

**University of the Western Cape**  
**Faculty of Community and Health Sciences**  
**School of Nursing**



**PATIENT SATISFACTION WITH THE CARE PROVIDED IN A  
PSYCHIATRIC HOSPITAL IN CAPE TOWN**

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A mini thesis submitted in partial fulfillment of the requirements for the degree of  
Master in Nursing (Advanced Psychiatric/Mental Health Nursing) in the School of  
Nursing, University of the Western Cape

**Lindiwe Oscarine Marepula**

Student Number: 9534655

**Supervisor:** Prof. Makombo Ganga-Limando

May 2012

**DECLARATION**

I declare that the study entitled “Patient satisfaction with the care provided in a psychiatric hospital in Cape Town” is my own work, and it has never been previously submitted for any degree or examination at this university or any other university. All sources used have been indicated and acknowledged by providing complete references.



Lindiwe Oscarine Marepula

Signed.....

May 2012

## ACKNOWLEDGEMENTS

I would firstly like to thank God for maintaining my health and for carrying me through this journey of knowledge.

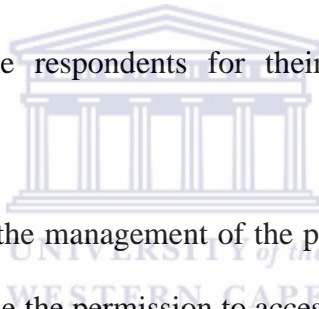
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## **ABSTRACT**

**Background:** Patient satisfaction is a well-researched area in general medicine worldwide, yet a full exploration of patient satisfaction amongst psychiatric patients appears to be lacking in South Africa. Patient satisfaction has become important because of the awareness of the patient's human rights. There is an increasing practice of applying a consumer viewpoint to health care, while safeguarding patients' rights and taking their views into account. This has been brought about by the inception of the Mental Health Care Act no. 17 of 2002.

**Purpose:** The purpose of this study was to describe psychiatric inpatients' satisfaction with the care provided in a psychiatric hospital in Cape Town.

**Objectives :** (1) To describe the psychiatric inpatients' satisfaction with the care provided in a psychiatric teaching hospital in terms of their views on the: care provided by nurses (interpersonal/nurse-patient- interaction and technical skills); care provided by doctors (interpersonal/doctor-patient interaction and technical skills; and the nature of the environment of care, and (2) to describe the psychiatric inpatients' overall satisfaction with the care received in a psychiatric teaching hospital in terms of the: quality of care received from nurses and doctors; nature of the environment of care; and the likelihood of future utilization of the hospital services.

**Method/Design:** The study made use of the quantitative descriptive design using the Primary Provider Theory of patient satisfaction and the Batho Pele Principles served as the conceptual framework. Data were collected from discharged patients using a self-administered questionnaire which was mailed to individual participants. A five and a four point Likert scales were used for different sections in the questionnaire. The study made use of 120 participants between the ages of 18 and 60.

**Findings:** Generally respondents were satisfied with the care provided in this psychiatric hospital. Greater satisfaction was noted on aspects of staff-patient interactions. Low satisfaction scores were observed on nurses' technical aspects of care. The Batho Pele principles of information, openness and transparency, consultation, access and redress seem not to have been adhered to.

**Conclusions:** General inpatient satisfaction in psychiatric hospital care was good. However, more innovative methods for improvement in the areas of dissatisfaction need to be developed. Special attention should be given to the implementation of the Batho Pele Principles and the protection of the patients' rights.

**Key words: patient satisfaction, patient, psychiatric care**

## LIST OF ABBREVIATIONS

MHCA      Mental Health Care Act no 17 of 2002

PRC        Patients' Rights Charter

BBP        Batho Pele Principles

PPT        Primary Provider Theory

NHA        National Health Act no 61 of 2003

SA         South Africa



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# **ORIENTATION TO THE STUDY**

## **1.1 INTRODUCTION**

The first chapter deals with the orientation to the study. It includes the background and rationale, the problem statement, the purpose of the study, the objectives of the study, the significance, the conceptual framework of the study, the operational definition of key concepts, and the outline of the report.

