

**MEASURING PATIENT EXPERIENCE IN A SUPER SPECIALTY HOSPITAL IN
PATNA USING THE PATIENT REPORTED EXPERIENCE MEASURE (PREM)
TOOL**

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by

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Under the Supervision and Guidance of

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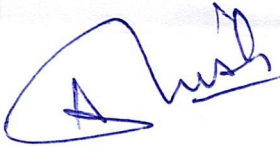
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This is to certify that Mr. Aahel Adhikary, pursuing his MBA (Hospital & Healthcare Management) from IIHMR University, Jaipur has successfully completed his internship at Global Health Patliputra Private Limited (Jay Prabha Medanta Super Speciality Hospital) in the department of Medical Administration & Clinical Operations from 17th March 2025 to 17th June 2025.

We found him sincere, hardworking, and result oriented during the tenure of the internship.

We take this opportunity to wish him all the best for his future endeavours.

For, Global Health Patliputra Private Limited.



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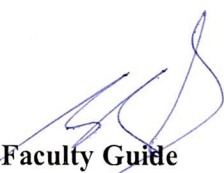
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This is to certify that dissertation titled **Measuring Patient Experience in a Super specialty hospital in Patna using the Patient Reported Experience Measure (PREM) Tool** is a record of the research work undertaken by Aahel Adhikary in partial fulfilment of the requirements for the award of the degree of (MBA Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

A handwritten signature in blue ink, appearing to be 'S. Gupta', written over the printed name 'Faculty Guide'.

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled Measuring Patient Experience in a Super specialty hospital in Patna using the Patient Reported Experience Measure (PREM) Tool is the Bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.



Aahel Adhikary

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ABSTRACT

INTRODUCTION: Patient experience is a fundamental determinant of healthcare quality, encompassing the entirety of a patient's interactions within the healthcare system, from initial contact through discharge and beyond. In an evolving healthcare landscape, understanding these experiences is crucial for improving care delivery and fostering trust. Patient Reported Experience Measures (PREMs) are psychometrically validated tools designed to capture patients' perspectives on how healthcare services are delivered. Despite their importance, there is a recognized need for more real-life studies, particularly in specific geographical contexts, to inform and develop effective healthcare models. This dissertation aims to address this gap by evaluating patient experience in a super specialty hospital in Patna, India.

STUDY OBJECTIVES: The primary objective of this study was to assess the overall patient experience using the Picker Patient Experience Questionnaire-15 (PPE-15) in a super specialty hospital setting. Secondary objectives included identifying key areas of patient satisfaction and dissatisfaction across various domains, such as communication, emotional support, and coordination of care. The study also aimed to analyze patient experience differences based on demographic factors like age, gender, and type of admission, and to provide actionable insights for hospital management to enhance patient-centered care and service delivery.

METHODOLOGY: This study employed a quantitative research design, utilizing a structured questionnaire based on the PPE-15 tool, augmented with two additional dimensions adapted from the HCAHPS tool. Data was collected from a sample of 200 participants (N=200) at Jay Prabha Medanta Super Speciality Hospital Patna. Questionnaires were administered physically or via Google Forms to patients and their attendants upon discharge, following the explanation of the discharge summary. Informed consent was obtained from all participants. Data analysis involved using MS Excel for visualization and SPSS for statistical analysis, including univariate and bivariate analyses of demographic factors and questionnaire dimensions. Monte Carlo estimation for Pearson chi-square test p-values and Fisher exact test for 2x2 tables were used to determine significant associations.

KEY RESULTS: The study found that patients generally reported a positive experience, particularly in areas of communication with doctors and nurses, respectful treatment, and the cleanliness of the hospital environment. A high percentage of patients (95.1%)

found doctors' answers easy to understand, and 88.2% found nurses' answers easy to understand. Most patients (77.5%) reported no conflicting information from staff. However, a significant concern emerged regarding discharge information on danger signs, with 49.0% of patients explicitly reporting no explanation. While the continuity and transition domain recorded a relatively high problem score (50%), it did not show a significant association with overall satisfaction or willingness to recommend the hospital. Educational qualification, length of stay, and first-time visitor status were identified as factors influencing certain aspects of patient experience.

CONCLUSION: This study successfully assessed patient experience at Jay Prabha Medanta Super Speciality Hospital, Patna, revealing predominantly positive perceptions across several critical care dimensions. The findings underscore the hospital's strengths in communication, respectful treatment, and maintaining a positive environment. Simultaneously, the study identified specific areas for improvement, notably the need for standardized and thorough communication of danger signs at discharge. These insights are crucial for enabling hospital management to implement targeted quality improvement initiatives, thereby enhancing patient-centered care and further solidifying patient trust.

KEY WORDS – Picker Patient Experience, Patient Reported Outcome Measures, Patient Experience.

TABLE OF CONTENTS

Sl no.	Topic	Page no.
1	Introduction	
1.1	Patient experience	1
1.2	Patient reported experience measure (prem)	2
1.3	Historical evolution and conceptual foundations of patient experience measurement	4
1.4	Types and applications of prems	7
1.5	Benefits and impact of prem	9
1.6	Limitations of prem	10
1.7	Picker patient experience questionnaire	13
1.8	Objectives of the study	15
2	Review of Literature	16
3	Methodology	21
4	Results	23
5	Discussion	
5.1	Recommendations	38
5.2	Limitation of study	38
6	Conclusion	39
7	References	40
8	Appendices	
8.1	Informed consent	44
8.2	Picker Patient Experience – 15 Questionnaire	46

ABBREVIATIONS

Sl no.	Abbreviation	Full form
1	PREM	Patient reported experience measures
2	PPE-15	Picker Patient Experience Questionnaire 15
3	PROM	Patient reported outcome measures
4	PRO	Patient Reported Outcome
5	AHA	American Hospital Association

6	PRC	Population Research Centre
7	NRC	National Research Corporation
8	SF-36	Short Form 36
9	PROMIS	Patient-Reported Outcomes Measurement Information System
10	IPFCC	Institute for Patient- and Family-Centered Care
11	PFA	Patient and Family Advisors
12	PFAC	Patient and Family Advisory Councils
13	CAHPS	Consumer Assessment of Healthcare Providers and Systems
14	HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
15	LOS	Length of Stay

LIST OF TABLES

Sl no.	Characteristics
Table 4.1	Section A of the questionnaire containing demographic variables, length of stay, admission type, and whether the patient has visited Medanta before or not.
Table 4.2	Section B of the questionnaire, covering all the dimensions of the PPE-15 questionnaire, with two additional dimensions adapted from HCAHPS.
Table 4.3	Bivariate analysis between independent variables and dependent variables
Table 4.4	Bivariate analysis between dependent variables and PPE-15, HCAHPS variables
Table 4.5	Percentage of problem scores of the dimensions of PPE-15 variables.
Table 4.6	Problem score excluding respondents whose LOS is less than 3 days

LIST OF FIGURES

Sl no.	Characteristics
Fig 4.1	Distribution of LOS
Fig 4.2	Distribution of age group
Fig 4.3	Distribution of type of admission of patients.
Fig 4.4	Distribution of educational qualification of patients.
Fig 4.5	Distribution of gender of the patients.
Fig 4.6	Distribution of whether the patient has visited Medanta in the past or not.
Fig 4.7	Patient's report on hygiene and cleanliness of rooms, beds, and washrooms.

Fig 4.8	Patient's report on whether they were able to get enough rest or not.
Fig 4.9	Patient's report on whether they will recommend the hospital or not.
Fig 4.10	Rating given by patient on a 10-point Likert scale.

INTRODUCTION

PATIENT EXPERIENCE

Hospitals play an important role in our healthcare system, in spite of dealing with many challenges and fewer resources. As interactions with healthcare professionals are evolving and chronic diseases are on the rise, patients should participate actively in their health, treating their symptoms, preparing care changes and watching out for problems. Adding patient experiences helps healthcare professionals think about care from new angles. But we need more studies reflecting real-life situations to better understand these experiences which helps create better healthcare models and organizational structures [1]. Usually, high patient experience scores point to good healthcare, since they are often related to strong clinical outcomes [2].

Patient experience is truly about the complete journey a person takes within the healthcare system. It's the entire collection of all their interactions, both big and small, from that very first phone call or appointment right through to when they're discharged and beyond. What makes this journey unique for each patient is deeply shaped by the hospital or clinic's overall culture – its values, how staff behave, and the general atmosphere. Crucially, this isn't just about whether someone ticked a 'satisfied' box on a survey; it's profoundly influenced by what the patient perceives and expects at every step. So, it really covers everything that touches their care, from the moment they first connect with the organization until their treatment process concludes [3].

A clear mismatch is found in healthcare: patients might have wants that are not shared, while care teams think they know what patients want, without having all the information. Encompassing both sets of information is what the actual environment of the hospital is capable of providing, made up of its spaces, usable tools and how things are done and by whom. Because the gap shows several challenges, it shows how difficult it is for patients' needs to be met by providers and the health care system in general [3].

Good communication between patients and healthcare professionals is crucial in hospitals because it helps figure what should be changed, guides the planning process, earns patient trust and supports accurate examination. In addition, the useful information gathered from patients is important for coming up with recommendations to improve healthcare quality, enhance how medical staff communicate, optimize hospitals

and increase the ability to monitor patients both in and out of the hospital. The patient experience should be focused on adding value, not on providing services unrelated to the needs of the patient. Rather, healthcare providers focus on explaining to patients why they are being treated that way and making sure they know that the treatment is right for them [4].

PATIENT REPORTED EXPERIENCE MEASURE (PREM)

Patient Reported Experience Measures (PREMs) are well-structured, psychometrically confirmed surveys that let patients report on their experiences with healthcare providers. Using these tools offers a consistent structure for analysing people's experiences, stressing how care is given, rather than the final results. Typical topics explored in PREMs focus on how easy and acceptable communication with clinicians is, how accessible care is, how acceptable waiting times are, how calm and safe the environment feels and how smooth it is to coordinate care from different doctors [5].

PREMs are different from the standard patient satisfaction surveys. While satisfaction surveys ask patients about their expectations, PREMs seek details about the care they experienced, as well as how these things were carried out. PREMs depend on the details of what happened and how, rather than the patient's personal feelings which helps them grasp the root causes and methods of a patient's medical experience [5]. Receiving feedback directly from patients is crucial as it provides clear understanding of what they need and where healthcare can improve [6].

PREMs and PROMs are both components of Patient Reported Measures (PRMs), but they have different and complementary roles. Patient Reported Outcomes (PROs) involve patients describing their health, quality of life or how they function, impacted by medical care or therapy. The most commonly used tools for collecting PROs are called Patient Reported Outcome Measures (PROMs) and they are often presented as questionnaires. The goal of these measures is to assess effects on physical capabilities, how much pain is felt, mental state and the seriousness of symptoms. Some well-known PROM tools are the SF-36, EQ-5D and PROMIS which assess different parts of health like mobility or emotional well-being. Alternatively, PREMs are mainly focused on how patients felt when they encountered healthcare providers and the healthcare system. They pay attention to elements of care that are not medical, for example, the ease with which the patient understands explanations, booked appointments fit with their needs

and services are smoothly provided when transitioning. Using both PREMs and PROMs together helps show a fuller picture of care quality. PROMs show the overall effect of the treatment on a patient's health and PREMs highlight the quality of care the patient receives. Studies have found that positive experiences often result in better medical outcomes. Research reveals that a good experience for patients may boost their health and better outcomes can improve how they view their care. Good health results are more likely to make a patient feel positively about the care they get. Because of this dependence, it is essential for healthcare systems to make collecting both PREM and PROM data a priority. Arranging health care measures just on outcomes might cover up what really guides overall improvement for the health system. This means that for those creating healthcare policy, improving what patients experience should focus on improving health and safety, not only on their opinions [7, 8].

The increase in the use of PREMs comes from their importance in assessing the quality and safety of care given to patients. It represents an increasing global aim to consider what matters to patients and the public when planning and assessing healthcare services. With PREMs, healthcare organizations can better understand their patients' concerns and choose ways to improve their services and foster stronger, more reliable connections with their patient base [5].

Measuring patient experience today not only meets legal requirements; it gives healthcare companies real, measurable information to base important decisions on. Using PREMs, healthcare providers can accurately pinpoint issues with communication or the way services are delivered. With continuous review and analysis of PREM data, healthcare organizations can notice emerging issues, evaluate the effectiveness of efforts to improve care and direct money to actions heavily appreciated by patients. PREMs are also important for building a strong bond between patients and their healthcare providers. Using patient feedback in clinical decisions helps build trust and teamwork which may lead to better long-term health results. They are necessary for providing top-notch care and add to the usual measures of clinical effectiveness and patient safety [9].

