PATIENT SATISFACTION WITH THE QUALITY OF NURSING CARE RENDERED IN PUBLIC HOSPITALS WITHIN MAKHADO MUNICIPALITY OF LIMPOPO PROVINCE: SOUTH AFRICA

by

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DECLARATION

I declare that **PATIENT SATISFACTION WITH THE QUALITY OF NURSING CARE RENDERED IN PUBLIC HOSPITALS WITHIN MAKHADO MUNICIPALITY OF LIMPOPO PROVINCE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

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PATIENT SATISFACTION WITH THE QUALITY OF NURSING CARE RENDERED IN PUBLIC HOSPITALS WITHIN MAKHADO MUNICIPALITY OF LIMPOPO PROVINCE: SOUTH AFRICA

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ABSTRACT

Background: Patient satisfaction has become an important indicator to measure the quality of care rendered to the patients while in hospital. Patient satisfaction surveys can help identify ways of improving nursing and health care services. The purpose of this study was to assess the patient satisfaction with nursing care in selected public hospitals.

Methods: A non-experimental, exploratory, descriptive design was used to obtain data by means of questionnaires. The population of this study consisted of all patients admitted in all two sampled hospitals of Vhembe district in Limpopo province. Respondents were selected by probability, systematic random sampling of 200 men and women who were admitted in the sampled public hospital at the time of data collections were recruited to participate in this study. A questionnaire with open and close ended questions was used to collect data.

Results: This study found that mean patient satisfaction with nursing care rendered score was significantly low at public hospitals (49.3%), the majority of the respondents (71.8%) reported that nurses do not respond on calls, helpless patients were not fed by

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(63.7%) respondents. However, communication and offering emotional support dimensions of nursing care had lowest score (9.3%).

Conclusion: Therefore, it is recommended to plan and implement the training programmes needed for nurses to improve their knowledge and skills of communication and use of emotional support measures for the patients.

Key words: Health, patient, patient satisfaction, nurse, nursing care, quality care, public hospital.

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DEDICATION

This work is dedicated to my late parents Mr and Mrs Chuuchuu who did not live longer enough to witness its completion, to my children Mutsitsielwa, Simon, Rotondwa and Vhukhudo and to the rest of the patients in the public hospitals as well as those treated at the Public Clinics and Health Centers.

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List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ALOS	Average length of stay
DOH	Department of Health
DPSA	Department of Public Service and Administration
HIV	Human Immunodeficiency Virus
LP	Limpopo Province
SA	South Africa
SANC	South African Nursing Council
SPSS	Statistical Package for Social Science
RSA	Republic of South Africa
UK	United Kingdom
USA	United State of America
WHO	World Health Organization.
WPTPS	White Paper on Transformation of Public Services

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Members of the public, prospective customers of healthcare services and stakeholders in general have often commented that a healthcare organisation is rated by the quality of nursing care it gives. Most of the healthcare organisations are investing into consumer care training so that quality care is given and patient satisfaction is attained. Nurses who spend more of their duty time at the bed side of the patient than any other healthcare provider are a very close link between patients and healthcare organisations. It is clear that nothing matters to the patient more than nursing which transcends all other aspects of the hospital experience. Seeking to understand patient satisfaction is an important step in the efforts to improve the quality of healthcare (Lumadi & Buch, 2011:14). The researcher is a professional nurse employed in one of Vhembe District public hospitals within Makhado Municipality. She served as a quality assurance manager and has an experience of fourteen years in quality assurance office and is involved in monitoring of patient's satisfaction on daily bases within her institution and around the district. Observations on daily practice revealed the importance of quality care provision to patients in public hospitals.

Because of the nature of her work, she often becomes part of the solution to such dissatisfactions that the patients forward to the hospital managers. It is in this light that the researcher felt that there is a need to research on whether the patients who were admitted in surgical and medical wards of the public hospitals within Makhado Municipality of Vhembe District within Limpopo Province are satisfied with the quality of care provided by the nursing staff.

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1.2 BACKGROUND OF THE STUDY

The Institute of Medicine (2004:23) in the United State of America (USA) found that mortality and morbidity reports showed that more than 44,000 Americans died each year due to medical and other avoidable errors, small children accounting for more errors than adults. This is also a matter of concern in the whole world and avoidable errors continue to be the eighth leading cause of deaths (Muller, 2001:605). Jones, Pearson, Cowsey, Bertal, Barett, White, White and Gillmour (2006:948) carried out a study and put forward the view from the findings that patients on chemotherapy were dissatisfied about lack of the information since they were not informed about the side effects of the treatment they received nor oriented to the environment that they were nursed in. A similar study was conducted in the United Kingdom (UK) among psychiatric patients; the report showed that respondents indicated that they felt isolated, while others reported that they felt indifferent (Hem & Heggen, 2004:63; Macdonald, Sibald & Hoare, 2008:296).

Carvel (2006:11) in a study done in hospitals across England; reported that 40% of the patients got food supplemented by relatives and friends, 37% leave the meal uneaten because it looked, smelled and tasted horrible. Some of the participants indicated that the food was either too hot or too cold; a quarter of bedridden patients who needed assistance with feeding, were not fed. As many as 4/5 of patients were not given the opportunity to choose meals in advance, 18% said that the dish of the day they liked most sometimes run out before the trolley reached their bedside. This was further supported by a comparative study undertaken between volunteers and nurses in the hospital for elderly found in Australia, the findings revealed that there were increased energy intake for the patients when fed by volunteers than by nurses, this was due to the fact that volunteers seemed to socialize more and encourage the patients to eat more often and they even fed those who cannot feed themselves (Walton, 2008:24).

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South African public hospitals are no exception; different forms of dissatisfactions are often brought to the attention of nursing staff and the hospital management for consideration. A South African study on post natal patients by Lumadi and Buch (2011:26) reported the findings of dissatisfactions on patient's lack of adequate information when procedures were performed on them. The study further revealed that patients were not informed about their conditions and relevant treatments thereof. According to Perry and Potter (2005:959), anxiety due to fear of unknown can interfere with the effectiveness of the medication resulting in delays in healing and increased period of admission. According to Muller (2001:605), the Average Length of Stay (ALOS) in the ward has also been a common indicator of nursing care. He further stated that nursing care organisation and nursing service delivery in the wards directly influences patient's length of stay; he also indicated that comfort is the main aspect that patients seek from the nursing staff and that attempts at all costs to resolve uncomfortable symptoms such as pain may greatly decrease the length of patient stay.

The New Zealand Medical Association conducted a study that revealed the findings about patient's satisfaction, that 1:10 admissions in public hospitals is associated with adverse events and some resulted in formal complaints. The study further reported that the following were identified:

- Hospital incurred patient injuries.
- Adverse drug reactions.
- Unplanned transfers from general to intensive care and other units (Davis, Lay-Yee & Briant, 2008:282).

The South African government demanded certain standards from practitioners who deliver health care services to the public; including nurses. Batho Pele is a name given to the government's initiative to improve service delivery to the public; it is a Sesotho word which implies 'people first' and it is a simple mechanism which allows the service recipients to hold health care personnel responsible and accountable for the level of service they deliver. It has its roots in the following policies:

- The constitution of Republic of South Africa (RSA) of 1996

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- White Paper on Transformation of Public Service (WPTPS) 1997
- Public service regulation of 2001

Batho Pele was developed to energise the transformation efforts and consist of a new belief set:

"We belong"

This is a belief that patients who feel satisfied will develop a sense of belonging.

"We care"

Nurses show compliance to this belief though listening to the patient's problems, apologising when necessary and serving people with smile. The care delivered need to be beyond customer's expectations.

"We serve"

This implies developing standards, provide information, seeking service delivery solutions and going beyond the call of duty. The nursing staff serves by delivering high quality care and making service recipients look forward to receiving high quality integrated service delivery. According to Meyer, Naude, Shangase & Van Niekerk, 2011:14), eight Batho Pele principles were developed to serve as acceptable policy and legislature framework for health service delivery as introduced by the Department of Health (DOH). According to the (DOH, 1997b:15), eight Batho Pele principles are as follows:

- **Consultation:** service recipients should be consulted about the level and quality of public services they will receive and if possible, they should be given choice about the services that are offered

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- **Service standards:** service recipients should be told about the level and quality of services they are entitled to receive
- **Access:** service recipients should have equal access to services that they are entitled to receive
- **Courtesy:** service recipients should be treated with consideration
- **Information:** a full accurate information should be given to the service recipients about the public services they are entitled to receive
- **Openness and transparency:** service recipients should be told how provincial and national departments are run, how much they cost and who is in-charge
- **Redress:** if promised standard of service is not delivered, service recipients should be given apology, followed by explanation and speedy and effective remedy. When complaints are made service recipients should receive sympathetic and positive response
- **Value for money:** public services should be provided economically and efficiently in order to give service recipients the best value for money.

The DOH also developed the White Paper on Transformation of Public service (WPTPS) which worked hand in hand with African National Congress (ANC) in an attempt to restructure the health care services. Despite the introduction of such policies and legislature frameworks to serve as guidelines for improvement of quality nursing care to be rendered to patients in the public hospitals, hospital managers often receive verbal and written complaints about the poor and inconsistent nursing care that is received by some of the patients. Patient's Right Charter is increasingly becoming familiar to most patients; therefore, patients are likely to lodge complaints regarding the violation of their rights by health professionals. The Department of Health (DOH, 2000:2) indicated that measuring client satisfaction has become an integral part of

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hospital management strategies across the globe. Moreover, the quality assurance and accreditation process in most countries requires that the satisfaction of clients be measured on a regular basis.

1.2.1 Service factors

According to Andaleeb, Saddiqui & Khandakar (2007:6), the six broad service factors to be measured are as follows:

- **Reliability**: refers to provider's ability to perform the promised service independently and accurately. It includes the consistency in the supply of medicine, supervision of patients by nursing staff and availability of nurse specialists.

- **Assurance:** implies the ability to have knowledge, skills and courtesy on the side of nursing staff, this will in turn inspire confidence and trust to those receiving care. It displays a sense of assurance that they have the patient's best interest in mind and that they will deliver service with integrity, fairness and beneficence. It further implies sufficient explanation of queries and generates a sense of safety.

- **Empathy:** which implies the ability to care and display compassion towards the patients. It further includes the understanding of patient's problems and their needs. Patients desire nursing staff that is attentive and understanding towards them. Personal care and moral support are important aspects of empathy.

- **Access:** refers to the availability of nurses and hospital beds and other facilities around the clock. Smiling and greeting that the nursing staff displays towards the patients allows them to be accessible.

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- **Responsiveness:** implies the willingness of nurses to respond promptly when needed. This requires the availability of equipment which is in good working order and that are able to provide quick diagnosis; above all patients expects the prescribed medicine to be available and administered as prescribed.

- **Tangibles:** refers to the physical evidence that the hospital will provide satisfactory services. This includes availability of equipment, personnel, physical facilities, clean and organised appearance of a hospital, wards and beds and written materials that create positive impression.

Within the hospitals, suggestion boxes are placed at the patient's disposal for the patients to give their inputs. Patient satisfaction surveys are done twice a year to determine the level of patient's satisfaction rate. This practice is also another way to encourage patients to submit their views about the nursing care they received. It is also believed that this practice will suggest proper planning and proper management, which will promote quality provision and resulting in overall patient's satisfaction. Investigating patient's perceptions of nursing care received in the surgical and medical wards at the public hospitals therefore, aims to seek if there is a relationship between patient's expectation and nursing care received (DOH, 1997a:12).

Findings of the study will provide systemic data which could be used to plan patient focused care with a view of satisfying patient's needs. It could serve to improve the outcomes and patient's compliance to the care rendered by the nursing staff. It is also hoped that by providing value-driven care which is in line with the patient expectations, healthcare services at Makhado Municipality of the LP will remain a market leader in the whole of Vhembe District.

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1.3 PROBLEM STATEMENT

The initiation of the Government of National Unity in 1994 and democratisation of the South African society brought in various changes, such as Batho Pele principles and the WPTPS in the health care system. The government has an active role to play in terms of ensuring patient's satisfaction on nursing care provision and this is evident when a lion's share of national budget is allocated for health care services on annual basis. This was further made possible by means of introducing Patient's Rights Charter as guidelines for improvement of nursing care rendered to all patients in the public hospitals of South Africa (SA). The government regards patient's satisfaction as one of the most important indicators in service delivery reports for all hospitals and these reports are made available on monthly basis. Despite the provision of the guidelines by the government of SA as an instrument to improve quality of nursing care, the number of complaints from relatives, the local radio talk shows and patients are continually received by hospital managers (DOH, 1997a:12; DOH, 1997b:5).

Seemingly, efforts to combat patient dissatisfactions with nursing care services in public hospitals have met with limited success. Patients who received nursing care from the public hospitals, generally indicated that the care received in the general wards is inconsistent and not of the same standard as the nursing care given in critical care. Poor quality care is associated with far-reaching effects, such as patient not following treatment regimen, failure to pursue follow up care and in some extreme instances resort to negative word-of-mouth that discourage others from seeking health care from the public hospitals. What is particularly disturbing is the lack of empathy of nursing staff, their lack of seriousness while rendering nursing care, poor level of competence, and the occasional disregard for the suffering that patients endure without being able to voice their concerns and their expectations. There is also a discrepancy between high scores on patient satisfaction and poor healthcare episodes that pose a problem when the purpose of healthcare quality research is to improve the quality of care. All those service failures are reported frequently in the print media (Andaleeb et al., 2007:2).

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- To describe patient's expectations about the nursing care given to patients in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP.
- To determine the effects of the inconsistent nursing care rendered to patients in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP.
- To establish recommendations that may be used by health care planners.

1.6 PURPOSE OF THE STUDY

The purpose of the study is to assess and describe patient's satisfaction with the care received from the nursing staff while admitted in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP and also determine if the care received met patient's expectations.

1.7 SIGNIFICANCE OF THE STUDY

The significance of the study relates to its "potential for contributing to, and extending, the scientific body of knowledge" (LoBiondo-Wood & Haber, 2002:56). Findings of this study will have the potential to improve nursing care rendered to patients in the surgical and medical wards of the public hospitals of Vhembe District as well as other public hospitals in SA. It could serve to improve the outcomes and patient's compliance to the care rendered by the nursing staff. It is hoped that the findings will help policy and decision makers to adopt and implement effective measures to improve health care services in the LP. It will also contribute towards the identification of training needs for professional nurses and other lower categories of nursing staff as well as the management, which are the foundation of nursing care practice. It is furthermore envisaged that the results of this study will influence the redefining of the nursing parameters and the importance of emphasising the scope of practice particularly that of registered nurses (R2598) as stipulated by the South African Nursing Council (SANC)

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with regard to maintenance of patient's health status, thus meeting patient's satisfaction of the care they received.

1.8 DEFINITIONS OF KEY TERMS

Operational definition is "a strategy through which a set of characteristics essential to the connotative meaning of concept is identified" (Burns & Groove, 2003:133). This helps the researcher to describe what is to be studied and how it will be investigated. Burns & Groove (2003:133) further defined a concept as "a term that abstractly describes and names the object, thereby giving it a separate identity or meaning". In this study, the following terms are used within the contents described in this section:

1.8.1 Health

Health is recognised as a goal to be attained and maintained. Both educational and cultural background and past experiences determine how the patients perceive health. Health is measured against the set of standards. The standards should reflect the presence or absence of disease or the ability or inability to function as a contributing independent member of the society (Donabedian, 2010:13).

The following factors can affect health and perception of health:

- Factors related to the lifestyle such as amount of physical exercise.
- Dietary habits.
- Smoking habits.
- Levels of stress and other relationships one has with others.

Recognition of patient identity by addressing patient by name, respect for personal preference and demonstration of flexibility contribute to a satisfactory relationship. As an advocate, speaking on behalf of the patient and providing information to assist the patient and the family to make informed decisions.

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1.8.2 Public hospital

Public hospital has been defined by Dagger and Sweeney (2006:14) as a center of technical services for the sick and well with great emphasis on preventive services and promotion of health among general population. In this study, public hospitals will be considered as health facilities which are under the support and direction of government and the services rendered are provided with no cost or at a reduced rate (DOH, 1997b:24).

1.8.3 Patient

The patient is the recipient of nursing care from a healthcare provider because of illness or injury and must always be seen as a person. Patient is viewed as a human being who is unique with a particular make-up, experiences and responses. The patient is a member of the family and the community and in constant interaction with the environment. Interactions and responses are influenced by the following factors:

- Socio cultural background
- Lifestyle
- Values
- Capabilities
- Interest
- Past experience
- Other behavior that result from past experience

Each patient has basic biological needs that include:

- Intake of oxygen
- Fluid and food
- Elimination of waste
- Rest
- Sleep
- Activity

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Significant psychosocial needs include:

- A sense of security
- Maintenance of identity as an individual
- Acceptance
- Sense of being wanted and belonging
- The opportunity of socialisation
- Independence
- Freedom to make decisions
- Opportunity to develop (Smeltzer & Bare, 2004:5).

For the purpose of this study, a patient is a person who is admitted in either medical or surgical ward of the selected public hospitals within Makhado Municipality of the LP.

1.8.4 Patient satisfaction

The degree to which the individual regards the healthcare service or product or the manner in which it is delivered by the provider as helpful, effective and beneficial to the recipients (National library of medicine, 2009:6). In this study, patient satisfaction will be regarded as an indicator of quality of care from patient's perspective.

1.8.5 Nurse

Refers to a person who is qualified in the art and science of nursing who meets certain prescribed standards of education and clinical competence. According to Weller (2005:274) and Kotze (2008:15), a nurse should have a managerial skills and basic educational skills in order to can supervise those under her command and is registered with the South African Nursing Council In this study, a nurse refers to medical and surgical ward nurse who provide nursing care services to the patients. As the nurse develops empathy with the patients, the patients in turn develop trust and confidence towards the nurse. The nurse displays interest and willingness to help through:

- Being non-judgmental
- Accepting the patient

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- Demonstrating thoughtfulness
- Anticipating the patient's needs
- Showing concern
- Ready to listen and to answer questions (Lewis, Heitkemper, Dirksen, O'Brien & Butcher, 2007:247).

1.8.6 Nursing

According to Lewis et al (2007:247), nursing is defined as assisting the individual, who might be well or sick in the performance of the activities that contribute to health or its recovery that he will perform without assistance if he had the necessary strength, will or knowledge. And to do this in such a way that the patients are assisted to gain independence as rapidly as possible. Meyer et al (2011:14) described nursing as the art and science of nursing. Its aim being to provide a human health care based on a scientific principle. It uses the knowledge derived from other disciplines, combined with nursing theory, delivered in a highly personalized and intimate manner to those in need.

Apart from rendering direct care to patients, nurses also manage care; therefore, provision of facilities, personnel and environment that will enhance quality care and recuperation is important. Kotze (2008:15) regarded nursing as an interpersonal service that is comprehensive in a manner which involves a dynamic and systematic process including management, teaching while facilitating the promotion of wellness and where this is not possible, a peaceful death.

Nursing takes place within the context of nurse-patient relationship; it is characterised by professional or therapeutic relationship. Nursing is directed towards meeting a patient's goals. Such goals can contribute to satisfaction on the side of the patient. It takes place in a structured and designated setting, such as the hospital. The professional purpose of the relationship gives direction to the role assumed by the nurse. The code of conduct expect each nurse to treat all patients as equal and to

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render high quality care; nursing staff has no right to refuse to give care to any patient (Lewis et al., 2007:247).

1.8.7 Nursing Care

According to Taylor, Wolfe & Cameron (2004:12), nursing care is a unique contribution of a nurse to assists individuals to be independent of such assistance as soon as possible. Nursing care is a core value of nursing profession, nursing profession originated because of the caring needs of others. It entails focusing on the needs of others, and determining the extent of these needs and taking appropriate actions to address these needs. Nursing care is considered to be undertaken by a nurse who behaves as a compassionate, committed, confident and competent person (Taylor et al., 2004:12; Jooste, 2010:25). In this study, nursing care will be considered as it connotes responsiveness between a nurse and a person with an intention to assist that person to gain control, become knowledgeable and promote health changes.

1.9 RESEARCH DESIGN AND METHODOLOGIES

According Fraser, Cooper and Nolte (2010:66), research method describes the complete research as it was planned. It begins with the subjects and the sample. Research method refers to the steps, procedures and strategies of gathering and analysing the data in a research. Research design refers to the researcher's overall plan for obtaining answers to the research questions (Polit & Beck, 2004:188).

In this study, a quantitative, descriptive, exploratory and non-experimental, research study was conducted to measure patient's satisfaction with the quality of nursing care they received. A survey method was used to collect data concerning the views regarding the care given, patient's expectations, effects of inconsistent nursing care and improvement of nursing care among the patients who are discharged from surgical and medical wards of the selected public hospitals within the LP.

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1.9.1 Research setting

Burns and Grove (2003:40) regarded research setting as the environment in which the research study takes place and can be a natural or controlled. The natural setting is a real-life study environment without any changes made for the purpose of the study. The study was conducted in the surgical and medical wards of the two public hospitals within Makhado municipality of the LP; Makhado municipality is located at the northern region of the RSA; it is about 70 kilometers west from Thohoyandou Township. The study was conducted in two selected public hospitals within Makhado municipality in Vhembe District. Those hospitals were Elim and Siloam. Elim hospital has 323 beds and Siloam hospital has 220 beds. Both hospitals have bed occupancy rate of 75%.

1.9.2 Sample

Sampling is the act of selecting elements, events, behaviours, or people representing the entirety of the population being studied. Sampling enables the researcher to determine a population's characteristics and variables by directly observing only a portion of it (Jooste, 2010:302). According to Burns and Grove (2005:478), sampling is a vital step in any research as it forms part of delineating the inquiry. In this study, a convenient sampling was used and was drawn from a section of population that was easily accessible. Patients who were conveniently admitted in the surgical and medical wards of the selected public hospital were used.

1.9.3 Population

According to Polit and Beck (2006:259) as well as Jooste (2010:302), population is the whole group of people or of the objects that are of interest to the researcher. The researcher does not have access to the whole population of interest. For the purpose of this study, the population consisted of all discharged patients from two selected public hospitals following 36 hours or more of admission in either medical or surgical wards, between the ages of 21 and 50.

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Content validity was ensured by developing the questionnaire with research objective as a point of departure. The structured interview was developed from relevant literature and from health system trust, client satisfaction survey tool and a sylhetic questionnaire which has previously been tested and utilised to measure patient satisfaction. Ready-made tools were not used, but specific items were derived from published articles where similar instruments had been used. Questionnaire was forwarded to three experts and a statistician at the University of Venda from the initial stage of its development. The questionnaire was also pre-tested on eight patients who did not participate in the actual study. Findings of the pre-test revealed that some questionnaire items were difficult to understand, the researcher made changes to those items to make them understood by the patients.

1.9.7 Data collection

In this study, the researcher used a systematic random sampling were a list totaling 200 patients that were about to be discharged was requested in advance from the operational managers of each participating ward of the participating hospitals. Two hundred (200) was then divided by 100 which was the desired number of patients that were to participate in the research and an answer of two was obtained. Names were then randomly selected in a manner that every second patient from the list was selected. In this study, only eighty (80) patients were interviewed by means of filling up the questionnaires. Data collection was done between September and October 2012. The pre-tested structured interviews schedule with close and open-ended questions was used to collect data from the surgical and medical patients aged 21-50. Patients were asked questions about biographic information; the broad factors that influence perceptions of service and open ended questions to assess views of the patients regarding the medical or surgical wards. The respondents for this study responded to the same question in the same order and with the same set of response options. Patients were asked to rate their experiences on a scale with 1 being agree, 2 disagree and 3 unsure.

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1.9.8 Data analysis

Data was analysed using the Statistical Package for Social Studies (SPSS) version 21. Data analysis and cleaning was done with the assistance of an experienced statistician from the University of Venda. During data analysis, the percentages, distributions, means and ranges of specific variables were reported. Descriptive statistics were presented in tables, a histogram and a pie diagram. For closed ended questions, total scores for each questionnaire was added together and divided by 43 which is the total number of questions. This was done to total score for satisfactions, dissatisfactions and for the unsure responses, and a total score for each was obtained.

1.9.9 Ethical considerations

Ethics are standards used by groups of people, professionals and communities to measure rightness or wrongness of actions and behaviours. According to Pera and Van Tonder (2005:5), ethics are concerned with rightness or wrongness, good or bad. The focus of ethics and/or ethical considerations therefore is to ensure that the participants under study are kept from harm.

Before data collection, ethical approval was obtained from the Ethics Committee of the University of Venda. Permission to conduct research was also obtained from the district office of the DOH, Limpopo Provincial DOH and the Chief Executive Officers from hospitals were the data was collected. A written permission was obtained from all participants. Patients who participated from surgical and medical wards were given time to read the information letter and the consent form and were given chance to ask questions.

1.10 ORGANISATION OF THE DISSERTATION

Chapter 1 introduced the study, described the purpose, objectives, significance and also defined the key terms.

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Chapter 2 discussed the literature review undertaken on the phenomenon under study.

Chapter 3 covers the research design and methodology, including the research design, population, sample and sampling methods, validity and reliability of the research instrument, ethical considerations, data collection and analysis.

Chapter 4 presents the data analysis and interpretation of the findings.

Chapter 5 presents the conclusions and limitations of the study and makes recommendations for further research.

1.11 CONCLUSION

This chapter described the background to the study, presented the problem statement, purpose and significance of the study, the research question and the definitions of the concepts and briefly discussed the methodology and ethical considerations.

Chapter 2 will discuss the literature review undertaken for the study.

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CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter described the background to the study and its significance, also presented the problem statement, the research objectives, and definitions of the concepts as well as the abbreviations used in the study. This chapter examines literature on the links between patient satisfaction and quality, factors that influence patient satisfaction, worldviews, nurse's worldviews and how these influence nursing care, the theoretical framework of patient satisfaction and lastly, patient satisfaction and its influence on return to business or market share gain. Review of relevant literature helps to identify what is already known about a topic so that duplication is avoided. Gaps in the topics previously researched can be identified while recommendations made in various studies can be used as research topics. Research design relevant to the study can also be identified through searching for appropriate literature (Meyer et al., 2011:381).

