Algoma
PUBLIC HEALTH
Santé publique Algoma

Client Centred Care

Survey Development and Validation
April 2011

Acknowledgements

Appreciation is extended to Dr. Carol M. Trivette, Research Scientist from the Orelena Hawks Puckett Institute in North Carolina who is our mentor for our Client Centred Care work and who was instrumental in the development and validation of our survey tools.

Organizing and analyzing the data was made possible by Susan Boston, Program Evaluator and Dr. Greg Zimmerman, Consulting Epidemiologist.

Clerical support and assisting with the layout and design by Tracy Alexander is greatly appreciated.

Special thanks to Leo Vecchio, Media Coordinator and Webmaster for the finishing touches on this report.

The report was written by the following Algoma Public Health staff:

Dr. Greg Zimmerman, Susan Boston, and Sharon Vanderburg RN, BScN.

The Development and Validation of a Client Centred Care Survey for Public Health Practices

Introduction

Algoma Public Health (APH) has identified Client Centred Care as a strategic direction for improving how staff delivers services to clients. Client Centred Care is also referred to as family centred care in the literature. For purposes of this report, the terms client centred and family-centred are used interchangeable. Research shows that programs and practitioners are not nearly as family centred as is generally believed, and it is easy to claim that one is family centred in the absence of standards or benchmarks for assessing the family centredness of programs (Dunst, Trivette, and Hamby, 2008). The Registered Nurses Association of Ontario (RNAO) has developed a best practice guideline for Client Centred Care defined as "an approach in which clients are viewed as whole; it is not merely about delivering services where the client is located. Client Centred Care involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision making." (RNAO, 2002, p.12).

This report describes how APH developed a survey instrument to measure how staff at APH are client centred. This survey was provided to clients accessing selected APH programs.

Why Client Centred Care is Important to Algoma Public Health

Algoma Public Health (APH) is committed to creating an agency culture that embraces Client Centred Care and has incorporated it as one of its four strategic directions. At present, the Client Centred Care approach is still in its infancy regarding public health application even though the concepts of caring or client centred are not new to public health. The idea to apply a client centred approach to public health came about when an APH public health nurse from the Healthy Babies Healthy Children program attended a conference on *Supporting Families with Young Children* in Grand Rapids, Michigan in 2005. A presentation by Dr. Carol M. Trivette, a research scientist from the Orelena Hawks Puckett Institute in North Carolina, identified and defined client centred care as an approach.

Dr. Trivette's presentation set off an "ah-ha" moment for this public health nurse as she recognized some strengths of practice that APH was already employing as well as highlighting areas for further development. After bringing this idea to her program director, who in turn brought it to the APH Management Committee, a dialogue began on how we might more formally incorporate this Client Centred Care approach into a multidisciplinary public health organization. Recognizing the need for a comprehensive approach, on June 21, 2006, the APH Board of Health endorsed Client Centred Care as a strategic direction with the following Guiding Principles:

Staff from Algoma Public Health will:

1. Treat you with respect and dignity.
2. Honour your right to privacy.
3. Identify and build on strengths to accomplish goals.
4. Really listen to your concerns, needs and requests.
5. Provide timely, flexible and individualized support.
6. Work with you to get what you need to make an informed decision.
7. Support decisions within limits of the law.

A Client Centred Care Committee formed with representatives from all programs to oversee the process of systematically implementing an agency wide client centred approach.

The goals and objectives of the committee include:

- Algoma Public Health will be committed to facilitating client involvement in goal setting and decision making through a framework of client centred care.
- Increase staff awareness and understanding about client centered care.
- Implement client centered care practices.
- Increase the involvement of clients in the development of Algoma Public Health services.

Purpose of the Survey

The purpose of the implementation of the Client Centred Care survey was to determine if the statements included in the survey were actually measuring the client centredness of staff. Through factor analysis, unnecessary questions were eliminated. The remaining questions make up a final version of the survey that will be administered to all APH client based programs. Another purpose was to determine whether the scale/survey performed in the way we expected it to by looking at the correlations between being treated in a client centred manner and participants' perceptions of self-efficacy. A serendipitous finding was how participant characteristics did not effect how clients responded to the relational and participatory survey statements.

Literature Review

Client centred practices have both relational and participatory components with each component having two clusters of practices as identified in the Dunst and Trivette studies (cited in Wilson and Dunst, 2005).

