's health and treatment being accurate

## Appendix 1

18B. Complete records	Written records being complete
18C. Record availability	Records being available to all staff treating patient
18D. Electronic records	Written records about patient's health and treatment being available electronically to authorised staff
18E. Documents comprehensible	Documents that patient is asked to read being easy to understand
18F. Form filling	Documents that patient is asked to fill in (e.g. forms) being easy to complete
<b>19. Patient orientation of health organisation</b>	
19A. Patients first	Feeling that the hospital or health service is set up to put the needs of patients first
19B. Preventive system	Feeling that the hospital or health service is set up to make sure health problems are prevented or addressed early
19C. PEx focus	Feeling that careful thought has been given to making patients' experiences as positive as possible.
19D. Supportive of carers and families	Feeling that the hospital or health service is set up to value and support carers and families
19E. Flexible system	Feeling that the hospital or health service is set up to be flexible around individual patients' needs
<b>20. Management of health services</b>	
20A. Cost transparency	Patient being told what out of pocket costs they will have before treatment begins (if any)
20B. Overall organisation	Feeling that the health service is well organised overall
20C. Sufficient services	Sufficient services being available to meet patient needs
20D. Sufficient staff	Sufficient staff being available to meet patient needs
20E. Staff morale	Feeling that staff morale is high
20F. Staff training	Feeling that staff are well trained and supervised.