A literature review is a process involving reading, understanding and forming conclusions about the theory and the published research on a particular topic. It is done to acquire the knowledge for use in practice or to provide a basis for conducting a study (Burns & Grove, 2003:55). The review provides information and background for understanding what has already been learned on a topic and illuminates the importance of the new study (Polit & Hungler, 2004:142). It also provides the identification of feasible research purpose and problems (Burns & Grove, 2003:117). The purpose of the literature review in a quantitative study is to place the findings in the context of what is already known about the topic. In this study, the researcher undertook an extensive literature review on the relevant sources on the topic in question in order to sensitise

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herself to the phenomenon under study, to develop an inventory of the vocabulary and to gain insight into the meaning of the topic under study.

According to (Burns & Groove, 2007:137; LoBiondo-Wood & Haber, 2002:79), a critical review of the literature:

- Uncovers the conceptual knowledge related to the particular subjects, concepts, or clinical problems and is used in all aspects of the research process
- Familiarises the researcher with the information that is already available and to the previous research on the selected topic
- Updates and expand the researcher's knowledge and skills with regard to the selected topic
- Presents a theoretical framework for the research
- Presents critical and analytic thinking of the recent developments concerning the research topic
- Indicates the methods, research instrument and statistics that could best be used
- Provides new knowledge that can lead to the development and validation of theories
- Reveals the research question for the discipline
- Provides the latest knowledge for education
- Generates ideas, develop and refine the scope, objectives and aims for the research study
- Uncovers the research findings that support evidence based practice
- Develop a data collection instrument
- Avoids duplication of the previous research and identifies the research gaps

In this study, the literature was searched from journals, relevant books and data base from the DOH of SA and internationally. Literature review was done to obtain information on the satisfaction of patients that are admitted in surgical and medical wards with the nursing care they received. The literature was reviewed to locate and analyse the relevant information that could assist in answering the following questions:

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- What are patient's views regarding the care given to them from the surgical and medical wards of the public hospitals within Makhado Municipality of the LP?
- What are patient's expectations about the nursing care given to them in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP?
- What are the effects of the inconsistent nursing care rendered to patients in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP?
- How can patient satisfaction be improved in surgical and medical wards of the public hospitals within Makhado Municipality of the LP?

2.1.1 Key words for the literature review

The results of the literature will be presented under the following headings:

- The nature and extent of patient satisfaction
- Linkages of patient satisfaction with quality care on patients
- Standards
- Monitoring and evaluation of standards in the health care
- Patient's perceptions of the nursing care
- Factors driving patient satisfaction
- Nursing and patient satisfaction
- Dimension of patient satisfaction
- Health service quality and the nursing milieu
- The process of nursing.
- Outcomes of nursing
- Patient satisfaction with nursing care and the intention to return to service

2.2 THE NATURE AND EXTENT OF PATIENT SATISFACTION

Measuring and reporting patient satisfaction with health care has become a major industry. Patient satisfaction measures have been incorporated into reports of hospital

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and health quality planning. Traditionally, decisions about health services were made on the basis of health care provider and health authorities' views on what is in the best interest of the patient. According to Ejeoma, Nwaneri, Iheanacho and Akpati (2011:7), the word patient was believed to mean passiveness on the side of the sick or injured person, and is therefore expected to accept all decisions imposed on him without him making any inputs. This is no longer accepted in this era of increased awareness of the public to health issues. This was also based on a view that members of the general public do not have the technical knowledge to make fully informed decisions themselves (Baker, 2014:3).

Currently, the development and the use of patient satisfaction surveys in developing countries are advancing. Governments and professionals have recognised that a systematic and consumer oriented approach toward welcoming patient's viewpoints about the level of care be adopted. This can result in feedback that is useful for promoting higher quality standards of care (Dagdeviren & Akturk, 2004:24; Peltzer, 2009:81; Newman, Gloyd, Nyangezi, Machobo & Muiser, 2009: 176).

According to Glick (2009:369), patient satisfaction should be seen as a means of determining patient's views on care given by nurses. In the USA, patients' surveys are increasingly being promoted as a means of understanding health care service quality and the demand for these services. According to Ajayi, Olumide and Oyedira (2005:136) Muhondwa, Leshabari, Mwangu, Mbembati and Ezekiel (2008:67) as well as Newman, et al (2009:176), developing countries are no exception regarding patient's satisfaction, pointing out that the developing countries should continuously seek the ways of promoting patient's satisfaction by highlighting and addressing those aspects of care that need improvement in a health care setting.

The South African government also endorses the centrality of consumers in service delivery. The DOH (1997a:7) the Department of Public Service and Administration (DPSA, 1997:12) the Department of Health's policy on quality in health care and the DOH (2007:13) state that public services need to respond to customer's needs, wants

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and expectations. Feedback from service recipients is required in terms of experiences of health services quality of care received. Such feedback will not only improve knowledge of decision makers, but will also facilitate more improved prioritisation, can be used as indicator for non-compliance and in choosing between health providers, can improve strategic resource allocation and value for money. It will also serve as a platform for providing better services to service recipients that will improve the overall satisfaction. Pilteri (2007:8) maintains that as goals become broader, so do activities. He further stated that when primary goal of nursing considered being caring for ill people, nursing actions were limited to the activities such as feeding, bathing and maintaining comfort. Currently with health promotion as major goal, teaching, supporting, counseling and advocacy are the common roles.

Studies that were conducted on patient's satisfaction revealed the phenomenon that satisfying patients have never been standard and straight forward. Satisfaction is a subjective concept to the patient and is individualised; it is as such a perception by the individual on the receiving end of healthcare services. Patient satisfaction is described as a judgment by the patient on aspects of quality in care which the patient is capable of appreciating. Patient satisfaction has also been viewed as an attitude reflecting the degree of congruence between patient expectations and their perception of nursing care received. Patient satisfaction is the most integrated factor that leads to attainment and maintenance of the overall satisfaction with healthcare received in the public hospital. Most of the hospital care is given as nursing and therefore, quality care tends to be measured by the nursing care standards (Merkouris, Papathanassglow and Lemonidou, 2004: 359; Muller, 2001:207; Jooste, 2010:25).

Effective and efficient care that meets expectations of the patients is a fundamental aim of the public health services (Imam, Syed, Ali, Ali, Fatima, Gill, Hassan, Hashmi, Siddiqui, Khan & Jameel, 2007:2). The public health sector has been continuously critisised of its inefficiency, including the allegations of the abuse of patient's rights. Country wide, people preferring to utilize private hospitals than public hospitals with resultant underutilisation of available public health facilities is of significant concern. It

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was found that the trend for the utilisation of public health service has been declining between 1999 and 2003 (Ricardo, Hussmann, Munoz & Zaman, 2004:29). Patient satisfaction is one of the most important outcomes of nursing care and it displays responsiveness to the needs and expectations of patients by nurses.

Nursing originated from a sincere desire by nurses to assist and care for others. The nursing actions are guided by the nursing values that create a character and spirit of care, this caring ethos is still considered to inform nursing practice. In order to enforce commitment to the nursing practice, the SANC, which is the governing body for the nursing profession, introduced a nursing pledge that contains statements of moral principles which are collectively upheld by the nursing profession. The SANC also introduced acts and regulations in order to direct the acts and commissions of nursing staff and to work within the ambit of those acts and regulations. Failure to comply with such acts can lead to disciplinary steps imposed on the nurse concerned by the SANC (Jooste, 2010:22; South Africa, 1978:4).

According to the DOH (1997a:5), listening to patient views, involving them in the issues concerning their care, welcoming the decisions of the patients and treating them with respect are necessary for rendering quality service and are the important aspects if quality and satisfactory care is to be provided. Kongnyuy and Vander Broek (2009:9) indicated that the management of the facility should evaluate the degree of quality of service rendered in order to be kept informed on how successful the providers are meeting client's objectives and values. Inviting inputs and involving the patients in decision making about their care and treating them with respect are important aspects that could lead the patient to feel included in their care. According to Ahmad and Din (2010:95), satisfaction is regarded as a 'psychological state resulting when the emotions surrounding unmet expectations are coupled with the consumer's prior feelings about the consumptions experience'. According to Smith and Engelbrecht (2001:5), client satisfaction is regarded as the level of satisfaction that client experience having used the service which reflects the gap between the expected service and the actual experience of the service. According to World Health Organisation (WHO, 2006:13) as

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client's expectations increase over time, the quality of service has to keep on improving and maintain a certain level of satisfaction in order to keep up with the expectations. The standard of nursing care services should therefore keep on improving rather than declining. Managers, staff and patients might interpret quality care differently.

For the patients, quality care could be meeting their perceived needs on time. If the medical and surgical patient's expectations were met, for example, for health education or informing the doctor when the patients were very sick, they could have believed that they had received quality care. Quality care further implies that the services are rendered timeously, thus reducing the needs for emergency interventions, which will help to prevent overburdening the referral facilities. Involvement of patients in their nursing care can lead to improved outcomes and hence improved compliance by the patients as a result of trust in nursing staff (Lawson, Harrison & Bergstrom, 2001:37; Baker, 2014:5). Thus this study was conducted on patient's satisfaction with the nursing care received in the medical and surgical wards at the selected public hospitals within the LP of SA.

2.3 LINKAGES OF PATIENT SATISFACTION WITH QUALITY CARE ON PATIENTS

Quality means different things to different people and in different contexts. In the healthcare industry, one can conclude that perception of quality by the healthcare providers, heath service managers and patients are similar; where patients view quality care as the interpersonal relation between patients and care providers, Andaleeb (2001:1359) in his study reported other attributes that were mentioned by the respondents regarding quality care that they were expecting; such as staff responsiveness to requests by patients, respect and kindness shown to patients by nurses, and confidence in performing procedures by the nursing staff. Nurses perceived quality care as the process of care or how care was delivered and they view the importance of patient education and appropriateness of diagnostic procedures as the

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indicators of quality care and the outcomes of care as factors of greater value to quality care (Zhao & Akkadechanunt, 2004:148).

Jooste (2010:8) pointed out that patients find it hard to define satisfaction, but appreciate or recognise it if they feel it themselves directly or appreciate caring if they observe it indirectly. He further argued that patients make less use of the criteria like uniformity in expertise, in qualifications and equipment between the health care facilities. Criteria such as caring for the patients individually, sensitivity to many and complex health problems and hospitalisation, addressing emotional, cultural and spiritual needs, as well as visibility of hospital staff working together as a team in caring for the patients becomes therefore increasingly important (WHO, 2006:13; Ghana Health Service, 2004:11).

According to Jooste (2010:8), the quality of nursing care has an impact on client satisfaction. Comparison between nurses and patient's perception of what is important in nursing care revealed that nurses rated the characteristics such as trust, empathy and competence higher, while patients considered aspects such as physical environment; especially comfortable bed, lighting, low level of noise, and room temperature that is comfortable. Patients even went to an extent of taking psychological aspects and professionalism of nurses far much higher than nursing staff did (Ozsoy, Ozgur & Akyol, 2007:249; Shaw, 2012:11).

Attree (2001:459) describes good quality care as individualised, patient focused and care which is delivered in a humanistic manner. According to findings of a study by Kunaviktikul, Anders, Srisuphan, Chontawan, Nuntasupawat and Pumarporn (2001:780), major themes which emerged indicated that quality nursing care from a patient perspective are good service behaviors such as caring behaviour and responsiveness to patient needs. In the same study, hospital directors perceived quality of nursing care as being based on fast and efficient service. The summary of findings of this study were however, condensed into one definition indicating that quality nursing

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care is how nurses respond to the physical, psychological, social, emotional and spiritual needs of the patients (Kunaviktikul et al, 2001:782; Burhans, & Alligood, 2010 :14).

Findings of the study by Kunaviktikul et al (2001:781) were categorised into Donabedian's concepts of structure, process and outcome quality indicators. Structure indicators included organisational vision and mission statement, policies for the management, human and material resources including staff development. It was concluded that these indicators needed to be in place if quality care is to be obtained. Process indicators from the study meant how nursing care was conducted and included nursing care plan, nursing practice, completion of indicators of the study included incidents and complications, client satisfaction with information, timeousness of services, satisfaction with pain and symptom management (Shaw, 2012:11).

The traditional approach was to define quality only at clinical level and was regarded as offering effective, safe, care that is technically competent and that contribute to the wellbeing of the patient. The new trend is measuring of the quality from the perspective of the patient-client orientated approach. Issues such as perceptions of care and patient satisfaction are at the center stage of defining the quality of care (Ejeoma et al., 2011:12).

2.4 STANDARDS

According to Ghana Health Service (2004:11), nurses should practice according to standards in order to minimise illness, disability and death. Donabedian culture of structure, process and outcome is based upon written and well communicated standards. These are rules that specifically guide care providers on how to carry out their activities. Standards clarify the way that procedures are to be performed by clearly defining requirements so that the desired outcomes are achieved. Structure standards provide non-negotiable legal parameters within which staff operates in an organisation and those includes mission, goals and job descriptions of the organisation. Structure

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also includes the physical environment within the hospital, policies, personnel, equipment, instruments and stock. It refers to the minimum requirements to enable the quality of care in the ward (Jooste, 2010: 170; Donabedian, 2010:11). Process standards provide guidelines on how to carry out procedures and therefore define the operations. It also refers to the scientific principles of nursing; describing step by step how nursing actions can be executed. It also describes the process of assessment, planning, implementation, diagnosis and evaluation. In the ward situation, process standards are usually made available in the form of procedures (Ghana Health Service, 2004:11). Outcome standards are the after results of both structure and process standard and refer to the expected results and should be measurable in comparison to the objectives and goals that have been set (Jooste, 2010: 171).

The nature or the quality of structures and processes that are laid down by policy makers have a bearing on the quality or standards of care that the client receives. Quality is linked to excellence. It is through simple, measurable, attainable, and realistic and time bound standards that clients can be satisfied with the nursing care given. Client satisfaction is an outcome indicator of quality (Booyens, 2005:606; Kunaviktikul et al., 2001:781) Donabedian's quality model was summarised because good structure increases good process while good process increases good outcomes. This means that vision and mission statement, job description and policies would interpret and lead to good process in the form of quality practice guidelines and plans. These will increase excellent outcomes such as patient satisfaction with the care given.

Jooste (2010: 170) describes the standards as written descriptions of statements of the expected level of performance against which measurements can be made and regarded them as serving as a basis for comparison. He further mentioned that the public is continuously demanding greater assurance from the regulatory bodies that the nursing staff that is register is really competent enough to practice. Standards outline the duties of nursing staff to the patients.

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Jooste (2010: 170) further stated that according to these standards, the nurse should:

- Maintain the highest standard of quality health care using available resources
- Practice within legal framework, ethical, core standards and scope of practice; all of which should serve to guide the nursing actions
- Maintain credibility, competence and excellence through education
- Develop and maintain team work, accurate recording and information management
- Promote and improve the health status of the patients at all times
- Create and promote safe and caring environment
- Provide relevant care that is effective and efficient
- Improve the practice through research and the use of research findings thereof.

This was further supported by Shaw (2012:11) who specified that patients need a lot of information concerning their conditions especially after surgery. It was further stated that the health care facilities need to have policies and guidelines that protect all the health care providers from carrying out tasks that are unsafe, questionable or that are beyond their competence (Jooste, 2010:54). When the standards are set, there is a need to have monitoring and evaluation mechanism in place in order to check as to whether the set standards are being implemented (Donasu, 2007:108). Muller (2001:207) stated that there is a need to ascertain whether the nurse in the unit conforms to the set standards, and that there should be a feedback mechanism that is done in writing to inform the nursing staff as to how patients rate their performance and how far they are complying with the set standards. He further specified that client satisfaction level should be kept satisfactory by giving each patient a satisfaction questionnaire to complete on discharge.

Review of the above literature has shown that satisfaction is an outcome standard linked to quality. Literature review by Attree (2001:457) however, revealed that even though measuring patient satisfaction still remains the popular method of finding out

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how patient's view the care given, patient's perception of quality of care does not automatically equate to patient satisfaction.

2.4.1 Monitoring and evaluation of standards in the healthcare

Once the standard has been set, there should be monitoring and evaluation strategies in place, in order, to evaluate the implementation of standards set. The following strategies can be adopted during monitoring of compliance to the service standards:

- Self-evaluation
- Direct observation
- Peer evaluation
- Evaluation of patient satisfaction
- Incidence reports
- Nursing audits
- Ward rounds

According to Ahmed and Alasaad (2004:239), hospital services need to include patients in the evaluation of the quality of service received while admitted in the wards. By direct communication with the patient while providing healthcare or treatment, patient satisfaction can be evaluated. The manager in charge of the ward may organise informal interview sessions to find out how patients are experiencing their period of their stay while admitted in the hospital. This is of outmost importance since immediate action can be taken if any form of patient dissatisfaction is identified. It can also be tested formally in writing by requesting the patient to complete satisfaction questionnaires. Suggestion boxes may be mounted in the wards where the patient can comment regarding their period of stay (Booyens, 2002: 612).

Jooste (2010:237) specified the reasons for evaluation of patient satisfaction as follows:

- It is a form of community participation
- It is a democratic right of public services
- It enables the patients to express their autonomy

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- It is itself a desirable outcome
- Patients have wider views than nurses
- Patients are the best people to judge
- It may assist with choosing the best methods of patient care
- It is a measure of organisational and professional performance

According to Ejeoma et al (2011:14), there might also be a discrepancy between the high scores obtained from quality assurance monitoring and evaluation measures like patient satisfaction surveys and satisfaction results from questionnaires looking at the poor healthcare episodes.

2.5 PATIENT'S PERCEPTIONS OF THE NURSING CARE

There is a direct relationship between patient's experiences with health care and the perception of quality of care (Thorne, Ellamushi, Mtandari, Evoy, Powel & Kitchen, 2002:243). Unless the nursing staff allows the patient to participate in the decision making process of the care they receive through research, surveys, and various audits, gaps will continue to exist between the nursing staff and patient views; therefore, the nursing staff have to welcome the view points of the patients even though they are different from their perceptions (Merkouris, Andreadon, Athizie, Hatzimbalasim, Rovithis & Papastavrou, 2013:35). Schroder and Ahlstrom (2004:209) conducted a study to gather the information on how clients and families viewed nursing care the psychiatric patient received in the psychiatric unit. Patients and their families pointed out the importance of partnership between patients and healthcare givers, and the importance of treating clients as individuals. Patient's resourcefulness was valued in this study and aspects such as information about mental illness were regarded as important as it could assist them to cooperate and to participate in care of their loved ones. The importance of gathering data on patient's perception of care received and how the data sensitises and alerts healthcare givers of patient requirements was stressed. Those data are then used to plan the care that is congruent to patient's needs (Shaw, 2012:11).

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According to Astrow, Wexler, Texeria, Kai He and Sulmasy (2007:99), there is one caring need of interest rarely mentioned in most literature; that is the spiritual need of the patient. Patients view themselves as complete invisible units with spiritual and existential needs. If this angle of perception is ignored by the nursing staff, it can easily lead to dissatisfaction in care given. Differences between what the patients perceive and what healthcare givers or nurses perceive as quality care can vary because of different dimensions that influence perceptions and worldviews. This was supported by Corbin (2007:164) who stated that "today the physical part of treatment is just important but tomorrow; the spiritual aspect will take over". He further specified that mutual relationship and shaking hands have the same effects on health as personal hygiene or timely therapy. According to Ejeoma et al (2011:12), the era when healthcare providers were in total control of care given to the patients because of the misconception that they knew what the patients needs best is past. Partnership in care planning through consumerism and the national patient's rights charter place patients where they have become partners by participating in their own care together with healthcare providers. All activities in the healthcare setting must place focus on the patient and should therefore be patient centered. Without the patients, hospital would have never existed (WHO, 2006:15).

According to Merkouris et al (2004:359), assessment of quality care by whatever criteria without patient's viewpoint is incomplete. Disregarding or ignoring patient's view point will result in failure to holistically address patient's needs and expectations. Merkouris et al (2004:356) specified that quality is whatever concern the customer and is very much in line with investigating client's perception of nursing care received so that identified gaps in patient expectations of care can be addressed in order to attain patient's satisfaction. Health care organisations that seek to be successful are those that take an interest in seeking patient's view so that the nursing staff will think like a customer.

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2.6 FACTORS DRIVING PATIENT SATISFACTION

Literature has cited several factors that influence patient satisfaction. Opinions from different patients were discussed on care received from the same nurse or nursing team. Such literature viewed the care received as subjective and therefore, a complex phenomenon. Biographical characteristics like sex, age, educational level and social class have been cited in the literature as having an influence on patient satisfaction (Lumby & England, 2000:140; WHO, 2006:15).

2.6.1 Age and influence on patient satisfaction

Thiedke (2007:34) pointed out that there is a link between age and patient satisfaction. Literature review had shown that the elderly are more likely to be satisfied with the care given than younger people, and that older patients tend to express higher levels of satisfaction. Younger patients on the other hand, were found to be quite open about their perception of care. A study done by Shaw (2012:12) during 2012 in Kenyatta National Hospital to surgical and medical patients revealed that respondents who were less than 19 years voiced greater dissatisfactions and were more critical. He further pointed out that more positive satisfaction of care increases with age. Contrary to these findings, Stutts (2001:294) stated that there seems to be no link between the level of patient satisfaction and age.

2.6.2 Gender and its influence on patient satisfaction

Danielsen, Grrantt, Bjertnaes and Petersen (2007:72) in his study find out that woman rated satisfaction lower than men. But he indicated that female patients made some few comments on the care given by nursing staff. A qualitative grounded theory by Attree (2001:460) showed very open comments by both male and female patients of both extremes of quality care. Patients gave their views of 'good quality care' and 'not so good' quality care. The study did not show differences between the levels of satisfaction between male and female patients; this was also confirmed by Thiedke (2007:34) who pointed out that studies on the effect *of gender are contradictory in a sense that some studies showed that women tend to be* less satisfied than men while other studies tend

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to show the opposite. Stutts (2001:294) similarly reported that there were no differences between the levels of satisfaction between male and female patients.

2.6.3 Educational and socio economic level and its influence on patient satisfaction

Patient's educational level is not commonly mentioned in the literature pertaining to patient satisfaction. According to Vukmir (2006:8), patients with lower level of education might be more satisfied with the care given than those patients who are most educated. This was in contradiction with Thiedke (2007:34) who pointed out that most studies found out that low socio economic status and less educated tend to be less satisfied with the healthcare. In a study undertaken by Stutts (2001:294) on parents of hospitalized neonates, there were no clear association between satisfaction levels and patient's educational level; even though lower income patients seemed to have lower satisfaction level.

2.6.4 Health status that have an effect on patient satisfaction

According to Danielsen et al (2007: 74), patients who are very ill are more likely to be less satisfied than those that are least ill. Patients with poor physical health rated quality of care lower than those with better physical disability. Those with lower psychological wellbeing were rated lower than those whose psychological wellbeing was higher (Jackson, Chamberlin & Kroenke, 2001:614; Westaway, Rheeder, Van Zyl & Seager, 2003:339). Thiedke (2007:34) specified that "patients with two or more chronic conditions reported more hassles with the health care system than those with single chronic condition".

2.6.5 Environmental factors that have an effect on patient satisfaction

Environmental factors that affect the provision and process of nursing can either be external or internal. External environmental factors are the ones present in the macro-environment. An example of macro-environmental factor is the general political economic situation and its influence in nursing.

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Donabedian has been cited in the number of quality improvement studies and has gained a lot of recognition for his three concept structure, process and outcome as they relate to care (Kunaviktikul et al., 2001:779). In these studies, the structure component is the nursing environment in which nursing care is carried out. Nursing care can be carried out in the building, a mobile caravan, a school or even in client's home. Structural factors like the age of the building, the layout of the wards and nursing models can hinder or enhance the quality of nursing care and ultimately promote patient satisfaction. Other factors include the caliber of nurses, employee organisations, nursing identification, absenteeism and turnover rate among nursing staff. A management that is not sensitive to these issues can have a negative impact on quality of nursing care even when nurses are willing and are competent performers.

According to Jooste (2010:8), patients perceived aspects such as physical environment; especially comfortable bed, lighting, low level of noise, and room temperature that is comfortable as important if nursing care is to be viewed as of good quality. An unhygienic environment in which nursing care is given will influence patient's perception on quality of nursing care. Care given in dirty wards with poor hotel service can lead to dissatisfaction with care given to patients. This is in line with Nightingale's views (1969) cited in Corbin (2007:164) that nurses have the responsibility to create the environment that foster health and healing. This was to be achieved through anticipating patient's caring needs such as fresh air, comfort and safety.

An investigation carried out by Todd (2002) cited in Whitehead, May and Agahi (2007:281) reveal the perception of patients in hospital ward environment as influenced by factors affecting their ability to eat, sleep, feeling of security, issues around privacy as well as heating and lighting of the environment. According to the Institute of Medicine (2004:1), nursing work environment needs to be constructed in a manner that it enhances patient safety. This includes the setting in which care is given, nature of the work, characteristics of nursing staff itself and the implications of these elements on the safety of the patient.

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2.6.6 Care and costs and their relationship to patient satisfaction

Care and costs are appearing in patient satisfaction literature more frequently than before. According to Andaleeb et al (2007:8), consumers have become more sensitive to healthcare cost despite health insurance coverage. Treatment cost may be perceived by the patients as excessive. Health care costs are continuously rising at a state that is sometimes faster than the inflation rates, it is therefore important that the quality care standard is kept up in order to balance the care received with the care standards set or else the unsatisfied patients may go and seek care where they believe their money will have the best value. The income that such hospital was supposed to earn may be lost. The lower the overall cost for health care service the higher will be the patient satisfaction.

Escalating costs of healthcare delivery have also had an impact on healthcare delivery in Thailand. Kunaviktikul et al (2001:777) explained how both the public and private sectors in Thailand are examining health care cost closely as the economic climate is unstable and declining. In order to ensure that clients in Thailand continue to receive high quality care, it has become quite critical to balance nurse staffing needs and costs. According to Stanton (2002:5), a study funded by an agency for healthcare research found out that all adverse events increased the cots; example being the cost of a patient who developed pneumonia that rose by 84%.

According to Toreson (2005:9), the highest degree of satisfaction to a previously admitted patient can lead to patient returning to hospital to seek service and to recommend and refer other people to the same hospital. This drives the market share of the institution concerned and improves financial success. Cost and patient satisfaction are therefore linked. However, there are financial implications in case of adverse events.