The relational component includes practices typically associated with a) good clinical skills including active listening, compassion, empathy, respect, and being

nonjudgmental; and b) professional beliefs about and attitudes toward families, especially those pertaining to parenting capabilities and competencies.
The participatory component includes practices that a) are individualized, flexible, and responsive to family concerns and priorities, and b) provide families with opportunities to be actively involved in decisions and choices, family-professional collaboration, and family actions to achieve desired goals and outcomes.

The simultaneous use of both sets of practices is what distinguishes a family centred approach from other approaches used when working with families (cited in Wilson and Dunst, 2005).

According to the theory, relational and participatory help-giving practices influence receiver self-efficacy beliefs. The self-efficacy beliefs are participant appraisals of benefits directly related to the focus of help giver and/or program practices (e.g. perceived control over the provisions of the program resources).

It is important to recognize that effective family centred practices include both relational and participatory elements. Relational practices alone will not likely have either empowering or capacity building consequences, since help receiver involvement in procuring resources and achieving desired goals is a necessary condition for help-giving to be effective, as indicated by Dunst, Trivette, and Snyder (as cited in Dunst, Trivette, and Hamby, 2008).

While the extensive work of Dunst and Trivette has focused on clinical practice with families, APH attempted to apply this theory to public health practice by developing a survey applicable to public health programs.

Survey Question Development

Algoma Public Health (APH) program staff were asked to identify behaviours that demonstrated how they presently incorporate Client Centred Care principles in their work. This information was collected from September 2006 to March 2007 with 729 discrete behaviours identified. These items were then organized according to the seven principles.

The survey instrument was developed through a process where APH staff who were members of the Client Centred Care Committee met to review the behaviours to determine if they fit under one of the seven APH Client Centred Care guiding principles.

For each identified behaviour, a decision was made to keep it under the guiding principle that it was originally assigned to, or move it to another guiding principle. If it was a duplicate response, that is if the behaviour was identified by multiple staff, it was only listed once. All behaviours from all programs were consolidated into an Excel spreadsheet. A breakdown of the number of behaviours identified by staff per guiding principle is summarized in Table 1.

Table 1

Guiding Principle	Identified Behaviour Count
1. Treat you with respect and dignity.	99
2. Honour your right to privacy.	142
3. Identify and build on strengths to accomplish goals.	51
4. Really listen to your concerns, needs and requests.	102
5. Provide timely, flexible and individualized support.	172
6. Work with you to get what you need to make an informed decision.	105
7. Support decisions within limits of the law.	58
Total	729

A theming exercise took place where again committee members participated in categorizing the behaviours per guiding principle. A list of themes emerged after reviewing the behaviours applicable to the first guiding principle. This list formed the basis for theming subsequent guiding principles with new themes added as needed. Some of examples of the themes that emerged were communication, choice, access, flexibility, and respect. The survey statements were developed based on the predominant themes that emerged from the theming exercise (Appendix A). The statements were worded so that they would apply to APH programs with long term client involvement like case management or long term home visiting. Questions from the Monograph Series written by Dunst, Trivette and Hamby were used as a guide in developing the survey statements (Dunst, Trivette, and Hamby, 2008 and 2006). The statements were categorized as either relational or participatory. Table 2 provides a list of the eleven participatory statements included in the survey.

Table 2

Participatory Statements
Staff explains things to me so I can understand.
Staff gives me information about different kinds of resources and supports available to me.
Staff works with me to set my goals.
Staff respects my choice around what information I choose to share.
Staff helps me use my strengths to reach my goals.
Staff helps me access different kinds of resources and supports available to me.
Staff supported my decision.
Staff helps me identify the benefits and risks of different options before I make a decision.
Staff made me aware of when they are required by law to share my information with someone else.
Staff and I worked together when I needed to make a decision.
Staff is flexible in scheduling appointments with me.

Table 3 cites a list if the 16 relational statements included in the pilot survey.

Table 3

Relational Statements
Staff meets with me wherever I feel comfortable.
Staff acknowledges my priorities and preferences.
Staff asks me about my strengths.
Staff ensures a private place in the office for me to share information.
Staff gives me their full attention.
Staff gives me positive feedback.
Staff acknowledges the things I am doing well.
Staff responds in a reasonable amount of time to my requests.
Staff sees me in a positive way.
Staff explains to me how my information may be shared with other professionals involved in my care.
Staff respects my choice of goals I want to work on.
Staff values what I say.
Staff interacts with me in a warm and caring manner.
Staff gives me the time and opportunity to respond.
Staff explains my rights about confidentiality.
Staff honors and respects my personal and cultural beliefs and values.

