

## SERVICE EVALUATION

# Analysis of patient satisfaction scores in response to a change in physiotherapy service provision for women with pregnancy-related pelvic girdle pain

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### Abstract

Pregnancy-related pelvic girdle pain (PPGP) is a common condition that affects approximately 20% of the pregnant population. Physiotherapy is often chosen as an intervention in the management of this condition. The experience of a local National Health Service women's health physiotherapy department led to a service evaluation to find out why patient experience appeared to be poor. Many patient concerns had been raised via the management team regarding the physiotherapy process for those suffering from PPGP. It was decided to assess the situation with pre- and post-physiotherapy patient satisfaction questionnaires alongside the Pelvic Girdle Questionnaire, which is currently used as a clinical outcome measure. Of those invited to participate in this survey, 70% completed the first questionnaire and 34% completed the second. Four main themes that affected patient experience emerged from the data analysis: pain, accessibility, communication and outcome. For example, if patients could access the physiotherapy department easily, and if they were offered an appointment in a timely manner, communicated with clearly and enjoyed some clinical improvements, then their expectations were met and they reported high levels of satisfaction. Of the patients who received physiotherapy intervention, 69% ( $n=33$ ) clinically improved, demonstrating reduced pain and increased mobility and function. In conclusion, it is extremely important to listen to, evaluate and change service provision as required in order to improve the patients' experience as they seek help for PPGP, which is often a very debilitating condition.

*Keywords:* patient satisfaction scores, pregnancy-related pelvic girdle pain, service provision.

### Introduction

Pregnancy-related pelvic girdle pain (PPGP) is a common condition that affects approximately 20% of pregnant women (POGP 2015a). Physiotherapy is often used to manage this condition, and the treatment options include: advice, education, individual stabilizing exercises, group exercise classes, acupuncture, hydrotherapy, and the provision of elbow crutches and support belts (Vleeming *et al.* 2008; RCOG 2015). Through the National Health Service (NHS) and private practice, physiotherapists often attempt to manage and even improve the symptoms

experienced by patients with PPGP. Doyle *et al.* (2013) described clinical effectiveness, patient safety and patient experience as the three pillars of quality in healthcare. The aim of the present article is to take a closer look at the patient experience element of this interdependent classification.

Because of several patient concerns relating to the method by which referrals for PPGP were managed in a local National Health Service (NHS) women's health physiotherapy department, an analysis of patient satisfaction was completed. This service evaluation led to several alterations to the women's health physiotherapy service provision for this patient population. The alterations were designed to improve patient satisfaction, reduce unnecessary waiting time for patients, and

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ultimately, improve clinical outcomes, thereby reducing the ratio of new to follow-up cases and easing the overall pressure on the women's health physiotherapy service (Fig. 1).

#### *Problems with the initial service provision*

The following problems with the initial service provision were identified:

- (1) dependence on the patients' ability to decide on the best treatment for them;
- (2) a variable waiting list, ranging from 2 to 9 weeks;
- (3) increased anxiety and dissatisfaction when initial patient expectations were not met;
- (4) high non-attendance rates for the education session and follow-up appointments; and
- (5) limited screening for red flags or other pregnancy-related complications.

The survey highlighted the fact that many patients did not feel confident enough to decide on the best treatment option for them. They often opted for an individual assessment with the physiotherapist because they thought that this was the safest option. Patients wanted and needed input from the physiotherapist on an individual level. It became clear that it was not appropriate to ask patients to make such a choice about the treatment they received. The data suggest that this seems to be one of the main causes of patient dissatisfaction. Participants also reported: dissatisfaction with long waiting times; difficulties with access to the hospital, especially at busy or peak times; and exasperation over the difficulty they experienced when trying to contact the department by telephone. Therefore, the patients' expectations of physiotherapy were not met, resulting in regular reports of anxiety that their symptoms would not be managed effectively, and that they would be left in pain and dysfunction, often fearful of the childbirth process that lay ahead of them.

#### *New service provision*

These results were discussed by the women's health physiotherapy team, and alterations were made to the service provision that were trialled over a period of 6 months.