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2.6.7 Other factors

According to Findik, Unsas and Sut (2010:164), length of patient stay has an influence on patient satisfaction. Patients who were admitted for a long time are more satisfied than those admitted for a short period. Other aspects also include the hospital and its size, the ward and its nurses, bed occupancy rate and nursing care models. There is higher impact on quality of care in smaller hospitals than in bigger hospitals (Holte, Bjertnaes & Stavem, 2005:87). According to Thiedke (2007:34), when coordination and communication of care increases, satisfaction of patient also increase; he also stressed factors on the side of the patient such as worry, drug abuse, post traumatic stress, fear, depression that occur in psychiatric patients as the factors that can lower satisfaction with the care received. Research done in Bangladesh identifies the most powerful predictors for patient satisfaction with the government services, these predictors were respect towards the patients and politeness from the side of the nursing staff, which were rated to be more important than the provider's technical competence. The second most important aspect was related to respect for privacy and thirdly; short waiting period. However perceptions and judgments of quality were reported to be highly individualistic (Aldana, Piechulek & Al-Sabir, 2002:512). A significant progress in improving access to quality health care services has been achieved in SA. However, several challenges has been highlighted such as providing quality health services and training adequate number of nurses and other health care professionals to meet the country's nursing care needs (DOH, 2007:7). Kongnyuy and Van der Broek (2009:9) indicated that the management of health facilities should evaluate the quality of service as one of the means to obtain information on nurse's success in meeting patient's values and objectives.

2.7 NURSING AND PATIENT SATISFACTION

Nurses do not only spend most of their time of work with patients, but they constitute the majority of healthcare working force. Nurse's beliefs, values and attitudes, behaviours, level of experience and competencies will determine the way patients perceive the

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nursing care they receive. Competence of the nursing staff especially those with specialty were rated higher than those without specialty. According to Merkouris et al (2013:29), there are many researchers whose findings revealed satisfaction with the technical aspect of nursing care.

2.7.1 Nurse's worldview and its influence on nursing care given

Individuals who decide to join the nursing profession enter the field from diverse cultural backgrounds. Meyer et al (2011:88) describes Leininger's theory of cultural diversity and universality and its influence on shaping people's worldviews. Social and cultural dimension in the community in which an individual resides influence the way a person looks at the world. These dimensions include education, economy, legal and political systems, family and religious among other things. These forces greatly influence how an individual reacts to different situations; their beliefs, values and norms are greatly shaped by the dimensions. The patients on the other hand, have also been influenced by these same social and cultural dimensions. A practical nurse will enter the place of work with a worldview which has already been shaped by the abovementioned dimensions. The way that nurses speak or relates to the patients, the empathy they display, and their friendliness or unfriendliness might have greatly influenced by how they grew up within their families and their communities.

According to Muller (2001:5), various worldviews have been categorised as humanistic. The humanistic world view places a human being or individual at the center. There are however, variables of the humanistic worldview and these extend from existential atheism where a human being has a freedom of choice but denies the existence of God, behaviourism that force the individual's behaviour and how the behaviour is controlled by the environment. Other relevant worldviews are the socialist view that focuses on the totality of the society rather than on the individual and the psychoanalyst view that put emphasis on law and rules. The Christian worldview however, place God at the center of all things and believes that human beings are sacred beings made in the image of God as total entities comprising of body, mind and spirit. Nurses who also believe in

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God and make him central to their life are more likely to care for the patients on the bases of God's divine love for the mankind and the ability to heal and restore life.

The nursing profession has a philosophical standing in the form of pledges and credos. Nurses make promises and take oaths of how they intend to carry out their duties through these oaths and credos. Included in the promises is the respect for all patients regardless of race, creed or social standing. Nurses therefore enter into a social contract with the clients and public through the oaths and credos. Care within the context of nursing refers to actions and activities that are put into place to assist, enable and support others to improve their health or life way (Searle, 2000:97).

2.7.2 Nursing competencies and proficiency

The nursing staff is the most important category in health care that occupies a more prominent position and that can influence patient's satisfaction. In a study by Webb, Pesata, Bower, Gill and Pallija (2001:416) views of patients with Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus (HIV/AIDS) were sought and the overall findings of the study indicated dissatisfaction with the nursing care. Reasons given by the patients for the dissatisfaction were about the nurse's inadequate knowledge of the disease condition and treatment.

Nursing competencies and proficiency should address the art of nursing. Benner's model of skill acquisition describes the four stages of nursing skill acquisition starting from the first stage of experienced novice, followed by an advanced beginner, competent nurse and the proficient nurse as the fourth stage. The proficient nurse addresses nursing situations with holistic understanding (Quinn, 2000:231). Zhang, Luk, Arthur and Wong (2001:468) cite Maatsch's model of general clinical competence with three overlapping constructs stated as the medical knowledge, clinical problem solving and general competence. The same authors mentioned that nursing care manifest by the five 'c' qualities namely: compassion, competence, confidence, conscience and commitment. Nurses who give care that show compassion and confidence while

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showing commitment will satisfy their patients. Newly qualified nurses were mentioned as incompetent and this can be compared to Benner's novice experienced nurse. The findings of a study by Zhang et al (2001:471) revealed that nursing competencies that are sought or rated highly were:

- Interpersonal understanding
- Commitment
- Information gathering
- Thoroughness
- Persuasiveness
- Compassion
- Comforting
- Critical thinking
- Self-control
- Responsiveness

In a study carried out by Ejeoma et al (2011:12) among 105 helpless patients, the findings revealed that patients were dissatisfied with the attitude of the nursing staff. In that same study, spiritual aspect was reported to be totally disregarded. To those who regarded it, little efforts were displayed and the nursing staff was lacking the necessary skills. It was therefore recommended that nursing staff should be trained on the nurse patient-relationship and on the care they give in order to attain patient satisfaction. It is therefore, clear that in order to meet the standards set for nursing care delivery, certain competencies are needed by the nursing staff. Such competencies stem from the abilities, knowledge, skills, attitudes, and personal traits of nurses.

2.7.3 Hospital nurse staffing and nursing sensitive outcomes

According Buchan and Calman (2004:4), hospital nurse staffing is a matter of significant concern since it can have a major effect on patient safety and quality of care. Nurses are regarded as front line staff in the health system and their contribution is regarded as important in meeting the Millennium Development Goals. According Stanton (2002:2),

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nursing sensitive outcomes on the other hand are one indicator for quality of care that can be defined as "variable patient or family, care giver state, condition or perception responsive to nursing intervention". Some adverse patient outcomes that are potentially sensitive to nursing care are longer hospital stay, shock pneumonia, urinary tract infections, etc. There is association between lower staffing level and adverse patient outcomes. Stake holders within the healthcare system are well aware about staff shortage and its impact as well as lack of qualified nursing staff and are actively seeking solutions. According to Buchan and Calman (2004:4), the scarcity of qualified personnel including nurses is considered as being one of the obstacles to achieving the Millennium Development Goals.

According to Aiken, Sean, Clarke, Douglas, Sloane, Sochalski, Jeffry and Silbert (2002:28), the Californian government passed legislation for nurse-patient ratio for the surgical and medical ward of 3-10 patients for each nurse and one licensed nurse for every 6 medical and surgical patients. This was taken as a measure to curb the nursing staff shortage that was escalating at that period, resulting in the increased staff turnover and patient dissatisfactions. Patients were concerned about inconsistency of care given to them by nurses because of nursing shortage and nurses having too many patients to care for. Specific staffing issues raised were burnout, shortage, new graduates and patient assignment. Nurse's burnout, emotional exhaustion, depersonalization and lack of personal accomplishment resulting from high workload for the nurses were cited by (Seago, 2002:51). It was further revealed that there is a relationship between nursing staffing level and patient outcomes. Nurse's availability according to the above literature has a profound bearing on the quality of care given.

2.8 DIMENSIONS OF PATIENT SATISFACTION

Patient satisfaction assesses the patient and views of quality care received (Booyens, 2005:612). While patient satisfaction might be subjective and individualised, it is also multidimensional. Quality is used to describe high standards, but of several dimensions.

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Booyens (2005:596) further indicated that such dimensions range from appropriateness, equity, accessibility and efficiency. For the scope of this study, however, efficiency is the dimension of interest as this indicates that both human and material resources are not wasted but are utilised to give cost effective quality care to the patients.

Attree (2001:456) mentioned attributes or dimensions of quality care as the nature of care providers give, which might be patient-focused, individualised and inclusive. Need anticipated was highly valued by patients and thus means nurse's ability to be proactive with client needs. Other dimensions mentioned were open communication and information passage, kindness to patients, concern, compassion, time available to communicate with patients and accessibility to health care facilities. According to the WPTPS of 1997, health service is transforming to ensure that quality care is distributed equitably to all sectors of communities. One of the eight identified Batho Pele principles of transforming health services focuses on quality of health care services through acceptable service standards (DOH, 1997b:27).

2.8.1 Patient expectations

According to Ajayi et al (2005:137), patient expectations are those pre-conceived ideas or opinions that the patients have about the care they hope to receive. He further explained how patient expectations are linked to the complex phenomenon of patient satisfaction or dissatisfaction. Just as nurses have different views affecting their attitude in caring, so do patients coming from various social and cultural backgrounds. Dagger and Sweeney (2006:18) cited findings which suggested that patient's backgrounds, beliefs and values play a role in building perceptions and expectations of nursing care. Pre-service expectations have a lot to do with patient satisfaction with care received in a sense that patient who enters a healthcare organisation with low expectations is more likely to be easily satisfied with nursing care received and therefore, when expectations are exceeded, patient satisfaction is attained or even excel. On the other hand, Attree (2001:459) stated that patient's expectations of care are not well defined before hospitalisation. Patients expect the best nursing care as possible, those expectations

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varies according to nature and seriousness of their illnesses. Patients expect a warm reception that they receive from the nursing staff, admission procedure that is satisfactory, correct medication given at correct time, comfort, relief of pain, to be fed where necessary and any other basic nursing care that will make them better and not worse. They also expect latest methods and technologies applied while doing procedures and other nursing related duties rather than old ones. Above all, they expect principle of equal fair treatment (Muller, 2001:201). Booyens (2005:595) reveals that patients were unsure about the level of care they are entitled to receive and what they should expect as patients. Fletcher (2001:328) carried out a survey on patient's satisfaction and the respondents indicated that safety measures were not enough. Similar findings by Booyens (2005: 595) revealed that, each time questions were asked on the patients and challenges posed about the adequacy of the information given to patients by nurses, patient's response focus on nurse's negative attitude and on various complaints such as inability to receive bedpan/urinals.

According to Corbin (2007:163), there are aspects that are lagging behind; such aspects are standing on the way of caring; tasks such as walking sick patients, bathing and doing back rubs. Failure to perform such tasks push nurses away from the patients and their time is consumed by paper work. There is less time to show the patients that nurses are there for them, know their needs and to get enough opportunity to connect and to teach them. Sitzia and Wood (2009:178) put forward their views through their findings that patients on chemotherapy were dissatisfied about the information that they were not getting about the side effects of the treatment they received as well as the environment that they were placed in. A South African study on asthmatic patients by Markson, Vollmer, Fitterman, O'Connor, Narayanan, Berger and Buist (2001:384) indicated similar findings of dissatisfactions on patient's education, absence of adequate communication and unavailability of written treatment plans. Reland, Robert, Kalman and Melani (2007:22) reported that terminally ill patients and their families reported dissatisfactions with end of life care in the sense that there is lack of adequate support and communication with patients and the families of patients facing death. Markson et al

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(2001:383) further concluded that not all patients with disease management problems were dissatisfied; giving example of asthmatic patients who did not report dissatisfaction, indicating that perhaps the patients with asthma may accept a lower level of functioning than possible.

2.8.2 Expectations for the patient education

According to Ejeoma et al (2011:12), patients are becoming better users of health care; they are becoming interested and well informed and want to know more about health related issues. Because of greater attention that is placed by media on health, patients are becoming aware of their rights and are more demanding about receiving information on their condition and treatment; some patients want to be involved in their care and treatment than the others. Patient education is nowadays viewed as an integral part of high quality care and has become part of total, comprehensive patient care. In order to provide quality care, patients need to know about their disease, prevention and health promotion. Patient education can have an impact on the length of hospital stay and can positively affect the quality of care. Some of the advantages of patient education are shorter hospital stay, reduced convalescence, reduced facility utilisation and reduced higher incidence of chronic illness. Most of the clients are nursed at home by family carers and they cannot do so without the necessary knowledge.

According to Lari, Tamburini and Gray (2004:23), expectations are modified through education, a patient knows that something is wrong in his body and acknowledges that treatment is needed but do not know the nature of the disease, diagnostic and therapeutic options; therefore, the patient needs information on what to expect as a way to begin the process of managing the expectations. Lewis et al (2007:54) maintain that teaching the patient is the most crucial but challenging aspect of patient care; teaching is frequently neglected hence with the most devastating effects on patient's quality of life. As adult patients, teaching needs to follow the principles of adult education. Adult education is a matter of concern in terms of self management and if ignored, may result into poor disease outcomes. He suggested that provider education and availability of

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office-based tools e.g. templates for treatment plans can foster communication and decrease dissatisfactions. He further indicated that the above mentioned views may warrant serious consideration in future quality improvement programmes. Nursing staff is the category of professionals who are constantly in close contact with the patients and with broader educational background and are the most ideal categories to engage in patient educational work. However, nursing realities, such as staff shortage, time pressures and needs for patients who are acutely ill often forces nursing staff to put patient education lowest on their list of priorities. Nurses need to be given more accountability for individual patient care in order to facilitate the impact of patient education.

2.9 HEALTH SERVICE QUALITY AND THE NURSING MILIEU

The environment within which nursing care is delivered has an influence on the quality of nursing care given. Nurses comprise the largest working force of the care givers and are the closest link group between healthcare organisations and the patient. Nursing shortages can therefore negatively affect quality of healthcare. Kunaviktikul et al (2001:777) cited concern about the effect of lack of human resources on quality of healthcare. Service quality and focus on acceptable standards have received a lot of attention both at organisational and national level. The DOH for SA approved a national health budget strategy. The strategy is meant amongst the other things, to address the quality of service with special emphases on outcomes hence attaining and maintaining patient satisfaction throughout.

2.10 THE PROCESS OF NURSING

Literature has cited responsiveness as an important part of the process of nursing. Availability of nurses and being there for the patients when needed and offering service pro-actively without waiting for the patients to request for the assistance promotes patient satisfaction during the process of nursing. Nursing care plans and prioritising of

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procedures according to patient's needs enables nurses to work in an organised manner. Procedures which require coordinated action or psychomotor skills like bathing, lifting or turning patients are part of the process of nursing. Procedures may be outlined in a manual in the form of series of steps from the beginning to the completion of a procedure. Practice guidelines provide direction which nurses can follow in order to manage the clinical symptoms. It is these guidelines that assist nurses and promote order in nursing practice. Nursing as an aesthetic experience is described as part of the process of attending to another by the nursing staff. It is the art of listening, responding and interacting between the nurse and the patient. Record keeping and documentation brings to the completion process of nursing. A nurse who checks the patient's vital signs but fails to keep record of the findings creates a gap in the process of nursing since the information is not communicated to other team players and might be lost (Leight, 2002:109).

2.11 OUTCOMES OF NURSING

Though Donebedian's framework emphasised the process, it is the outcome which is an indicator of the nature of the care given to patients. The structural and process standards that are present in an organisation will result into outcome standards. The result of how nursing is structured and how the processes are carried out will also result in an outcome of nursing. Nursing outcomes can either be positive or negative depending on how the person perceives them. Kunaviktikul et al (2001:777) declared negative outcome indicators of their study as incidence and complications; administration of wrong medication, falls of patients or visitors and nosocomial infections while the positive outcomes were patient satisfaction, comfort, safety, satisfaction with information, less anxiety, health education, and satisfaction with pain and symptom management. A study by Langemo et al (2002:99) pointed out that the outcomes of nursing on patient satisfaction with overall care can be achieved through pain management, patient education, monitoring of adverse incident like falls and complications such as pressure sores.

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Attree (2001:458) in a study of patients and relatives perspectives of 'good' and 'not so good' quality identified outcomes based on three themes of nature of care provided nature of patient relationship and outcomes. 'Good' quality attributes, focused on care given, close relationships and if patients were respected as people through demonstration of kindness, concern and compassion, sensitivity and giving the patients time to give inputs and attending to their needs. 'Not so good' outcomes included keeping patients uninvolved, non-individualised care, little rapport, limited communication, lack of kindness, concern, empathy and being unavailable for the patients. Outcomes from those studies were either negative or positive from patients and relative's points of view.

2.12 PATIENT'S SATISFACTION WITH NURSING CARE AND THE INTENTION TO RETURN TO SERVICE

Patients that are satisfied with the service rendered are likely to return to the same service and even to tell their next of kin or friends about the good service. In the Public health sector, patient satisfaction with the care received will attract more patients to the organisation. A happy and satisfied patient with care received will attract four other plus eleven potential clients. Zimhost Workshop (2000:25) on the other hand, also reveals that dissatisfying one customer will dissatisfy 378 others within a short period. Dissatisfied patients will send away potential clients while satisfied clients will attract more clients. Satisfied patients will be loyal and increase market share for the service.

2.13 CONCLUSION

This chapter discussed the literature review undertaken by the researcher. The literature review provided insight into the nature and extent of patient satisfaction, patient expectations about nursing care, patient's views regarding the care given and the effects of the inconsistent nursing care rendered to patients in the medical and surgical wards of the public hospitals.

Chapter Three will deal with the research methodology used in the study.

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CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The previous chapter presented the literature review on the links between patient satisfaction and quality, factors that influence patient satisfaction, worldviews, nurse's worldviews and how these influence nursing care, the theoretical framework of patient satisfaction and lastly, patient satisfaction and its influence on return to business or market share gain. This chapter discusses the research design and methodology used in the study. Research methodology refers to the entire strategy of the study from problem identification to final plans for data collection (Burns & Groove, 2003:361). Cohen, Manion and Morrison (2000:44) found that methodology in research refers to "a systematic way of gathering data from a given population so as to understand a phenomenon and to generalise factors obtained from a large population"; whereas according to Polit and Hungler (2004:233), methodology refers to the ways of obtaining, organising and analysing data. Methodology decisions depend on the nature of the research question. Methodology in research can be considered to be the theory of correct scientific decisions (Burns & Grove, 2005:216). In this study, methodology refers to how the research will be done and its logical sequence. The main focus of this study was to assess patient's satisfaction on the nursing care received; therefore, the research approach was quantitative.

According to LoBiondo-Wood and Haber (2002:116), the methodology of research project strongly influences the research process because it defines the method of carrying out the research and presenting the methods for data collection and measurement as well as the techniques used for data analysis.
This chapter describes the following:

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- The research design.
- Population.
- Sample and sampling techniques.
- Ethical considerations.
- Data collection instrument.
- Methods used in data gathering.
- Data analysis.

The aim of the study was to assess and describe patient's satisfaction with the care received while admitted in medical and surgical wards of the two selected public hospitals: namely Siloam and Elim.

3.2 RESEARCH OBJECTIVES

The objectives of the study were:

- To identify patient's views regarding the care given to them in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP.
- To describe patient's expectations about the nursing care given to patients in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP.
- To determine the effects of the inconsistent nursing care rendered to patients in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP.
- To establish recommendations that may be used by health care planners.

3.3 RESEARCH QUESTION

The following research questions formed the basis of this study:

- What are patient's views regarding the care given to them in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP?

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- What are patient's expectations about the nursing care given to them in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP?
- What are the effects of the inconsistent nursing care rendered to patients in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP?
- How can patient satisfaction be improved in surgical and medical wards of the public hospitals within Makhado Municipality of the LP?

3.4 PURPOSE OF THE STUDY

The purpose of the study is to assess and describe patient's satisfaction with the care received from the nursing staff while admitted in the surgical and medical wards of the public hospitals within Makhado Municipality in the LP and if the care received met patient's expectations. The researcher also held informal meetings with the professional nurses working in the surgical and medical wards of the selected public hospitals in order to identify aspects to be included in the questionnaire. Data collection was done between September and October 2012.

3.5 RESEARCH DESIGN

Polit and Hungler (2004:36) define research design as an overall plan for obtaining answers to questions being studied and handling difficulties encountered during the research. Uys and Basson (2004:37) regard a research design as the total strategy for the study from identification of the problem to the final plans for the collection of data or the structural framework within which the study is to be implemented. According to Morris (2000:74), the research design represents the major methodological thrust of the study. Fraser et al (2010:66) also added that the researcher's understanding of the issue relating to the design will demonstrate the approach that will seek to answer the research questions. Burns and Groove (2005:242) identified the research design as a

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blueprint for the conduct of a study maximising control over factors that could interfere with the desired outcomes and is the end result of the researcher's decisions about how the study should be conducted.

A non-experimental, exploratory, descriptive and quantitative research design was used to describe how patients admitted in the surgical and medical wards in the two selected hospital perceived the nursing care they received. Brink (2006a:111) stated that the purpose of non-experimental research is to describe the phenomena and explore the relationship between variables and data can be collected without making any changes or introducing any treatment. Elements central to study design included the presence or absence of some treatment, number of groups in the sample, number and timing measurements to be performed, sampling method, the time frame for data collection planned comparisons and control of extraneous variables (Babbie & Mouton, 2001:221). Non-experimental research was suitable for this study because the researcher collected the data without introducing any treatment or changes to the subjects.

According to Polit and Hungler (2004:38), a research design is a set of logical steps taken by the researcher to elicit a response to a research question and to control variance. The research design includes a plan structure and strategy that will ascertain whether the eventual validity of the research findings is maximised. The purpose of a research design is to achieve greater control over the study and to improve the validity of the study in examining the research problem. The research design must therefore be appropriate to the purpose of the study, and be feasible given realistic constrains and effective in reducing threat to validity (Burns & Groove, 2003:42). A structured questionnaire was used to collect data concerning the views regarding the care given, patient's expectations, and effects of inconsistent nursing care and improvement of nursing care among the patients who are discharged from surgical and medical wards of the selected public hospitals within the LP during September and October 2012.

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3.5.1 Dimensions/features of the research design

3.5.1.1 Quantitative

Burns and Grove (2003:30) define quantitative research as a formal, objective, systematic process in which numerical data are used to obtain information about the world. The research method is used to describe variables, examine relationships among variables and determine the cost and the effect to interactions between variables. In quantitative research, the researcher seeks to maintain objectivity, remain impartial and reduces bias by avoiding personal involvement with the data or participants (Fraser et al., 2010:61). In this study, the research was quantitative and therefore the data collected was analysed in quantitative (numerical) form. Quantitative analysis involved the manipulation of numerical data through statistical procedures for the purpose of describing phenomena or assessing the magnitudes and reliability or relationships among them (Burns & Grove, 2003:26).

Quantitative research uses structured tools to generate numerical data and uses statistics to interpret, organise and represent the collected data. In this study, the research uses structured tools to generate numerical data, giving rise to one of its strength, being easily replicable (Burns & Grove, 2003:30). The research design was quantitative as the researcher used a structured interview schedule to collect data from the respondents. The approach allowed the researcher to ask all the respondents the same questions with predetermined responses, which allowed the objective data to be collected throughout the study. The researcher also used frequency tables and graphs to analyse and interpret the findings. The researcher adopted a quantitative approach to obtain more information about variables affecting patients' views regarding the care given, expectations, and effects of inconsistent nursing care and to examine relationships in order to suggest improvement in nursing care practices that will result in patient satisfaction.

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Burns and Groove (2005:23) broadly characterised quantitative design as follows:

- It is a formal, objective and a systemic process in which numerical data are used to obtain information about the research topic.
- The researcher positions herself in a distant and non-participant relationship towards the subjects.
- The researcher determines the cause and effect relationships among the variables.

3.5.1.2 Descriptive research

According to Burns and Grove (2007:34), a study is descriptive when it intends to describe the phenomenon accurately within its specific context and when it is based on the collected data. The emphasis is on an in-depth description of an individual group, situation, or organisation. It provides accurate portrayal or account of the characteristics of particular subjects, events, determining the frequency with which something occurs and categorises the information. In descriptive studies, phenomenon is described or relationships between variables are examined. The types of variables of interest can be classified as opinions, attitudes, or facts (LoBiondo-Wood & Haber, 2002:223).

The purpose of descriptive study is for providing the opinions of respondents regarding the phenomenon that is being studied. De vos, Strydom, Fouche and Delport (2002:274) further state that a descriptive research determine what exists, frequency with which something occurs and the categories of various aspects. With a descriptive design, the researcher either plans to assemble new information about the phenomenon which is not yet studied or to gain more information about characteristics within a particular field of study, for the purpose of providing a picture of a situation as it naturally occurs. Such studies give service providers and planners the information that helps them to design services and allocate recourses more effectively (Burns & Grove, 2007:34). A descriptive design was used in this study to describe the prevailing situation on the views regarding care given, patients' expectations, and effects of inconsistent nursing care and improvement of nursing care among patients discharged from general

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wards of the selected public hospitals within the LP between September and October 2012.

3.5.1.3 Exploratory research

As defined in the Collins English Dictionary (2001:540), exploratory actions are done in order to discover or learn the truth about something. Polit and Beck (2004:194) regarded exploratory research as meant for investigating the full nature of a phenomenon, the manner in which it is manifested and other factors to which it was related. Exploratory research is aimed at exploring the dimensions of the phenomenon. The goal of explorative design is to arrive at a description of an experience or its meaning (Polit & Beck, 2004:194).

According to Uys and Basson (2004:38), exploratory studies set out to explore unknown field. The purpose of such exploration being:

- To gain new insight into the phenomenon.
- To extend preliminary investigation into more structured study.
- To develop new hypotheses in respect of an existing phenomenon.
- To determine the priorities for further research.

Exploratory research is therefore; conducted to gain new insight, determine whether there are interesting patterns in the data, discover new ideas and/or increase knowledge of a phenomenon. In this study, the researcher used exploratory method to gain new insight, discover new ideas and/or increase knowledge of patient's satisfaction on the nursing care received as the researcher is a lecturer and was also a coordinator for quality provision within Vhembe District. The researcher, therefore, entered the research field with curiosity from the point of not knowing and to provide new data regarding the phenomenon in the context (Burns & Grove, 2005:313).

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3.5.1.4 Non-experimental

Non-experimental research design was used because it allows the researcher to construct a picture of a phenomenon and to explore events, people and situations as they naturally occurred. The effects of human characteristics such as perceptions and beliefs cannot be studied experimentally. Events have occurred naturally and the researcher cannot control these events by manipulation (LoBiondo-Wood & Haber, 2002:222).