After consultation with Dr. Carol Trivette, it was decided to include some outcome statements that will measure the client's degree of self-efficacy. The self-efficacy beliefs are a central feature of the practice based theory of family centred help-giving, and have been included in almost every help-giving study conducted by Dunst, Hamby, and Trivette (Dunst, Trivette, and Hamby, 2008).

Self-efficacy is the belief that one is capable of performing in a certain manner to attain certain goals. Measuring self-efficacy is important because it moves the survey/scale beyond a satisfaction measure and measures how people feel about themselves. If people believe they can reach their goals then they can. You can't change behaviour until you change self-efficacy. An important part of changing self-efficacy is how people are treated by those they interact with regularly. Table 4 contains the 4 statements that measure self-efficacy that were included in the survey.

Table 4

Self-Efficacy/Outcome Statements
I access the resources I need when I need them.
I help other people get the services they need from Algoma Public Health.
My opinion is just as important as staff's opinions regarding the services I receive.
I am able to make good decisions about what services I need.

Table 5 shows how the survey statements relate back to the Algoma Public Health Guiding Principles (Table 1) as well as if they are relational, participatory, or outcome.

Table 5

Q. #	Survey Statements	Question Type
	1. Treat you with respect and dignity	
2	Staff explains things to me so I can understand.	Participatory
15	Staff sees me in a positive way.	Relational
22	Staff interacts with me in a warm and caring manner.	Relational
30	Staff honors and respects my personal and cultural beliefs and values.	Relational
	2. Honour your right to privacy.	
5	Staff ensures a private place in the office for me to share information.	Relational
10	Staff respects my choice around what information I choose to share.	Participatory
16	Staff explains to me how my information may be shared with other professionals involved in my care.	Relational
28	Staff explains my rights about confidentiality.	Relational
	3. Identify and build on your strengths to accomplish your goals.	
4	Staff asks me about my strengths.	Relational
7	Staff works with me to set my goals.	Participatory
9	Staff gives me positive feedback.	Relational
11	Staff acknowledges the things I am doing well.	Relational
14	Staff helps me use my strengths to reach my goals.	Participatory
17	Staff respects my choice of goals I want to work on.	Relational
	4. Listen to your concerns, needs and requests.	
1	Staff meets with me wherever I feel comfortable.	Relational
8	Staff gives me their full attention.	Relational
20	Staff values what I say.	Relational
27	Staff gives me the time and opportunity to respond.	Relational
	5. Provide timely, flexible and and individualized support.	
3	Staff acknowledges my priorities and preferences.	Relational
6	Staff gives me information about different kinds of resources and supports available to me.	Participatory
12	Staff responds in a reasonable amount of time to my requests.	Relational
21	Staff helps me access different kinds of resources and supports available to me.	Participatory
31	Staff is flexible in scheduling appointments with me.	Participatory
	6. Work with you to get what you need to make an informed decision.	
23	Staff supported my decision.	Participatory
24	Staff helps me identify the benefits and risks of different options before I make a decision.	Participatory
29	Staff and I worked together when I needed to make a decision.	Participatory
	7. Support your decisions within the limits of the law.	
26	Staff made me aware of when they are required by law to share my information with someone else.	Participatory

Table 5(con'd)

Q. #	Survey Statements	Question Type
	Self-Efficacy	
13	I access the resources I need when I need them.	Outcome
18	I help other people get the services they need from Algoma Public Health.	Outcome
19	My opinion is just as important as staff's opinions regarding the services I receive.	Outcome
25	I am able to make good decisions about what services I need.	Outcome

Survey Focus Group

Prior to distributing the Client Centred Care survey to clients in selected APH programs, two focus groups were held to get feedback on various aspects of the survey (i.e., preference of form, understanding of the 5-point scale, readability, and general likes and dislikes). The focus groups consisted of active clients of the Preschool Speech and Language Services at Algoma Public Health. These clients had significant interactions with the speech and language staff members. One of the focus groups had 4 participants while the other had 3 participants. All participants were female.

Focus group participants reviewed two surveys with identical content; one survey was printed on 8 ½ by 11 paper and the other one on 8 ½ by 14 paper. Some participants preferred the longer form as it was easier to read while others felt that the shorter form was "less daunting". Both groups gave positive feedback on the use of the 5-point scale and liked the neutral option of a rating of 3. They also stated that the descriptive labels (i.e., little or never, some of the time, most of the time, almost always and always) corresponded appropriately to the numerical values. All participants commented that the survey was easy to read and demonstrated understanding of terms such as "confidentiality" and "honour". Some participants mentioned that some of the questions were repetitive. In addition, the "I" questions or self-efficacy questions (e.g., "I am able to make good decisions about services that I need") were found to be somewhat confusing to the participants. Overall, participants of the focus group liked many aspects of the survey and stated that the survey was straightforward and easy to complete. After the focus groups, the survey was distributed.