The first change was to cancel the education session and ask women to download the booklet about PGP for mothers-to-be and new mothers from the POGP website (POGP 2015b). Much of the education session was based on the information held in this booklet, and therefore, women were empowered to read the information for themselves.

The first appointment with physiotherapy then became a triage appointment, in which 10 min were allocated for the physiotherapist to conduct essential assessment and screening. The patients had to complete a pre-screening self-assessment questionnaire, which included: the Pelvic Girdle Questionnaire outcome measure (Stuge *et al.* 2011); red-flag screening; recording a pain score on a visual analogue scale; and standard subjective assessment questions (Petty & Moore 2001). This questionnaire was screened by the physiotherapist, and objective assessments, such as lumbar range of movement, the Trendelenburg test, the active straight leg raise test and observations of various daily activities, were completed according to the recommendations found in the European guidelines for the diagnosis and treatment of PGP (Vleeming *et al.* 2008).

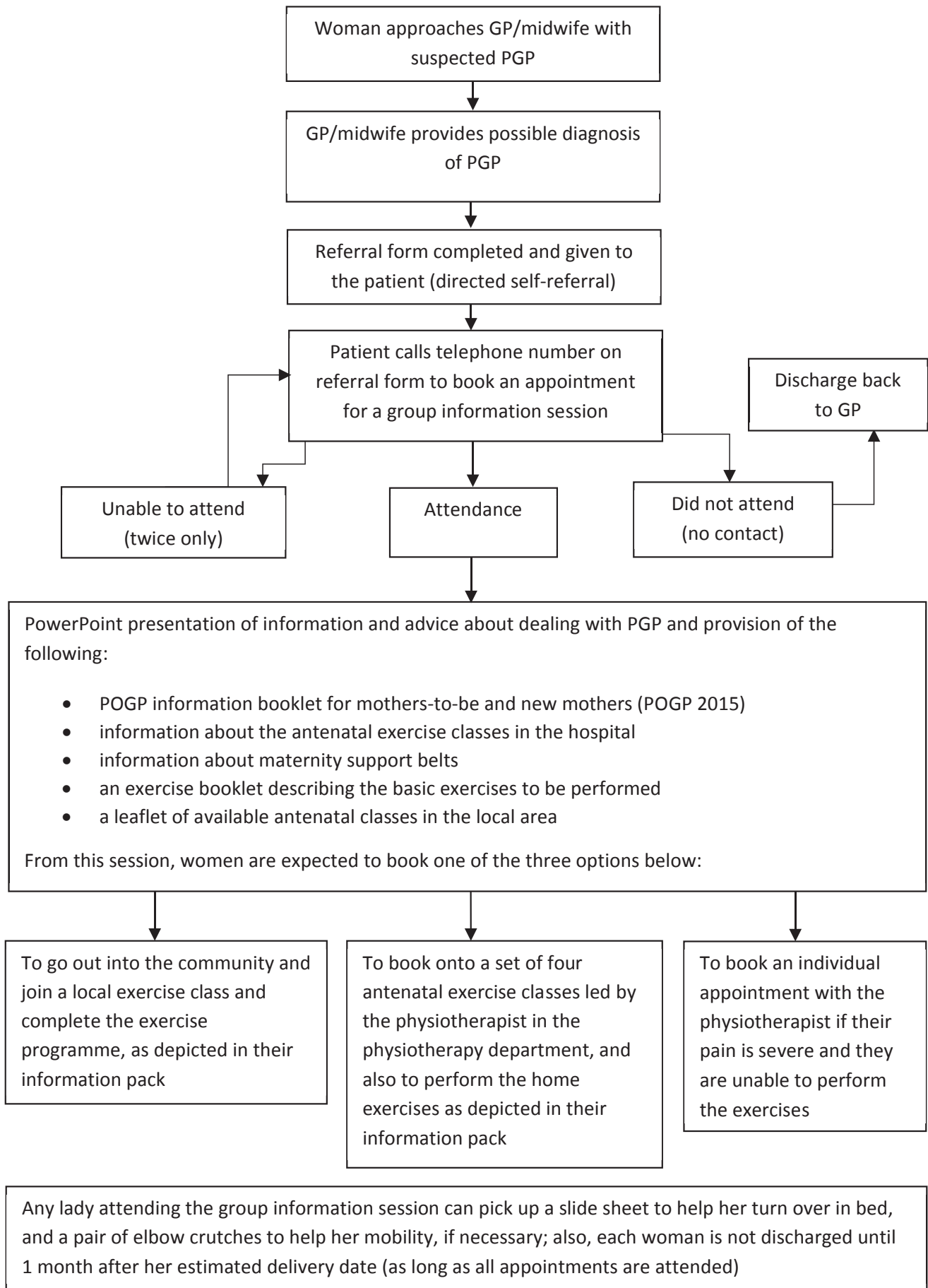
This triage appointment equipped the physiotherapist with the ability to select the most appropriate form of treatment for each individual. The treatment options remained the same as those for the previous service provision, but with the addition of a "fast track" to hydrotherapy for those who fulfilled the criteria.