## **1.2 BACKGROUND AND RATIONALE**

Over the years, public psychiatric hospitals and institutions have been the main providers of psychiatric care to the South African population. The increasing unemployment rate and the economic hardship in the country mean that most people are not able to afford private psychiatric services. Furthermore, the healthcare professionals are challenged to provide quality care with the limited resources. Thus health professionals are often tempted to focus on set institutional standards of care rather than paying attention to the patients' expectations. Research indicates that standards of care set by an institution should meet the expectations of consumers. These expectations are strong predictors of consumers' satisfaction and one of the key indicators of the quality of care (Clark, Howard & Rayens 2004; Olusina, Ohaeri & Olatawura 2002; Wood 2006; Ozsoy, Ozgur & Akyola (2007).

Access to basic public services, including health services in the democratic South Africa, is no longer a privilege but a legitimate right of all citizens. The 1996 Constitution, through the Bill of Rights ensures citizens of certain rights to take

action against the state or the service provider if they believe that these rights have been violated. The national policy framework on “Transforming Public Services Delivery” published in October 1997 (Batho Pele White Paper) provides a policy framework and practical implementation strategy for efficient, effective and equitable provision of public services. Batho Pele as a government strategy on service delivery was developed with the view of putting people at the centre of planning and delivering services; fostering new attitudes to service delivery; and improving the image of the public service (South Africa 1997). The Batho Pele principles are aligned with the “Constitutional ideals of:

- *Promoting and maintaining high standards of professional ethics;*
- *Providing service impartially, fairly, equitably and without bias;*
- *Utilising resources efficiently and effectively;*
- *Responding to people's needs; the citizens are encouraged to participate*
- *in policy-making; and*
- *Rendering an accountable, transparent, and development-oriented public administration (South Africa 1997).*

The Mental Health Care Act no 17 of 2002 (MHCA) and Patients’ Rights Charter (PRC) emphasise the need for the mental health care providers to include the rights of the mental health user in the provision of health care (Moosa & Jeenah 2008). The MHCA signalled the provision of quality care, treatment and rehabilitation services at all levels of mental health care services.

Evidence suggests that meeting the patients’ expectations is critical in ensuring their satisfaction with the services received and future utilization. Authors (Johansson, Oleni & Fridlund 2002) argue that patients’ satisfaction is the result of the subjective evaluation of the cognitive and emotional reaction of the interaction between their

expectations regarding ideal care and the actual care. These authors further emphasise that this subjective evaluation is influenced amongst others by the socio demographic background of patients, the organization of health care and the patients' previous experiences with the services. It is also suggested that patient satisfaction with the service received, influences his or her adherence with the treatment plan and future utilization of health services (Wood 2006). Patient satisfaction increases patients' self-esteem, self-worth, security, trust and the ability to relate to others. It also results in the development of high performance, team spirit, opportunity for learning, job satisfaction and staff development (Olusina et al 2002).

According to Graham, Denoual & Cairns (2005) patient satisfaction plays a big role in clinical mental health care rendered to the patients. Graham et al (2005) further stress the importance of hearing what the consumer's experience of a mental health care facility is. It is a useful way of evaluating and monitoring the quality of services rendered and to design interventions to improve patient care (Finnegan & Finnegan, 2007). The nurse is at the forefront when it comes to patients' satisfaction as nursing care provided is the most important factor in assessment of their satisfaction with health care. According to Johansson et al (2002) nurses need to provide personalized care, be attentive, show empathy, respect, patience, consideration, dedication, honesty, responsiveness, encouragement, as well as listen and be able to understand patients' unexpressed needs. Failure to meet the above will result in the patient feeling inadequate and negatively impacting on satisfaction. Johansson et al (2002) suggest that health care organizations need to play an important role in boosting nurses' ability to achieve the above by providing a supportive work environment.