Survey Distribution

Clients from the Healthy Babies Healthy Children (HBHC) home visiting program and clients from the Community Mental Health case management program were selected as the APH programs to pilot the Client Centred Care survey beginning in April 1, 2008. These two programs were selected because they involve significant interaction between client and staff to the point that there is time for a client/staff relationship to be established. For the HBHC home visiting program, the family support workers

distributed the survey and for the Community Mental Health home visiting program, the case managers gave out the survey during a home visit with their clients.

Participants in both these programs were provided with an explanation of the survey along with ethical information required for informed consent. It was decided not to have participants sign the informed consent, but rather the home visitor/case manager would review the information on the consent, provide an opportunity for questions, and distribute the survey and self-addressed stamped envelope. Clients involved in the Community Mental Health program have historically not responded well to signed consents, and it was felt a signed consent would be a participation barrier for them. The home visitor inserted the client's name on the consent form, and returned the consent to Algoma Public Health for filing. The survey included a check box for participants to indicate that the purpose of the survey had been explained to them.

In May 2008, the committee reviewed the survey response to date and decided that the targeted survey response of 200 surveys would not be achieved by June 2008. In an effort to increase the distribution rate, it was decided to distribute the survey to additional public health programs from the Parent Child Services office. These included classes facilitated by public health nurses such as prenatal classes and, *You and Your Baby* classes (a class for new moms and their infants under 6 months).

Clients accessing the Canada Prenatal Nutrition Program were also included. These clients are pregnant women experiencing financial hardships. For these programs, the procedure for informed consent was the same, except participants were given the option of completing the survey in the reception area and giving the completed survey to the receptionist in a sealed envelope or returning the completed survey to the facilitator at the next class in the sealed envelope. Survey distribution was extended until October 31, 2008. The original survey with 31 statements is found in Appendix B. The Participant Information Sheet and Consent Form and survey are found in Appendix C.

Results

Frequency distributions were calculated for the 135 survey participants on their demographic information to gain a better understanding of the participant characteristics. This information is shown in Tables 5 to 8.

Table 6 provides background information on length of time in an Algoma Public Health program. Overall 42% of participants had received services from the health unit for less than one year. A higher percentage of Community Mental Health Program participants have been receiving services for longer than participants in the HBHC Program and the other Parent Child Services.

Table 6

Length of Time in Program

	Community Mental Health		Healthy Babies Health Children		Parent Child Services		Grand Total	
Length of time in program	Count	%	Count	%	Count	%	Count	%
1 year or less	16	19	17	68	24	89	57	42
1 to 2 years	39	47	5	20	1	4	45	33
3 or more years	22	27	1	4	0	0	23	17
No answer	6	7	2	8	2	7	10	7
Grand Total	**83**	**100**	**25**	**100**	**27**	**100**	**135**	**100**

Table 7 provides information on the participants' highest level of education. Overall 52% of the participants had at least some college or university experience with 24% having graduated from college or university. High school graduate was the highest level of education for 32% of the participants. Parent Child Services had the highest percentage of participants with at least some college or university education (74%) while the other 2 programs had considerably lower percentages of participants with higher education with the HBHC program at 36% and the Community Mental Health Program at 37%.

Table 7

Highest Level of Education

	Community Mental Health		Healthy Babies Healthy Children		Parent Child Services		Grand Total	
Highest education level	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Grade 8	3	4	0	0	0	0	3	2
Some high school	10	12	7	28	2	7	19	14
High school graduate	31	37	9	36	3	11	43	32
Some college/university	16	19	7	28	4	15	27	20
College/university graduate	15	18	2	8	16	59	33	24
Other	4	5	0	0	0	0	4	3
No answer	4	5	0	0	2	7	6	4
Grand Total	**83**	**100**	**25**	**100**	**27**	**100**	**135**	**100**

Table 8 provides information on the gender of the participants. Overall, the majority of the participants were females (69%). The Community Mental Health program had 54% female participants while both the other 2 programs had a higher percentage of female participants with Healthy Babies Healthy Children at 96% and Parent Child Services at 89%.