It is especially clear in this context why PREMs differ from patient satisfaction surveys. While patient satisfaction can change based on many things, including what a patient expects or has experienced before, PREMs focus on objective experiences. This helps ensure the information is more useful for making improvements and is not as easily affected by the many expectations patients may have. For example, a PREM could ask if discharge information was provided which gives a clear answer and is easier to use

for changes than a rating of how satisfied someone is with the information. They give specific goals for action, shifting away from general ideas to provide clear advice on care. This demonstrates that healthcare is now paying more attention to the patient's voice, changing from general satisfaction to measuring particular aspects of the care given [6].

HISTORICAL EVOLUTION AND CONCEPTUAL FOUNDATIONS OF PATIENT EXPERIENCE MEASUREMENT

The concept of patient experience, while seemingly modern in its systematic measurement, possesses deep historical roots. In the pre-modern era, healthcare was often viewed through a holistic lens, emphasizing a balance of body, mind, and spirit. Ancient traditions, such as traditional Chinese medicine and Ayurveda, alongside prominent figures like Hippocrates in Europe, championed an approach that prioritized observation and attentive listening to patient narratives for diagnosis and treatment. Galen, a Roman anatomist, further expanded this understanding by linking illness not solely to physical occurrences but also to emotional shock, reinforcing the idea of engaging patients as more than mere objects of care. This focus on holistic care, incorporating sensory evaluations and patient stories, persisted through the Middle Ages, laying an early foundation for person-centered approaches to medicine. However, the 19th century witnessed a significant paradigm shift with the emergence of the "medical model." This new approach redirected the focus from the patient as a whole individual to a concentrated emphasis on the disease itself. This disease-centric perspective, while advancing scientific understanding and treatment of specific ailments, inadvertently marginalized the patient's subjective experience and broader human needs for a considerable period. The re-emergence of patient-centeredness and the formal recognition of patient experience were largely catalysed by consumer-led movements and a gradual re-evaluation of the patient's role within clinical professions. A pivotal moment arrived in the early 1970s with the formal publication of the Patients' Bill of Rights by the AHA, signalling a growing societal conversation around patient entitlements in healthcare organizations. Preceding this, Mount Sinai Hospital in New York established the first known Patient Representative Department, envisioned by Ruth Ravich. This pioneering initiative gave birth to the patient advocacy profession, dedicated to addressing patient concerns and complaints, and eventually led to the founding of the Society for Healthcare Consumer Advocacy. These early efforts marked

a crucial turning point, shifting the focus back towards the individual patient's perspective and rights within the healthcare system. [10].

The journey of patient experience measurement has been punctuated by several key milestones, reflecting a progressive integration of patient perspectives into healthcare quality frameworks.

Early 1980s: Focus on Patient Satisfaction and Quantification: This period saw the integration of private business principles, often referred to as New Public Management, into public healthcare systems, particularly in the United Kingdom. This shift emphasized cost-effectiveness, accountability, and a customer-centric approach, leading to an increased focus on performance measurement. Consequently, "patient satisfaction" emerged as a crucial metric, driven by the understanding that satisfied patients were more likely to adhere to treatment plans, achieve better clinical outcomes, and less likely to pursue malpractice lawsuits. To quantify this satisfaction, research firms such as Press Ganey, PRC, and NRC Health were established, developing standardized survey tools to enhance the precision and trustworthiness of patient satisfaction metrics. Concurrently, the Picker Institute was founded, highlighting the disparity between technological advancements in healthcare and the actual needs of patients. In 1987, the Picker Institute, in collaboration with Harvard researchers, developed the seminal Picker Principles, which outlined eight key dimensions of patient-centered care. These principles, emphasizing patient engagement, individual needs, clear communication, and a supportive care environment, significantly stimulated research and interest in patient-centered care [10].

1990s: Expansion of Patient Voice and Quality Focus: The 1990s witnessed further advancements in amplifying the patient voice. The IPFCC was established, advocating for the active engagement of PFAs and the creation of PFACs within healthcare settings. This movement was grounded in the powerful principle: "Nothing about me without me," aiming to involve patients and their families directly in decision-making processes to improve healthcare delivery and outcomes. A landmark publication, the Institute of Medicine's (IOM) "To Err is Human: Building a Safer Health System" (1999), brought critical attention to systemic flaws leading to medical errors and compromising patient safety. This report advocated for a shift from individual blame to systemic improvements, prompting healthcare organizations to implement measures that incorporated patient-reported feedback to bolster safety. The publication of "The Experience Economy" (1999) further broadened the conceptualization of patient

experience, moving beyond mere satisfaction metrics to emphasize the intrinsic value of comprehensive experiences, suggesting that organizations offering superior experiences could achieve greater success [10].

2000s: Mandating Measurement and Leadership Roles: The turn of the millennium marked a period of formalization and mandating of patient experience measurement. The IOM's "Crossing the Quality Chasm" report (2001) explicitly identified patient-centeredness as a core aspect of healthcare quality, strengthening the conceptual link between patient experience and overall quality. This decade saw the proliferation of national patient survey programs. In the UK, the Picker Institute expanded its efforts, leading to the development of the first national survey program for the NHS and the Care Quality Commission (CQC) in 2002, marking the beginning of mandatory national patient experience surveys for evaluating healthcare quality. In the United States, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, a joint initiative by CMS and AHRQ, was endorsed by the National Quality Forum in 2005. Crucially, the Deficit Reduction Act mandated the public disclosure of HCAHPS ratings, linking them to financial outcomes by requiring hospitals to publish their scores to secure full Medicare compensation. This linkage provided significant financial incentives for hospitals to focus on and improve patient experience. Institutionally, the Cleveland Clinic pioneered the role of Chief Experience Officer (CXO) in 2004, establishing the Office of Patient Experience. This demonstrated a profound organizational commitment to patient-centric strategies and deliberate improvement of patient experience indicators. The concepts of Value-Based Care and the Triple Aim framework, gaining momentum in 2006-2007, further solidified patient experience as one of the three core objectives for enhancing healthcare systems, alongside improving population health and reducing per capita costs [10].

2010s - Present: Fostering Leadership, Research, and Global Expansion: The 2010s and beyond have seen a deepening of commitment and a global expansion of patient experience initiatives. The Beryl Institute, established in 2010, emerged as a global community for healthcare professionals, dedicated to sharing knowledge and practices for improving patient experience. The Institute played a pivotal role in defining patient experience as the "sum of all interactions" across the continuum of care, advocating for an integrated perspective beyond mere survey results and fostering patient experience as a distinct professional field. National strategies, such as the NHS Patient Experience Framework (2011) in the UK and Australia's National Safety and Quality Health Service

Standards (NSQHS) (2011), mandated robust consumer engagement in all stages of healthcare, from design to evaluation. The launch of the Patient Experience Journal (PXJ) in 2014 provided a dedicated academic platform for research, further professionalizing the field globally. The expansion of the Triple Aim to the Quadruple Aim in 2014 incorporated the enhancement of healthcare providers' work lives, recognizing the interconnectedness of the experiences of all stakeholders within the healthcare ecosystem. The COVID-19 pandemic further underscored this interconnectedness, reaffirming the essential elements of human experience and highlighting the critical link between staff well-being and overall health system performance. Recent discourse advocates for an integrated view of "human experience" that extends beyond just patients to encompass all individuals involved in care, emphasizing equity and addressing disparities.

The evolution of patient experience measurement, particularly PREMs, is profoundly shaped by policy and regulatory mandates. The direct linkage of HCAHPS scores to Medicare compensation serves as a clear illustration of how financial incentives, driven by policy, can significantly accelerate the adoption and institutionalization of patient experience measurement. This suggests that the widespread and effective implementation of PREMs in the future will depend as much on robust policy frameworks and financial incentives as on the clinical recognition of their inherent value. To further advance the utility and impact of PREMs, sustained policy support, seamless regulatory integration, and the development of value-based reimbursement models that explicitly incorporate PREM data will be crucial. Without such external drivers, the adoption of PREMs might remain localized or inconsistent, hindering their full potential to transform healthcare delivery [10].

TYPES AND APPLICATIONS OF PREMS

PREMs are used in many ways because they are designed to measure the different aspects of patient experiences in healthcare. They are often sorted into categories and used in particular situations to get useful insights.

PREMs are mostly divided into two main categories.

Generic PREMs are meant to evaluate the overall experience of patients in any healthcare setting, regardless of what they are treated for. They make it possible to measure how patients feel at various institutions or healthcare systems. Some examples

are surveys that ask about different parts of a visit to a doctor or a hospital. These PREMs are created to measure issues that are important for certain health conditions or treatments. For cancer patients, a PREM would center on aspects of care specific to oncology such as discussing chemotherapy side effects and organizing teams of different specialists [11].

Setting-Specific PREMs are designed for use in specific places, for example, emergency rooms, primary care clinics or long-term care facilities. They deal with the special situations and patient encounters common in those places [11].

Several standardized and widely used PREM instruments have been developed, each with specific applications.

Consumer Assessment of Healthcare Providers and Systems (CAHPS):

CAHPS surveys, developed by the Agency for Healthcare Research and Quality (AHRQ), are important for understanding how patient-friendly healthcare is and for spotting areas where it can be improved. CAHPS surveys are standardized, tested and reliable and they ask patients about important parts of their care such as talking with clinicians, courtesy, respect, access and care coordination. There are several versions of CAHPS surveys designed for different places.

Hospital Consumer Assessment of Healthcare Providers and Systems

(HCAHPS): This is one of the most widely used PREM instruments, particularly in the United States. It measures patient experiences in hospitals, covering domains such as communication with doctors and nurses, responsiveness of hospital staff, and cleanliness of the facility. HCAHPS provides crucial insights into hospital service quality and is often linked to public reporting and reimbursement models [12].

CG-CAHPS: For assessing experiences with doctors and their teams in outpatient care.

Health Plan CAHPS: To measure experiences with health plans.

Child CAHPS: Created for children and usually, parents or guardians fill out the survey on their behalf.

Home and Community-Based Services (HCBS) CAHPS: For people who use long-term care services.

Medicare Fee-for-Service (FFS) CAHPS: For those who are covered by Medicare.

Accountable Care Organization (ACO) CAHPS and Merit-Based Incentive Payment System (MIPS) surveys are designed to meet the organization's goals and focus on the quality of care for underserved groups as well as how patients feel about their experience [13].

Picker Patient Experience Questionnaire (PPEQ): This instrument is recognized for its wide applicability and reliable, standardized methodology, offering insights into patient experiences within healthcare settings. It has been primarily used in UK, US, China, Germany [14].

NHS Friends and Family Test: Widely used in the UK, this simple yet powerful tool asks patients if they would recommend the healthcare service to others, serving as an indicator of overall satisfaction and service quality.

"HowRwe" Patient Experience Measure: Developed between 2012-2014, this PREM focuses on four dimensions: Compassion ("We treat you kindly"), Communication ("We listen and explain"), Timeliness ("We see you promptly"), and Reliability ("We are well organised").

CAHO patient experience measures: Consortium of Accredited Healthcare Organizations has developed 13 setting specific PREMs. They are available in English as well as in 12 Indian languages [15].

BENEFITS AND IMPACT OF PREM

It's clear that the widespread adoption and thoughtful use of Patient Reported Experience Measures (PREMs) bring about truly significant advantages right across the entire healthcare landscape, from the deeply personal interactions of individual patient care to the bigger picture of how policies are developed.

Impact in clinical practice

In clinical practice, PREMs empower professionals to deliver truly person-centered care by providing direct insights into individual patient experiences, leading to more personalized plans and continuous quality improvement by pinpointing areas needing attention and tracking progress. This active integration of patient feedback also

strengthens the patient-provider relationship, fostering trust and partnership, which in turn can lead to better treatment adherence and improved long-term health outcomes by enhancing communication and shared understanding [16].

Impact on Healthcare System Performance

When we look at the bigger picture of healthcare, PREMs are absolutely vital for making things better and more consistent across all our hospitals and clinics. By bringing together all that patient feedback, PREMs allow us to really compare how different places are doing, pushing us towards a healthcare system that genuinely values what matters to patients, focusing on real improvements rather than just the number of services provided. What's more, PREMs help keep everyone accountable. When patient experience scores are shared publicly, it really encourages healthcare providers to step up their game, rewarding what's working well and quickly flagging problems before they get bigger. Plus, these insights help us spend our healthcare dollars smarter, guiding investments towards what patients truly appreciate and cutting out services that don't really add value to their well-being [16, 17].