According to Polit and Beck (2004:188), a vast number of human characteristics are not subject to experimental manipulation. A non-experimental design was used because the study was descriptive; since the intent of descriptive research is to observe, describe and document aspects of a situation as it naturally occurs; the experimental design was not considered to be appropriate for this particular study. The variables of interest in this study concern human perceptions that would be difficult to collect using experimental research. This was also supported by Uys and Basson (2004:37) who specified the reasons for selecting non-experimental design as that:

- The independent variable cannot be manipulated.
- The practical problem prevents the researcher from creating divided groups at random for experimental studies.
- The study used a quantitative, non-experiential, exploratory, descriptive, and survey research design.
- The circumstances make it ethically undesirable to carry out experimental or quasi experimental studies.

A non-experimental design was therefore, appropriate to collect the required information in the real, natural setting of the participants.

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3.6 RESEARCH SETTING

Burns and Grove (2003:40) regarded research setting as the environment in which the research study takes place and can be a natural or controlled. The natural setting is a real-life study environment without any changes made for the purpose of the study. The study was conducted in the surgical and medical wards of the two public hospitals within Makhado municipality of the LP. Makhado municipality is located at the northern region of the RSA; it is about 70 kilometers west from the Thohoyandou Township. The study was conducted in two selected public hospitals within Makhado municipality in Vhembe District. Table 3.1 presents the names, type and number of beds of public hospitals at Makhado municipality, Vhembe District (See page 63).

3.7 RESEARCH METHOD

According to Fraser et al (2010:66), research method describes the complete research as it was planned. It begins with the subjects and the sample. This section discusses the methodology, population, the sample, the study population, sampling procedure, number of participants, the setting and ethical considerations. Research method refers to the steps, procedures and strategies of gathering and analysing the data in a research investigation (Polit & Beck, 2004:188). In this research, the methodology of quantitative research studies was used to guide the researcher in conducting this study.

3.7.1 POPULATION AND SAMPLING

3.7.1.1 Selection of public hospitals

A list of all public hospitals falling within Makhado Municipality was obtained from the District DOH (see Table 3.1 below). Two public hospitals within Makhado Municipality were purposively chosen from the list; namely: Siloam and Elim hospital. These hospitals were purposively chosen because their general wards were 30 bedded and above and it was thought that this could enhance representation.

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All hospitals available at Makhado Municipality as listed in Table 3.1 below

Table 3.1 Public hospitals within Makhado municipality VD of the LP.

Name of the hospital	Level of the hospital	Total number of active beds	Average number of beds in medical or surgical wards,
Siloam hospital	Community hospital	220	30
Elim hospital	Community hospital	323	36
Louis Trichardt Memorial hospital	Community hospital	52	12

3.7.1.2 Selection of the or surgical and medical wards

The four wards which provide the setting of the study were thirty and above bedded. The medical or surgical wards were purposively chosen as they contain patients with various health problems. Two of the wards are acute medical wards which have an average monthly bed occupancy rate of 75% and the fact that condition such as congestive cardiac failure are admitted. The other two are surgical wards; one of these two wards accommodating general surgical patient such as gynaecology and surgical cases. The reasons for selecting such sections of the general wards are that they admit acute patients that require more nursing care. In the selected general wards, only the discharged patients who met the inclusion criteria for this study were considered to participate in the study.

3.7.1.3 Target population

According to Jooste (2010:302) as well as Polit and Beck (2006:259), population is the whole group of people or of the objects that are of interest to the researcher. The researcher does not have access to the whole population of interest. The population that the researcher has access to is referred as accessible population. The researcher defines the target population of the research study by identifying parameters that are relevant to the research question, thereby further limiting the population. The population

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contains all the elements of the total population that the researcher needs for the research project, therefore, the target population contains all the elements that the researcher needed for the study. For the purpose of this study, the population consisted of all discharged adult patients, from the selected public hospitals after 36 hours and more of admission, male and female between the ages of 21-50 at the two selected public hospitals within Makhado Municipality of the LP.

3.7.1.4 Sampling and sampling techniques

The researcher can often not study the whole population due to time and cost constraints. Thus, a portion or sample of that population is subjected to research. The importance of appropriately selected sample can never be undermined because the results of the study are not more trustworthy than the quality of the population or the representativeness of the sample. It was initially difficult to determine the exact number of the population of those admitted in medical and surgical wards during the time of the research. Through the operational managers of participating wards, a list of patient who were about to be discharged was obtained. Sampling is the act of selecting elements, events, behaviours, or people representing the entirety of the population being studied (Brink, 2006a: 292). In any research a sample is obtained for many reasons, such as geographical spread of the population, and practical and economic purpose. The researcher sought to draw a conclusion about the population from the sample.
This enables the researcher to determine a population's characteristics and variables by directly observing only a portion of it. The characteristics must all be replicated in the sample (Jooste, 2010:302). According to Burns and Grove (2005:478), a sampling method is a strategy used to obtain a sample; it is therefore a vital step in any research as it forms part of delineating the inquiry. The method can either be probability or non-probability sampling (Burns & Grove, 2005:479). In probability sampling, every member of the population has the possibility to be included in the sample.

Jooste (2010:302) refers to sampling as a process whereby the participants or subjects are selected from the target population to ensure that the selected subjects or

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participants are representative of the total population. Burns and Grove (2005:746) further described sampling as involving selection of a group of people, events, behaviour, or other elements through which to conduct a study. It is a subset of the population that represents entire population in order to obtain information regarding the phenomenon. The selected sample should therefore have similar characteristics to the population under study; thus allowing generalisability of the results to represent the population (Polit & Hungler, 2004:259). Uys and Basson (2004:86) considered the basic purpose of sampling as to enable the researcher to obtain the desired information in a reliable manner without involving the entire population. The researcher thus wants to make observations of the sample in a practical economic manner and to generalise the findings to the population. There are two types of sampling; probability and non-probability sampling. Probability sampling is characterised by an equal chance of inclusion of each element in a sample. It is based on probability theory and therefore includes the principle of equal chance (De Vos et al., 2002:30; Uys & Basson, 2004:86). In the case of non-probability sampling there is no equal independent chance of being selected for the sample. During the present study, participants (medical and surgical wards patients) were selected by probability sampling; more specifically systematic random sampling method was used.

In systematic random sampling the sample is obtained by selecting units of analysis at every spaced interval until the desired number of units of analysis is obtained from some list or group. A list or a frame might be used where respondents can be selected randomly; the desired sample size established at some number (n), the size of population must be known or estimated (N). By dividing N by n the sample interval width is established. Example of this can be 200 students who are registered in a certain training institution. If a researcher wishes to take 50 students to participate, 200 is going to be divided by 50 and the answer is four, the researcher will then select every 4th name until the last name. In most cases systematic random sampling is preferred because the same results are obtained in a more convenient and efficient manner.

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Systematic random sampling procedure can also be applied to lists that have been stratified (Polit & Hungler, 2004:262; Jooste, 2010:302).

Uys and Basson (2004:86) specified the advantages of sampling as follows:

- It is time and cost-effective.
- If the target population is too large, smaller units can be studied.
- If sampling is carried out correctly, the data can be of more value.
- The Hawthorne and other effects can be better controlled.
- Harmful experiments can be carried out in smaller groups.

In this study, the researcher uses a systematic random sampling were a list totaling 200 patients that were about to be discharged was requested in advance from the operational managers of each participating ward of the participating hospitals. Two hundred (200) was then divided by 100 which was the desired number of patients that were to participate in the research and an answer of two was obtained. Names were then randomly selected in a manner that every second patient from the list was selected. In this study, only eighty (80) patients were interviewed by means of filling up the questionnaires.

The reason for choosing a systematic sampling method was that the results are obtained in a quick, easy and in more convenient and efficient manner. Selected names of the respondents were returned to the operational managers of the wards under study. In addition, a purposive sampling represents judgmental sampling involving conscious selection of certain subjects or elements to be included in the study. The judgment is made on the basis of available information or the researcher's knowledge about the population. In this study, purposive sampling was used to ensure that only patients between the ages of 21-50 were included in the sample. To be eligible for the study, patients were required to meet the following criteria:

- Be 21-50 years of age.
- Be admitted for three or more days.

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- Be admitted for medical or surgical condition.
- Be conscious enough to answer the questions.
- Agree to participate in the study.

Purposive sampling was also used to select the public hospitals in order to ensure that only the hospitals with 30 bedded surgical and medical wards were selected. Eighty (80) respondents from surgical and medical wards were interviewed at the two public hospitals within Makhado Municipality of the LP.

3.7.1.4.1 Empirical aspects

3.7.1.4.1.1 Consultation

The study was carried out in accordance with the existing ethical guidelines. Research ethical clearance was obtained from the University of Venda: University Higher Degree Committee.

3.7.1.4.1.2 Inclusion criteria

Burns and Grove (2005:367) define inclusion criteria as the characteristics that the respondents must have in order to be included in a study. The characteristics therefore delimit the population of interest (Polit & Hungler, 2004:230). In this study, the researcher's target population was all patients who received nursing care in the surgical and medical wards and are discharged from the medical or surgical wards, under study during the time of data collection. The respondents of this study therefore, met the following criteria:

- Male and female adult patients.
- Between the ages of 21 – 50.
- Have been admitted in the medical or surgical wards, of the selected public hospitals for at least 36 hours or more.
- Discharged and were willing to be interviewed by the researcher.
- Are conscious, that they can respond to questionnaires.

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3.7.1.4.1.3 Exclusion criteria

Exclusion criteria refer to the characteristics existing in the population that would have a negative effect on the research findings (Burns & Grove, 2005:348). Exclusion criteria for this study were:

- Day care cases.
- Patients under the age of twenty one (21) and those above fifty (50) years.
- Patients who were confused.
- Patients who were still admitted.
- Patients who were admitted for less than 36 hours.
- Patients who participated in the pre-test.
- Patients who were not admitted in the surgical and medical wards.

3.8 DATA COLLECTION INSTRUMENT

Structured data collection is an approach to collect information from subjects, either through self-report or observation, wherein the researcher determines in advance the response categories of interest. According to (Polit & Beck, 2004:213), data collection involves the gathering of information to address a research problem. Three types of approaches to data collection has been used frequently by nurse researchers, namely self-reports, observations and biophysiological measures. In this study, the researcher used the self-report method of data collection. Self-report is a method of data collection whereby a good deal of information can be gathered by questioning people. Structured interviews were used to collect data from the patients. Where structured interviews are used, subjects need to respond to the same question in the same order and with the same set of response options (Polit & Beck, 2004:349). With structured interviews, the researcher enjoys a degree of control over the contents of the interview. The order of questions is specified and the researcher is not allowed to deviate from the order in which the question appears on the interview schedule. This was done to minimise the role and influence of the researcher and to ensure an objective comparison of the results (Burns & Grove, 2005:396; Brink, 2006b: 151).

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In this study, a structured questionnaire was developed to elicit responses relevant to achieve the aim of the study. According to Burns and Grove (2005:426), a questionnaire is a printed self-report form designed to elicit information and is developed with specific items to assist with the data collection. It is used to gather information from a large number of participants that can be easily quantified and analysed. The advantages of using a questionnaire to collect data in this study is that it requires less time and energy to administer and that it is less costly. In this study, a questionnaire was used comprising of closed and open ended items, which were a type of composite measure of knowledge (LoBiondo-Wood & Haber, 2002:301; Babbie, 2005:485).

3.8.1 Development of the questionnaire

Structured data collection is an approach of collecting the information from the subjects, either through self-report or observations wherein the researcher determine in advance the response category of interest. In order to collect the needed data or information for the study, the researcher developed a measuring instrument to be responded to by all the participants to ensure uniformity and consistency. Meyer et al (2011:14) specified that the researcher can use either open-ended, close-ended, or both. Open-ended question is used when variable is unexplored or unknown to the researcher and enable the researcher to explore the variables better. Close-ended questions on other hand make it possible for the participant to choose from the variables included according to the instructions of the researcher. The respondents are also to choose from the variables included according to the researchers' instructions. The participants usually understand the meaning of close-ended question better and questions are answered within the same framework, thereby making it easier to compare the responses. He suggested that as many close ended questions as possible should be used since open-ended questions are to be processed manually there by consuming more time during interpretation and categorisation (Meyer et al., 2011:15).

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According to Meyer et al (2011:15) certain principles are to be followed in order to ensure a quick and complete response when using questionnaire:

- Decide on the type of information needed for the research
- Even though necessary information should be gathered, the questionnaire should not take up too much of the participant's time
- Questions should be relevant to the research
- Questions and alternatives for answering should not show any bias from the researcher
- The format of the questionnaire should be on the level of the participants and sentences should be clear and brief

In this study, use was made of a questionnaire comprising closed and open-ended items; the questions formulated were guided by the objectives of this study. Advantages of questionnaires are as follows:

- Data can be collected by post from a big sample of participants at low costs.
- A large amount of data can be collected.
- Participants enjoy freedom in completing the questionnaire.
- Questionnaires are easy to compile and analysed.

According to (Polit & Beck, 2004:319), a self-report is a method of data collection whereby a good deal of information can be gathered by questioning people. In this study, a self-report method was used. The instrument addressed issues concerning the patient's satisfaction on the quality of nursing care received. The design of the questionnaire was developed in consultation with a statistician and the supervisor of the study at the University of Venda who critically reviewed and verified the interpretations of the questions in the questionnaire before being finalised. The questionnaire was also evaluated by experts in the research unit under the DOH at both regional and provincial levels.

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3.8.1.1 Structure of the questionnaire

A structured interview schedule with closed-ended questions, that could be completed quickly and analysed easily, and enabled direct comparison between variables was used in this study. Open-ended questions were also included for the respondents to provide information in their own words. Responses to open-ended questions were grouped into similar categories and subjected to statistical analysis. The questionnaire comprised of three sections: Section A; covered questions on biographic information; Section B contained items covering the broad factors that influence perception of service and Section C; comprised of four open ended questions to assess views of the patients regarding the medical or surgical wards. The questionnaire can be summarised by means of the following table:

Table 3.2 Summary of the questionnaire used for the study

Section	Type of information	Rationale
Section A	Biographic	To obtain personal information about patients in order to contextualise their satisfaction
Section B	Broad factors	To obtain information which might influence perceptions of service
Section C	Open-ended questions	Assess views of the patients regarding public hospital's medical or surgical wards

3.8.1.1.1 Rationale for using a questionnaire

The questionnaire was selected as the most appropriate data collection instrument for this study because:

- The researcher can obtain data from respondents over a wide geographic area of the LP.
- Questionnaires can be distributed to a large number of respondents simultaneously.

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- The respondents remain anonymous.
- Personal and sensitive information can be investigated with no fear of being identified.
- Respondent's responses are not influenced by the interviewer since instructions, wording sequence and response categories are standardised (Polit & Hungler, 2004:262).

3.8.1.1.2 Advantages of self-administered questionnaire

Self-administered questionnaire have the following advantages:

- The researcher can assist the respondents in case of queries or difficulties.
- Self-administered questionnaire have a positive impact on the response rate.
- Response rate can be monitored since the questionnaire is completed by the respondents on the day and at the time of the researcher's visit and collected by researcher herself.
- The information is easy to tabulate.
- It is inexpensive to administer.
- There is no expertise needed to administer.
- Confidentiality is maintained (Meyer et al., 2011:302).

3.8.1.1.3 Pre-testing of the instrument

A pre-test is a method used to test the instrument of a proposed study in order to refine the research tool before the actual study is commenced. It involves the trial administration of a newly developed instrument in order to identify flaws as well as time that will be required (Polit & Hungler, 2004:264). Uys and Basson (2004:98) regard pilot study as a small scale study using a small sample of the population but not the same group who will eventually form part of the sample group.

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According to LoBiondo-Wood and Haber (2002:199), as well as Meyer et al (2011:385), the rationale for pre-testing the research instrument is to:

- Assess relevance, adequacy, comprehensiveness and appropriateness of the instrument.
- Acquaint field workers with instrument, respondents and analysis of data.
- Assess the availability of research subjects.
- Determine reliability and validity of research instrument.
- Identify the action of intervening variables so that they can be eliminated.
- Identify gross inadequacies before doing the full scale study.
- Determine the feasibility of the sampling method.
- Refine and update the skills of the researcher and co-workers.
- Detect unforeseen problems and flaws.
- Refine the data collection instruments and data analysis methods.
- Acts as a miniature trial run of the methodology planned for the main study.
- Determine whether the sample is representative of the population.
- Eliminate bias as far as possible.
- Evaluate the questionnaire for clarity of question, effectiveness of the instruction and completeness of response set.

Pre-testing of an instrument is therefore, a crucial step in the research process. Problems with regard to the research project such as too narrow or too wide scope, objectives and aims, the research design and problems with planned instruments such as unclear, incomplete or omitted questions are corrected before the implementation of the research project, thereby increasing the validity and reliability of the data collection instrument. It also saves the researcher from frustration, time loss, unnecessary efforts and finances during implementation of the main research project. Pre-testing of the instrument was done in order to ensure that the information about all identified issues is obtained.

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After the development of the research instrument, the research instrument was submitted to the following categories of people:

- Three colleagues for comments: one quality assurance manager from regional hospital and two from community hospitals in Vhembe District.
- Two operational managers from surgical wards and two operational managers from medical wards; that is, one operational manager from each participating ward.
- A statistician from the University of Venda.
- A computer analyst from Department of Computer Services at the University of Venda was involved and critically examined the questionnaire.
- Two patients from each participating ward.

This was done to establish whether the questionnaire was clearly worded and will be correctly interpreted by the participants. A pre-test was done with two patients from each participating ward. A total of eight patients were involved; the number consisted of patients who were not included in the actual research project. After the pre-testing and further discussions, problems that were identified were clarified and corrected to improve comprehension. All patients who participated in the pre-testing were excluded from participating in the actual study.

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Table 3.3 Pre-testing/pilot study participants

Categories of persons	Area	Number of questionnaires distributed
Researcher's colleagues	Quality managers: Regional hospital Two public community hospitals	 1 2
Operational managers	Each general ward of two public hospitals in Makhado Municipality	4
Statistician	Department of Statistics University Of Venda	1
Computer analyst	Department of Computer Services University of Venda	1
Patients	Two from each general ward of the two public hospitals in Makhado Municipality	8
TOTAL		19

3.8.2 Validity and reliability of the questionnaire

For the research findings to be acceptable, the aspects of validity, reliability and bias need to be examined.

3.8.2.1 Validity

Validity refers to the truthfulness of the scientific findings. According to Brooks-Brurnn (2000:42), validity of an instrument refers "*to whether an instrument measures what it is meant to measure".* Validity in the study therefore referred to whether the instrument measured patient satisfaction or not. A valid study should demonstrate what actually exists and a valid instrument should measure what it is suppose to measure under study. Validity and reliability depends upon each other, a measuring device that is not reliable cannot possibly be valid (Duff, Lamping & Ahmed, 2001:215; Smith & Engelbrecht, 2001:1).

Content validity was measured by giving the questionnaire to three experts and a statistician at the University of Venda from the initial stage of its development. The

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structured interview was developed from relevant literature and from health system trust client satisfaction survey tool and a sylhetic questionnaire which has previously been tested and utilised to measure patient satisfaction. Ready-made tools were not used, but specific items were derived from published articles where similar instruments had been used. The instrument was reviewed by the statistician then pre-tested on eight patients who did not participate in the actual study. External validity was ensured by measuring every second discharged patient who met inclusion criteria so that results could be generalised beyond the sample used in the study. The following steps were taken to ensure validity of the study:

- Literature was examined to identify variables to be delineated.
- The researcher's supervisors examined each item for its appropriateness to the research questions.
- Data collection instrument was pre-tested on eight patients.

3.8.2.2 Reliability

Reliability refers "*to the extent to which an instrument is consistent in the results obtained in the use of a particular instrument repeatedly overtime on the same person, or if used by two researchers.* A reliable instrument measures phenomena accurately and reflects true score of items being measured (Pilot & Hungler, 2004:347; Fraser et al., 2010:61). Reliability is concerned with consistency, stability and repeatability of the information's accounts as well as investigators ability to collect and record the information accurately. A reliable measure is the one that can produce the same result if the behaviour is measured again with the same scale. A reliable measure is the one that maximise the true score and minimise the error component (Burns & Grove, 2005:749; LoBiondo-Wood & Haber, 2002:499).

3.9 DATA COLLECTION

Data collection details how the research instrument was chosen, designed, tested and applied. This applies to questionnaires and can also be applied to interview schedules

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or observation checklists. Data collection is the process of gathering information using a selected technique, which can either be questionnaire, interview or observation (Burns & Grove, 2005:460; Fraser et al., 2010:66). The researcher used a self-administered structured questionnaire to collect data. Questionnaire was completed by conveniently selected patients from surgical and medical wards of the two public hospitals within the Makhado Municipality of the LP. Respondents were between the ages of 21– 50, most of the respondents were able to read and write. A questionnaire is a document used to collect data through structure or semi-structured questions. Advantages of using questionnaire for data collection are that the respondents can take their time to complete the questionnaire without being rushed by the researcher. A large sample can be managed through the use of questionnaire. Data collection was done between September and October 2012. Systematic sampling was used where a list of patients that were about to be discharged were requested in advance from the operational managers of each surgical and medical ward of the participating public hospitals. Names were randomly selected in a manner that every second patient from the list was selected. Selected names of the respondents were returned to the operational managers in order to inform the researcher when the patients are discharged (Fraser, et al., 2010:66).

Upon discharge operational managers from each ward notified the researcher. Data was obtained via personal interviews at the hospital premises on the day of discharge. The researcher explained the purpose and significance of the study and the time required to complete the questionnaire. Informed consent was also obtained from the respondents by giving them the option of consenting or refusing to participate in the study. The researcher invited and answered all questions that the respondents asked. Participation was voluntary and respondents could discontinue at any stage of the process if they wanted to do so without incurring any disadvantage by such withdrawal. Respondents were informed that the information would be confidential and that because they could not be identified, they should feel free to express their views and feelings without any reservations.

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After the researcher had obtained the signed consent from the participants, the participants completed the questionnaire in the presence of the researcher. The respondents were encouraged to ask questions, and all questions were answered as they arose. The respondents handed the completed questionnaires to the researcher. For those who could not read and write the researcher used the questionnaire to ask them the question and they responded. However, a total number of nine (9) questionnaires were discarded as they were spoiled or incomplete and were rendered useless for data analysis purposes; Six (6) patients were in such a hurry that they could not participate and five (5) were collected by the relatives immediately after discharge and could not participate. A total of 80 questionnaires were analysed, comprising the total sample for this study. Results were presented statistically and no names of persons nor institutions were linked to any respondents in order to maintain anonymity of the results. It was agreed that the report findings will be forwarded to Limpopo Provincial DOH. No remuneration was paid to any participant.

3.10 DATA ANALYSIS

Data was analysed using the SPSS version 21 computer software. Data cleaning was done with the assistance of an experienced statistician from the University of Venda. Descriptive statistics was presented in tables, a histogram and a pie diagram. For closed ended questions, total scores for each questionnaire was added together and divided by 37 which is the total number of questions. This was done to total score for satisfactions, dissatisfactions and for the unsure responses, and a total score for each was obtained.

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3.11 ETHICAL CONSIDERATIONS

Ethics are standards used by groups of people, professionals and communities to measure rightness or wrongness of actions and behaviours. Ethics also refer to moral principles, which ought to be considered. In research ethical considerations are principles that govern the process of research in order to safeguard the humans under study or investigation. According to Pera and Van Tonder (2005:5), ethics are concerned with rightness or wrongness, good or bad. The focus of ethics and ethical considerations therefore is to ensure that the participants under study are kept from harm. This was also emphasised by Fraser et al (2010:66) who pointed out that the researcher's ethical implications are considered with discussion of how ethical dilemmas were resolved. Obtaining ethical approval is discussed and the possibility of harm to the participant is outlined, considering physical or emotional trauma or lowered self-esteem. Strategies to maintain anonymity and confidentiality are spelled out. Various professions have come up with a code of ethics and principles that safeguard clients or recipients of service. The researcher therefore, considered the following principles throughout research:

- The right to autonomy and confidentiality
- The right to self determination
- The right to justice
- The right to privacy
- The right to fair treatment

3.11.1 Consent for conducting research

Permission to conduct the study was obtained from:

- The district office of the DOH.
- Limpopo Provincial DOH.
- Chief Executive Officers from the healthcare institutions were the data was collected.

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A written permission was obtained from all participants. Patients who participated from medical and surgical wards were given time to read the information letter, that is sampled in annexure F and the consent form that is sampled in annexure G and were given chance to ask questions. For those who could not read, the information letter and the consent form were read to them. The purpose of the study was fully explained to them using the language they can understand. Risks and benefits were highlighted; respondents were further informed that participation is voluntary, the respondents had the right to choose whether to participate in the research or not. They were given choice to withdraw their participation at any point if they feel like.

3.11.2 Respect for person as an autonomous being

Respect for a person's rights is a basic human right. Respect refers to worthiness or value of a human being. Autonomy refers to patient's ability to reason and to take rational decisions. Autonomous individual have the right to choose to either participate in the research or not (Jooste, 2010: 23). Collins English Dictionary (2001:286) defines choice as "the act or instance of choosing or selecting; the opportunity or power of choosing". The respondents need to make decisions voluntarily without coercion. In this study, the respondents were allowed to give their informed consent to participate in the study. Before consent was obtained from the respondents, the purpose of the study was fully explained to them using the language they can understand. Risks and benefits were highlighted; respondents were further informed that participation is voluntary, so the respondents had the ability and rights to choose whether to participate or not in the research.

3.11.3 Confidentiality and Anonymity

Confidentiality is a basic ethical principle while anonymity is one way in which confidentiality is maintained. To ensure anonymity, steps were taken to protect the identity of the individual by ensuring that their names and any identifying details which may reveal their identity such as work place, personal characteristics and occupation are not included (Brink, 2006a:151). This was further supported by Burns and Grove

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(2005:163) who stated that anonymity is guaranteed if the participant's identity cannot be linked to the data collected. In this study, the researcher had not used names, referred to or indicated participant's names in any way during data collection. Questionnaires were coded with numbers indicating the ward and a questionnaire number. This number was not in any way connected to a specific person. In the end, data collected was not linked to individuals. Confidentiality entails the researcher's handling of private information. It involves the right of the participant to choose information they wish or not wish to divulge without being victimised by the researcher. The researcher ensured that data collected was not revealed to anybody other than personnel relevant to the study and the statistician.