This is reflective of the higher percentage of females participating in these two programs.

Table 8

Participants' Program by Gender

	Community Mental Health		Healthy Babies Healthy Children		Parent Child Services		Grand Total	
Gender	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Female	45	54	24	96	24	89	93	69
Male	23	28	1	4	2	7	26	19
No Answer	8	10	0	0	1	4	9	7
Other Answer	7	8	0	0	0	0	7	5
Grand Total	**83**	**100**	**25**	**100**	**27**	**100**	**135**	**100**

Table 9 provides information on the ages of the participants that ranged from under 19 to over 60 years of age. Forty-four percent of participants were under 40 years old and 53% of participants were over 40 years old. In the Community Mental Health program, 86% of participants were 40 years and over. In the 2 programs geared to parents and young children, 96% of Healthy Babies Healthy Children participants and 93% of Parent Child Services participants were 39 years or younger.

Table 9

Participants' Program by Age Group

	Community Mental Health		Healthy Babies Healthy Children		Parent Child Services		Grand Total	
Age (years)	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
19 and under	0	0	3	12	2	7	5	4
20-29	3	4	14	56	14	52	31	23
30-39	8	10	7	28	9	33	24	18
19-39	**11**	**13**	**24**	**96**	**25**	**93**	**60**	**44**
40-49	47	57	0	0	1	4	48	36
50-59	19	23	0	0	0	0	19	14
60 & over	5	6	0	0	0	0	5	4
40-60 and over	**71**	**86**	**0**	**0**	**1**	**4**	**72**	**53**
No answer	1	1	1	4	1	4	3	2
Grand Total	**83**	**100**	**25**	**100**	**27**	**100**	**135**	**100**

We used a procedure called factor analysis to determine how well the scale items were measuring (client centred practices and self efficacy). The procedure looks at the correlations between the item scores to determine if using a total scale score is justified. In those cases where one total score is not justified, the procedure yields a two scale or

factor solution. The degree to which each item relates to the factor is called the factor loading. The factor loadings for the two factor model of the 16 relational questions are presented in Table 10.

Table 10

Relational items with Q5 included

Sorted Rotated Factor Loadings (Pattern)			
Q#	**Question**	**Factor 1**	**Factor 2**
Q22.	Staff interacts with me in a warm and caring manner.	0.93	0.00
Q15.	Staff sees me in a positive way.	0.93	0.00
Q20.	Staff values what I say.	0.90	0.00
Q1.	Staff meets with me wherever I feel comfortable.	0.89	0.00
Q30.	Staff honors and respects my personal and cultural beliefs and values.	0.88	0.00
Q3.	Staff acknowledges my priorities and preferences.	0.84	0.00
Q27.	Staff gives me the time and opportunity to respond.	0.83	0.00
Q8.	Staff gives me their full attention.	0.79	0.00
Q9.	Staff gives me positive feedback.	0.78	0.00
Q11.	Staff acknowledges the things I am doing well.	0.71	0.25
Q17.	Staff respects my choice of goals I want to work on.	0.64	0.00
Q28.	Staff explains my rights about confidentiality.	0.62	0.31
Q4.	Staff asks me about my strengths.	0.55	0.28
Q5.	Staff ensures a private place in the office for me to share information.	0.00	0.90
Q16.	Staff explains to me how my information may be shared with other professionals involved in my care.	0.26	0.61
Q12.	Staff responds in a reasonable amount of time to my requests.	0.38	0.52

Note that only question 5 (“Staff ensures a private place in the office for me to share information”) had a high loading factor for the second index. In other words, question 5 did not fit the overall pattern of the other questions. We thus ran a factor analysis in which we eliminated question 5. Table 11 shows the factor loadings of those remaining 15 relational questions. Note that once question 5 was removed from the analysis, a one-factor model was justified.

Table 11

Relational items with Q5 excluded

Sorted Rotated Factor Loadings (Pattern)		
Q #	**Question**	**Factor 1**
Q15.	Staff sees me in a positive way.	0.92
Q27.	Staff gives me the time and opportunity to respond.	0.89
Q20.	Staff values what I say.	0.87
Q9.	Staff gives me positive feedback.	0.87
Q11.	Staff acknowledges the things I am doing well.	0.85
Q22.	Staff interacts with me in a warm and caring manner.	0.84
Q8.	Staff gives me their full attention.	0.82
Q30.	Staff honors and respects my personal and cultural beliefs and values.	0.82
Q28.	Staff explains my rights about confidentiality.	0.80
Q3.	Staff acknowledges my priorities and preferences.	0.78
Q1.	Staff meets with me wherever I feel comfortable.	0.75
Q4.	Staff asks me about my strengths.	0.74
Q12.	Staff responds in a reasonable amount of time to my requests.	0.73
Q17.	Staff respects my choice of goals I want to work on.	0.72
Q16.	Staff explains to me how my information may be shared with other professionals involved in my care.	0.66

Likewise, Table 12 shows the factor loadings of the 11 participatory questions. A one-factor model i.e. a total scale score is justified to capture the information in these 11 questions.