Advantages for Healthcare Policy and Research

For policymakers, PREMs offer a valuable framework for developing patient-centric policies that directly address patient needs and align compliance requirements with what truly matters to patients. They provide a systematic method for evaluating the quality of healthcare services and can inform national strategies for improving patient experience. The increasing international attention on PREMs reflects their growing recognition as a quality indicator of patient care and safety, supporting the broader health service commitment to involving patients and the public in healthcare development and evaluation [8].

LIMITATIONS OF PREM

While PREMs hold significant promise for evaluating service quality and fostering patient-centered care, a review of the literature reveals several inherent conceptual, methodological, and practical limitations that challenge their utility and reliability [18, 19].

Conceptual and Methodological Constraints

A primary limitation of PREMs stems from persistent conceptual ambiguity. Patient-reported experience is frequently conflated with "patient satisfaction" or "patient expectation," subjective terms that may reflect judgments on the adequacy of care rather than objective quality. This blurring of conceptual boundaries suggests a low level of maturity in defining patient-reported experiences, which can inadvertently lead to misinterpretations of data. For instance, a PREM might be confounded by factors unrelated to care quality, such as a patient's health outcomes, or by their preconceived "ideals" of care rather than their actual experience. This lack of clear delineation undermines the instrument's ability to precisely measure the intended construct, potentially yielding data that is not truly indicative of care quality [19].

Beyond conceptual clarity, many PREMs exhibit significant gaps in psychometric validation. A systematic review found that a substantial proportion of identified PREMs (over 50%) did not undergo comprehensive validity and reliability testing across all ten established criteria. While internal consistency, structural validity, and content validity are frequently assessed, crucial aspects like responsiveness—the ability to detect meaningful change over time—and measurement error are often neglected. This deficiency means that many PREMs may not consistently or accurately capture patient experiences, limiting their utility for robust healthcare evaluation or tracking improvements. If a measure cannot reliably detect small changes in experience, its capacity to inform iterative quality improvement initiatives is severely compromised. The pervasive lack of robust validation, coupled with conceptual ambiguity, creates a fundamental challenge to the scientific credibility and actionable utility of PREM data. When measures are not adequately validated or their core concepts are unclear, the confidence placed in their results for decision-making is diminished. This situation implies that PREMs, despite their potential, may not reliably or accurately reflect the patient experience, thereby limiting their effectiveness as a basis for quality improvement or benchmarking [19].

Practical and Systemic Implementation Barriers

Implementation challenges present significant barriers. Healthcare providers frequently cite resource limitations (staff, funding, time) and increased workload as major hurdles. A lack of commitment, awareness, or expertise among staff regarding PREM collection and interpretation further impedes adoption. The inherent complexity of healthcare systems and inadequate planning or leadership also hinder successful integration of

PREMs into routine care. Technological difficulties with automated data systems can compound these issues [17].

One big problem is that hospital staff often don't get enough training on how to actually use and understand the data from PREMs. This can make doctors and nurses pretty sceptical about whether these measures genuinely help them care for individual patients. This doubt, combined with a general lack of awareness or a reluctance to change, creates what we call a "know-do gap"—meaning, we understand PREMs *could* be useful, but those benefits just aren't showing up in daily practice. Healthcare providers also worry about how accurate patient feedback truly is. They might feel patients tend to be overly positive, or perhaps aren't really in a position to judge complex medical care. And if staff are concerned about being held accountable for poor outcomes, or accidentally setting unrealistic expectations for patients, it can make them even less likely to fully engage. Ultimately, bringing PREMs into a hospital isn't just a technical fix; it's a complicated organizational change challenge, often met with resistance because staff feel it's more work, question its value, and worry about being blamed [11, 17].

Then there's the inherent complexity of healthcare systems. These are unpredictable environments, and many different groups within them can actually block new ideas like PREMs from taking hold. A major headache is the difficulty sharing data between PREMs and electronic health records (EHRs), often because there's no standard way to code the information. This creates isolated pockets of data that aren't useful in real-time. Plus, the data itself often contains "noise"—meaning variations in patient responses that can come from consistent individual habits, how they prioritize problems, or even unpredictable outside factors. This "noise" is an often-overlooked issue that just makes interpreting the data even harder. When you combine these systemic problems with doubts about how accurate patient feedback really is, it starts to look like the "patient voice" captured by PREMs might be distorted. And that, of course, challenges the whole idea that patient-centered care should be driven by truly reliable patient experience data [11].

Challenges in Data Quality and Bias

PREM data can be compromised by various biases. Low response rates are common, and the method of data collection (e.g., phone vs. online surveys) can introduce systematic differences. Other biases includes,

Non-response bias, where patients with poorer experiences might be less likely to respond.

Proxy bias, occurring when caregivers provide subjective responses on behalf of patients.

Recall bias, as patients might inaccurately remember past experiences.

Language bias, stemming from ambiguous or unclear questionnaire wording.

Timing bias, where the point of data collection can skew results.

Fatigue bias, which can affect data accuracy in longer surveys.

Provider scepticism about the accuracy of patient feedback, driven by concerns about positive bias or a perceived inability of patients to evaluate clinical competence, can also hinder full engagement. Worries about accountability and potentially raising unmet patient expectations further contribute to resistance among healthcare professionals [17, 20].

PICKER PATIENT EXPERIENCE QUESTIONNAIRE

The Picker Patient Experience Questionnaire is a widely recognized instrument developed to measure patients' experiences during hospital stays. It was derived from the original Picker Inpatient Questionnaire, which included over 100 items, and was later refined to a concise 15-item tool based on factor analysis and patient-centered care domains. The PPE-15 has been widely validated and adopted in many countries, including the UK, the US, and parts of Europe, to monitor hospital performance and enhance the quality of care.

The Picker Patient Experience Questionnaire (PPE-15) consists of fifteen items that span eight categories, including information and education, as well as care coordination. The PPE-15 was initially intended for use in inpatient settings. It is applicable to both planned and emergency inpatient settings and was designed to detect patient experiences and issues with specific health care procedures that impact inpatient care quality. It asks precise questions regarding whether certain procedures and events occurred during the patient's care experience. This compendium contains patient-reported measures that are either designed to specifically measure aspects of Person-Centred Co-Ordinated Care, the compendium takes the form of PREM [21].

Coulter et al. (2002) were instrumental in refining the PPE-15 from the original Picker surveys, focusing on items most strongly associated with patients' overall satisfaction and care quality perceptions. The PPE-15 captures aspects of care such as:

Information transmission and patient education

Coordination of care

Emotional Support

Respect for patient preferences

Involvement of friends and family

Physical comfort

Continuity and transition

Each item is scored dichotomously (problem/no problem), making it easy to analyze and compare across time or between institutions [22].

Research has demonstrated the reliability and validity of the PPE-15, showing good internal consistency and construct validity. The tool has a Cronbach's alpha value generally above 0.7, which indicates acceptable reliability [23]. Studies further supported its cross-cultural applicability, noting that the PPE-15 maintained reliability in diverse healthcare systems when adapted appropriately [24]. PPE-15 has been used extensively in performance benchmarking and quality improvement initiatives. Hospitals often use this tool to identify areas needing attention and to implement patient-centered changes. For instance, its results have influenced communication training for clinicians and the redesign of discharge procedures.

A key benefit of the PPE-15 is that it captures problem frequencies rather than satisfaction scores, which provides actionable data and avoids the ceiling effects often seen in satisfaction-based tools.

Some critiques point out the binary scoring system may oversimplify patient experiences. Others argue that while the PPE-15 provides breadth, it may lack depth in certain areas (e.g., emotional support or continuity of care over time). However, its brevity and focus on key experience domains continue to make it a valuable tool in hospital settings [22, 25].

The PPE-15 remains relevant in modern patient experience measurement, especially as healthcare moves toward value-based care models. Its continued use in NHS England's National Patient Surveys and other national assessments underlines its robustness and policy relevance [25].

For this study, the PPE-15 has been chosen as the main tool for collecting feedback from patients. In a hospital setting, where patients are often under stress and not always in the best frame of mind, it's important to keep things simple and respectful of their time. Long or repetitive surveys can easily lead to frustration or disengagement. The PPE-15, with just 15 thoughtfully chosen questions, offers a practical balance—it's short enough to encourage responses, yet still covers the most important aspects of care, like communication with staff, being treated with respect, involvement in decisions, pain control, and clear information at discharge. This makes it a suitable and patient-friendly option for understanding their overall experience.

OBJECTIVES OF THE STUDY

Primary Objective:

1. To assess the overall patient experience using the Picker Patient Experience Questionnaire-15 (PPE-15) in a super specialty hospital setting.

Secondary Objectives:

1. To identify key areas of patient satisfaction and dissatisfaction across domains such as communication, emotional support, physical comfort, coordination of care, and respect for privacy.
2. To analyze patient experience differences based on demographic factors like age, gender, and type of department visited (excluding ICU and neurology).
3. To provide actionable insights to hospital management for enhancing patient-centered care and service delivery.

REIVEW OF LITERATURE

Authors (Year)	Study Location	Hospital Type	Sample Size	Sampling Techniques	Salient Features
Pelletier, D et al. (2019)	Switzerland	Large University Hospital, tertiary tier.	54,686	Patients filled out the Picker Patient Experience questionnaire (PPE-15) after discharge over a 5-year period. Patients in intensive and intermediate care units were excluded. No self-selection bias was found.	Documented the multidimensional structure of the PPE-15. Tested a patient communication/satisfaction model. Confirmed a five-factor structure for PPE-15: communication with patient, with family, addressing fears/concerns, preparation for discharge, and patient satisfaction. Found positive relationships between communication dimensions and patient satisfaction. Communication with patient was a key foundational factor influencing other communication dimensions and patient satisfaction.
Khiari H et al. (2021)	Tunisia	Salah Azaiez Institute of Cancer	200	Cross-sectional study; patients were recruited by doctors when they visited the hospital to fill out a questionnaire.	Found good internal consistency for the questionnaire. Overall patient satisfaction was 38.5%. Highest scores were obtained in coordination of care (76.8%), respect for patient

					preferences/dignity (72.7%), and physical comfort (70.1%). Lowest scores were in emotional support (40.2%), continuity and transition (40.6%), and information and education (48.1%). The study highlighted aspects of care needing improvement from the patient perspective.
Harrison R et al. (2018)	NSW, Australia	Hospitals (Random sample, likely includes private)	7,661 (from 20,000 administered)	Random sample of hospitalized patients (Jan-Jun 2014)	PPE-15 measures 'problems' experienced; explored influence of patient demographics and adverse events on experience; aimed for international comparisons.
Jenkinson, C et al. (2003)	England	Two hospital trusts	1445 questionnaires mailed, 949 (65.67%) returned.	Postal questionnaire survey. Patients recently discharged were randomized to receive the PPE-15 in either a four-page or a 12-page survey instrument.	Compared the performance of the 15-item Picker Patient Experience questionnaire (PPE-15) when embedded in a short form instrument versus a longer form measure. Found no significant difference in response rate or item completion and psychometric properties of the PPE-15 between the two versions (four-page vs. 12-page).
Wong et al. (2011)	Hong Kong, China	Public and Private Hospitals	1264	Secondary data analysis (Thematic	Mean global satisfaction: Public 7.3/10, Private 7.8/10; communication, respect, patient

				Household Survey) face-to-face interviews	engagement are the key determinants.
Vandan et al. (2020)	Hong Kong, China	Public and Private Hospitals	783 (388 South Asian, 395 Chinese)	South Asian: Convenience sampling Chinese: Stratified sampling from household survey	Used PPE-15 to compare in-hospital experiences between ethnic groups across 7 dimensions of care.
Min, R et al. (2019)	Shandong Province (Eastern China) Hubei Province (Central China) Chongqing Municipality (Western China)	10 county-level public hospitals	1300 (500 outpatients, 800 inpatients) 1241 valid questionnaires analysed (95.46% response rate)	Multicentre, cross-sectional, questionnaire-based survey conducted from August 2016 to March 2018. One province randomly selected from each of China's three economic areas. Three counties chosen by convenience sampling within each province.	This was the first study to use the Picker Patient Experience Questionnaire (PPE-15) to assess patient experience in China's county-level hospitals. The PPE-15 comprised 15 items across six dimensions: information transmission and patient education, respect for patient preference, emotional support, physical comfort, involvement of family or friends, and continuity of medical service. It found a mean PPE-15 score of 41.33 (range, 23–56) and a strong positive correlation between patient experience, satisfaction, and loyalty. Physical comfort had the

				The public hospital with the largest healthcare delivery system selected in each county. Patient recruitment used convenience sampling until the required sample size (80 inpatients/50 outpatients per hospital) was met.	highest score, while respect for patient preference had the lowest. The most common problem reported was "staff providing conflicting information" (39.24%). The study concluded that prioritizing patients' and their families' preferences is crucial for enhancing patient experience.
Yathindra, C., & Saldanha, A. L. (2024)	Mangalore, Karnataka, India.	Father Muller Medical College. Tertiary tier teaching hospital.	997	All in- patients who could communicate in English or Kannada were taken for the study. Day care patients and bystanders were excluded.	Aims to assess the level of patient reported experience measures among inpatients. Highlights the importance of identifying patient needs and taking timely measures to meet them as a key factor for the healthcare industry.