3.11.4 The principle of beneficence

3.11.4.1 Freedom from Harm

According to Uys and Basson (2004:98), nursing research should be planned and undertaken in such a manner as to avoid as far as possible any kind of harm to the patient. The right to protection from discomfort and harm is based on the ethical principle of beneficence which states that one should do good and do no harm. Doing no harm refers to doing no psychological, physical, emotional, spiritual and any other harm. The researcher protected the participants from discomfort and harm by ensuring that no physical or psychological harm was inflicted on the participants. Participants were not paid any remuneration.

3.11.4.2 Freedom from exploitation

The questions were asked in a simplified manner to avoid unnecessary stressing up of the participants. Participants were reassured against victimisation stating the fact that they are completing the questionnaires after they were discharged but before going home, furthermore, their names will not appear on the forms. Exploitation refers to taking advantage of participants in any order to acquire information. Participants were

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informed that the information they offer would be used in a clinical area to improve clinical practices.

3.11.5 The principle of respect for human dignity

3.11.5.1 The right to self-determination

Human beings are sacred beings with right of choice of events. Autonomy is the principle of self-determination where humans have the right to choose a course of action. Participants who are part of a research study only do so if they consent and wish to get involved in the research. The principle of autonomy is linked with informed consent. Participants have a right to choose to participate in a research, discontinue at any stage or process of the study. Coercion of prospective participants is considered unethical. The researcher ensured participants are informed of what is involved in participating in the study then obtained consent from participants.

3.11.5.1 The right to full disclosure

Consent to participate in the study was granted by each participant after a full explanation of the purpose of the study and what the study comprised. This process entails a full disclosure.

3.11.6 The principle of justice

3.11.6.1 The right to fair treatment

Right to fair treatment is based on the ethical principle of justice. According to this principle, a person should be treated fairly and should receive what he or she is due or owed (Burns & Grove, 2005:189). Fairness is when the care givers are treating the patients equally with due consideration of their individual nursing needs. This includes not allowing race, creed, faith, religion and social consideration to adversely affect the care rendered to patients, relatives or community (Jooste, 2010: 25). During the sampling process, the researcher ensured that the study population included

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participants of various ages, ethnic backgrounds and socioeconomic status. The participants were treated with respect and courtesy and were informed that they could contact the researcher at any point in the study to get clarifications.

3.11.6.2 The right to privacy

According to Uys and Basson (2004:98), privacy mean that a person can behave as he pleases without interruption and without the possibility that private conduct or thoughts may later be misused to embarrass or humiliate the patient. This can better be achieved when the researcher guides against collecting more data than necessary for achieving the objectives of the study. Furthermore, the researcher should take the necessary precautions to ensure that the self-respect and dignity of the patient is maintained. Burns and Grove (2005:186) emphasised that the right to privacy involves the right of an individual to determine the time, extent and general circumstance under which personal information will be shared with or withheld for others. This may include the information concerning the beliefs, behaviours, opinions and records. In order to maintain privacy, Burns and Grove (2005:186) warn that the following factors should be considered:

- The sensitivity of the information
- The place where research is conducted
- How public will the research findings be made

In this study, the beliefs, habits, culture and lifestyles were respected for the participants. An opportunity was provided for each participant to ask questions and to clarify misunderstandings.

3.12 LIMITATIONS OF THE STUDY

The study focused on surgical and medical wards; other wards were not included because surgical and medical wards need more nursing care than other wards. The

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study focused on one municipality, one district and in one province; therefore, the findings will not be generalised to other provinces of SA.

3.13 METHOD OF DATA ANALYSIS

Data analysis involves, categorising, ordering, manipulating and summarising the data and describing it in meaningful terms. A powerful tool that is available to the researcher in analysing quantitative data is statistics (Brink, 2006b:170). In this study, the quantitative data collected was analysed using the SPSS version 21 software data was presented as tables and figures in Chapter 4 of this dissertation. The service of a statistician was employed in order to identify and to calculate appropriate statistics.

3.14 CONCLUSION

In this chapter, the research methodology that was used in the study was discussed at length. The aspects discussed were research design, research method, population, sampling method and sampling process, research setting, data collection, and data analysis. Measures were adhered to in order to ensure the validity and reliability of the research results. Ethical issues that could have impacted on the study were addressed.

Chapter 4 presents the analysis and discussion of the data obtained from 80 structured interviews conducted in surgical and medical wards patients regarding their perception on the quality of nursing care received.

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CHAPTER 4

DATA PRESENTATION, ANALYSIS AND DISCUSSIONS

4.1 INTRODUCTION

This chapter deals with the analysis and discussion of data collected. According to Brink (2006a:170), data analysis involves categorising, ordering, manipulating and summarising the data and describing them in meaningful terms. In this study, the data was analysed statistically. This chapter deals with the analysis of data obtained from discharged patients who were admitted in the medical and surgical wards. Of the target population of 100, only 80 patients who were discharged in medical and surgical wards gave their consent and participated in the study. These 80 structured interviews were conducted to patients who were admitted for 36 hours and more.

4.2 RESEARCH OBJECTIVES

The objectives of the study were:

- To identify patient's views regarding the care given to them in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP.
- To describe patient's expectations about the nursing care given to patients in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP.
- To determine the effects of the inconsistent nursing care rendered to patients in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP.
- To establish recommendations that may be used by health care planners.

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4.3 RESEARCH QUESTION

The following research questions formed the basis of this study:

- What are patient's views regarding the care given to them in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP?
- What are patient's expectations about the nursing care given to them in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP?
- What are the effects of the inconsistent nursing care rendered to patients in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP?
- How can patient satisfaction be improved in surgical and medical wards of the public hospitals within Makhado Municipality of the LP?

4.4 PURPOSE OF THE STUDY

The purpose of the study is to assess and describe patient's satisfaction with the care received from the nursing staff while admitted in the surgical and medical wards of the public hospitals within Makhado Municipality in the LP and if the care received met patient's expectations. The researcher also held informal meetings with the professional nurses working in the surgical and medical wards of the selected public hospitals in order to identify aspects to be included in the questionnaire. Data collection was done between September and October 2012. The findings of this study are presented in accordance with the sections of interview schedule:

Section A: Biographic data.

Section B: Broad factors which might influence perception of service.

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Section C: Four open ended questions to assess views of the patients regarding public hospital surgical and medical wards.

SECTION A:

4.4 BIOGRAPHIC DATA

This section dealt with information such as the patient's age, sex, educational level, occupational status and monthly income. According to Mudokwenyu-Rawdon (2001:16), biographic questions gather data on respondent's characteristics. The purpose of providing biographic data is to ensure that the rest of the information can be contextualised against the background knowledge of who the participants in the study were. Biographic descriptions of the sample are presented in the graph below: (see figure 4.1 to 4.5).

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4.1 RESPONDENT'S AGES

Figure 4.1

Age distribution of the patients (n=80)



Figure 4.1 indicates that out of the 80 respondents who answered this question, 14% (n=11) were between 21 and 26 years; 11% (n=9) were between 27 and 30 years; 11% (n=9) were between 31 and 34 years; 20% (n=16) were between 35 and 38 years; 14% (n=11) were between 39 and 42 years; 12% (n=10) were between 43 and 46 and 18% (n=14) were between 47 and 50 years. The findings reveal an even distribution of the respondent's age with slight increase of 20% (n=16) in the age group between 35-38 and 18% (n=14) in age group of 47-50 and the overall impression therefore is that all age groups equally responded in the study. Stutts (2001:294) reported that there seems to be no link between the level of patient satisfaction and age.

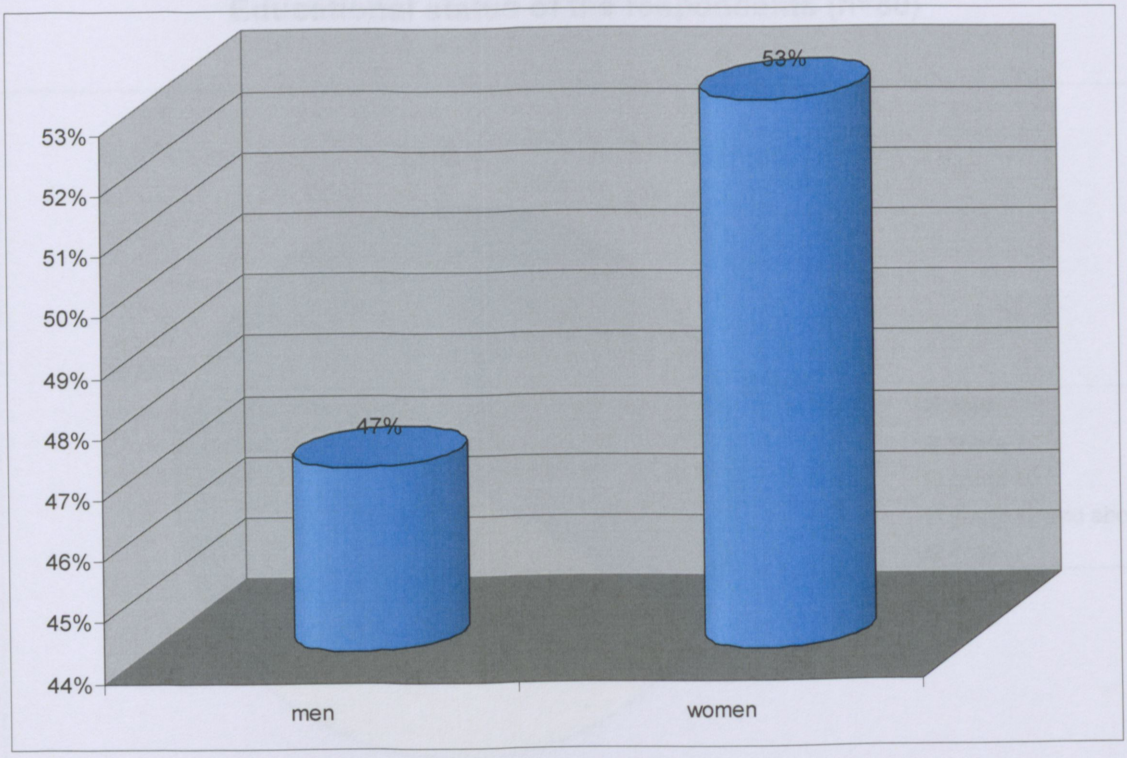
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4.2 GENDER DISTRIBUTION OF THE RESPONDENTS

Figure 4.2

Gender distribution of the respondents (n=80)



The study comprised 80 respondents, of whom just below half; 47.5% (n=38) were males and just above half; 52.5% (n=42) were females. This shows a slight increase in the number of females who were admitted than males. The findings of the study did not show differences in perceptions of nursing care according to gender. These findings concur with Attree (2001:460) who specified that previous studies have not indicated the significance of relationship in perceptions between males and females.

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4.3 EDUCATIONAL STATUS OF DISCHARGED MEDICAL AND SURGICAL PATIENTS

Figure 4.3

Educational status of the respondents (n=80)

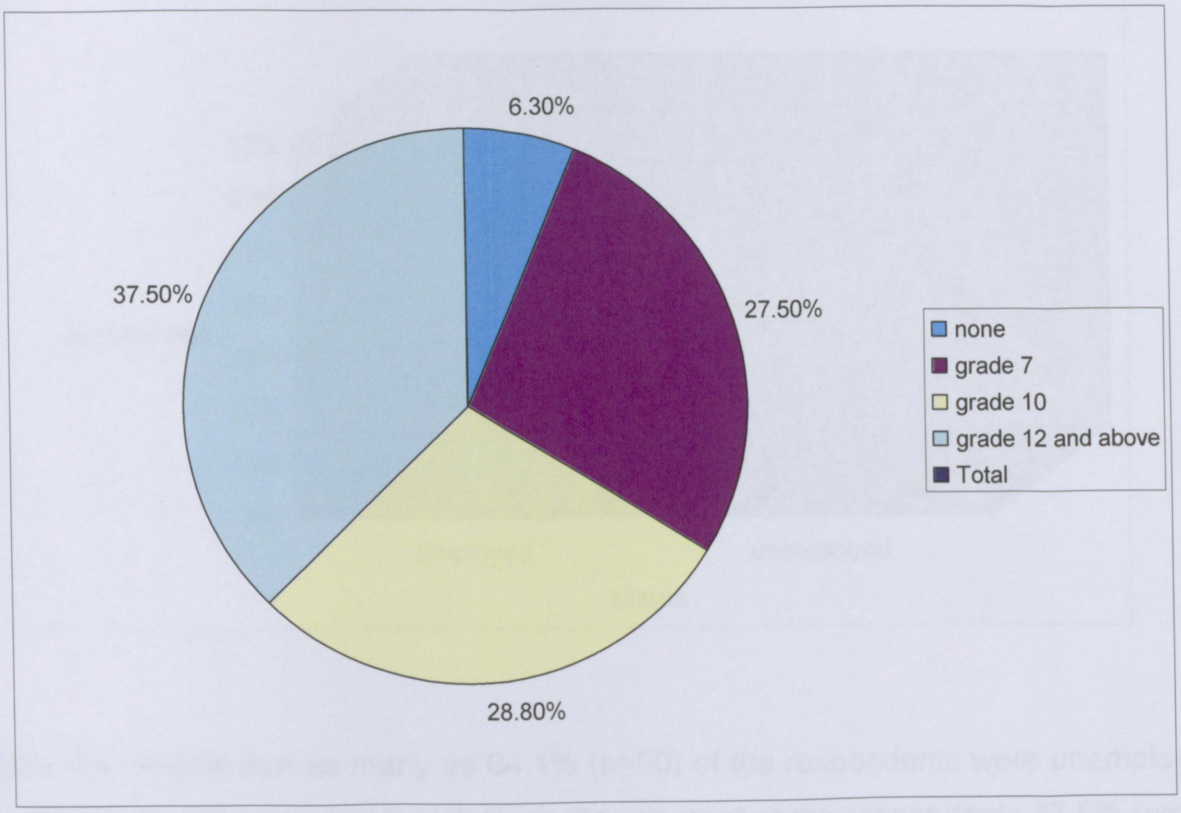


Figure 4.3 reveals that, 6.3% (n=5) of the respondents have no educational background; 27.5% (n=22) had grade seven; 28.8% (n=23) had grade ten and 37.5% (n=30) had grade twelve and above. Total number of respondents who had at least attained secondary education level was 93.7% (n=77). It can therefore, be assumed that the findings are views of people who are mostly having sound level of education that assumingly have the capacity to think critically. Thiedke (2007:34) reported that most studies find out that low socio economic status and the less educated tend to be less satisfied with the healthcare they received.

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4.4 EMPLOYMENT STATUS OF DISCHARGED PATIENTS

Figure 4.4

Employment status of discharged patients (n=80)



Figure 4.4 reveals that as many as 64.1% (n=50) of the respondents were unemployed and 35.9% (n=28) were employed. Even though most of the respondents 37.5% (n=29) had grade 12, this does not necessarily indicate socio-economic status or income levels, since most of the respondents remained unemployed. This is due to scarcity of jobs in the rest of SA including Makhado Municipality of the LP.

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4.5 FINANCIAL STATUS OF THE RESPONDENTS

Figure 4.5

Financial status of the respondents (n=80)

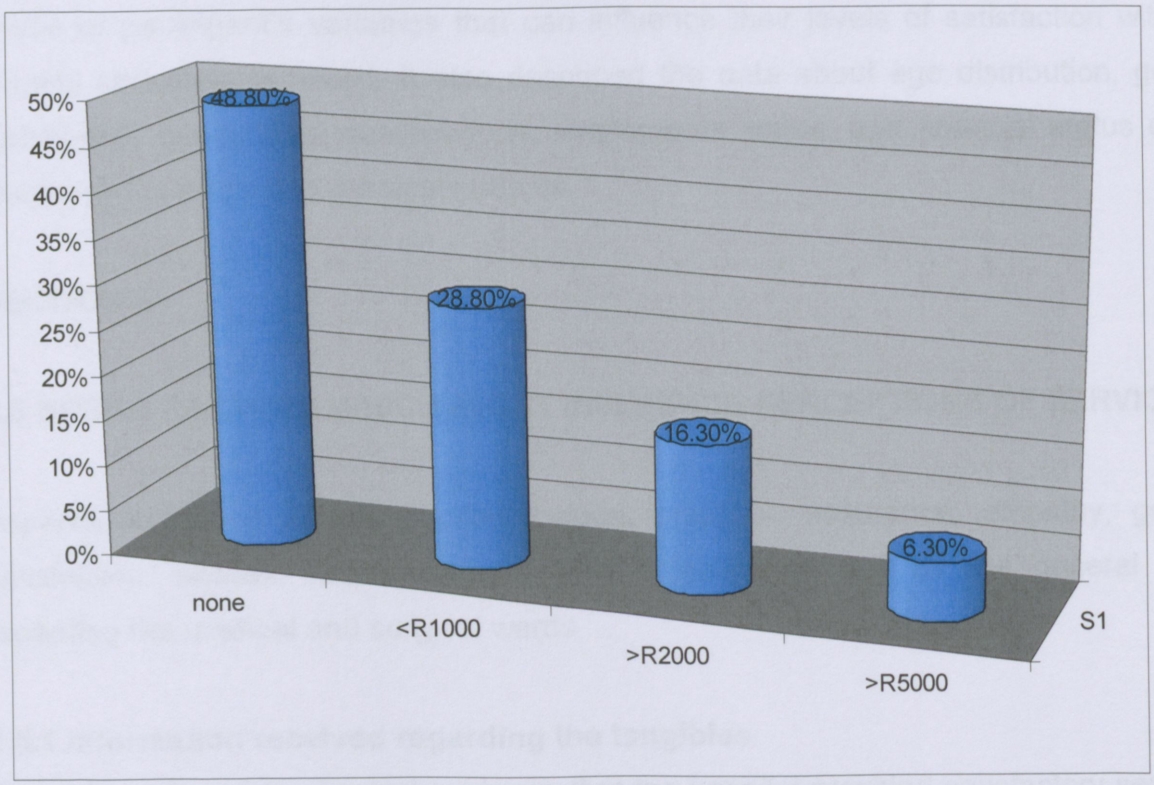


Figure 4.5 reveals that 48.8% (n=39) of the respondents has no income; 28.8% (n=23) earned less than R1000; 16.3% (n=13) earned more than R2000; 6.3% (n=5) earned more than R5000 and 2.5% (n=2), of the information on financial status was not obtained. The absence of income was due to unemployment of 48.8% (n=39) together with 28.8% (n=23) of those who earned less than R1000 and who serve as casual workers, and is assumed that their financial status could influence decision on coming to public hospitals where charges for health care service are lower and even free to others depending on their financial status. In a study undertaken by Stutts (2001:294)

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on parents of hospitalised neonates, it was revealed that lower income patients seemed to have lower satisfaction level.

4.2.1 Summary of respondent's biographic data

Respondent's biographic information was considered essential as it provides descriptive profile of participant's variables that can influence their levels of satisfaction with the nursing care they received. It also described the data about age distribution, gender distribution, educational qualifications, employment status, and financial status of the discharged medical and surgical patients.

SECTION B:

4.5 BROAD FACTORS WHICH MIGHT INFLUENCE PERCEPTIONS OF SERVICE

Aspects discussed in this section include tangibles, assurance, empathy, general satisfaction, access, responsiveness, and reliability as well as the general views regarding the medical and surgical wards.

4.5.1 Information received regarding the tangibles

Tangibles referred to physical evidence that the hospital provided satisfactory services. This include availability of equipment, physical facilities, clean and organised appearance of the hospital, wards and beds and written materials that create positive impression. For the purpose of this study, the following information was included in the questionnaire: The availability of materials, cleanliness of the ward, cleanliness of the beddings, and cleanliness of the hospital attire.

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Table 4.1: Availability of materials (n=80)

Availability of materials	Frequency	Percent
agree	51	63.7
disagree	28	35.0
unsure	1	1.3
Total	**80**	**100.0**

Table 4.1 revealed that although 63.7% (n=51) of the respondents were satisfied with the availability of equipment and other materials; 35.0% (n=28) were dissatisfied, while minority, 1.3% (n=1) were unsure. The study revealed that the resources such as equipment were insufficient. Those equipment that were available, became out of order few months from the day of reception from the central stores and had to be budgeted for the following financial year. Equipment and other materials enhanced the service delivery and can greatly influence satisfaction of the patients. Without materials and equipment, nursing staff become frustrated since their plans for nursing care fails. However, availability of equipment and other materials can be influenced by each patient's perception, knowledge and expectations (Hughes, 2008:13).

Table 4.2: Cleanliness of the ward (n=80)

Cleanliness of the ward	Frequency	Percent
agree	69	86.3
disagree	11	13.7
Total	**80**	**100.0**

Of the 80 respondents, the majority of 86.3% (n=69) were satisfied with the cleanliness of the ward; however, 13.8% (n=11) were dissatisfied. All the areas of the ward premises need to be scrupulously clean. Aspects such as shortage of cleaners, cleaner's negative attitude, lack of necessary skills and lack of effective cleaning materials were found to contribute to the dissatisfaction of 13.8% (n=11) of the respondents. This is a serious concern in as far as the disease prognosis is concerned

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and with the principles of infection control, especially in surgical wards where cleanliness is a mandatory necessity for wound healing. According to Lewis et al (2007:58), the risk of nosocomial infections can be prevented through maintenance of cleanliness of the ward environment.

Table 4.3: Cleanliness of the beddings (n=80)

Cleanliness of the beddings	Frequency	Percent
agree	78	97.5
disagree	2	2.5
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 97.5% (n=78) were satisfied with the cleanliness of the beddings and only 2.5% (n=2) were dissatisfied. Clean beddings are vital for comfort of patients as well as infection control (Lewis et al., 2007:58).

Table 4.4: Cleanliness of the hospital attire (n=80)

Cleanliness of the hospital attire	Frequency	Percent
agree	78	97.5
disagree	2	2.5
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 97.5% (n=78) were satisfied with the cleanliness of the hospital attire and only 2.5% (n=2) were dissatisfied. Cleanliness of the attire is crucial in order to maintain dignity and worth of the patients. It is of value to maintain comfortable and relaxing atmosphere. Cleanliness of the attire is crucial if infection is to be effectively controlled.

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4.5.2 Information received regarding assurance

Assurance implies the ability to have knowledge, skills and courtesy by nursing staff, and to inspire confidence and trust in those receiving care. It displays a sense of assurance in mind of the patients that they have the nurse's best interest. And that they will deliver service with integrity, fairness and beneficence. It further implies sufficient explanation of queries and generates a sense of safety. For the purpose of this study, the following information was included in the questionnaire: The safety throughout the admission period, answering or assistance to answer all questions, nurse's identification, giving permission before physical examination, and informing the doctor when the patients are very sick.

Table 4.5: Safety throughout the admission period (n=80)

Safety throughout the admission period	Frequency	Percent
agree	73	91.2
disagree	7	8.8
Total	**80**	**100.0**

This question attempted to determine the respondent's views about their safety while admitted in their respective wards. Of the 80 respondents, the highest proportion equaling 91.2% (n=73) felt safe throughout their admission period and 8.8% (n=7) felt unsafe. Reasons for dissatisfaction were cited as dilapidated infrastructure and long grass which was difficult to maintain. Lewis et al (2007:366) stresses that the nurse promotes advocacy for and strive to protect health, safety and rights of patients. Safety risks may be in the form of injury, infection, physical trauma from positioning or equipment use. They also indicated that the nurse should ensure safety of the patients in their hands (Smeltzer & Bare, 2004:5).

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Table 4.6: Answering or assistance to answers all questions (n=80)

Answering or assistance to answers all questions	Frequency	Percent
agree	77	96.3
disagree	3	3.7
Total	**80**	**100.0**

This question attempted to determine the respondent's views on whether the nursing staff answered their questions or referred patients to other members of multidisciplinary care team who can give answers. Of the 80 respondents, the highest proportion of 96.3% (n=77) were satisfied with the assistance they received in answering all questions and only 3.7% (n=3) were dissatisfied mentioning the fact that nursing staff avoided their question or promised to answer those questions later and never came back, some of the nurses became hostile, indicating that the patients are too inquisitive. Patients believe that they are cared for by people with expert knowledge; from time to time patients ask questions to get answers and clarifications. If their questions are not answered, they feel anxious and frustrated and do not know were to turn to for answers.

Table 4.7: Nurse's identification (n=80)

Nurses' identification	Frequency	Percent
agree	80	100.0
Total	**80**	**100.0**

Table 4.7 reveal that all of the respondents, 100.0% (n=80) were satisfied with the nurse's identification. This is because of the compulsory enforcement for putting on name tags by the institutions under study, especially those who serve directly with the patients. Nursing staff compliance in this regard was 100%. Identification of the nursing staff ensures that patients are nursed by a person whom they know, and if the patients are willing to make some inputs, or lay complaints they can even refer to the names of those nurses.

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Table 4.8: Giving permission before the physical examination (n=80)

Giving permission before the physical examination	Frequency	Percent
agree	70	87.5
disagree	10	12.5
Total	**80**	**100.0**

This question attempted to determine the respondent's views on whether the nursing staff requested permission from the patients before performing physical examination or not. Of the 80 respondents, the majority of 87.5% (n=70) were asked permission before physical examination and to 12.5% (n=10) no permission was asked. According to the DOH (997b:14), most health workers have poor communication skills and therefore, they cannot communicate effectively with patients.

Table 4.8 reveal that even though 87.5% (n=70) respondents were asked permission before physical examination, for 12.5% (n=10) respondents no permission was asked, patients are often surprised when they are ordered to take off their clothes without knowing what is going to be done to them and why.

Nursing staff have a duty to explain the procedure thoroughly to the patient before commencement of each procedure, this even involve answering questions where necessary until the patient is fully aware of what is going to be done to them. This enhances cooperation on the side of the patient. Getting permission before physical examination is crucial since patients need to be part of their care. The decision of the patient; whether to accept the procedure or not needs to be respected without cohesion (DOH, 1997a:6).