Table 12

Participatory items

Sorted Rotated Factor Loadings (Pattern)		
Q #	**Question**	**Factor 1**
Q14.	Staff helps me use my strengths to reach my goals.	0.89
Q29.	Staff and I worked together when I needed to make a decision.	0.87
Q10.	Staff respects my choice around what information I choose to share.	0.83
Q2.	Staff explains things to me so I can understand.	0.83
Q24.	Staff helps me identify the benefits and risks of different options before I make a decision.	0.83
Q23.	Staff supported my decision.	0.82
Q21.	Staff helps me access different kinds of resources and supports available to me.	0.79
Q7.	Staff works with me to set my goals.	0.77
Q26.	Staff made me aware of when they are required by law to share my information with someone else.	0.74
Q6.	Staff gives me information about different kinds of resources and supports available to me.	0.71
Q31.	Staff is flexible in scheduling appointments with me.	0.68

Finally, Table 13 shows the factor loadings of the 4 self-efficacy questions. Again, a one-factor model i.e. a total scale score was justified for representing the information in these four questions.

Table 13

Outcome items

		Sorted Rotated Factor Loadings (Pattern)
Q #	**Question**	**Factor 1**
Q13.	I access the resources I need when I need them.	0.87
Q25.	I am able to make good decisions about what services I need.	0.81
Q19.	My opinion is just as important as staff's opinions regarding the services I receive.	0.80
Q18.	I help other people get the services they need from Algoma Public Health.	0.70

How Self Efficacy is affected by Participants' Characteristics and Relational and Participatory Variables

Both components of client centred help-giving (relational and participatory) were significantly correlated with the self-efficacy outcomes. The correlation between relational help-giving and self-efficacy was $r = .67$; the correlation between participatory help giving and self-efficacy was $r = .72$. Both these correlations are considered strong. These results indicate a strong relationship between being treated in a client centred manner and participants' perceptions of self-efficacy.

It is interesting to note that for the help-giving statements for both relational and participatory, we found that age, education, and time in program did not effect how clients responded to these statements (Table 14).

Table 14

Correlations between participant characteristics, client centred help-giving and self-efficacy outcomes

	Participant			Helpgiving	
Items	Age	Education Level	Time in Program	Relational	Participatory
Age					
Education level	.01	-			
Time in program	.48	-.16	-		
Relational helpgiving	.02	.08	.01	-	
Participatory helpgiving	-.00	.06	-.00	.95	-
Self-efficacy outcomes	-.15	.00	-.11	.67	.72

Discussion

The purpose of piloting the Client Centred Care survey with selected Algoma Public Health programs was to determine if the statements included in the survey were actually measuring if clients thought that Algoma Public Health staff were displaying client centered behaviours during client interactions. The next section describes how factor analysis was used to develop the final scale comprised of relational, participatory and outcome statements.

Based on the factor analysis we can now determine the questions with weaker correlations. After re-examining the content of the survey, we decided that it would be beneficial from a client perspective to shorten our survey from 31 questions to 26 questions. This factor analysis guided us in making decisions on the questions to eliminate based on the item loadings in each factor. The remaining questions make up a final version of the survey that will be administered to all APH client based programs.

Relational Statements

Based on the factor loadings for the 16 relational statements as shown in Table 10, the loadings of the first 12 statements (22, 15, 20, 1, 30, 3, 27, 8, 9, 11, 17, and 28) ranged from .93 to .64. As noted previously, statement 5, “Staff ensures a private place in the office for me to share information” did not fit the overall pattern of the other questions. A second factor analysis was run with statement 5 eliminated. Table 11 shows the factor loadings of those remaining 15 relational statements. Note that once statement 5 was removed from the analysis, a one-factor model was found. For the relational statements, we decided to eliminate the 4 statements with the lowest loadings based on the first factor analysis.