Makkar et al. (2018)	Tertiary care hospital, North India	Specialized de-addiction treatment center (AIIMS)	113	Purposive (adults, >7-day stay)	Used PPE-15 questionnaire to assess patient experience among substance use disorder inpatients; emphasis on communication and decision-making involvement; found high respect/dignity but low satisfaction with shared decision-making and information clarity.
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Although several studies in Indian hospitals have explored patient experiences and looked at outcomes through tools like PROs and PROMs, there's still a noticeable gap when it comes to using PREMs. Not many studies in the public domain have tapped into this approach to truly understand how patients feel about the care they receive.

METHODOLOGY

RESEARCH QUESTION –

1. What is the level of patient experience among individuals receiving care at Jay Prabha Medanta Super Specialty Hospital, Patna, as measured by the Patient Reported Experience Measure (PREM) tool?
2. What factors, as measured by PPE-15, are most strongly associated with patient satisfaction in healthcare services?

PLACE OF STUDY – Jay Prabha Medanta Patna Super Specialty Hospital

DURATION FOR DATA COLLECTION – 1.5 months.

STUDY DESIGN – Descriptive cross-sectional study.

SAMPLE SIZE CALCULATION

Confidence Level (Z-Score): For a 95% confidence level, the Z-score is 1.96.

Margin of Error: 5%.

Population Proportion (P): 78% or 0.78, as 22% patients were daycare patients who were excluded from this study.

Population Size (N): 3000 patients.

Sample Size Formula:

$$n = \frac{Z^2 \times P \times (1-P) / E^2}{1 + \left(\frac{Z^2 \times P \times (1-P) / E^2}{N} \right)}$$

Where,

n is the sample size.

Z is the Z-score corresponding to the 95% confidence level (1.96).

P is the estimated proportion of the attribute present in the population (0.78).

E is the margin of error expressed as a decimal (0.05).

N is the population size.

SAMPLE SIZE – 200.

SAMPLING TECHNIQUE – Purposive sampling.

INCLUSION CRITERIA - Patients who received services in IPD during the study period and consented to participate.

EXCLUSION CRITERIA - Critically ill patients, patients admitted in ICU, and daycare, those unwilling to participate, and patients admitted in the neurological department.

STUDY INSTRUMENTS: Structured questionnaire based on the Picker Patient Experience Questionnaire-15 tool covering dimensions like information and education, coordination of care, physical comfort, emotional support, respect of patient privacy, involvement of friends and family, continuity and transition. Additionally, questions for dimension such as hospital environment and overall impression has been adapted from HCAPHS tool. Overall rating by respondents is taken via 10-point Likert scale.

DATA COLLECTION PROCEDURE: Distribution of questionnaires in physical format or in google forms to patients and attendants during the day of discharge after explanation of discharge summary to the patients.

DATA ANALYSIS PLAN: MS Excel is used for visualization of distribution of responses. SPSS is used for univariate and bivariate analysis of demographic factors and concerned dimensions. Average mean problem score of all dimensions of PPE-15 tool is measured with SPSS to find out the level of patient experience.

STATISTICAL METHODS EMPLOYED – Monte Carlo method is used to estimate p value of Pearson chi square test. Fisher exact test is used if 2*2 tables are involved. Median of numeric variables is calculated to determine average due to skewness of dataset.

INFORMED CONSENT – Consent form is signed by patient or attendant before filling the questionnaire.

RESULTS

Table 4.1 – Section A of the questionnaire containing demographic variables, length of stay, admission type, and whether the patient has visited Medanta before or not.

Characteristics (N=200)	Frequency	Percentage
LOS		
1 day	27	13.7
2 days	35	17.6
3 days	18	8.8
4 days	31	15.7
5 days	23	11.8
6 days	18	8.8
7 days	18	8.8
8 days	8	3.9
9 days	6	2.9
10 days	4	2.0
11 days	2	1
13 days	2	1
14 days	2	1
20 days	2	1
21 days	2	1
27 days	2	1
Age Group		
0 to 25 years	29	14.7
26 to 60 years	114	56.9
61 years & above	57	28.4
Type of admission		
Planned	145	72.5
Emergency	55	27.5
Educational Qualification		
School level	49	24.5
College – Undergraduate	73	36.5
College – Postgraduate	54	27.0

Professional or Technical course	4	2.0
Prefer not to answer	20	10.0
Gender		
Female	135	67.6
Male	65	32.4
First time Visitor		
No	49	24.5
Yes	151	75.5

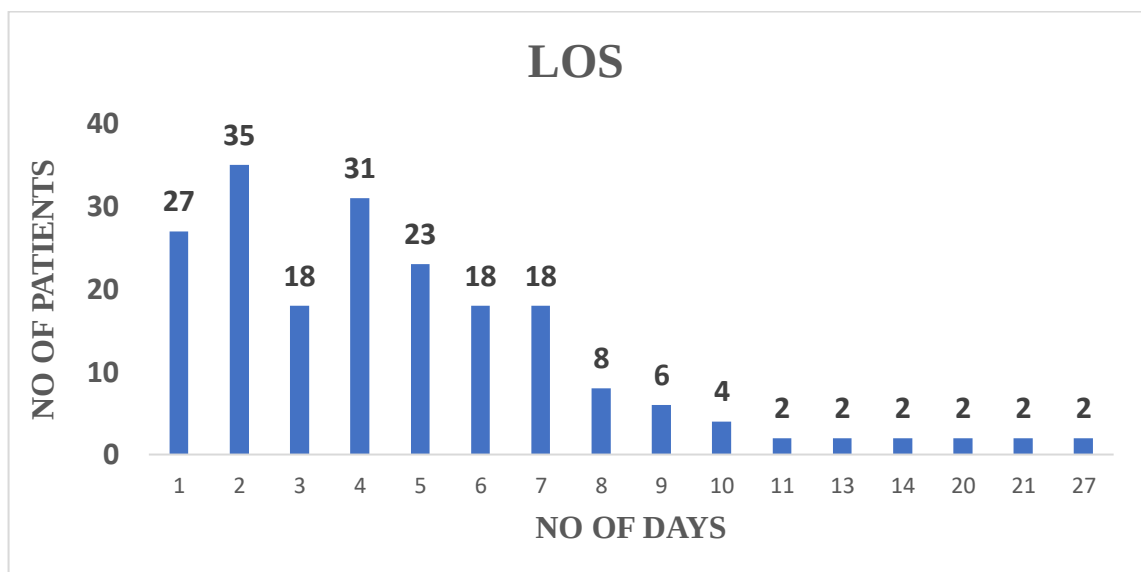


Fig 4.1 – Distribution of LOS

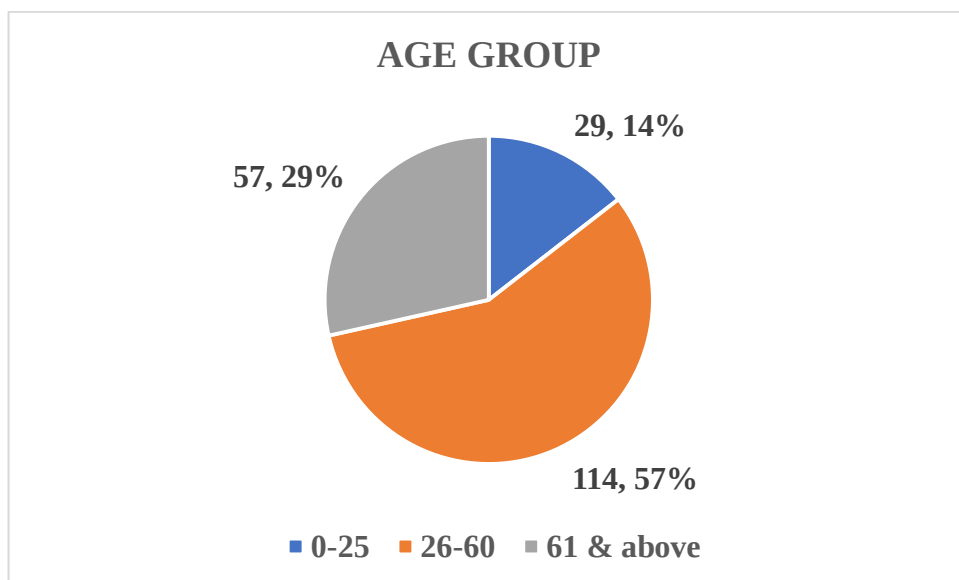


Fig 4.2 – Distribution of age group

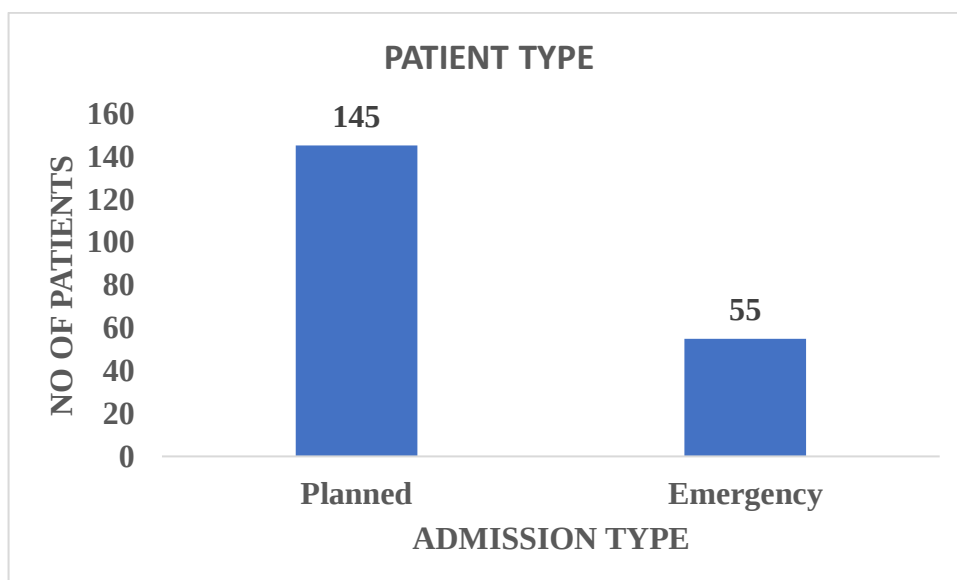


Fig 4.3 – Distribution of type of admission of patients.

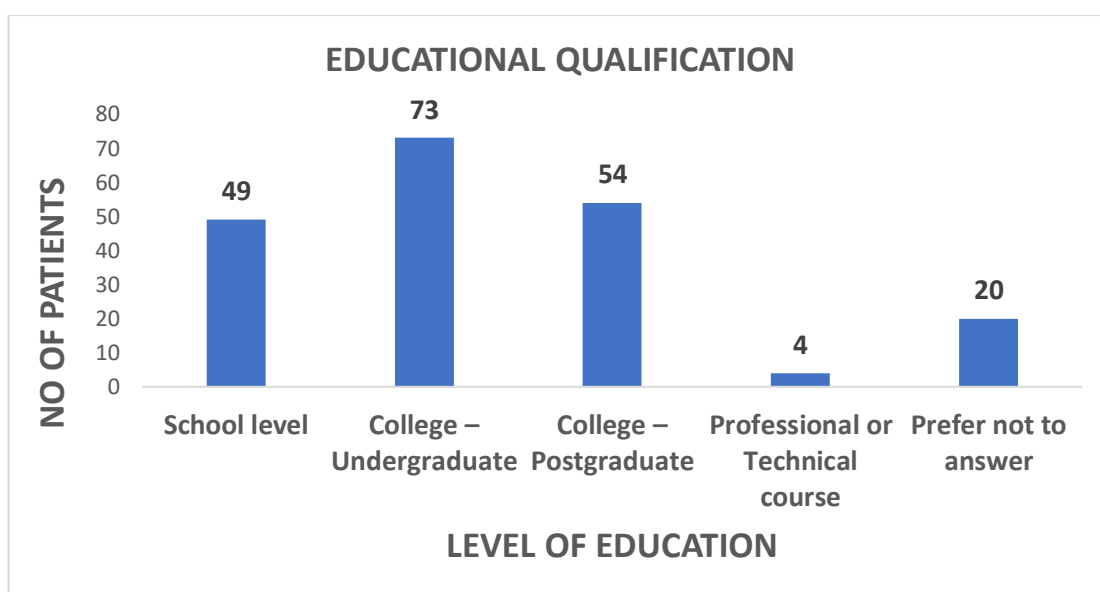


Fig 4.4 – Distribution of educational qualification of patients.