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Table 4.9: Informing the doctor when the patients are very sick (n=80)

Informing the doctor when the patients are very sick	Frequency	Percent
agree	72	90.0
disagree	7	8.8
unsure	1	1.2
Total	**80**	**100.0**

Of the 80 respondents, the highest promotion of 90.0% (n=72) were satisfied since the doctor was informed when the patients got very sick; only 8.8% (n=7) were dissatisfied indicating that nurses over looked the fact that they are so sick that there was a need to inform the doctor, therefore informing the doctor was delayed until they were seen during doctor's normal rounds; 1.2% (n=1) was unsure. Informing the doctor on time contributes to prevention of unnecessary pain, suffering, prevention of complication and can save lives (DOH, 1997a:6).

4.5.3 Information received regarding empathy

Empathy implies having the courage to enter into the patient's world in a manner that does not judge, sympathise, or correct but in a manner where the goal is that of understanding. It means putting aside one's own self for a moment and stepping into the shoes of the patient. Empathy implies the ability to care and display compassion towards patients. It further includes understanding of the patient's problems and their needs. Patients desire nursing staff that are attentive and understanding towards them. Personal care and mental support are important aspects of empathy (Lewis et al., 2007:56). For the purpose of this study, the following information was included in the questionnaire: nurses introducing themselves to the patients, introducing the patients to those next to their bed, interest of nurses in their patients, politeness of nurses, respect for privacy by nursing staff and counseling of the patients in a separate room.

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Table 4.10: Nurses introducing themselves to the patients (n=80)

Nurses introducing themselves to the patients	Frequency	Percent
agree	45	56.2
disagree	35	43.8
Total	**80**	**100.0**

Of the 80 respondents, just above half of the patients of 56.2% (n=45) indicated that nurses introduced themselves and 43.8% (n=35) stressed that nurses just performed procedures on them without informing them first and those patients were therefore dissatisfied. Creating climate of respect and trust is critical to establish a therapeutic relationship. When nurses introduce themselves to the patients, it encourages the patients to feel free to share even personal information to people who they trust. It also creates a warm, relaxed feeling towards the patient (DOH, 1997a:6).

Table 4.11: Introducing the patients to those next to their bed (n=80)

Introducing the patients to those next to their bed	Frequency	Percent
agree	41	51.3
disagree	39	48.7
Total	**80**	**100.0**

Of the 80 respondents, 51.3% (n=41) respondents were introduced to the patients next to their beds and just below half of the respondents; 48.7% (n=39) were not introduced to the patients next to their beds on admission; they therefore had to acquaint themselves to the patients next to their beds; some patients were kind enough to welcome them and made them feel home. This is a crucial part that makes patient feel at home with the patients whom they know from admission. Failure to introduce patients to others may result in alienation on the side of admitted patients and may take long for newly admitted to adjust to the ward environment.

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Table 4.12: Interest of nurses to their patients (n=80)

Interest of nurses to their patients	Frequency	Percent
agree	73	91.2
disagree	7	8.8
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 91.2% (n=73) were satisfied with the interest that the nurses showed in them and 8.8% (n=7) were dissatisfied stating that some nursing staff showed interest in other patients than the others. Showing interest in the patients allows them to rely on the nursing staff that they can even confide in them; this makes the patients to be ready to provide any kind of information to the nursing staff that can assist with their speedy recovery. According to Rafi, Hajine, Zhad & Haghani (2008:76), patients like the nursing staff to be kind, joyful and work with smile.

Table 4.13: Politeness of nurses (n=80)

Politeness of nurses	Frequency	Percent
agree	71	88.7
disagree	9	11.3
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 88.7% (n=71) were satisfied with the politeness of the nurses and 11.3% (n=9) were dissatisfied and stated the fact that some nurses were not greeting them or smiling at them as patients. Some nursing staff showed politeness to one group of patients and not to others. Politeness of the nursing staff is integrated into compassion both of which are linked to caring. Without displaying politeness, compassion and empathy, nursing is incomplete (Whyte & Grant, 2005:199).

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Table 4.14: Respect of privacy by nursing staff (n=80)

Respect of privacy by nursing staff	Frequency	Percent
agree	74	92.5
disagree	5	6.3
unsure	1	1.2
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 92.5% (n=74) were satisfied with the way privacy was maintained; 6.3% (n=5) were dissatisfied and 1.2% (n=1) were unsure. 6.3% (n=5) of dissatisfied patients was attributed to shortage of screens in some units. Basic components of healing environment include privacy. Patients are entitled to privacy relating to treatment, care discussion, consultation and examinations to prevent confidential information from spreading to other patients. Nursing staff have therefore, a moral duty to respect patients' privacy (Pera & Van Tonder, 2005:103).

Table 4.15: Counseling of patients in a separate room (n=80)

Counseling of patients in a separate room	Frequency	Percent
agree	56	70.0
disagree	6	7.5
unsure	18	22.5
Total	**80**	**100.0**

This question attempted to determine the respondent's views on whether they were counseled in a separated room or not. Of the 80 respondents, majority of 70.0% (n=56) were counseled in a separate room; 7.5% (n=6) were dissatisfied stating that they were counseled on their beds and only screens were used and 22.5% (n=18) were unsure since counseling was not necessary during their admission period.

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Table 4.15 reveal that while 70.0% (n=56) of the respondents were counseled in a separate room, 7.5% (n=6) were not. This is due to the unavailability of a separate room meant for counseling in some of the wards. This is attributed to the ancient nature of the plan for those buildings, and few screens that are available are used for that purpose. Some of the information concerning the patients could be easily heard by patients on the next bed. With the stigma that accompanies conditions like Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus (HIV/AIDS), it is important that counseling be done in a separate room to ensure the implementation of the principle of confidentiality and privacy.

4.5.4 Information received regarding general satisfaction

General satisfaction addresses the most crucial information that reflects picture of the overall service received in the ward; it balances out all facets of patient's experiences; it displays the unforgettable portrayal of the service in general that will determine whether the patient would use the hospital or recommend it to relatives and friends in future. For the purpose of this study, the following information was included in the questionnaire: visit to the hospital in future when ill, the quality of food, the way food is served, satisfaction with the way that patients are treated in the wards, and boredom while admitted.

Table 4.16: Visit to the hospital in future when ill (n=80)

Visit to the hospital in future when ill	Frequency	Percent
agree	76	95.0
disagree	4	5.0
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 95.0% (n=76) were willing to visit the hospital in future. There is however, 5.0% (n=4) of some patients who were dissatisfied during their period of hospital stay starting nurse's uncaring, rude, hostile and

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inconsiderate attitudes as well as shortage of medication as the reasons for their dissatisfaction. Response to this item contributed to reflection of the general care that the nursing staff is providing to the patients. Seeking of information in relation to visit of hospital in future is an important feed back that reflects the service in general. This implies that despite the dissatisfactions mentioned in some of the aspects, most of the patients are determined to visit the hospital in future.

Table 4.17: Quality of food (n=80)

Quality of food	Frequency	Percent
agree	60	75.0
disagree	20	25.0
Total	**80**	**100.0**

Of the 80 respondents, the majority of 75.0% (n=60) were satisfied with the food quality while 25.0% (n=20) were dissatisfied citing that cultural practices were not considered. There were shortage of important food items such as milk, meat, and even mealie meal; most of the relatives were brought food for the patients.

Regardless of the cause of illness, most of the patients have increased nutritional needs. Food is of therapeutic importance for body energy, maintenance and repair of body tissues etc. Food therefore needs to be well balanced and acceptable to all patients since it serves as part of treatment and contains necessary nutrients that are needed for recovery and healing (Lewis et al., 2007:948).

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Table 4.18: The way how food was served (n=80)

The way food is served	Frequency	Percent
agree	78	97.5
disagree	2	2.5
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 97.5% (n=78) were satisfied with the way food was served and 2.5% (n=2) were dissatisfied, citing that the food looked and smelt terrible. Food needs to be served in an attractive manner and in the correct temperature and according to patient's preferences in order to stimulate appetite of the patients. Patients with poor appetite are more likely to tolerate a meal if it looks attractive and tempting.

Table 4.19: The way patients were treated in the wards (n=80)

The way patients were treated in the wards	Frequency	Percent
agree	79	98.7
disagree	1	1.3
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 98.7% (n=79) were satisfied with the way they were treated in the wards and 1.3% (n=1) were dissatisfied. Generally, the respondents were satisfied with the way they were treated in the wards. This is also in line with Table 4.16 where many as 98.7% of the patients were happy to visit the hospital in future while ill.

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Table 4.20: Boredom while admitted (n=80)

Boredom while admitted	Frequency	Percent
agree	44	55.0
disagree	35	43.7
unsure	1	1.3
Total	**80**	**100.0**

Of the 80 respondents 55% (n=44) were bored while admitted; just below half of the patients, 43.7% (n=35) were dissatisfied and 1.3% (n=1) were unsure. Boredom is a serious concern, 43.7% (n=35) of the respondents were dissatisfied indicating that there were no radios; no reading books and there was only one television set per ward which is placed at the nursing station, out of those available, some television sets were out of order. Patients need to be occupied whilst admitted in the ward; the therapeutic impact that music can bring about on emotional aspect of an individual can not be over emphasised. Listening to relaxing music may act as a diversion to focus the patient away from pain, anxiety and stressful situation (Lewis et al., 2007:119).

4.3.5 Information received regarding access

Access: refers to the availability of nurses and hospital beds and other facilities around the clock. Smiling and greeting that the nursing staff displays towards the patients is priceless, and make it possible for the patient to feel free to approach the nursing staff at any given moment when a need arose. For the purpose of this study, the following information was included in the questionnaire: orientation to the ward environment, availability of medication, transport arrangements, and the time spent before the patients are shown to bed.

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Table 4.21: Orientation to the ward environment (n=80)

Orientation to the ward environment	Frequency	Percent
agree	39	48.8
disagree	41	51.2
Total	**80**	**100.0**

Of the 80 respondents, 48.8% (n=39) were shown around the ward environment on admission and 51.2% (n=41) were not; they were therefore dissatisfied. Table 4.21 reveals that less than half of the respondents of 48.8% (n=39) were shown around the ward environment and an unexpected number of 51.2% (n=41) were not. Respondents mentioned that orientation on admission was not done and those that were orientated it was incomplete; the patients have to acquaint themselves to the ward environment and the routine without the nursing staff involvement.

Orientation to the ward environment serves to make patients feel at home by reducing frustrations and anxiety to already stressed patients and to assist them to get acquainted to strange and unusual environment as soon as possible; it also enhances self-care and reduces unnecessary burdens from the shoulders of the nursing staff.

Table 4.22: Availability of medication (n=80)

Availability of medication	Frequency	Percent
agree	77	96.2
disagree	3	3.8
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 96.2% (n=77) were given all the medicine prescribed for them and 3.8% (n=3) stated that they could not receive some of the medicine prescribed and in some cases, the doctor even replaced the medication with ones that have similar effects.

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This is a provincial concern; some of the medications have run short for more than eight months; the reason being that they are unavailable at the central provincial depot. Unavailability of medication may delay healing, can lead to complications that might be fatal, long period of hospital stay and can lead the community to loose confidence in the public health services.

Table 4.23: Transport arrangements (n=80)

Transport arrangements	Frequency	Percent
agree	60	73.7
disagree	13	17.1
unsure	7	9.2
Total	**80**	**100.0**

Of the 80 respondents, 73.7% (n=60) were assisted with transport to go home; 9.2% (n=7) were unsure and 17.1% (n=13) were dissatisfied since they were left alone to struggle without assistance to the taxi rank, some of those patients were not strong enough to cover such distance on foot indicating that they are afraid that they might collapse on the way without the assistance of the nursing staff. Nursing staff need to ensure that patients arrive home safely; a transport arrangement on discharge was therefore, crucial.

Table 4.24: Time spent before the patients are shown to bed (n=80)

Time spent before the patients are shown to bed	Frequency	Percent
agree	68	85.0
disagree	12	15.0
Total	**80**	**100.0**

Of the 80 respondents, the majority of 85.0% (n=68) spent less than 30 minutes before they were shown the bed and 15.0% (n=12) spent more than 30 minutes. Hulton,

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Matthews and Stones (2000:39) found that patients admitted in public hospitals had to queue for a long time before they are admitted due to large number of patients who are admitted before them. Lacks of space and facilities as well as shortage of staff and equipment contribute to the long waiting period of patients before admission. This was the case with 15.0% (n=12) of the patients under study. Upon arrival to the ward, patient needs to be assisted immediately and since some initial doses of medications could result into drowsiness; a bed need to be allocated to them in order for them to get some rest.

4.5.6 Information received regarding responsiveness

Responsiveness: implies the willingness of the nurses to respond promptly when needed. This requires the availability of equipment that is in good working order and that is able to assist with quick diagnosis; above all, patients expect prescribed medicine to be available and administered as prescribed. For the purpose of this study, the following information was included in the questionnaire: awareness of patients to their rights charter, assistance to the patients during meal time, informing patients of delays from time to time, informing patients of changes in service from time to time.

Table 4.25: Awareness of Patient's Rights Charter (n=80)

Awareness of Patient's Rights Charter	Frequency	Percent
agree	38	47.5
disagree	42	52.5
Total	**80**	**100.0**

Of the 80 respondents, less than half; 47.5% (n=38) were shown the Patient's Rights Charter and more than half 52.5% (n=42) were not shown the Patient's Rights Charter, and were not in the know of what the Patient's Rights Charter entails, and therefore remained without the knowledge for the rest of their admission period.

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This is not in line with The DOH (1997a:6) which specify that all patients should know the Patients' Rights Charter and their responsibilities while on admission. Through the knowledge of their rights, patients know exactly how to behave in a particular situation and to identify any deviations during nursing care that warrant them to lodge complains. According to the (ANC, 1994:45), patients have the rights to the following:

- To refuse treatment to the extent permitted by the law
- To be informed about the payments or medical scheme
- To be seen by a named personnel
- To be in a safe healthy environment
- To lodge a complaint
- To be referred for second opinion
- To refuse treatment after explanation
- To choose the care provider they desire.

This finding emphasised the necessity for providing education to nursing staff on the importance of Patient's Rights Charter to patients as the beneficiaries of nursing care.

Table 4.26: Assistance during meal time (n=80)

Assistance during meal time	Frequency	Percent
agree	38	46.3
disagree	42	63.7
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 96.3% (n=77) were assisted to during meal time and 3.7% (n=3) who needed assistance were not assisted. Respondents mentioned that those patients who cannot feed themselves were not assisted and their meal was returned untouched to the kitchen, and no attempts were made to help those who cannot swallow, and those who had no appetite were not assisted. It was further revealed that the relatives assumed responsibility of feeding their loved ones.

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According to Lewis et al (2007:952), hospitalised patients, especially adults are at risk of becoming malnourished; nurses should therefore assume responsibility to meet the patient's nutritional needs. Assistance during meal time is therefore important to ensure that all patients eat most of the food that is served for them. Any refusal should prompt the nursing staff to seek further assistance, be it from a dietician or from a doctor.

Table 4.27: Informing the patients of delays from time to time (n=80)

Informing the patients of delays from time to time	Frequency	Percent
agree	70	87.5
disagree	10	12.5
Total	**80**	**100.0**

Of the 80 respondents, the majority of 87.5% (n=70) were informed of the delays of service from time to time and 12.5% (n=10) were dissatisfied since they waited unaware of some of the delays in getting services that they were entitled to, the patients specified that they felt that they were not taken seriously. Informing the patients of delays from time to time equipped them to anticipate such delays and give them confidence that they are included in the nursing care regimen.

Table 4.28: Informing the patients of changes in service (n=80)

Informing the patients of changes in service	Frequency	Percent
agree	58	72.5
disagree	8	10.0
unsure	14	17.5
Total	**80**	**100.0**

Of the 80 respondents, the majority of 72.5% (n=58) were informed of changes in service from time to time, 10.0% (n=8) were not and were dissatisfied with reasons

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similar to those stated in Table 4.27 in page 105, 17.5% (n=14) were unsure. Informing patient of changes is of outmost importance and it reveals the nurses attempt to include the patients in their care. It prevents keeping patients on hold and to keep them informed of what is transpiring at that moment.

4.5.7 Information received regarding reliability

Reliability refers to provider's ability to perform the promised service independently and accurately. It includes the consistency in the supply of medicine, supervision of patients by nursing staff and availability of nurse specialists. For the purpose of this study, the following information was included in the questionnaire: Feedback for each complaint, listening to the patient's problems, patients informed of service standards, patient education, handouts concerning the patient's illnesses, availability of enough nurses, time for giving medicine, assistance during the night, and explanation of procedures to the patients.

Table 4.29: Feedback for each complaint (n=80)

Feedback for complaint	Frequency	Percent
agree	39	51.2
disagree	41	48.8
Total	**80**	**100.0**

Of the 80 respondents, 48.8% (n=39) were given feedback for each complaint raised and 51.2% (n=41) were not given feedback. They therefore felt that the nursing staff is not doing anything about their complaints. They felt frustrated and helpless since their concerns remained unresolved. In order to improve the nursing care services, each patient's complaint needs to stimulate positive attention and feedback by the nursing staff from time to time. This is a necessary reaction if patient satisfaction is to be met. According to the Patient's Rights Charter, patients have the rights to complain and to receive feedback for each complaint.

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Table 4.30: Listening to the patient's problems (n=80)

Listening to patient's problems	Frequency	Percent
agree	76	95.0
disagree	4	5.0
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 95.0% (n=76) accepted that nurses who treated them listened to their problems; 5.0% (n=4) were not and were dissatisfied. They cited intolerant behaviour together with the pre-judgmental attitude that the nursing staff displayed towards them. According to Lewis et al (2007:56), the nurse should develop an art of active listening; this involves paying attention to what the patient is saying as well as observing patient's non verbal cues. The nurse concentrates in listening to the patient as communicator without interrupting. Nodding in response to patient statements and rephrasing and reflecting what the patient is saying will help clarify communication. The nurse should listen to the patient without showing that she is in hurry. Attentive listening allows the nurse to obtain important information that can assist with further patient recovery (Royan & Timmins, 2004:38). Furthermore, holistic approach to nursing care needs nurses who listen to patient's concerns with an aim towards resolving them. Active listening and valuing of each patient as an individual is an aspect of customer focus that is essential not only to healthcare, but also in all spheres of life.

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Table 4.31: Patients informed of service standards (n=80)

Information on service standards	Frequency	Percent
agree	37	46.3
disagree	43	53.7
Total	**80**	**100.0**

Of the 80 respondents, 46.3% (n=37) were informed of the service standards which were pasted on the wall; 53.7% (n=43) were not and were therefore dissatisfied. Table 4.31 reveals that more than half of the respondents were not informed of the service standards which were pasted on the wall. This might be due to staff shortage as well as the value that the nursing staff attaches to the service standards.

A standard is a specific description of the desired level of performance, containing the characteristics associated with excellence used for measuring and evaluating the actual performance of service delivery. Standards are therefore, approved written statements against which measurement can be made and which thus serve as a bases for comparison. Patients need to have knowledge of the level of service they are entitled to receive. Since most of the patients are not fully aware of the existence of the service standards, the orientation programme should include informing the patients of the service standards as well as their implications.

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Table 4.32: Patient education (n=80)

Patient education	Frequency	Percent
agree	67	83.8
disagree	11	13.7
unsure	2	2.5
Total	**80**	**100.0**

Of the 80 respondents, the majority of 83.8% (n=67) were taught how they can live a healthy life, 13.7% (n=11) were dissatisfied indicating the fact that they were in darkness without having a true picture of what they are suffering from and how they can lead a healthy life in future, and 2.5% (n=2) were unsure. Schoen (2000:290) stressed that teaching the patient should be a well planned activity. Teaching sessions are to be scheduled when there is less activity in the ward and the time should be convenient for the patients to learn. Lewis et al (2007:53) added that patient and family education is a crucial part of nursing care and is one of the most challenging roles that nurses are facing today. Even though patient and family education is required by accrediting bodies and institutional regulations, constraints such as time and nurses shortage may limit the abilities of nurses to offer patient education. As a result, patient education is usually neglected even though its omission can have devastating effects on the patients and their families.

Teaching the patients about their health care often make some difference in the patient's quality of life. Nurses provide patient and family education to help patient and their families to maintain health and to cope with acute and chronic problems. Teaching can help patients to make informed decisions about health practices and treatment choices. All patients should be involved in patient teaching and every interaction that the nurse has with the patient should be taken as an opportunity to provide education (Lewis et al., 2007:53).

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Table 4.33: Handouts concerning the patient's illness (n=80)

Handouts concerning the patients' illness	Frequency	Percent
agree	12	41.4
disagree	17	58.6
Total	**29**	**100.0**

Of the 29 respondents who received health education, it was found that less than half of the patients; 41.4% (n=12) were given handouts about their illness and more than half of the respondents; 58.6% (n=17) were not given handouts and some few patients who received verbal education reported that they forgot most of the information and can remember very little. Some respondents indicated that information was given to them while they were not yet ready since they were too sick to concentrate. A study by Attree (2001:460) revealed how regular dissemination of information concerning illness was valued by both patients and their families. According to Whyte and Grant (2005:200), factors such as language barriers, learning disabilities and cultural barriers might necessitate supplementing information with written materials and drawings. Walker (2007:29) pointed that handouts in the form of booklets, leaflets or pamphlets which are disease specific can be very useful in acting as a point of reference, help to reduce confusion and minimise the time spent on routine repetitive information. It can also assist to supplement verbal information because the patient might not be able to recall all the information that had been provided. Handouts need to be designed with relevant accurate information written in simple, brief terms in order to prepare the patients during recovery and rehabilitation.

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Table 4.34: Availability of enough nurses (n=80)

Availability of nurses	Frequency	Percent
agree	77	96.3
disagree	3	3.7
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 96.3% (n=77) accepted that there were enough nurses to care for all patients and 3.7% (n=3) indicated that the nursing staff was not enough. Shortage of nursing staff is a national issue. And for the hospitals under study, staff turnover is the main reason for staff shortage. Adequate nursing staff is of importance because the nursing staff can provide timeous, safe, holistic and effective care, since where there is appropriate nurse/patient ratio, relationship can exist between nurse staffing levels and outcomes (Seago, 2002:50). Aiken et al (2002:24) stated that the ratio for staffing medical and surgical wards should be one nurse to five patients (1:5).

Table 4.35: Time for giving medicine (n=80)

Time for medicine	Frequency	Percent
agree	79	98.8
disagree	1	1.2
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 98.8% (n=79) accepted that they always received their medicine on time and 1.2% (n=1) did not and were therefore dissatisfied. Effectiveness of medicine also depends on the correctness of time, especially antibiotics. Failure to comply can contribute to resistance and ultimately poor disease prognosis (Lewis et al., 2007:247).

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Table 4.36: Assistance during the night (n=80)

Assistance during the night	Frequency	Percent
agree	76	95.0
disagree	4	5.0
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 95.0% (n=76) accepted that there were always nurses to help them when they needed help during the night and 5.0% (n=4) were dissatisfied. This can be due to limited number of nursing staff that are allocated to night duty. Prompt assistance when patient needed one can relieve insomnia that can result from anxiety, pain and emotional stress.

Table 4.37: Explanation of procedures to the patients (n=80)

Explanation of procedures	Frequency	Percent
agree	75	93.8
disagree	5	6.2
Total	**80**	**100.0**

Of the 80 respondents, the highest proportion of 93.8% (n=75) accepted that all procedures were explained to them before they were carried out and 6.2% (n=5) were dissatisfied stating that no attempts were made to give any explanation for the procedures before commencement, for example, in case of injection, patients were just ordered to expose the injection site without knowing the reasons and effects that the injection will have on them. Phipps, Monahan and Sands (2003: 380) indicated that the information specific to procedures and activities that promotes physiological healing helps to alleviate anxiety. They further maintained that such information addressed individual needs of the patients, promotes sense of safety and comfort and can be of value to gain patient's cooperation.

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4.5.8 Summary of the broad factors that influence perception of service

Participant's broad factors that influence perception of service were considered essential as this information provides descriptive profile of the variables that can influence participant's levels of satisfaction with the nursing care they received. It also described the data about age distribution, gender distribution, educational qualifications, employment status, and financial status of the discharged medical and surgical patients.

SECTION C

4.6 OPEN ENDED QUESTIONS

This part of the questionnaire comprised of open ended questions which enabled patients to offer as much information as possible about how they perceived nursing care in surgical and medical wards of the public hospitals. Those questionnaires consisted of the following: effects of inconsistent nursing care, expectations for the patients, areas of care that needed improvement and overall service in the ward. These questions were grouped and analysed quantitatively.

4.6.1 Information received from the nursing staff regarding expectations for the patients

A patient is viewed as a human being who is unique with a particular make-up, experience and response. The patient is a member of the family and community and in constant interaction with the environment. Nursing is directed towards meeting a patient's goal. It takes place in a structured and designated setting, such as a hospital. The professional purpose of the relationship gives direction to the role assumed by a nurse. As a nurse develops empathy with a patient, the patient develops trust and confidence towards the nurse. A nurse displays interest and willingness to help by virtue of the profession that she is in. Nursing care is a unique contribution of a nurse to assists individuals to be independent of such assistance as soon as possible is crucial (Taylor et al., 2004:12).

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Upon admission, there are various expectations that the patients anticipate. These expectations are a picture of various aspects of care that patients are longing to receive such as: how the nursing staff should behave towards patients, treatment, level of care, patient education, hotel service and communication.