The eliminated relational statements include:

Q4.	Staff asks me about my strengths.
Q5.	Staff ensures a private place in the office for me to share information.
Q16.	Staff explains to me how my information may be shared with other professionals involved in my care.
Q12.	Staff responds in a reasonable amount of time to my requests.

The remaining 12 relational statements will be included in the revised shorter version of the survey.

Participatory Statements

The factor loadings for the participatory statements in table 12 ranged from .89 to .68. Keeping our goal in mind of shortening the survey, as well as balancing the three types of questions, Question 31 “Staff is flexible in scheduling appointments with me” was eliminated from the survey as it had the lowest loading of .68. We realize that this may be considered a strong loading in other analyses, in serving our purposes of decreasing the number of statements in our survey; it was eliminated solely of the basis of its lowest loading.

The remaining 10 participatory statements will be included in the shorter version of the survey.

Outcome (Self-Efficacy) Statements

The factor loadings for the 4 outcome (self-efficacy) questions ranged from .87 to .70 indicating strong loading for this set of statements, (Table 13). These 4 statements will be included in the shorter version of the survey.

The revised shorter survey version with 26 questions is found in Appendix D.

Next Steps

The revised validated survey will be administered to programs at Algoma Public Health in Fall 2009 and will serve as the baseline for subsequent Client Centred Care surveys.

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APPENDIX A

Themes used to Group the Client Centred Behaviours identified by APH Staff

The table below lists the themes that emerged during the analysis of staff behaviours. These themes were used to develop the statements in the Client Centred Care client survey.

Themes used in Developing the Client Centred Care Client Survey	
access	flexibility
advocacy	follow through
advocate	full attention
body	full attention and empathy
choice	golden rule
circle of care	greet
closure	group
communication	individual
consent	judgement
continuity	life event
contractual	mandate
culture	nonjudgemental
diffuse	nonverbal
dress	parameters
education	participation
empathy	positive light
environment	practice reflection
evaluate	professionalism
evaluation	respect

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APPENDIX B
Original Survey - 31 Questions
CLIENT CENTERED SURVEY

The purpose of the survey has been explained to me and I agree to fill it out ☐

Instructions:

- Please circle the response that best describes your point of view.

	Little or Never	Some of the Time	Most of the Time	Almost Always	Always
Staff meets with me wherever I feel comfortable.	1	2	3	4	5
Staff explains things to me so I can understand.	1	2	3	4	5
Staff acknowledges my priorities and preferences	1	2	3	4	5
Staff asks me about my strengths.	1	2	3	4	5
Staff ensures a private place in the office for me to share information.	1	2	3	4	5
Staff gives me information about different kinds of resources and supports available to me.	1	2	3	4	5
Staff works with me to set my goals.	1	2	3	4	5
Staff gives me their full attention.	1	2	3	4	5
Staff gives me positive feedback.	1	2	3	4	5
Staff respects my choice around what information I choose to share.	1	2	3	4	5
Staff acknowledges the things I am doing well.	1	2	3	4	5
Staff responds in a reasonable amount of time to my requests.	1	2	3	4	5
I access the resources I need when I need them.	1	2	3	4	5
Staff helps me use my strengths to reach my goals.	1	2	3	4	5
Staff sees me in a positive way.	1	2	3	4	5
Staff explains to me how my information may be shared with other professionals involved in my care.	1	2	3	4	5
Staff respects my choice of goals I want to work on.	1	2	3	4	5
I help other people get the services they need from Algoma Public Health.	1	2	3	4	5

	Little or Never	Some of the Time	Most of the Time	Almost Always	Always
My opinion is just as important as staff's opinions regarding the services I receive.	1	2	3	4	5
Staff values what I say.	1	2	3	4	5
Staff helps me access different kinds of resources and supports available to me.	1	2	3	4	5
Staff interacts with me in a warm and caring manner.	1	2	3	4	5
Staff supported my decision.	1	2	3	4	5
Staff helps me identify the benefits and risks of different options before I make a decision.	1	2	3	4	5
I am able to make good decisions about what services I need.	1	2	3	4	5
Staff made me aware of when they are required by law to share my information with someone else.	1	2	3	4	5
Staff gives me the time and opportunity to respond.	1	2	3	4	5
Staff explains my rights about confidentiality.	1	2	3	4	5
Staff and I worked together when I needed to make a decision.	1	2	3	4	5
Staff honours and respects my personal and cultural beliefs and values.	1	2	3	4	5
Staff is flexible in scheduling appointments with me.	1	2	3	4	5

Length of Time in Program: Less than 6 months___ 6 months to 1 year___ 1 to 2 years_____ 3 years or more ___

Highest Education Level: Some High School___ High School Graduate___ Some College/University___ College/University Graduate___ Other____

Age in Years: 19 and under___ 20 to 29___ 30 to 39___ 40 to 49___ 50 to 59___ 60 and over___

Sex: Male___ Female___ Other___

COMMENTS

Thank you for your time.