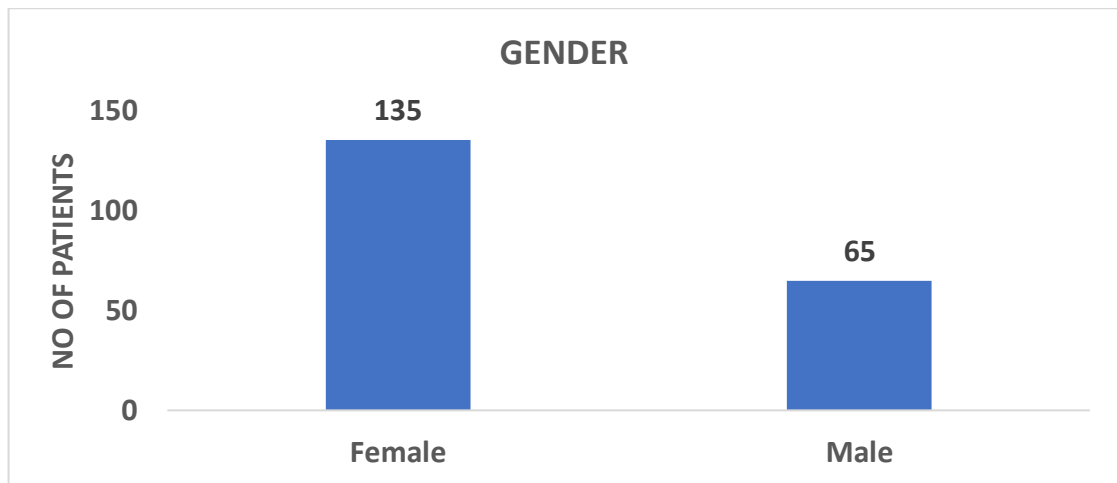


Fig 4.5 – Distribution of gender of the patients.

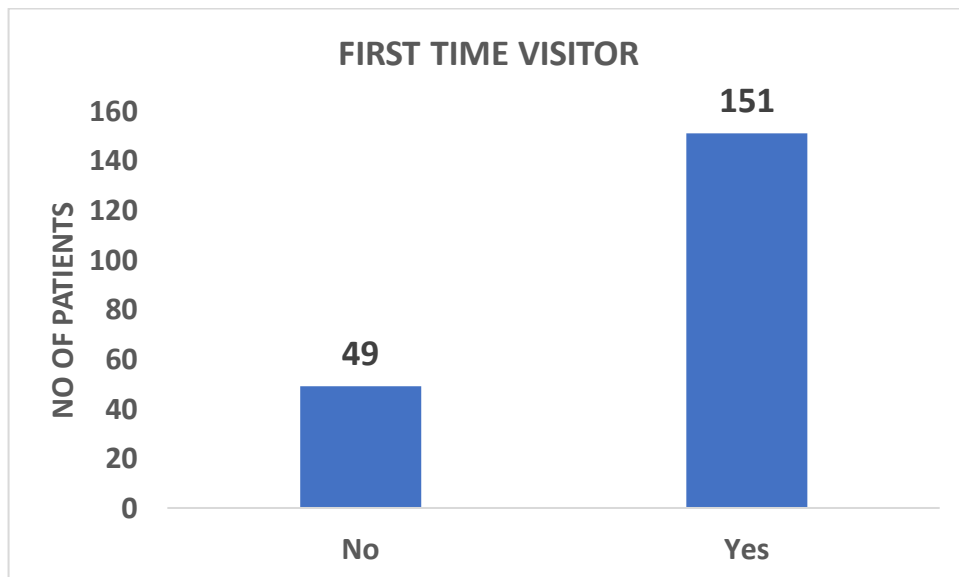


Fig 4.6 – Distribution of whether the patient has visited Medanta in the past or not.

The above tables and figures visualize the demographic analysis of the 200 study participants revealing a sample predominantly characterized by shorter hospital stays, a majority of adult patients within the 26-60 age bracket, and a higher prevalence of planned admissions.

Specifically, the length of stay (LOS) was primarily short, with the highest frequencies observed for 2-day (17.6%), 4-day (15.7%), and 1-day (13.7%) admissions, indicating that most participants experienced relatively brief hospitalizations. The median LOS was 7 days.

Regarding age group, the most substantial portion of the sample comprised individuals aged 26 to 60 years (56.9%), followed by those 61 years and above (28.4%). The

youngest group (0-25 years) represented a smaller segment at 14.7%. This suggests the study primarily captured the experiences of adult patients. The median age of the study participants was 50 years.

Majority of the admissions were planned, accounting for 72.5% of the admissions, in contrast to 27.5% for emergency admissions. This means the study largely reflects patient experiences from scheduled medical procedures or treatments.

The educational qualification data indicates a relatively well-educated sample, with the largest groups holding undergraduate (36.5%) and postgraduate (27.0%) degrees. This educational profile could influence patient expectations and their ability to articulate experiences.

In terms of gender, females constituted a larger proportion of the sample (67.6%) than males (32.4%).

Finally, the study population largely consisted of first-time visitors to Medanta, with 75.5% reporting no prior visits. This highlights that the collected patient experience data primarily reflects initial impressions and care encounters at the facility.

In summary, the study's sample is predominantly adult, female, and relatively well-educated patients undergoing planned, short-term admissions, primarily as first-time visitors to Medanta. This demographic profile provides essential context for interpreting the PPE-15 findings on patient experience.

Table 4.2 – Section B of the questionnaire, covering all the dimensions of the PPE-15 questionnaire, with two additional dimensions adapted from HCAHPS.

Characteristics (N = 200)	Frequency	Percentage
Doctor answer easy to understand		
Yes, always	190	95.1%
Yes, sometimes	6	2.9%
No	2	1.0%
I had no need to ask	2	1.0%
Nursing answer easy to understand		
Yes, always	176	88.2%
Yes, sometimes	14	6.9%
No	6	2.9%
I had no need to ask	4	2.0%
Staff giving conflicting information		
Yes, always	8	3.9%
Yes, sometimes	37	18.6%
No	155	77.5%

Patient was ever in unbearable pain		
Yes	18	8.8%
No	182	91.2%
If yes, did the staff responded satisfactory to reduce the pain		
Yes, definitely	16	88.9%
Yes, to some extent	0	0.0%
No	2	11.1%
Nurse counselled for fear and anxiety		
Yes, always	55	27.5%
Yes, to some extent	8	3.9%
No	6	2.9%
I didn't need to talk to nurse	131	65.7%
Doctor counselled for fear and anxiety		
Yes, always	153	76.5%
Yes, sometimes	6	2.9%
No	2	1.0%
I didn't have any anxieties or fear	39	19.6%
Solutions given by staff for concerns		
Yes, always	157	78.4%
Yes, sometimes	27	13.7%
No	8	3.9%
I had no need to ask	8	3.9%
Wanted to be more involved in decision making		
Yes	0	0.0%
Yes, to some extent	12	5.9%
No	188	94.1%
Treated with respect and dignity		
Yes, often	182	91.2%
Yes, sometimes	12	5.9%
No	6	2.9%
Doctors talk as if I'm not there		
Yes, often	4	2.0%
Yes, sometimes	10	4.9%
No	186	93.1%
Family got opportunity to talk to doctor		
Yes, definitely	178	89.2%
Yes, to some extent	16	7.8%
No	2	1.0%
my family didn't want or need information	4	2.0%
All reports and information given		
Yes, definitely	194	97.1%
Yes, to some extent	4	2.0%
No	2	1.0%
Medicines post discharge explained		
Yes, definitely	194	97.1%
Yes, to some extent	4	2.0%
No	0	0.0%
I didn't need an explanation	2	1.0%
Danger signs explained		
Yes definitely	94	47.1%
Yes, to some extent	2	1.0%
No	98	49.0%
I didn't need an explanation	6	2.9%

Hygiene and cleanliness maintained		
Always	190	95.1%
Never	2	1.0%
Sometimes	4	2.0%
Usually	4	2.0%
Able to get enough rest		
Always	182	91.2%
Never	2	1.0%
Sometimes	4	2.0%
Usually	12	5.9%
Will recommend hospital		
Definitely Yes	180	90.2%
Definitely No	0	0.0%
Probably Yes	14	6.9%
Probably No	6	2.9%
Rating given		
Bad (0-5)	2	1%
Average (6-7)	14	6.9%
Good (8-9)	116	57.8%
Excellent (10)	69	34.3%

When it comes to communication and information, patients generally felt well-informed and included. The vast majority found their doctors' explanations clear and easy to understand (95.1% always), with only a small number reporting difficulty (2.9% sometimes, 1.0% no). Similarly, most patients felt that nurses provided answers they could easily grasp (88.2% always). Families also largely experienced open communication, with 89.2% definitely and 7.8% to some extent getting the opportunity to speak with doctors. Furthermore, patients reported receiving all the necessary reports and information (97.1% definitely), showing a strong commitment to transparency. Most patients also felt that doctors did not speak over them or as if they weren't present (93.1% no), fostering a sense of inclusion.

In terms of comfort and emotional support, Medanta appears to prioritize patient well-being. The vast majority of patients reported that they did not experience unbearable pain (91.2% no). Notably, for those who did experience unbearable pain (8.8%), staff generally responded well to their discomfort (88.9% definitely). Doctors were also quite active in offering counseling for fear and anxiety (76.5% always, 2.9% sometimes). For nurses, the data indicates that a significant proportion of patients did not feel the need for counseling (65.7%), suggesting that for many, anxieties were managed or absent. Among those who potentially needed it, 27.5% always and 3.9% to some extent received counseling from nurses.

Patients also largely felt respected and involved in their care. The overwhelming majority reported being treated with dignity and respect (91.2% often, 5.9% sometimes). Most patients felt they had the right level of involvement in decisions about their health, as 94.1% did not want more involvement. When concerns arose, staff were generally effective in providing solutions (78.4% always, 13.7% sometimes).

The hospital's environment also contributed positively to the patient experience. Patients consistently noted that hygiene and cleanliness were well-maintained (95.1% always). Most also found it possible to get enough rest (91.2% always), indicating a generally calm healing environment.

Looking beyond the hospital stay, Medanta seems to prepare patients well for their return home regarding medication. The vast majority confirmed that their medicines were explained clearly upon discharge (97.1% definitely).

A major concern emerged regarding discharge information on danger signs. Only 47.1% of patients definitely received explanations, and 1.0% received it to some extent. Crucially, a significant 49.0% of patients explicitly reported receiving no explanation for danger signs upon discharge. While danger signs are clearly mentioned in the discharge summary handed out to the patients, they are not informed to read about the danger signs or the emergency contact number of Medanta as well, and as Bihar has one of the lowest literacy rates in India, many patients are not comfortable reading in English thus they tend to ignore the discharge summary handed out to them. This is a critical safety aspect that needs immediate attention to ensure patients are fully prepared for their recovery at home.

Another area that could cause confusion is conflicting information from staff contradicting doctor's advice. A notable 22.5% of patients (18.6% sometimes, 3.9% always) experienced this, suggesting that while communication is generally good, consistency across the care team needs to be improved.

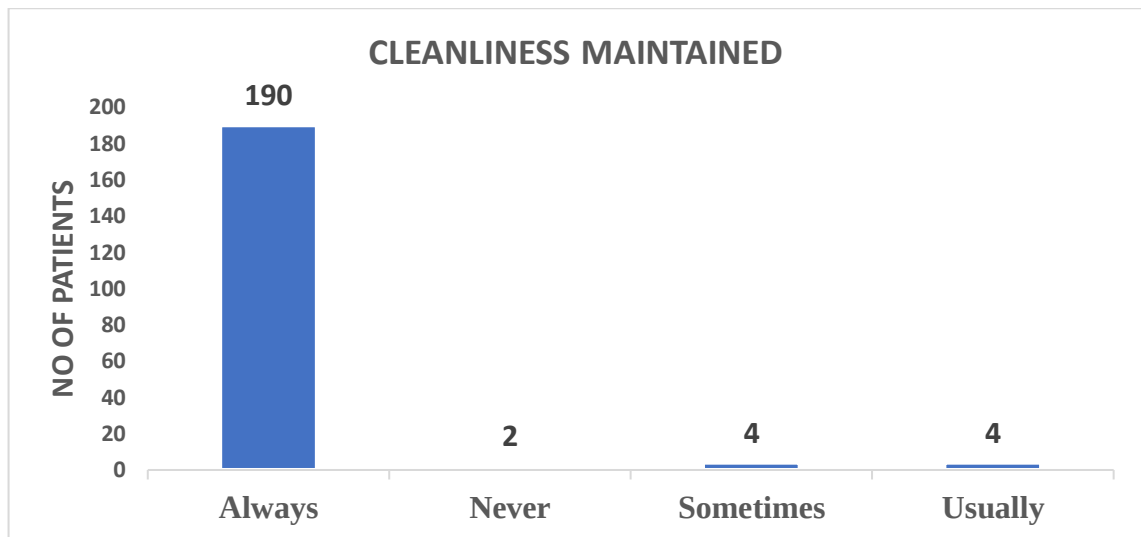


Fig 4.7 – Patient’s report on hygiene and cleanliness of rooms, beds, and washrooms.