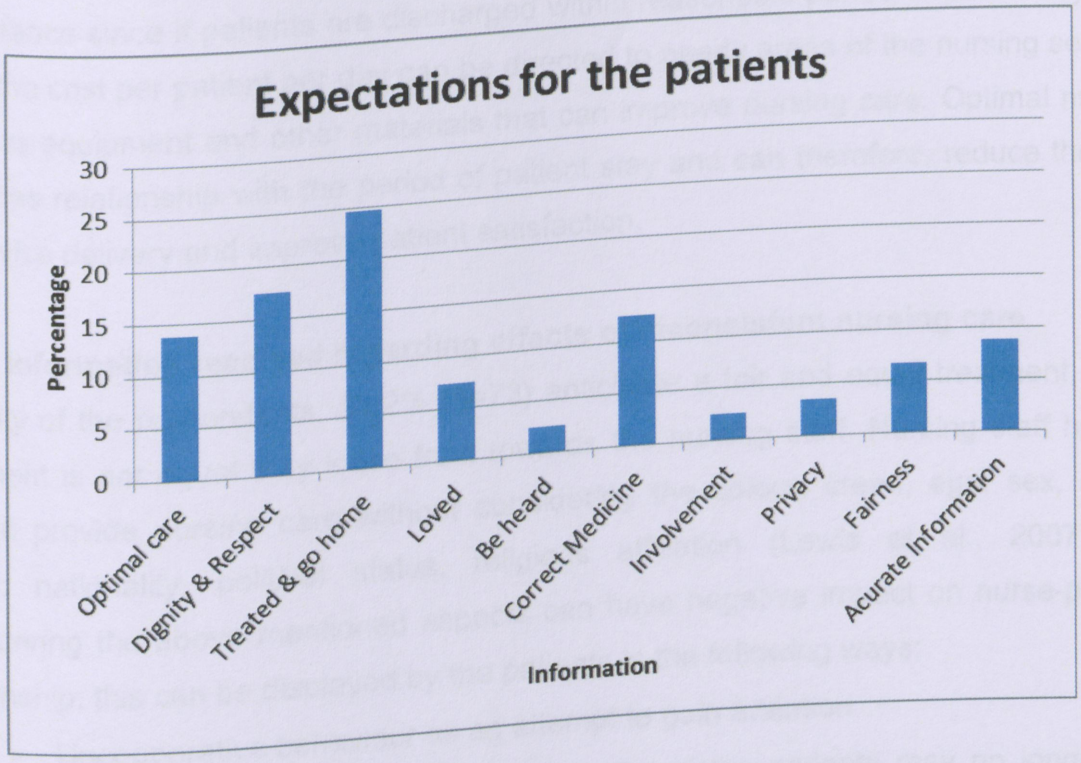
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4.6 EXPECTATIONS FOR THE PATIENTS

Figure 4.6

Patient's expectations (n=80)



Ten items that were indicated by the respondents represented the expectations of the respondents under study whilst admitted in both surgical and medical wards. Of the 80 respondents, 13.8% (n=11) expected to be cared optimally and in totality; 17.5% (n=14) expected to be treated with dignity and respect; most of the respondents; 24.7% (n=13) expected to be treated effectively and be discharged within reasonable period of time; 7.5% (n=6) expected to be treated with love 2.5% (n=2); expected that their voices be heard; 12.5% (n=10) expected to be given correct medicine which will be exact in healing them; 2.5% (n=2) expected to be involved in the issues concerning their health and not to be ignored when decisions about their care are taken; 3.5% (n=3) expected privacy of their name, person and possession to be maintained throughout their admission period; 6.7% (n=7) expected to be treated fairly and equally; 8.8% (n=12)

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expected to be given accurate, timeous and relevant information that will empower them to make responsible decisions concerning their health. According to Figure 4.6, it is clear that most of the respondents expected to be admitted for a brief period of time and be discharged, this was the desire of most patients 24.7% (n=13). This is of utmost importance since if patients are discharged within reasonable period of seven days and less, the cost per patient per day can be directed to needy areas of the nursing services such as equipment and other materials that can improve nursing care. Optimal nursing care has relationship with the period of patient stay and can therefore, reduce the cost of service delivery and improve patient satisfaction.

4.6.2 Information received regarding effects of inconsistent nursing care

Majority of the respondents, 91.2% (n=73) anticipate a fair and equal treatment, if the treatment is not equal they loose trust towards the nursing staff. Nursing staff have a duty to provide nursing care without considering the colour, creed, age, sex, social status, nationality, political status, religious affiliation (Lewis et al., 2007:246). Considering the above mentioned aspects can have negative impact on nurse-patient relationship; this can be displayed by the patients in the following ways:

- Uncooperative behaviour as an attempt to gain attention.
- Loss of trust towards the nursing staff and the patients may no longer be open enough to confide in the nurses.
- Refusal of treatment in case of loss of trust.

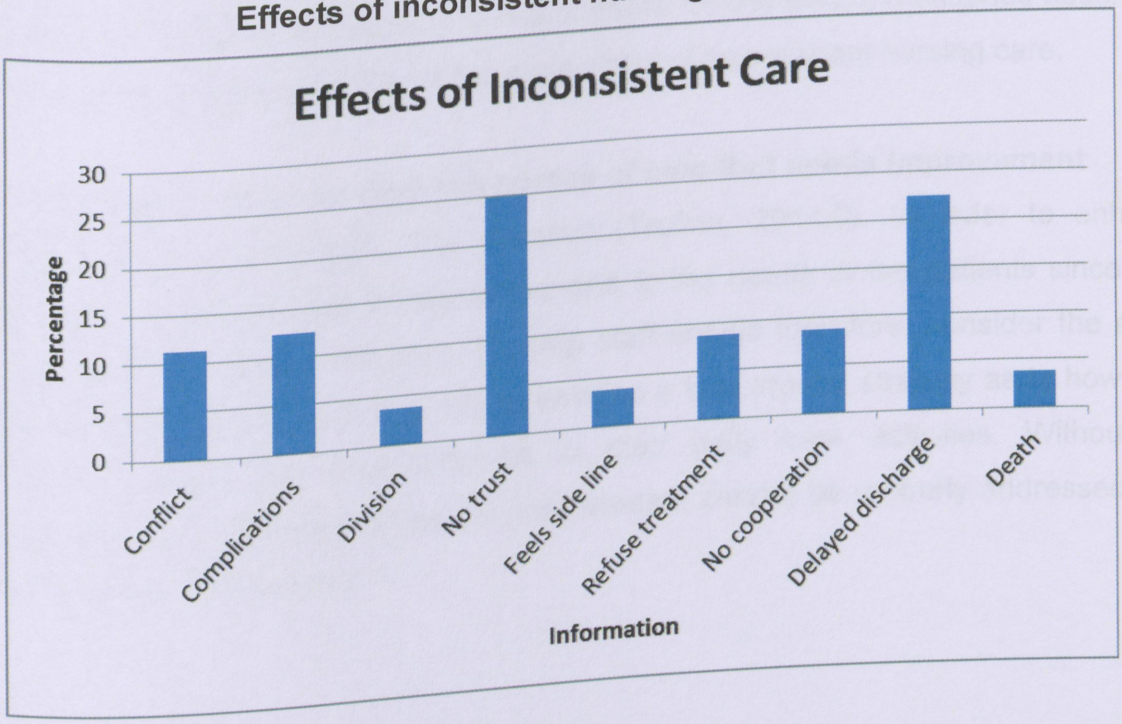
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4.7 EFFECTS OF INCONSISTENT NURSING CARE

Figure 4.7

Effects of inconsistent nursing care (n=80)



Different information was given concerning the effects of inconsistency in nursing care. Nine items were specified by the respondents. Of the 80 respondents, 11.25% (n=9) mentioned that conflict between patients themselves as well as between patients and nurses can occur as a result of inconsistency in care given to them; 12.5% (n=10) mentioned complications of disease to these whose nursing care is of sub-standard; 3.75% (n=3) mentioned division between patients themselves as well as between patients and nurses that can result from conflicts and when some of the patients feel sidelined and not taken seriously; 25.0% (n=20) mentioned absence of trust; 3.75% (n=3) mentioned that they felt sidelined while some are favoured; 8.75% (n=7) believed that they may lose confidence in nursing staff which can be manifested through refusal of treatment and prefer not to visit the hospital in future and 8.75% (n=7) mentioned that some patients may be uncooperative as they may view the behaviour of the nursing staff as meant to deliberately harm them; 22.5% (n=19) mentioned delayed discharge

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since sub-standard care and complications prolong the ALOS and 3.75% (n=3) mentioned death that can occur as a result of negligence, sub-standard care, complications, and uncooperative behavior that the patients can display. From the findings, it is obvious that most of the respondents, 25.0% (n=20) mentioned absence of trust to nursing staff by patients as the main effect of inconsistent nursing care.

4.6.3 Information received regarding areas of care that needs improvement

Nursing service is not static, but dynamic (Trofino, 2014:5). In order to enhance satisfaction, nursing service needs to respond to the needs of the patients since they are the ones that receive the care. Nursing staff should therefore, consider the areas that need improvement positively and to develop a turn around strategy as to how best they can include such improvements in their daily care activities. Without an improvement plan, identified areas for improvement cannot be properly addressed and some will remain unattended.

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Table 4.38: Areas of care that needs improvement (n=80)

Areas that needs improvements	Frequency	Percent
Staff attitude	18	22.5
Resources	5	6.25
Education	9	11.25
Orientation	10	12.5
Boredom	17	21.25
Assistance with transport	7	8.7
Food quality	10	12.5
Safety and security	4	5.0
Total	**80**	**100.0**

Of the 80 respondents, 22.5% (n=18) mentioned negative staff attitude; 6.25% (n=5) mentioned the unavailability of enough physical resources in the form of equipment and other materials and human resources as evidenced by shortage of nursing staff; 11.25% (n=9) mentioned health education which they believe that every patient needs to receive pertaining to their conditions; 12.5% (n=10) mentioned patient orientation to the physical layout, nursing staff, ward routine and to patients next to their beds on admission; 21.2% (n=17) mentioned boredom; 8.7% (n=7) mentioned assistance with transport after discharge; 12.5% (n=10) mentioned food quality; and 5.0% (n=4) mentioned safety and security as the areas that needs improvement. Staff attitude was regarded as uncaring, rude, and inconsiderate. Recourses such as equipment were regarded as insufficient. In order to provide nursing care to the patients, the nursing staff had to resort to sharing or even borrowing from other wards, those available become out of order few months from the day of reception from the central stores and had to be budgeted for the following financial year.

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Education of the patient regarding their condition was lacking, patients are discharged without knowing the main causes of their condition and how could they live a healthy life in future. Orientation of the patient on admission was not done and if it was done it is incomplete, the patients had to acquaint themselves to the ward environment and the routine. Boredom was a serious concern, no radio, no reading books only one television set per ward. After discharge, nursing staff did not take responsibility of assisting the patients with transport arrangements. Quality of food was also a serious concern, shortage of food items such as milk, meat, and even mealie meal, relatives taking initiatives of bringing food to their patients. Patients verbalised that they did not feel safe, reasons being that of dilapidated infrastructure and long grass which was difficult to maintain.

4.6.4 Information received from the nursing staff on views regarding the overall service

Views regarding the overall service received are crucial to nursing care. They can redirect the service to improve patient satisfaction. Formulation of new policies and procedures and amendment of old ones can be enhanced through patient's feedback. Attitudes of the staff can be changed if such views are received in good faith. Better prioritisation can be made possible and relevant authorities can channel funds towards areas of need.

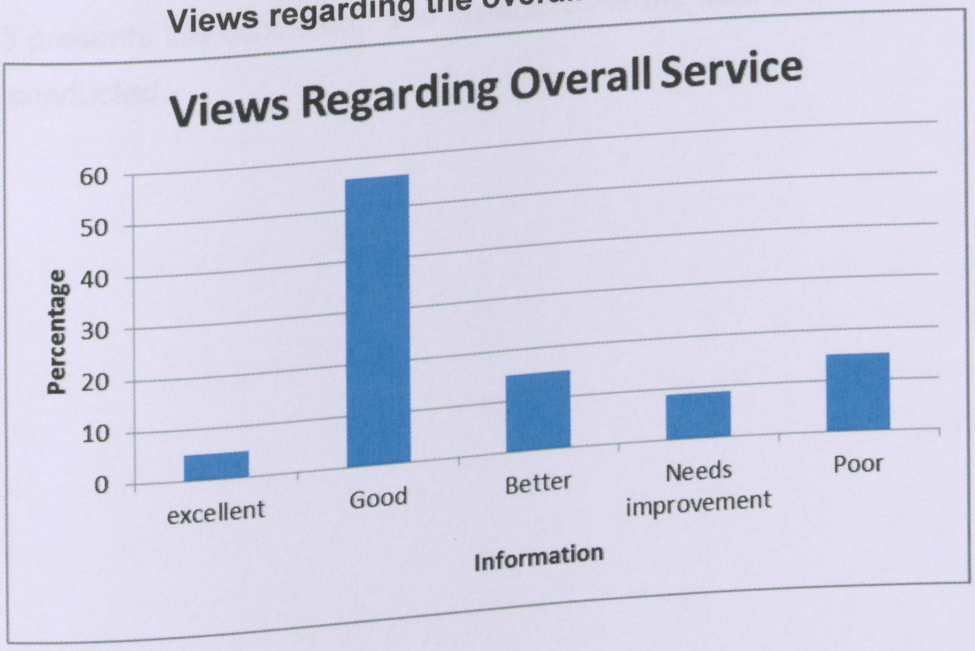
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4.8 VIEWS REGARDING THE OVERALL SERVICE

Figure 4.8

Views regarding the overall service (n=80)



Of the 80 respondents, 5.0% (n=4) indicated that the overall service was excellent; 56.25% (n=45) rated the overall service as good; 15.0% (n=12) indicated that the overall service was better; 8.75% (n=7) indicated that the overall service needed improvements and 15.0% (n=12) rated the overall service as poor. Figure 4.8 revealed that out of 80 respondents, 56.25% (n=45) rated service in the surgical and medical wards as good. Most of the aspects that needed improvements were already identified in Table 4.38.

4.3.3 CONCLUSION

Respondent's open ended questions were considered essential as this information provided a descriptive profile of the respondent's opinions and views with regard to the overall service received. The following information was obtained and compared: effects

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of inconsistent nursing care, expectations for the patients, areas of care that need improvement and overall service in the ward.

Chapter 5 presents the conclusion and discussion of the data obtained from structured interview conducted.

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CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter 5 presents the conclusions based on research results of the study about the patient satisfaction with the care received whilst admitted in the medical and surgical wards of the public hospitals within Makhado Municipality of the LP. Following the analysis and interpretation of data, the objectives and assumptions were correlated with the results to determine the relationships among various variables. Limitations of the study were also identified.

5.2 PURPOSE OF THE STUDY

The purpose of the study was to assess and describe patient's satisfaction with the quality of nursing care received from the nursing staff while admitted in the surgical and medical wards of the public hospitals within Makhado Municipality in the LP and to find out if the care received met patient's expectations.

5.3 CONCLUSION IN RELATION TO THE RESEARCH OBJECTIVES

This chapter discusses the conclusion in accordance with the findings and the research objectives that guided the study were:

- To identify patient's views regarding the care given to them from the surgical and medical wards of the public hospitals within Makhado Municipality of the LP.
- To describe patient's expectations about the nursing care given to patients in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP.

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- To determine the effects of the inconsistent nursing care rendered to patients in the surgical and medical wards of the public hospitals within Makhado Municipality of the LP.
- To establish recommendations that may be used by health care planners.

The limitations of the study were discussed and recommendations for practice and for further research were also provided based on the conclusions.

5.3.1 Biographic information

The biographic data explored in this study entailed the following:

- Age.
- Sex.
- Educational status.
- Employment status.

5.3.2 Age distribution of the patients

Figure 4.1 indicates that out of the 80 respondents who answered this question, 14% (n=11) were between the ages of 21 and 26; 11% (n=9) were between the ages of 27 and 30; 11% (9) were between the ages of 31 and 34; 20% (n=16) were between the ages of 35 and 38; 14% (n=11) were between the ages of 39 and 42; 12% (n=10) were between the ages of 43 and 46; 18% (n=14) were between the ages of 47 and 50. The findings reveal the even distribution of the respondent's age and this can be attributed to the fact that all ages were represented and not only inclined to few age groups. The lowest age being 21 and the highest age was 50.

5.3.3 Gender distribution of the patients

The study comprised 80 respondents, of whom about half 47.5% (n=38) were male and 52.5% (n=42) were female. This shows a slight increase in the number of females who were admitted than males. However, the issue of females found to be the most admitted in the surgical and medical wards in this study, might be attributed by the fact that male

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persons might not be opting to consult public hospitals than to consult general practitioners due to fear of admission, although this study did not verify this variable since it was not the focus of this study. The findings of the study did not show differences in perceptions of nursing care according to gender. Previous studies have not indicated significant differences in perceptions of care given between the sexes (Attree, 2001:460).

5.3.4 Educational status of the patients

Table 4.3 reveals that 6.3% (n=5) of the respondents have no educational background; 27.5% (n=22) had grade seven; 28.8% (n=23) had grade ten and 37.5% (n=30) had grade twelve and above. This is evident that the majority of respondents can read and it can be assumed that such respondents have the capacity to obtain, to process and to understand basic health information and service needed to make appropriate health decisions (Lewis et al., 2007:589).

5.3.5 Employment status of patients

Table 4.4 reveals that as many as 64.1% (n=50) of the respondents were unemployed and 35.9% (n=28) were employed. Even though most of the respondents 37.5% (n=28) had grade 12, this does not necessarily indicate socio-economic status or income levels; since most of the respondents were unemployed. This might be due to scarcity of jobs in the whole of SA including the Makhado Municipality where the study was focused.

5.3.6 Financial status of patients

Table 4.5 reveals that 48.8% (n=39) of the respondents have no income; 28.8% (n=23) earn less than R1000; 16.3% (n=13) earn more than R2000; 6.3% (n=5) earn more than R5000 and 2.5% (n=2), of the information on financial status was not obtained. The unemployment rate of 48.8% (n=39) together with 28.8% (n=23) of those who serve as casual workers reveal the general poverty level of the respondents and it is assumed that their financial status could influence decision on coming to public hospitals where

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charges for health care services are low and even free, depending on their financial status.

5.3.7 Summary of respondent's biographic data

Respondent's biographic information was considered essential as this provides a descriptive profile of respondent's variables that can influence their levels of satisfaction with the quality of nursing care they received. It also described the data about age distribution, gender distribution, educational qualifications, employment status, and financial status of the discharged medical and surgical patients.

5.3.8 Patient's views regarding the care given to them

Aspects discussed in this section include tangibles, assurance, empathy, general satisfaction, access, responsiveness, reliability and general views regarding the general wards information received regarding the tangibles.

5.3.9 Availability of materials

It was revealed that although 63.7% (n=51) of the respondents indicated that they were satisfied with the availability of equipment and other materials; 35% (n=28) were dissatisfied stating the reasons that resources such as equipment were not sufficient to provide satisfactory nursing care to the patients, the nursing staff have to resort to other means such as sharing or even borrowing from other wards in order to ensure that service delivery is rendered for the day. Those available become out of order few months from the day of reception from the central stores and have to be budgeted for the following financial year.

5.3.10 Cleanliness of the ward, beddings and attire

Although the majority of respondents, 86.3% (n=69) were satisfied with the cleanliness of the ward; 13.7% (n=11) were dissatisfied about the cleanliness; however, according to the national core standards, all areas of the ward premises need to be scrupulously clean. Aspects such as shortage of cleaners, cleaner's negative attitude and lack of

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effective cleaning materials attributed the dissatisfaction of 13.8% (n=11) of the respondents. The highest proportion of 97.5% (n=78) were satisfied with the cleanliness of the beddings and only 2.5% (n=2) were dissatisfied.

5.3.11 Safety throughout admission period

Of the 80 respondents, the highest proportion of 91.2% (n=73) felt safe throughout the admission period and 8.8% (n=7) were dissatisfied stating that they felt unsafe. Reasons being that of dilapidated infrastructure, wards that are far apart and long grass which was difficult to maintain.

5.3.12 Answering or assistance to answers all questions

Of the 80 respondents, the highest proportion of 96.3% (n=77) were satisfied with the assistance they got to answer all questions and only 3.7% (n=3) were dissatisfied indicating that nursing staff avoided their questions or promised to answer those questions later without fulfilling the promise and some becomes hostile, stating that the patients are too inquisitive and too demanding.

5.3.13 Nurse's identification

Table 4.12 reveals that all of the respondents, 100.0% (n=80) were satisfied stating that all nurses who cared for them were identifiable. This is because it is compulsory to put on name tags in the institutions under study, especially those who serve directly with the patients. Nursing staff compliance in this regard was 100%.

5.3.14 Interest of nurses to their patients

Of the 80 respondents, the highest proportion of 91.2% (n=73) were satisfied with the interest that the nurses showed in them and 8.8% (n=7) were dissatisfied stating that some nursing staff showed interest in other patients while others were left out.

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5.3.15 Giving permission before the physical examination

Of the 80 respondents, the majority of 87.5 % (n=70) were asked for the permission before physical examination and for 12.5% (n=10) no permission was asked. Patients were often surprised when they are ordered to take off their clothes without knowing the details of procedures that were to be performed on them, to some patients whose permission was asked, consent was not asked to perform some of the procedures and they felt coerced. Relationships between nurses and patients as well as the in-service training, workshops about ethical aspects regarding patients and their rights, be emphasised.

5.3.16 Informing the doctor when the patients are very sick

Of the 80 respondents, the highest promotion of 90.0% (n=72) were satisfied since the doctor was informed when the patients got very sick; only 8.8% (n=7) were dissatisfied stating that nurses overlooked the fact that they are so sick that there was a need to inform the doctor, therefore, informing the doctor was delayed until they were seen during doctor's normal rounds.

5.3.17 Nurses introducing themselves to the patients

Of the 80 respondents, more than half 56.2 % (n=45) of nurses introduced themselves to patients and 43.8% (n=35) of nurses performed the procedures on the patients without introducing themselves first and patients were therefore dissatisfied.

5.3.18 Introducing the patients to those next to their bed

Of the 80 respondents, 51.3% (n=41) were introduced to the patients next to their beds and just below half of the patients 48.7% (n=31) were not introduced to the patients next to their beds on admission; they therefore, had to acquaint themselves to the patients next to their beds in order to get themselves welcomed. Some patients were kind enough to welcome them and made them feel at home.

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5.3.19 Politeness of nurses

Of the 80 respondents, the highest proportion of 88.7% (n=71) were satisfied with the politeness of the nurses and 11.3% (n=9) were dissatisfied. Reasons stated being that some nurses were neither greeting them nor smiling at them. Another reason was some nursing staff showed politeness to one group of patients and not to others.

5.3.20 Respect for privacy by nursing staff

Of the 80 respondents, the highest proportion of 92.5% (n=74) were satisfied with the way privacy was maintained 1.2% (n=1) were unsure and 6.3% (n=5) were dissatisfied, this was attributed to shortage of screens in some units.

5.3.21 Counseling patients in a separate room

Of the 80 respondents, the majority of 70.0% (n=56) were counseled in a separate room and 7.5% (n=6) were not. This is due to the unavailability of separate rooms meant for counseling in some of the wards due to an ancient nature of the plan for those buildings, and 22.5% (n=18) were unsure since counseling was not necessary during their admission period.

5.3.22 Visit to the hospital in future when ill

Of the 80 respondents, the highest proportion of 95.0% (n=76) were willing to visit the hospital in future. There is however, 5.0% (n=3) of some patients who were dissatisfied during their period of hospital stay indicating that nurses were uncaring, rude, hostile and had inconsiderate behaviour. Shortage of medication was also one of the reasons for the dissatisfactions.

5.3.23 Quality of food

Of the 80 respondents, the majority of 75.0% (n=60) were satisfied with the quality of food and 25.0% (n=20) were dissatisfied since their cultural practices were not considered, this attributed to the shortage of food items such as milk, meat, and even mealie meal.

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Regardless of causes of illness, most of the sick patients have increased nutritional needs. Food is important for energy, maintenance and repair of body tissues. Food therefore need to be well balanced and acceptable to all patients since it serves as part of treatment and contains necessary nutrients that are needed for speedy recovery and healing (Lewis et al., 2007:948).

5.3.24 The way how food is served

Of the 80 respondents patients, the highest proportion of 97.5% (n=78) were satisfied with the way food was served and 2.5% (n=2) were dissatisfied stating that some of the food like tea was served being cold during the morning.

5.3.25 Way that the patients were treated in the wards

Of the 80 respondents, the highest proportion of 98.7% (n=79) were satisfied with the way they were treated in the wards and only 1.3% (n=1) were dissatisfied.

5.3.26 Boredom while admitted

Of the 80 respondents, 55.0% (n=43) were not bored while admitted; and just below half of the patients; 43.7% (n=35) were dissatisfied stating the fact that there were no radios, no reading books only one television set per ward which is placed at the nursing station. 1.3% (n=1) were unsure.

5.3.27 Orientation to the ward environment

Of the 80 respondents, less than half 48.8% (n=39) were shown around the ward environment on admission and 51.2% (n=41) were not. Orientation of the patients on admission is not done and if it is done it is incomplete, the patients have to acquaint themselves to the ward environment and the routine without the nursing staff involvement.

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5.3.28 Availability of medication

Of the 80 respondents, the highest proportion 96.2% (n=77) were given all the medicine prescribed for them and 3.8% (n=3) stated that they did not receive some of the medicine prescribed for them. This is a provincial concern; some of the medications have run short for more than eight months the reason being that they are unavailable at the central provincial depot resulting in a general shortage of medication in LP.

5.3.29 Transport arrangements

Of the 80 respondents, 73.7% (n=56) were assisted with transport to go home on discharge; 17.1% (n=13) were dissatisfied since they were left alone to struggle without assistance to the taxi rank, some of those patients were not strong enough to cover such distance on foot. They indicated that they feared that they may collapse on the way and 9.2% (n=7) were unsure.

5.3.30 Time spent before the patients are shown to bed

Of the 80 respondents, the majority of 85.0% (n=68) spent less than 30 minutes before they were shown the bed and 15.0% (n=12) spent more than 30 minutes and had to wait for a long time before admission due to large number of patients who were being admitted, lack of space and facilities, shortage of staff and equipment.

5.3.31 Awareness of the rights charter

Of the 80 respondents, 47.5% (n=38) were shown their rights charter and more than half of the patients 52.5% (n=42) were not. And were not in the know of what patient rights charter entails, and therefore, remained without the knowledge for the rest of their admission period.

5.3.32 Assistance during meal time

Of the 80 respondents, the highest proportion 46.3% (n=38) were assisted during meal time and 63.7% (n=42) who needed assistance were not. respondents mentioned that those patients who could not feed themselves were not assisted and their meal was

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returned untouched to the kitchen, and no further assistance were made to those who cannot swallow, those who have no appetite were not assisted. It was further revealed that relatives assume responsibility of feeding their loved ones.

5.3.33 Inform the patients of delays from time to time

Of the 80 respondents, the majority of 87.5% (n=70) were informed of the delays of service from time to time and 12.5% (n=10) were dissatisfied since they waited unaware of some of the delays in getting services that they were entitled to, the patients specified that they felt that they were not taken seriously.