#### **Participants and methods**

Following the service evaluation and alteration, a new set of patients were asked to complete the satisfaction questionnaires both before and after 4–6 weeks of physiotherapy intervention, as previously administered. The questions related to access and waiting times, expectations of physiotherapy, goals, and outcomes (both clinical and functional). The questionnaires were collected, and the results were entered into a database and then analysed using qualitative research methods. The data were categorized according to response type and content, and each similar category was combined until the main themes emerged.

#### **Results**

Respectively, the response rates for the first and second questionnaires were 70% and 34% (48% of those who completed the first). Of those patients who completed the first questionnaire, 66% were either satisfied or very satisfied with their care prior to attending their first physiotherapy appointment. Of those who completed the second questionnaire after receiving 4–6 weeks of physiotherapy intervention, 94% were either satisfied or very satisfied with the care that they had received. These significant



**Figure 1.** Flowchart depicting physiotherapy service provision prior to evaluation and alteration: (GP) general practitioner; (PGP) pelvic girdle pain; and (POGP) Pelvic, Obstetric and Gynaecological Physiotherapy.

percentages suggest a high overall satisfaction rating following the change in service provision.

Of the 70% of patients who completed the first questionnaire, 85% now waited 2–4 weeks to see a physiotherapist, as opposed to 9 weeks. Therefore, patients are waiting for a shorter time, and are more satisfied with their care both before and after physiotherapy. However, 69% of patients demonstrated an improvement in their symptoms, which is a similar score to the data retrieved prior to the service alteration. This seems to suggest that improving patient satisfaction is not necessarily linked to clinical or functional improvements.

## Discussion

The European guidelines (Vleeming *et al.* 2008) suggest individualized exercises for stability and control of the pelvis. However, in the NHS environment, it has been impossible to provide this level of service without dramatically increasing the waiting list. We have striven to overcome this shortcoming by providing a 4-week exercise class based on the principles of Pilates that is intended to strengthen core stabilizing muscles, increase the flexibility of notoriously tight muscles and improve general posture. These classes involve patient education and advice about activities of daily living, the avoidance of aggravating factors and so on.

When patients struggle to complete a land-based exercise class or the triage process because of the severity of their symptoms, they are fast tracked to hydrotherapy. The physiotherapist or assistant completes a full and thorough screening process prior to admission. Once admitted to hydrotherapy, patients attend for 4 weeks before being reviewed in a similar manner to that of the initial triage appointment. If their symptoms and function improve, they are progressed to the land-based exercise class, but if these are the same, they are given a further 4 weeks in the hydrotherapy pool.

Patients who report a worsening in their symptoms, despite intervention, are invited to an individual appointment with the physiotherapist. During this meeting, the advice is reiterated, and patients are requested to reconsider their daily activities, working practices, lifting, carrying and so on. Then they are fully assessed to find out if they require manual therapy or an alteration to their exercise technique.

The whole process is designed to be flexible and responsive to changes in patients' circumstances

and symptoms. However, this whole process is dependent on several factors:

- (1) human resources;
- (2) administrative resources;
- (3) accessibility;
- (4) time;
- (5) competence;
- (6) communication; and
- (7) multidisciplinary working.