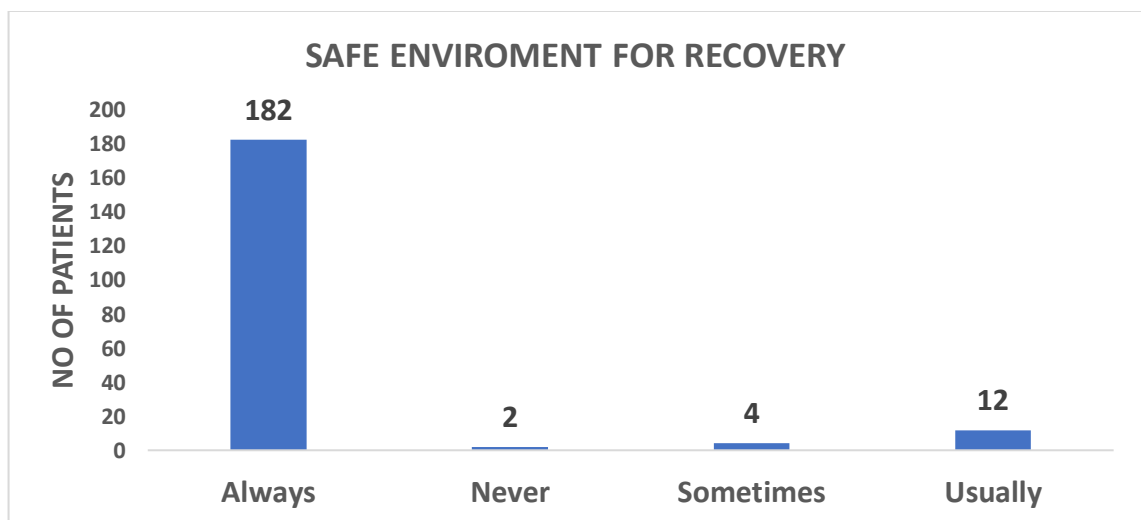


Fig 4.8 – Patient’s report on whether they were able to get enough rest or not.

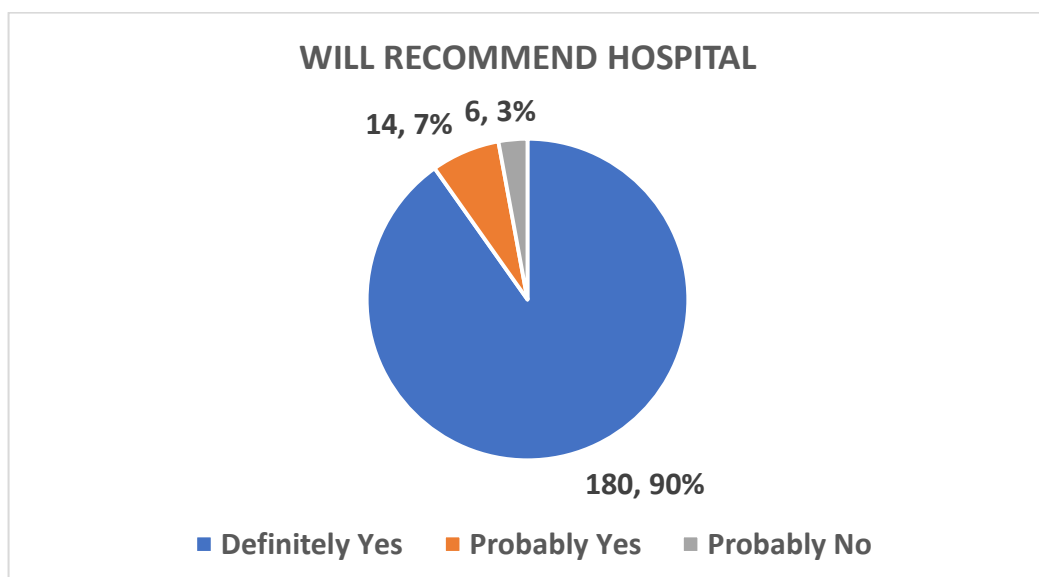


Fig 4.9 – Patient’s report on whether they will recommend the hospital or not.

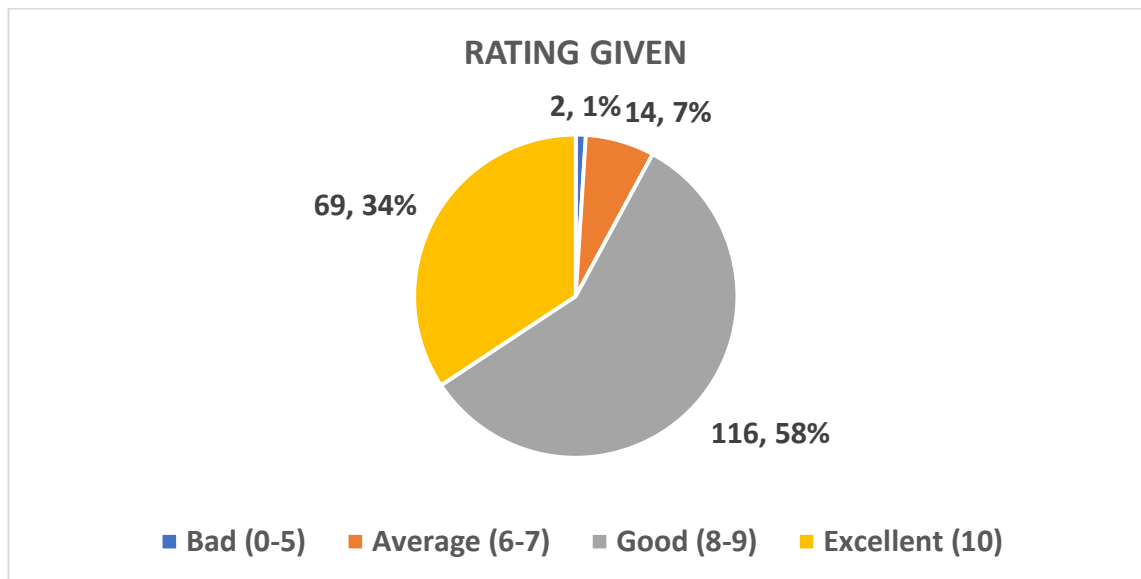


Fig 4.10 – Rating given by patient on a 10-point Likert scale.

A significant majority of patients consistently praised the hospital's cleanliness, with 95% reporting it was "Always" maintained in their rooms and washrooms (Fig 4.7). This suggests a well-kept and comfortable setting.

Furthermore, most patients found the hospital conducive to healing, as 91% reported they were "Always" able to get enough rest (Fig 4.8), indicating a generally peaceful environment for recovery.

Reflecting these positive experiences, patients expressed strong loyalty and willingness to recommend the hospital. An impressive 90% would "Definitely Yes" recommend it, with an additional 7% saying "Probably Yes" (Fig 4.9).

This high level of satisfaction is clearly reflected in the overall patient ratings (Fig 4.10). A combined 92% of patients rated their experience as "Good" (58%) or "Excellent" (34%), underscoring a highly favourable perception of the care received. The median rating received on the 10-point Likert scale is 9.

Table 4.3 – Bivariate analysis between independent variables and dependent variables

	Age (N = 200)
Rating given	0.04 (p-value)

To observe the association between demographic characteristics of the respondents with and patient reported experience measures Pearson chi square test is conducted. It is seen no statistical association exists between age, gender, educational and other PREM variables. However, Monte Carlo method of estimating p value revealed significant statistical association between educational qualification of patients and the rating given by patients on 10-point Likert scale.

Table 4.4 – Bivariate analysis between dependent variables and PPE-15, HCAHPS variables

PPE-15 variables	Rating given	Will recommend hospital ^a	First time Visitor ^a	LOS
Doctor answer easy to understand	No significance	0.03	No significance	No significance
Nursing answer easy to understand	0.00	0.02	No significance	0.02
Staff giving conflicting information	0.03	No significance	No significance	No significance
doctor counselled for fear and anxiety	No significance	No significance	No significance	0.02
Solutions given by staff for concerns	0.00	0.00	No significance	No significance
Wanted to be more involved in decision making	No significance	No significance	0.03	No significance
Treated with respect and dignity	0.00	0.00	0.01	No significance
Family got opportunity to talk to doctor	0.01	0.01	No significance	No significance
<i>Values marked in red is the p-value.</i> ^a is for variables where fisher exact test is used.				

Monte Carlo method is used for the rest.

To observe the association between rating given by patient on a Likert scale of 10 and variables of the PREM, Pearson chi square test is conducted. The result suggests that whether nurses answer was easy to understand, staff giving conflicting information contradicting doctor's advice, treating patient with respect and dignity, staff discussing concerns with patients, and whether patient's family or friends got opportunity to talk with the doctor are dimensions found to have significant statistical association with rating given by patients.

Similarly, whether patients will recommend the hospital or not is found to have significant statistical association with whether doctor and nurses answer was easy to understand, treating patient with respect and dignity, staff discussing concerns with patients, and whether patient's family or friends got opportunity to talk with the doctor.

The results also show that whether the patient was visiting the hospital for the first time or not has significant statistical association with dimensions like treating patient with respect and dignity, and the satisfaction level of patients with their involvement in the decision-making process.

Additionally, the result suggests length of stay of the patients have significant statistical association with whether nurses answer was easy to understand, and counselling of anxiety or fear by doctors.

Table 4.5 – Percentage of problem scores of the dimensions of PPE-15 variables.

Dimensions of PPE-15 (N = 200)	Problem score percent	Frequency	No problem percent	No Problem score
Information and education - Q1, Q2	10.0%	20	90.0%	180
Coordination of care - Q3	22.5%	45	77.5%	155
Physical comfort - Q10	1%	2	99%	198
Emotional support - Q4, Q5, Q9	23.5%	47	76.5%	153
Respect for patient preferences - Q6, Q7, Q8	10.5%	21	10.5%	179
Involvement of friends and family - Q11, Q12	10.8%	22	89.2%	178
Continuity and transition Q15, Q17	50%	100	50%	100
Total	69.6%	139	30.4%	61
Total excluding Q17	38.2%	76	61.8%	124

Table 4.5 presents the distribution of problem scores across the various dimensions of the PPE-15, based on responses from 200 patients.

In the Information and Education domain (Q1, Q2), 10.0% of respondents reported experiencing issues, while 90.0% did not report any problems. Regarding Coordination of Care (Q3), 22.5% of patients indicated difficulties, whereas 77.5% felt the coordination was satisfactory.

For Physical Comfort (Q10), only 1% of patients reported a problem, with 99% expressing no concerns. The Emotional Support domain (Q4, Q5, Q9) saw 23.5% of patients reporting unmet needs, while 76.5% reported no issues.

In the dimension of Respect for Patient Preferences (Q6, Q7, Q8), 10.5% of patients perceived problems, and 89.5% felt their preferences were respected. Similarly, Involvement of Friends and Family (Q11, Q12) had a problem score of 10.8%, with 89.2% of patients reporting no such concerns.

The Continuity and Transition domain (Q15, Q17) showed a balanced outcome, with exactly 50% of respondents indicating challenges and 50% reporting a smooth experience during care transitions.

Overall, when all PPE-15 dimensions are considered, 69.6% of respondents reported at least one problem, while 30.4% did not report any issues. When the item related to danger signs (Q17) is excluded, the total problem score decreases to 38.2%, suggesting this dimension had a significant impact on the overall patient experience.