5.3.34 Inform the patients of changes in service

Of the 80 respondents, the majority of 72.5% (n=58) were informed of the changes in service from time to time and 10.0% (n=8) were dissatisfied. Their reasons were similar to those stated in Table 4.32 in Page 111.

5.3.35 Feedback for each complaint

Of the 80 respondents, 48.8% (n=39) were given feedback for each complaint and 51.2% (n=41) were not. They therefore felt that nursing staff was not doing anything about their complaints and they felt frustrated and helpless. They even lost trust in the nursing staff.

5.3.36 Listening to the patient's problems

Of the 80 respondents, the highest proportion of 95.0% (n=76) accepted that nurses who treated them listened to their problems 5.0% (n=4) were dissatisfied. Reasons were that of intolerant behaviour together with the pre-judgmental attitude that the nursing staff displayed towards them.

5.3.37 Patients informed of service standards

Of the 80 respondents, 46.3% (n=37) were informed of the service standards which were pasted on the wall 53.7% (n=43) were not and were therefore, dissatisfied. This

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might be due to staff shortage as well as the value that the nursing staff attached to the service standards.

5.3.38 Patient education

Of the 80 respondents, the majority of 83.8% (n=67) were taught how they can leave a healthy life 13.7% (n=11) were dissatisfied stating the fact that they were in darkness without having a true picture of what they were suffering from and how they could lead a healthy life in the future and 2.5% (n=2) were unsure.

5.3.39 Handouts concerning the patient's illness

Of the 80 respondents, less than half of patients 58.6% (n=17) were given handouts about their illness and more than half of the respondents 41.4% (n=12) were not given. They reported that verbal education made them to forget most of the information and to remember very little. Some information was given to them while they were not yet ready since they were too sick to concentrate.

5.3.40 Availability of enough nurses

Of the 80 respondents, the highest proportion of 96.3% (n=77) accepted that there were enough nurses to care for all of the patients and 3.7% (n=3) indicated that the nursing staff was not enough. Shortage of nursing staff is a national issue. For the hospitals under study, staff turnover is the main reason for staff shortage.

5.3.41 Time for giving medicine

Of the 80 respondents, the highest proportion of 98.8% (n=79) accepted that they always received their medicine on time and 1.2% (n=1) were dissatisfied.

5.3.42 Assistance during the night

Of the 80 respondents, the highest proportion of 95.0% (n=76) accepted that there were always nurses to help them when they needed help during the night and 5.0% (n=4) were dissatisfied. This was attributed to the limited number of nursing staff that are

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allocated to night duty which is burdened with poor supervision that is associated with night staff allocation where the most senior staff is allocated day duty than night duty.

5.3.43 Explanation of procedures to the patients

Of the 80 respondents, the highest proportion of 98.8% (n=75) accepted that all procedures were explained to them before they were carried out and 6.2% (n=5) were dissatisfied stating the following reasons: No full explanation for the procedures, for example, in case of injection, patients were just ordered to expose the site to be injected without knowing the reasons and effects that the injection will have on them. Full explanation of the procedures is important to address individual needs of the patients, promotes sense of safety and comfort and can be of value to gain patient's cooperation.

5.4 PATIENT'S EXPECTATIONS ABOUT THE NURSING CARE GIVEN

Ten items that were indicated by the respondents represented the expectations of the respondents under study whilst admitted in both surgical and medical wards. Of the 80 respondents, 13.8% (n=11) expected to be cared optimally and in totality; 17.5% (n=14) expected to be treated with dignity and respect; most of the respondents; 24.7% (n=13) expected to be treated effectively and be discharged within reasonable period of time; 7.5% (n=6) expected to be treated with love 2.5% (n=2); expected that their voices be heard; 12.5% (n=10) expected to be given correct medicine which will be exact in healing them; 2.5% (n=2) expected to be involved in the issues concerning their health and not to be ignored when decisions about their care are taken; 3.5% (n=3) expected privacy of their name, person and possession to be maintained throughout their admission period; 6.7% (n=7) expected to be treated fairly and equally; 8.8% (n=12) expected to be given accurate, timeous and relevant information that will empower them to make responsible decisions concerning their health. According to Figure 4.6, it is clear that most of the respondents expected to be admitted for a brief period of time and be discharged, this was the desire of most patients 24.7% (n=13). This is of utmost importance since if patients are discharged within reasonable period of seven days and

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less, the cost per patient per day can be directed to needy areas of the nursing services such as equipment and other materials that can improve nursing care. Optimal nursing care has relationship with the period of patient stay and can therefore, reduce the cost of service delivery and improve patient satisfaction

5.5 EFFECTS OF INCONSISTENT NURSING CARE

Different information was given concerning the effects of inconsistency in nursing care. Nine items were specified by the respondents. Of the 80 respondents, 11.25% (n=9) mentioned that conflict between patients themselves as well as between patients and nurses can occur as a result of inconsistency in care given to them; 12.5% (n=10) mentioned complications of disease to these whose nursing care is of sub-standard; 3.75% (n=3) mentioned division between patients themselves as well as between patients and nurses that can result from conflicts and when some of the patients feel sidelined and not taken seriously; 25.0% (n=20) mentioned absence of trust; 3.75% (n=3) mentioned that they felt sidelined while some are favoured; 8.75% (n=7) believed that they may lose confidence in nursing staff which can be manifested through refusal of treatment and prefer not to visit the hospital in future and 8.75% (n=7) mentioned that some patients may be uncooperative as they may view the behaviour of the nursing staff as meant to deliberately harm them; 22.5% (n=19) mentioned delayed discharge since sub-standard care and complications prolong the ALOS and 3.75% (n=3) mentioned death that can occur as a result of negligence, sub-standard care, complications, and uncooperative behavior that the patients can display. From the findings, it is obvious that most of the respondents, 25.0% (n=20) mentioned absence of trust to nursing staff by patients as the main effect of inconsistent nursing care.

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5.6 AREAS OF CARE THAT NEEDS IMPROVEMENTS

Of the 80 respondents, 22.5% (n=18) mentioned negative staff attitude 6.2% (n=5) mentioned the unavailability of enough physical resources in the form of equipment and other materials and human resources as evidenced by shortage of nursing staff 11.2% (n=9) mentioned health education which they believed that every patient need to receive pertaining to their conditions 12.5% (n=10) mentioned patient orientation to the physical layout, nursing staff, ward routine and to the patients next to their beds on admission, 21.2% (n=17) mentioned boredom 8.7% (n=7) mentioned assistance with transport after discharge 12.5% (n=10) mentioned food quality and 5.0% (n=4) mentioned safety and security as the areas that needs improvement. Staff attitude was regarded as uncaring, rude, and inconsiderate and resources such as equipment were insufficient. In order to provide nursing care to the patients, the nursing staff had to resort to sharing or even borrowing from other wards, those available become out of order few months form the day of reception from the central stores and had to be budgeted for the following financial year.

Education to the patient regarding their condition was lacking, patients were discharged without knowing the factors that caused their condition and how they could live a healthy life in future. Orientation of the patient on admission is not done and if it was done it was incomplete, the patients had to acquaint themselves to the ward environment and the routine. Boredom is a serious concern, no radio, no reading books only one television set per ward. After discharge, nursing staff did not take responsibility of assisting the patients with transport arrangements. Quality of food was also a serious concern; there were shortage of milk, meat, and even mealie meal. On safety and security, patients verbalised that they did not feel safe, reasons being that of dilapidated infrastructure and long grass which was difficult to maintain.

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5.7 OVERALL SERVICE IN THE WARD

Of the 80 respondents, 5.0% (n=4) indicated that the overall service was excellent; 56.25% (n=45) rated the overall service as good; 15.0% (n=12) indicated that the overall service was better; 8.75% (n=7) indicated that the overall service needed improvements and 15.0% (n=12) rated the overall service as poor. Figure 4.8 in page 123 revealed that out of 80 respondents, 56.25% (n=45) rated service in the surgical and medical wards as good. Most of the aspects that needed improvements were already identified in Table 4.38n in page 121.

5.8 LIMITATIONS

- The research was conducted when the LP government was placed under administration. There were shortage of financial and other physical resources at the hospitals under study; possible effects on patient care and nurse's responses could not be generalised.
- The study focused on one municipality, one district and in one province; therefore the findings will not be generalised to other provinces of SA.
- The study was done at two public hospitals within LP; hence the results might not be applicable to other hospitals as they have different infrastructure, developmental and geographical features.
- In addition, the research covered patients aged 21-50; these limitations therefore, restricted the generalisation of the findings.
- Some patient could not be interviewed as their relatives picked them and rushed back home to attend to certain issues.
- The data was collected by using self-administered questionnaire for those who can read and write, although the researcher was there to answer queries, it is possible that some patients might have misinterpreted some questions and some might be longing to go home and complete the questionnaire with divided concentration.

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- The questionnaires were available in English only, although, the researcher was there during the time of their completion, English was not the patients' first language and this may influence their capacity to comprehend.

5.9 RECOMMENDATIONS

Based on the findings of the study, the following recommendations are made to improve the nursing care that will be provided to patients in the public hospitals, and for conducting future research in similar field:

5.9.1 Improvement of patient's care

- Quality materials need to be provided in the hospital in order to enhance proper diagnosis and accurate execution of nursing care.
- A clean and healthy environment should be provided and maintained since this is of outmost importance in order to minimise infection and to promote therapeutic environment.
- Revamping of the buildings and demolishing those that are declared inhabitable to ensure safety while patients are admitted, the grounds should be regularly maintained.
- Workshops for all nursing staff on communication, customer care and change management engagement in order to equip them to treat patients as individuals.
- Provision of a room in each ward that will be used for counseling the patients in order to provide privacy and confidentiality of the information, especially those who are counseled for HIV/AIDS, bearing in mind the stigma associated with such condition.
- Food quality should be improved; including the ingredients that are used, the way it is cooked as well as how it is served.
- Provision of items such as television sets, radios, reading materials within patients' reach to relieve boredom and to obtain information that can contribute to healthy lifestyle and to create a home-like environment for the patient.

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- Orientation programme for each patient should be part of each patient's admission to ensure that patients are fully acquainted with the ward environment and routine.
- Nursing staff should feel responsible and ensure that all discharged patients arrive home safely; arrangements or assistance with arrangements should therefore be made.
- Upon reception to the ward, admission procedure should be commenced immediately and the patients be shown to their bed within 30 minutes, to ensure rest.
- Patient right's charter together with the service standards need to be known by patients, it should be the duty of every nurse to teach the patients until they are fully conversant with such right's charter.
- As recipients of nursing care, patients need to be told of delays and changes from time to time in order to anticipate them.
- Complaint mechanism need to be well known and be followed, patient should receive feedback on each complaint lodged.
- Patient education is an important element in nursing care and is one of the therapeutic measures that can equip them to take independent action to living a healthy life. Every patient should educated about their conditions, availability of pamphlets, leaflets, CDs and any other items that can stimulate internalization of health related information is therefore crucial.

5.9.2 Future research

The researcher recommends that future research be conducted on the following topics:

- Nurse-patient relationship
- Attitude of nursing staff
- Challenges in patient education
- Length of patient stay in medical and surgical wards
- Challenges in nurse patient communication
- Holistic approach in nursing care

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- Handling of patient's complaints
- Change management
- Quality management
- Relationship amongst the nursing staff

5.10 CONCLUDING REMARKS

The overall scores achieved from the data were classified as satisfied, dissatisfied and unsure. The findings of the study revealed the satisfaction rate of 61%, rate of 47% dissatisfaction and 2.0% unsure rate.

With regard to the tangibles, patients were satisfied with the general cleanliness of the ward, hospital attire and the beddings. In as far as assurance is concern, patients were satisfied and viewed nurses as responsible in ensuring that most of the patient's questions were answered; all nursing staff was identifiable by means of name tags; permission was asked from the patients before they were actually performed and a doctor was informed when the patients felt very sick.

Empathy was ensured since the nursing staff was interested and polite to the patients; patient's privacy was respected by all nurses; and most of the patients were willing to visit the hospital when they become ill again in future; they were pleased with the way food was served and with the quality thereof. Most of the patients indicated that the nursing staff was responsive to their needs since they received all of the medicine prescribed for them; patients who needed assistance were assisted during meal time; patients were notified of the delays in service from time to time by the nursing staff; and changes communicated to them.

Patient were satisfied with the reliability of nursing care services and viewed nurses as kind enough to listen to their problems; and to teach the patients how to lead a normal life at home; there were enough nurses to care for the patients; assistance to the

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patients were offered even during the night and all procedures were explained to the patients before they were commenced. It was also noted that even though nursing care is rendered to patients in a satisfactory manner, there were however, some omissions and commissions that were not meant to be on the process of nurse-patient encounter, some of which were crucial for the survival of mankind.

It was found that some of the basic aspects that are crucial to patient's recovery were not taken seriously, and that if such aspects were considered, patient care could have been of best quality, and allocated length of patient stay would have been drastically reduced, the financial and other resources might have been channeled to other measures that can improve the level of service for the public hospitals as a whole. The patients viewed the hospital as the institution that can assist them to get better as fast as possible, without complications and to be discharged with enough knowledge of their conditions, but that was not always the case with some of the patients.

Some of the patients were dissatisfied with the tangibles and assurance that they have witnessed while admitted in the public hospitals under study. They were not satisfied with the availability of materials; to some patients empathy was not displayed since nurses did not introduce themselves to the patients; other patients were introduced to the newly admitted patients and to some patients, counseling was not done in a separate room. To most of the patients, general satisfaction was not ensured, boredom was a problem; other patients were not shown around the ward on admission and transport arrangements was not made for most of the patients. To most of the patients, responsiveness was not enhanced since patient's rights charter was not shown to them; reliability was not ensured since most of the patient did not receive feedback when they complained; service standards were not taught to most of the patients and even though patient education was given to most of the patients, they rarely received the handouts to enforce the health education conducted. Patients expected to be cared for optimally and in totality; to be treated with dignity and respect; most of the patients expected to be treated effectively and be discharged within reasonable period of time. Some patients

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expected to be treated with love and expected their voices be heard; expected to be given correct medicine that will be exact in healing them; some expected to be involved in the issues concerning their health and not to be excluded when decisions about their care were taken. Some patients expected privacy of their name, person and possession to be maintained throughout their admission period; some expected to be treated fairly and equally and above all expected to be given accurate, timeous and relevant information that will empower them to make responsible decisions concerning their health. Different information was given concerning the effects of inconsistency in nursing care and nine items were identified by the patient:

- Conflict between patients themselves as well as between patients and nurses can occur as a result of inconsistency in care given them.
- Complications for the patients who received sub-standard care.
- Death can occur as a result of negligence.
- Sub-standard care complications.
- Uncooperative behaviour that the patients can display.
- Delayed discharge since sub-standard care and complications prolong the ALOS.
- Division between patients themselves as well as between patients and nurses that can result from conflicts.
- Some of the patients felt sidelined and not taken seriously.
- Absence of trust.
- Patients felt sidelined while some are favoured.
- Lost confidence in nursing staff which can be manifested through refusal of treatment.

The following aspects were regarded by the patients as areas that need improvements:

- Negative staff attitude
- Unavailability of enough physical resources in the form of equipment and other materials and human resources as evidence by shortage of nursing staff

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- Health education which the patients believed that every patients need to receive pertaining to their conditions
- Patient orientation to the physical layout, nursing staff, ward routine and to the patients next to their beds on admission
- Boredom
- Assistance with transport after discharge
- Assistance during meal time
- Poor food quality
- Safety and security

Overall service was regarded as excellent by some patients; other patients rated the overall service as good; the overall service was regarded as better; some patients regarded the overall service as poor; and some felt that the overall service needs improvement.

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ANNEXURE A

UNIVERSITY CLEARANCE CERTIFICATE

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NAME OF THE RESEARCHER/ INVESTIGATOR:

Mureri M.M

PROJECT TITLE: Patient satisfaction with the quality of nursing care rendered in public hospitals within Makhado municipality of Limpopo province: South Africa

PROJECT NO: SA/10/PDC/04

SUPERVISORS/CO-RESEARCHERS/CO-INESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Mureri M.M	University of Venda, Department of Advanced Nursing Science(Student)	Investigator: Student
Prof. M.L. Netshikweta	University of Venda, Department of Advanced Nursing Science	Supervisor
Dr. N.H. Shilubane	University of Venda, Department of Advanced Nursing Science	Co-Supervisor

ISSUED BY:
UNIVERSITY OF VENDA, HEALTH, SAFETY AND RESEARCH ETHICS COMMITTEE

Date Considered: 15 November 2012
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee .....
Name of the Chairperson of the Committee: PROF. G.E. EKOSSE

University of Venda

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ANNEXURE B

REQUEST FOR DISTRICT PERMISSION

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P.O.Box 311
Vhulaudzi
0926
10.04.2013

The Head of Department
Department of Health, Vhembe District

PERMISSION TO CONDUCT A RESEARCH, VHEMBE DISTRICT

I am currently registered in Magister Curationis (Nursing Masters Degree) at the University of Venda. The title of my research study is **'patient satisfaction with the quality of nursing care rendered in public hospitals under Makhado municipality of Limpopo Province'.**

I am humbly requesting for the permission to conduct a research at Makhado municipality public hospitals. This will involve patients who are admitted in the general wards aged between 21 and 50. The study aims at exploring the satisfaction of patients with the quality of care they receive from the nursing staff.

The participation is voluntary, and anonymity of the participants will be maintained throughout the research.

Thanking you in anticipation.

Yours Sincerely

.....

Mureri MM

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ANNEXURE C

REQUEST FOR PROVINCIAL PERMISSION

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LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

Ref:4/2/2

12 March 2013
Mureri M.M
University of Venda
P/Bag X 5050
0950

Dear Mureri M.M

Patient satisfaction with the quality of nursing care rendered in public hospitals within Makhado Municipality of Limpopo province: South Africa

- The Department of Health and Social Development will expect a copy of the completed research for its own resource centre after completion of the study.
- The researcher is expected to avoid disrupting services in the course of his study.
- The researcher/s should be prepared to assist in interpretation and implementation of the recommendation where possible
- The institution management where the study is being conducted be made aware of this.
- A copy of the permission letter can be forwarded to Management of the Institutions concerned

HEAD OF DEPARTMENT
HEALTH AND SOCIAL DEVELOPMENT
LIMPOPO PROVINCE

18 College Street, Polokwane, 0700, Private Bag x9302, POLOKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

© University of Venda

P.O.Box 311
Vhulaudzi
0926
27.04.2013

The Head of Department
Department of Health, Limpopo Province
Dear Sir/ Madam

PERMISSION TO CONDUCT A RESEARCH, MAKHADO MUNICIPALITY

I am currently registered in Magister Curationis (Nursing Masters Degree) at the University of Venda. The title of my research study is **'patient satisfaction with the quality of nursing care rendered in public hospitals under Makhado municipality of Limpopo Province'.**

I am humbly requesting for the permission to conduct a research at Makhado municipality public hospitals. This will involve patients who are admitted in the general wards aged between 21 and 50. The study aims at exploring the satisfaction of patients with the quality of care they receive from the nursing staff.

The participation is voluntary, and anonymity of the participants will be maintained throughout the research.

Thanking you in anticipation.

Yours Sincerely

.....

Mureri MM

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ANNEXURE D

REQUEST FOR HOSPITAL PERMISSION

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PO Box 311
Vhulaudzi
0926
01.05.2013

The Chief Executive Officer
Elim Hospital

PERMISSION TO CONDUCT A RESEARCH

I am currently registered in Magister Curationis (Nursing Masters Degree) at the University of Venda. The title of my research study is **'patient satisfaction with the quality of nursing care rendered in public hospitals under Makhado municipality of Limpopo Province'.**

I am humbly requesting for the permission to conduct a research at your institution. This will involve patients who are admitted in the general wards aged between 21 and 50. The study aims at exploring the satisfaction of patients with the quality of care they receive from the nursing staff.

The participation is voluntary, and anonymity of the participants will be maintained throughout the research.

Thanking you in anticipation.

Yours Sincerely

.....

Mureri MM

© University of Venda

PO Box 311
University of Venda
Creating Future Leaders
Vhulaudzi
0926
01.05.2013

The Chief Executive Officer
Siloam Hospital

PERMISSION TO CONDUCT A RESEARCH

I am currently registered in Magister Curationis (Nursing Masters Degree) at the University of Venda. The title of my research study is **'patient satisfaction with the quality of nursing care rendered in public hospitals under Makhado municipality of Limpopo Province'.**

I am humbly requesting for the permission to conduct a research at your institution. This will involve patients who are admitted in the general wards aged between 21 and 50. The study aims at exploring the satisfaction of patients with the quality of care they receive from the nursing staff.

The participation is voluntary, and anonymity of the participants will be maintained throughout the research.

Thanking you in anticipation.

Yours Sincerely

.....

Mureri MM

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- Should you feel threatened during the interview in any way, please discuss it with the researcher.
- Should you have any question at any time please direct it to the researcher.

THANK YOU

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ANNEXURE F

CONSENT FORM

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Consent form

TITLE OF RESEARCH: Patient satisfaction with the quality of nursing care rendered in public hospitals under Makhado municipality of Limpopo Province.

RESEARCHER: Musingadi Magdeline Mureri.

Please mark your answer by circling the choices provided.

Do you understand that you have been asked to get in a research study?

Yes **No**

Have you read and received the copy of the attached information sheet?

Yes **No**

Do you understand the benefits and risks involved in taking part in the research?

Yes **No**

Have you head an opportunity to ask questions and discuss the study with the researcher

Yes **No**

Do you understand that you are free to participate or withdraw from the study at any time?

Yes **No**

Do you understand who will access this information?

Yes **No**

Was this study explained to you by the researcher?

Yes **No**

I agree to take part in this study. I agree to be interviewed for the purpose described in the information letter. I understand that my name will not be associated with the collected information and the identifier will be removed.

....

Signature of participant **Date** **Printed name**

I believe that the person signing this form understands what is involved in the study and voluntarily agree to participate.

....

Signature of researcher **Date** **Printed name**

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ANNEXURE G

STRUCTURED INTERVIEW SCHEDULE

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QUESTIONNAIRE

Answer each question by placing an "x" in the appropriate box or write down your response in the space provided.

Patient satisfaction on the care received in the selected public hospitals in Vhembe district of Limpopo province.

SECTION A: BIOGRAPHIC INFORMATION		OFFICE USE
1. Your age at your last birthday ☐☐ **Years**		1
2. Sex		2
2.1. Men	1	
2.2. Women	2	
3. Educational status		3
3.1 None	1	
3.2 Grade 7	2	
3.3 Grade 10	3	
3.4 Grade 12 and above	4	
4. Employment status		4
4.1 Working	1	
4.2 Not working	2	
5. Financial status		5
5.1 None	1	
5.2 <R1000	2	
5.3 >R2000	3	
5.4 >R5000	4	

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SECTION B: BROAD FACTORS THAT INFLUENCE PERCEPTION OF SERVICE

Indicate whether you agree, disagree or unsure by placing an "x" in the appropriate box provided

6.Tangibles

	Agree	Disagree	Unsure	OFFICE USE
6.1 The ward was having enough materials to care for all patients				6
6.2 The ward was always clean				7
6.3 The beddings were clean				8
6.4 My hospital attire were always clean				9

7. Assurance

	Agree	Disagree	Unsure	OFFICE USE
7.1 I felt safe throughout my admission period				10
7.2 Nurses answered or assisted me to get answers to all my questions				11
7.3 All nurses who cared for me had a name tags on				12
7.4 I gave permission to be examined and treated				13
7.5 Nurses informed the doctor when I felt very sick				14
7.6 Nurses who treated me answered all questions about my illness				15

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8. Empathy

	Agree	Disagree	Unsure	OFFICE USE
8.1 The nurses who treated me introduced themselves				16
8.2 I was introduced to the patients next to my bed in the ward				17
8.3 Nurses in this ward are very interested in their patients				18
8.4 Nurses who treated me were polite				19
8.5 My privacy was respected by all the staff				20
8.6 I was counseled in a separate room when I needed counseling				21

9. General Satisfaction

	Agree	Disagree	Unsure	OFFICE USE
9.1 Next time I am ill I will come back here				22
9.2 I was pleased about the quality of food				23
9.3 I was pleased with the way how food was served				24
9.4 I was pleased with the way I was treated in this ward				25
9.5 I was very bored during my admission period				26

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10. Access

	Agree	Disagree	Unsure	OFFICE USE
10.1 I was shown around the ward on admission				27
10.2 I was given all the medicine/pills prescribed for me				28
10.3 A transport to go home was arranged for me on discharge				29
10.4 The time I had to wait before I was shown the bed was less than 30 minutes				30

11. Responsiveness

	Agree	Disagree	Unsure	OFFICE USE
11.1 Patient's right charter was explained to me				31
11.2 I was assisted during meal time				32
11.3 Nurses inform patients of delays in service from time to time				33
11.4 Nurses informs patients of changes in service from time to time				34

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12. Reliability

	Agree	Disagree	Unsure	OFFICE USE
12.1 when I complained I received feedback				35
12.2 Nurses who treated me listened to my problems				36
12.3 I was informed about service standards pasted on the wall				37
12.4 I was taught how I can live a healthy life at home				38
12.5 I was given a handout concerning my illness				39
12.6 There were enough nurses to care for all patients				40
12.7 I was given my medicine/pills on time				41
12.8 When I needed help during the night there was always a nurse to help me				42
12.9 All procedures were explained to me before they were carried out				43

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SECTION C:VIEWS REGARDING GENERAL WARDS

Write down your response in the space provided.

	OFFICE USE
13. What are your expectations as patient admitted in a general ward?	44
14. What do you think are the effects of inconsistent nursing care?	45
15. Which areas of care do you think will need improvement?	46

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	OFFICE USE
16. How do you rate the overall service in the ward?	47

THANK YOU FOR YOUR PARTICIPATION IN THE STUDY.

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ANNEXURE H

LANGUAGE EDIT CERTIFICATE

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Department of English

14 April 2014

TO WHOM IT MAY CONCERN

This serves to confirm that I have proof-read Ms MM Mureri's (Student # 11585567) dissertation entitled *Patient satisfaction with the quality of nursing care rendered in public hospitals within Makhado Muncipality of Limpopo province: South Africa.*

I further attest that all glaring language related issues have been addressed, corrected and thus accounted for.

Yours sincerely

Dr E K Klu (HoD)

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