The human resources required to run this level of service are: a qualified physiotherapist or physiotherapists, ideally at a band 6 level, with approximately 16 h available each week; and a physiotherapy assistant or technician who is competent in dealing with this patient group with approximately 6 h available each week. A department that has room availability is also essential (e.g. a gymnasium or large area for group exercise provision, and a hydrotherapy pool). Furthermore, all staff must be trained in dealing with PPGP both before and after childbirth. There is a heavy reliance upon effective communication and action within the physiotherapy department and among the entire multidisciplinary team (especially between the physiotherapy and midwifery teams). If all these factors work well, the process is smooth, and patients move on to treatment knowing what to expect at each stage. If any one of these factors does not work, the risk of failure to meet expectations is very real, and this can easily lead to patient dissatisfaction and non-compliance.

## Conclusion

The alterations to physiotherapy service provision described above have brought about an improvement in patients' experiences. However, the evidence of little or no change in clinical and functional outcomes places a question mark over the efficacy of the specific physiotherapy treatment provided. The present results demonstrate an improvement in the process of managing referrals, but work still needs to be done to evaluate the most-effective, evidence-based and appropriate treatment options for this group of patients.

## Recommendations

From this conclusion, it is recommended that the new service provision continues as a method of dealing with the referrals and waiting list for PPGP. However, further research in the form of literature searches, discussions, in-service training, and benchmarking across health boards and

private practice, where possible, should be undertaken to establish the most effective form of treatment for this specific group of patients. A review should be planned within 6–12 months to assess any differences in both clinical and functional outcomes following any changes to physiotherapy practice.

A useful evidence-based clinical guideline for the management of PPGP has been produced by Chartered Physiotherapists in Women's Health and Continence, and the Directorate of Strategy and Clinical Programmes, Health Service Executive of Ireland (CPWHC & DSCPHSE 2012). This may be a valuable resource to use along with the European guidelines (Vleeming *et al.* 2008) when deciding upon the best course of clinical action over the next few years.

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### References

- Chartered Physiotherapists in Women's Health and Continence (CPWHC) & Directorate of Strategy and Clinical Programmes, Health Service Executive (DSCPHSE) (2012) *Clinical Practice Guideline: Management of Pelvic Girdle Pain in Pregnancy and Post-Partum*. [WWW document.] URL <http://www.hse.ie/eng/about/Who/clinical/natclinprog/obsandgynaeprogramme/no16.pdf>
- Doyle C., Lennox L. & Bell D. (2013) A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open* **3**: e001570. DOI: 10.1136/bmjopen-2012-001570.

- Pelvic, Obstetric and Gynaecological Physiotherapy (POGP) (2015a) *Pregnancy-related Pelvic Girdle Pain*. [WWW document.] URL <http://pogp.csp.org.uk/publications/pregnancy-related-pelvic-girdle-pain-pgp-health-professionals>
- Pelvic, Obstetric and Gynaecological Physiotherapy (POGP) (2015b) *Pregnancy-related Pelvic Girdle Pain*. [WWW document.] URL <http://pogp.csp.org.uk/publications/pregnancy-related-pelvic-girdle-pain-mothers-be-new-mothers>
- Petty N. J. & Moore A. P. (2001) *Neuromusculoskeletal Examination and Assessment: A Handbook for Therapists*, 2<sup>nd</sup> edn. Churchill Livingstone.
- Royal College of Obstetricians and Gynaecologists (RCOG) (2015) *Pelvic Girdle Pain and Pregnancy*. [WWW document.] URL <https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-pelvic-girdle-pain-and-pregnancy.pdf>
- Stuge B., Garratt A., Krogstad Jenssen K. & Grotle M. (2011) The Pelvic Girdle Questionnaire: a condition-specific instrument for assessing activity limitations and symptoms in people with pelvic girdle pain. *Physical Therapy* **91** (7), 1096–1108.
- Vleeming A., Albert H. B., Östgaard H. C., Stureson B. & Stuge B. (2008) European guidelines for the diagnosis and treatment of pelvic girdle pain. *European Spine Journal* **17** (6), 794–819.

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