Table 4.6 - Problem score excluding respondents whose LOS is less than 3 days

Dimensions of PPE-15 (N = 137)	Problem score percent	Frequency	No problem percent	Frequency	Difference Table 4.5 and Table 4.6
Information and education - Q1, Q2	13.0%	18	87.0%	119	3%
Coordination of care - Q3	27.1%	37	72.9%	100	5%
Physical comfort - Q10	2.9%	4	97.1%	133	2%
Emotional support - Q4, Q5, Q9	24.3%	33	75.7%	104	1%
Respect for patient preferences - Q6, Q7, Q8	12.9%	18	87.1%	119	2%
Involvement of friends and family - Q11, Q12	12.9%	18	87.1%	119	2%
Continuity and transition Q15, Q17	55.7%	76	44.3%	61	6%
Total	77.1%	106	22.9%	31	8%
Total excluding Q17	42.9%	59	57.1%	78	5%

Table 4.6 presents the distribution of problem scores across the various dimensions of the PPE-15 of respondents with more than 2 days of LOS. Out of 200 patients, 137 patients were eligible for the analysis. The table highlights whether percentage distribution of problem score varies significantly for respondents with longer length of stay.

In the Information and Education domain (Q1, Q2), three percent difference is observed. Regarding Coordination of Care (Q3), five percent difference between problem scores is reported. In other dimensions such as physical comfort, emotional support, respect for patient preferences, involvement of friends and family, the observed difference between percentage distribution was (2%, 1%, 2%, 2%) respectively. Among the dimensions of PPE-15, the highest difference was observed in continuity and transition with observed difference between percentage distribution of problem scores being six percent.

Overall, when all PPE-15 dimensions are considered, five percent difference between the percentage distribution of problem scores of all respondents and respondents with more than 2 days of LOS is seen, with respondents with longer length of stay reporting facing more problems. When the item related to continuity and transition (Q17) is excluded, the difference increases to eight percent.

DISCUSSION

The findings suggest that patients at Medanta generally reported a positive experience, particularly in areas related to communication, respect, and the hospital environment. Most patients felt that doctors and nurses communicated clearly, treated them with dignity, and provided care in a clean and restful setting. These aspects are reflected in the high levels of patient satisfaction, willingness to recommend the hospital, and strong overall ratings.

Key dimensions such as respect and dignity, clarity of communication, discussion of concerns, and involvement of family members were significantly associated with overall patient ratings and their likelihood to recommend the hospital. These elements appear to strongly influence how patients evaluate their hospital experience.

An important issue that emerged was the presence of conflicting information provided by staff contradicting the advice of doctors, which indicates a need for better coordination and consistent communication across clinical teams.

The analysis also found that educational qualification was significantly associated with overall patient ratings, suggesting that patients with higher education levels may have different expectations or be more articulate in expressing their experiences. First-time visitors and patients with shorter hospital stays showed significant associations with dimensions related to involvement in decision-making and clarity of communication, highlighting the importance of patient engagement and orientation.

Although the continuity and transition domain recorded a high number of reported issues, no significant association was found with overall satisfaction or willingness to recommend the hospital.

Patients with LOS more than 2 days reported more problems overall. The results suggests while respondents with over 2 days of length of stay reported more problems, the difference does not significantly affect the overall patient experience. While lack of explanation regarding danger signs increase the percentage distribution, as no significant statistical association was found between explanation of danger signs before discharge and the overall impression by patients (Q18, Q19), it reflects operational challenges but does not influence patient's perception of care.

RECOMMENDATIONS

Standardize Communication Across Teams

Efforts should be made to ensure consistency in the information shared by primary doctors, resident medical doctors, nurses, and dieticians to avoid confusion and reinforce trust. Communication during the handover between shifts of the nurses should be improved.

Verbal Reinforcement of Discharge Instructions

Discharge summaries should be supplemented with verbal explanations for the follow-up visit date, appointment contact number, and especially regarding danger signs using language appropriate to patients' literacy levels. Adopting the “teach-back” method for explaining discharge summary to patients is a reliable and validated strategy in healthcare [\[35\]](#).

LIMITATIONS OF THE STUDY

The sample size wasn't uniformly distributed between the floors where IPD patients were admitted. As the sample size was not randomized data may be biased.

This study is affected by the same biases that PREM tool is affected by. Additionally, as review of literature for PREM is scarce in Indian context, comparison with other studies could not be made.

CONCLUSION

This study assessed patient experience at Medanta using the PPE-15 instrument among a sample of 200 participants. The results indicate that patients largely perceived their hospital experience positively, particularly in areas related to communication, respect, environmental cleanliness, and overall service quality. Key aspects such as respectful treatment, clear communication by staff, and opportunities for family involvement were significantly associated with higher satisfaction and willingness to recommend the hospital.

While the majority of domains performed well, certain issues—such as conflicting information from staff and emotional support regarding concerns faced—highlight areas for improvement. Although continuity and transition showed a high number of reported concerns, it did not significantly impact overall satisfaction. Educational qualification, length of stay, and first-time visits were found to influence certain aspects of patient experience, underscoring the need for tailored patient engagement strategies.

Overall, the findings provide valuable insights into patients' perceptions and offer a foundation for targeted quality improvement initiatives.

REFERENCES

1. López-Ibort N, Boned-Galán A, Cañete-Lairla M, Gómez-Baca CA, Angusto-Satué M, Casanovas-Marsal JO, et al. Design and Validation of a Questionnaire to Measure Patient Experience in Relation to Hospital Nursing Care. *Nursing Reports*. 2024 Mar 1;14(1):400–12.
2. Etingen, B.; Miskevics, S.; LaVela, S.L. Assessing the Associations of Patient-Reported Perceptions of Patient-Centered Care as Supplemental Measures of Health Care Quality in VA. *J. Gen. Intern. Med.* 2016, 31, 10–20.
3. Wolf JA, Marshburn D, Lavela SL. Issue 1 Inaugural Issue Article 3 2014 Part of the Health and Medical Administration Commons, Health Policy Commons, Health Services Administration Commons, and the Health Services Research Commons Recommended Citation Recommended Citation Wolf JA, Niederhauser V, Marshburn D, LaVela SL. Defining Patient Experience. *Patient Experience Journal* [Internet]. 2014;1(1):7–19.
4. Khateeb, R.; Keniston, A.; Moore, A.; Hrach, C.; Indovina, K.A.; Kneeland, P.; Rudolph, M.; Burden, M. Perspectives on Patient Experience: A National Survey of Hospitalists. *J. Patient Exp.* 2020, 7, 1482–1490.
5. Graham B, Smith JE, Nelmes P, Squire R, Latour JM. Initial Development of a Patient Reported Experience Measure for Older Adults Attending the Emergency Department: Part I—Interviews with Service Users. *Healthcare (Switzerland)*. 2023 Mar 1;11(5).
6. Male L, Noble A, Atkinson J, Marson T. Measuring patient experience: A systematic review to evaluate psychometric properties of patient reported experience measures (PREMs) for emergency care service provision. Vol. 29, *International Journal for Quality in Health Care*. Oxford University Press; 2017. p. 314–26.
7. Black N, Varaganum M, Hutchings A. Relationship between patient reported experience (PREMs) and patient reported outcomes (PROMs) in elective surgery.
8. Weldring T, Smith SMS. Article Commentary: Patient-Reported Outcomes (PROs) and Patient-Reported Outcome Measures (PROMs). Vol. 6, *Health Services Insights*. SAGE Publications Ltd; 2013.
9. Patient experience improvement framework. 2018.

10. Adams C, Harrison R, Wolf JA. The Evolution of Patient Experience: From Holistic Care to Human Experience. Vol. 11, Patient Experience Journal. The Beryl Institute; 2024. p. 4–13.
11. Benson T. Why it is hard to use PROMs and PREMs in routine health and care. Vol. 12, BMJ Open Quality. BMJ Publishing Group; 2023.
13. Attar A, Shukla K, Mulay P. Top 100 most cited articles on Patient Reported Experience Measures (PREM): insights and perspectives. Vol. 8, Journal of patient-reported outcomes. 2024. p. 114.
14. Measures for person centred coordinated care [Internet]. Available from: <http://www.p3c.org.uk/prom-detail/60>.
15. A WHITE PAPER on Patient-Reported Experience Measures (PREMs) C A H O COMMITTED TO SAFER HEALTHCARE [Internet]. [cited 2025 Jun 1].
16. Churrua K, Pomare C, Ellis LA, Long JC, Henderson SB, Murphy LED, et al. Patient-reported outcome measures (PROMs): A review of generic and condition-specific measures and a discussion of trends and issues. Vol. 24, Health Expectations. John Wiley and Sons Inc; 2021. p. 1015–24.
17. Shunmuga Sundaram C, Campbell R, Ju A, King MT, Rutherford C. Patient and healthcare provider perceptions on using patient-reported experience measures (PREMs) in routine clinical care: a systematic review of qualitative studies. Vol. 6, Journal of Patient-Reported Outcomes. Springer Science and Business Media Deutschland GmbH; 2022.
18. Kingsley, Charlotte & Patel, Sanjiv. (2017). Patient-reported outcome measures and patient-reported experience measures. BJA Education. 17. 10.1093/bjaed/mkw060.
19. Bull C, Byrnes J, Hettiarachchi R, Downes M. A systematic review of the validity and reliability of patient-reported experience measures. Health Services Research. 2019 Oct 1;54(5):1023–35.
20. Zini M, Banfi G. A narrative literature review of bias in collecting patient reported outcomes measures (PROMs). Vol. 18, International Journal of Environmental Research and Public Health. MDPI; 2021.
21. Measures for person centred coordinated care [Internet]. Available from: <http://www.p3c.org.uk/prom-detail/60>.

22. Jenkinson, C., Coulter, A., & Bruster, S. (2002). The Picker Patient Experience Questionnaire: development and validation using data from in-patient surveys in five countries. *International Journal for Quality in Health Care*, 14(5), 353–358.
23. Coulter, A. (2006). Can patients assess the quality of healthcare? *BMJ*, 333(7557), 1–2.
24. Garratt, A., Solheim, E., & Danielsen, K. (2008). National and cross-national surveys of patient experiences: a structured review. *BMJ Quality & Safety*, 17(1), 41–46.
25. Coulter, A., & Cleary, P. D. (2001). Patients' experiences with hospital care in five countries. *Health Affairs*, 20(3), 244–252.
26. Pelletier, D., Green-Demers, I., Collette, P., & Heberer, M. (2019). Modeling the communication–satisfaction relationship in hospital patients. *Patient Education and Counseling*, 102(5), 947-955.
27. Khiari, H., Chraïet, M., Mallekh, R., Cherif, I., & Hsairi, M. (2021). Patients' experiences and satisfaction with health care in the Salah Azaiez Institute of Cancer in Tunisia in 2020. *Journal of Patient Experience*, 8, 23743735211025531.
28. Harrison, R., Walton, M., Kelly, P., Manias, E., Jorm, C., Smith-Merry, J., Iedema, R., Luxford, K., & Dyda, A. (2018). Hospitalization from the patient perspective: a data linkage study of adults in Australia. *BMJ Quality & Safety*, 27(12), 972-981.
29. Jenkinson C, Coulter A, Reeves R, Bruster S, Richards N. Properties of the Picker Patient Experience questionnaire in a randomized controlled trial of long versus short form survey instruments. Vol. 25, *Journal of Public Health Medicine*. 2003. p. 197–201.
30. Wong, E.L., Leung, M.C., Cheung, A.W., Yam, C.H., Yeoh, E.K. and Griffiths, S. (2011). A population-based survey using PPE-15: relationship of care aspects to patient satisfaction in Hong Kong. *International Journal for Quality in Health Care*, 23(3), 329-336.
31. Vandan, N., Wong, J. Y-H., Yip, P. S-F., & Fong, D. Y-T. (2020). Patients' experience in Hong Kong hospitals: A comparison between South Asian and Chinese people. *Journal of Patient Experience*, 7(6), 1801-1808.

32. Min, R., Li, L., Zi, C., Fang, P., Wang, B., & Tang, C. (2019). Evaluation of patient experience in county-level public hospitals in China. *Patient Preference and Adherence*, 13, 1989-1997.
33. Yathindra C, Saldanha AL. Patient reported experience measures: an assessment of the in-patients in a tertiary care teaching hospital. *International Journal Of Community Medicine And Public Health*. 2024 Jun 28;11(7):2679–85.
34. Makkar N, Jain K, Siddharth V, Sarkar S. Patient Involvement in Decision-Making: An Important Parameter for Better Patient Experience—An Observational Study (STROBE Compliant). *Journal of Patient Experience*. 2019 Sep;6(3):231–7.
35. Tamura, E., & Tamura, M. (2017). The teach-back method: a tool to improve patient understanding and adherence.

APPENDICE

INFORMED CONSENT

Researcher Name – Aahel Adhikary, 8900446166

You are invited to participate in a research study by [Aahel Adhikary/IIHMR/Jay Prabha Medanta Super Specialty Hospital]. This study aims to measure the satisfaction level of patient experience in Jay Prabha Medanta Super Specialty Hospital, Patna.

If you agree to participate, you will be asked to complete a questionnaire that will take approximately 10 minutes.