APPENDIX C

Client Centered Care Pilot Survey
Participant Information Sheet and Consent Form

To be read to the participant before providing the survey, home visitor obtains informed consent then signs and dates the consent. The home visitor who signed the consent ensures that the signed copy is returned to Algoma Public Health for filing with the assigned corporate clerical staff.

We want to know how our clients feel about Algoma Public Health services. We plan on using a survey to find this out, and wish to test the survey on a small group of people.

Your participation will help Algoma Public Health develop a final survey to be used with Algoma Public Health clients in the future.

The survey will take about 15 minutes to complete.

You do not need to complete this survey to receive services at Algoma Public Health.

Your participation is voluntary and you can decide not to complete the survey at any time. Your name will not be attached to the survey.

This information and consent form will be kept in a separate locked cupboard at Algoma Public Health for the length of this project, and will be shredded when this project is completed.

Please return the completed survey in the self addressed stamped envelope provided today with the survey.

You can ask someone to help you complete the survey, as an APH employee I cannot help you complete the survey.

If you have questions about the survey contact myself as your case manager or home visitor.

Algoma Public Health appreciates and values your opinion.

Thank you for taking the time to complete the survey

I now need to confirm the following with you

- I have reviewed this information sheet with you.
- I have provided an opportunity for questions, and answered your questions.
- I have provided the survey and self addressed envelope.

_____
Client name

_____ _____
Signature of staff obtaining consent Date (dd/mm/yy)

APPENDIX D
Revised Survey -26 Questions
How are we doing?
Client Centered Care Survey

The purpose of the survey has been explained to me and I agree to fill it out ☐

Instructions:

- Please circle the response that best describes your point of view.

	Little or Never	Some of the Time	Most of the Time	Almost Always	Always
Staff meets with me wherever I feel comfortable.	1	2	3	4	5
Staff explains things to me so I can understand.	1	2	3	4	5
Staff acknowledges my priorities and preferences.	1	2	3	4	5
Staff gives me information about different kinds of resources and supports available to me.	1	2	3	4	5
Staff works with me to set my goals.	1	2	3	4	5
Staff gives me their full attention.	1	2	3	4	5
Staff gives me positive feedback.	1	2	3	4	5
Staff respects my choice around what information I choose to share.	1	2	3	4	5
Staff acknowledges the things I am doing well.	1	2	3	4	5
I access the resources I need when I need them**.**	1	2	3	4	5
Staff helps me use my strengths to reach my goals.	1	2	3	4	5
Staff sees me in a positive way.	1	2	3	4	5
Staff respects my choice of goals I want to work on.	1	2	3	4	5
I help other people by telling them about the services they can get from Algoma Public Health.	1	2	3	4	5
My opinion is just as important as staff's opinions regarding the services I receive.	1	2	3	4	5
Staff values what I say.	1	2	3	4	5
Staff helps me access different kinds of resources and supports available to me.	1	2	3	4	5

	Little or Never	Some of the Time	Most of the Time	Almost Always	Always
Staff interacts with me in a warm and caring manner.	1	2	3	4	5
Staff supported my decision.	1	2	3	4	5
Staff helps me identify the benefits and risks of different options before I make a decision**.**	1	2	3	4	5
I am able to make good decisions about what services I need.	1	2	3	4	5
Staff made me aware of when they are required by law to share my information with someone else.	1	2	3	4	5
Staff gives me the time and opportunity to respond.	1	2	3	4	5
Staff explains my rights about confidentiality**.**	1	2	3	4	5
Staff and I worked together when I needed to make a decision.	1	2	3	4	5
Staff honours and respects my personal and cultural beliefs and values.	1	2	3	4	5

Length of Time in Program: Less than 6 months___ 6 months to 1 year___ 1 to 2 years_____
3 years or more ___

Highest Education Level: Some High School___ High School Graduate___ Some College/University___
College/University Graduate___ Other____

Age in Years: 19 and under___ 20 to 29___ 30 to 39___ 40 to 49___ 50 to 59___ 60 and over___

Sex: Male___ Female___ Other___

COMMENTS

Thank you for your time.