There are no known risks associated with participating in this study. However, some questions may be sensitive, and you may choose not to answer any questions that make you uncomfortable.

Your responses to the questionnaire will be kept confidential. All data collected will be anonymized, and no identifying information will be linked to your responses. The data will be stored securely and only accessible to the research team.

Your participation in this study is entirely voluntary. You have the right to refuse to participate or to withdraw at any time.

If you have any questions about the study or your participation, please contact [Aahel Adhikary] at [8900446166].

By selecting "I Agree" below, you acknowledge that you have read and understood the information provided above and consent to participate in this study.

[☐] I Agree

[☐] I Do Not Agree

सूचित सहमति पत्र

अनुसंधानकर्ता का नाम – आहेल अधिकारी, 8900446166

नमस्ते, आपको [आहेल अधिकारी/IIHMR/जय प्रभा मेदांता सुपर स्पेशियलिटी हॉस्पिटल] द्वारा किए जा रहे एक शोध अध्ययन में भाग लेने के लिए आमंत्रित किया गया है। इस अध्ययन का उद्देश्य जय प्रभा मेदांता सुपर स्पेशियलिटी हॉस्पिटल, पटना में मरीजों की सेवा गुणवत्ता की धारणा का मूल्यांकन करना है। यदि आप इस अध्ययन में भाग लेने के लिए सहमत होते हैं, तो आपको एक प्रश्नावली भरनी होगी, जिसमें लगभग 10 मिनट का समय लगेगा।

इस अध्ययन में भाग लेने से जुड़े कोई ज्ञात जोखिम नहीं हैं। हालांकि, कुछ प्रश्न संवेदनशील हो सकते हैं, और आप किसी भी ऐसे प्रश्न का उत्तर देने से इनकार कर सकते हैं जिससे आपको असहजता हो।

आपके द्वारा दी गई सभी जानकारीयों गोपनीय रखी जाएंगी। सभी उत्तरों को गुप्त और पहचान से रहित रूप में संग्रहित किया जाएगा। यह जानकारी केवल अनुसंधान टीम की पहुँच में रहेगी और सुरक्षित रूप से संग्रहित की जाएगी।

इस अध्ययन में भाग लेना पूरी तरह से स्वैच्छिक है। आप किसी भी समय बिना किसी कारण के भाग लेने से इनकार कर सकते हैं या अपनी सहमति वापस ले सकते हैं।

यदि आपके पास इस अध्ययन या इसमें भागीदारी से संबंधित कोई प्रश्न हैं, तो कृपया [आहेल अधिकारी] से [8900446166] पर संपर्क करें।

नीचे "मैं सहमत हूँ" चुनकर, आप यह स्वीकार करते हैं कि आपने उपरोक्त जानकारी को पढ़ लिया है, समझ लिया है और इस अध्ययन में भाग लेने के लिए अपनी सहमति दे रहे हैं।

☐ मैं सहमत हूँ

☐ मैं सहमत नहीं हूँ

PICKER PATIENT EXPERIENCE QUESTIONNAIRE

Section A – Demographic details 1) Name: _____ 2) UHID (Hospital ID): _____ 3) Age: _____ years 4) Educational Qualification: • School level • College – Undergraduate • College – Postgraduate • Professional/Technical course • Other: _____ • Prefer not to answer 5) Gender: ☐ Male ☐ Female ☐ Other 6) Type of Admission: ☐ Emergency ☐ Planned 7) Length of Stay: _____ days 8) Are you a first-time visitor? ☐ Yes ☐ No	रोगी जानकारी फॉर्म 1) नाम: _____ 2) यूएचआईडी (अस्पताल आईडी): _____ 3) आयु: _____ वर्ष 4) शैक्षिक योग्यता: • स्कूल स्तर • कॉलेज – स्नातक • कॉलेज – स्नातकोत्तर • व्यावसायिक/तकनीकी पाठ्यक्रम • अन्य: _____ • उत्तर नहीं देना चाहते 5) लिंग: ☐ पुरुष ☐ महिला ☐ अन्य 6) प्रवेश का प्रकार: ☐ आपातकालीन ☐ नियोजित 7) रहने की अवधि: _____ दिन 8) क्या आप पहली बार अस्पताल आए हैं? ☐ हाँ ☐ नहीं
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Section C – Questionnaire 1) When you had important questions to ask a doctor, did you get answers that you could understand?	प्रश्नावली a) Yes, always b) Yes, sometimes c) No d) No, I had no need to ask
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जब आपको डॉक्टर से महत्वपूर्ण सवाल पूछने थे, तो क्या आपको ऐसे उत्तर मिले जो आप समझ सकें?	a) हाँ, हमेशा b) हाँ, कभी-कभी c) नहीं d) नहीं, मुझे कोई सवाल पूछने की जरूरत नहीं पड़ी
2. When you had important questions to ask a nurse, did you get answers that you could understand? जब आपको नर्स से महत्वपूर्ण सवाल पूछने थे, तो क्या आपको ऐसे उत्तर मिले जो आप समझ सकें?	a. Yes, always b. Yes, sometimes c. No d. No, I had no need to ask a) हाँ, हमेशा b) हाँ, कभी-कभी c) नहीं d) नहीं, मुझे कोई सवाल पूछने की जरूरत नहीं पड़ी
3. Sometimes in a hospital, doctor will say one thing and nurse, or other staffs will say something quite different. Did this happen to you? कभी-कभी अस्पताल में डॉक्टर कुछ कहता है और नर्स या अन्य कर्मचारी कुछ और कहते हैं। क्या आपके साथ भी ऐसा हुआ है?	a. Yes, often b. Yes, sometimes c. No a) हाँ, हमेशा b) हाँ, कभी-कभी c) नहीं
4. If you had any anxieties or fears about your condition or treatment, did a doctor discuss them with you?	a. Yes, completely b. Yes, to some extent c. No d. I didn't have any anxieties or fear a. हाँ, पूरी तरह से

अगर आपको अपनी स्थिति या इलाज को लेकर कोई चिंता या डर था, तो क्या डॉक्टर ने उस पर आपसे बात की?	b. हाँ, कुछ हद तक c. नहीं d. मुझे कोई चिंता या डर नहीं था
5. Did doctors talk in front of you as if you weren't there or ignored your concerns? क्या डॉक्टर आपके सामने ऐसे बात करते थे जैसे आप वहां मौजूद ही नहीं थे या आपकी चिंताओं को नजरअंदाज कर देते थे?	a. Yes, often b. Yes, sometimes c. No a) हाँ, हमेशा b) हाँ, कभी-कभी c) नहीं
6. Were you satisfied with your involvement in the decisions made for your treatment, if not, did you want to be more involved in decisions made about your care and treatment? क्या आप अपने उपचार के लिए लिए गए निर्णयों में अपनी भागीदारी से संतुष्ट थे, यदि नहीं, तो क्या आप अपनी देखभाल और उपचार के बारे में लिए गए निर्णयों में अधिक शामिल होना चाहते थे?	a. Yes, completely b. Yes, to some extent c. No a. हाँ, पूरी तरह से b. हाँ, कुछ हद तक c. नहीं
7. Overall, did you feel you were treated with respect and dignity while you were in hospital? कुल मिलाकर, क्या आपको ऐसा महसूस हुआ कि अस्पताल में रहते हुए आपको सम्मान और गरिमा के साथ इलाज किया गया?	a. Yes, often b. Yes, sometimes c. No a) हाँ, हमेशा b) हाँ, कभी-कभी

	c) नहीं
8. Whenever you had concerns or issues, did anyone from the hospital talk to you to solve your concern when you discussed with them? जब भी आपको कोई चिंता या समस्या हुई, क्या अस्पताल से किसी ने आपसे बात की और आपकी चिंता का समाधान किया?	a) Yes, definitely b) Yes, to some extent c) No d) I had no concerns a. हाँ, पूरी तरह से b. हाँ, कुछ हद तक c. नहीं d. मुझे कोई चिंता नहीं थी
9. If you had any anxieties or fears about your condition or treatment, did a nurse discuss them with you? अगर आपको अपनी स्थिति या इलाज को लेकर कोई चिंता या डर था, तो क्या किसी नर्स ने उस पर आपसे बात की?	a. Yes, completely b. Yes, to some extent c. No d. I didn't have any anxieties or fear a. हाँ, पूरी तरह से b. हाँ, कुछ हद तक c. नहीं d. मुझे कोई चिंता या डर नहीं था
10. Were you ever in unexpected and unbearable pain during your stay in hospital? क्या अस्पताल में रहने के दौरान आपको कभी अप्रत्याशित एवं असहनीय पीड़ा का सामना करना पड़ा? Do you think the hospital staff did everything they could to help control your pain? क्या आपको लगता है कि अस्पताल के स्टाफ ने आपके	a. Yes b. No a. हाँ b. नहीं If yes, a) Yes, definitely b) Yes, to some extent c) No

दर्द को नियंत्रित करने के लिए अपनी पूरी कोशिश की?	अगर हाँ, a) हाँ, बिल्कुल b) हाँ, कुछ हद तक c) नहीं
11. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so? अगर आपके परिवार या किसी करीबी व्यक्ति ने डॉक्टर से बात करना चाहा, तो क्या उन्हें ऐसा करने का पर्याप्त अवसर मिला?	a) Yes, definitely b) Yes, to some extent c) No d) No family or friends were involved e) My family didn't want or need information a) हाँ, बिल्कुल b) हाँ, कुछ हद तक c) नहीं d) कोई परिवार या दोस्त शामिल नहीं थे e) मेरे परिवार को जानकारी नहीं चाहिए थी या जरूरत नहीं थी
12. Did the doctors or nurses give your family or someone close to you all the information they needed to help you recover? क्या डॉक्टरों या नर्सों ने आपके परिवार या आपके करीबी व्यक्ति को वह सारी जानकारी दी जो आपकी रिकवरी में मदद करने के लिए जरूरी थी?	a) Yes, definitely b) Yes, to some extent c) No a) हाँ, बिल्कुल b) हाँ, कुछ हद तक c) नहीं
13. During this hospital stay, how often were your room and bathroom kept clean?	a) Never b) Sometimes

अस्पताल में रहने के दौरान आपके कमरे और बाथरूम को कितनी बार साफ रखा गया?	c) Usually d) Always a) कभी नहीं b) कभी-कभी c) आम तौर पर d) हमेशा
14. During this hospital stay, how often were you able to get the rest you needed? अस्पताल में रहने के दौरान, आपको कितनी बार आवश्यक आराम मिल पाया?	a) Never b) Sometimes c) Usually d) Always a) कभी नहीं b) कभी-कभी c) आम तौर पर d) हमेशा
15. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand? क्या स्टाफ के किसी सदस्य ने आपको घर पर ली जाने वाली दवाओं के उद्देश्य को इस तरह समझाया कि आप उसे समझ सकें?	a) Yes, definitely b) Yes, to some extent c) No d) I didn't need an explanation a) हाँ, बिल्कुल b) हाँ, कुछ हद तक c) नहीं d) मुझे किसी स्पष्टीकरण की आवश्यकता नहीं थी
16. Did a member of staff tell you about medication side effects to watch for when you went home? क्या स्टाफ के किसी सदस्य ने आपको उन दवाओं के	a) Yes, definitely b) Yes, to some extent c) No

दुष्प्रभावों के बारे में बताया, जिन पर घर जाने के बाद ध्यान देना चाहिए?	a) हाँ, बिल्कुल b) हाँ, कुछ हद तक c) नहीं
17. Did someone tell you about danger signals regarding your ill-ness or treatment to watch for after you went home? क्या किसी ने आपको आपकी बीमारी या इलाज से जुड़ी ऐसी चेतावनी संकेतों के बारे में बताया, जिन पर घर जाने के बाद ध्यान देना चाहिए?	a) Yes, definitely b) Yes, to some extent c) No a) हाँ, बिल्कुल b) हाँ, कुछ हद तक c) नहीं
18. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay? 0 से 10 तक किसी भी संख्या का उपयोग करते हुए, जहाँ 0 सबसे खराब अस्पताल है और 10 सबसे अच्छा अस्पताल है, आप अपने प्रवास के दौरान इस अस्पताल को किस संख्या से रेट करेंगे?	0 (Worst/ बहुत बुरा) 1 2 3 4 5 6 7 8 9 10 (Best/ सबसे अच्छा)
19. Would you recommend this hospital to your friends and family? क्या आप अपने मित्रों और परिवार को इस अस्पताल की सिफारिश करेंगे?	a) Definitely no b) Probably no c) Probably yes d) Definitely yes a) बिल्कुल नहीं b) शायद नहीं c) शायद हाँ d) बिल्कुल हाँ