Patients' satisfaction with psychiatric care has not been systematically explored and remains a neglected area of health service delivery (Olusina et al 2002). Authors (Woods, 2006; Baumann, 2008) attribute this lack of research to various factors including lack of proper legislation, poor development of health services, patients' lack of understanding of the idea of quality care and their rights, and the perceived unreliability of psychiatric patients' responses. Ozsoy et al (2007) argue that measuring patient satisfaction with psychiatric care is difficult because of the complexity of the psychiatric conditions. Several variables are used to measure patient satisfaction with psychiatric care. Some studies have used the clients' expectations; input into treatment, the treatment process, and the client's perception of his/her overall stay at a specific type of service as measurement of patient satisfaction with psychiatric care (Graham et al 2005). Other studies have used patient-staff interaction, information sharing, perceived quality of the technical skills, promptness and courtesy of admission procedure, and physical environment as measurements of patient satisfaction with the quality of care (Almeida & Adejumo 2004; Clark et al 2004; Myburgh, Solanki, Smith & Lallo 2005). Despite these variations, there seems to be a consensus around the focus of what should be measured. It is generally accepted that satisfaction should be measured from the patients' perspective and not from the perspective of the providers (Graham et al 2005; Ozsoy et al 2007).

The literature examined reveals that patient satisfaction is a key measurement indicator of patient/consumer-centred approach to health care delivery and consequently of the quality of care. The existing policies on the transformation of the public services and the new MHCA in the country stress the need for public health care institutions to provide consumer/patient-oriented services. It is assumed that the

implementation of these policies at the health care delivery level would translate into high level of consumer satisfaction, an indication of patient-centred approach to care. It is against the above background that the current study was conducted. As a nurse manager working in this institution, the researcher wanted to ascertain the extent to which patients admitted to the institution are satisfied with the care they receive during their admission and if certain individual characteristics influence their satisfaction.

### **1.3. PROBLEM STATEMENT**

This study intended to address the lack of scientific information regarding patient satisfaction with the care provided to the psychiatric patients during their stay in a tertiary psychiatric teaching hospital in Cape Town. From the researcher's own experience working as a manager at the targeted institution, there is a great need for scientific information on patients' views regarding the services they receive at the institutions. Unfortunately no research has been conducted to address this need. The researcher believes that the findings will contribute to bridging the gap in the literature and providing scientific information that could be used by hospital managers to design scientific based health care programmes that address the needs of the clients.

There is clear indication from the literature that patient satisfaction is a key indicator of a patient-centred approach to health care services. The current transformation legal frameworks guiding the delivery of services in public sectors (Constitution of South Africa, 1996; Batho Pele White Paper 1997; Mental Health Care Act of 2002), including the delivery of psychiatric care emphasize the need for a patient/user-

centred approach to service delivery. Therefore scientific information on patients' satisfaction is critical in assisting the health care managers to have ideas regarding the consumers' views on the nature of health care services provided by their institutions and consequently the level of the institutional response to the government transformation agenda.

#### **1.4. PURPOSE OF THE STUDY**

The purpose of this study was to describe the psychiatric inpatients' satisfaction with the care provided in a public psychiatric hospital in Cape Town.

#### **1.5. OBJECTIVES OF THE STUDY**

The objectives of the study were two fold:

- (1) To describe the psychiatric inpatients' satisfaction with the care provided in a psychiatric teaching hospital in terms of their views on the:
  - care provided by nurses (interpersonal/nurse-patient- interaction and technical skills);
  - care provided by doctors (interpersonal/doctor-patient-interaction and technical skills; and
  - nature of the environment of care.
- (2) To describe the psychiatric inpatients' overall satisfaction with the care received in a psychiatric teaching hospital in terms of the:
  - quality of care received from nurses and doctors;
  - nature of the environment of care; and
  - likelihood of future utilization of the hospital services.

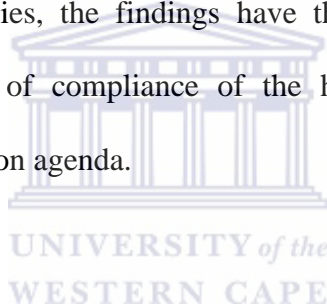


## **1.6. SIGNIFICANCE OF THE STUDY**

*Body of knowledge:* The findings of the study will contribute to bridging the gap in the body of knowledge on patient satisfaction with care provided in psychiatric tertiary teaching hospitals in South Africa. The findings can also be used to inform further research on patient satisfaction with inpatient care.

*Nursing practice and education:* Mental healthcare managers in the targeted institution could use the findings to improve the quality of care provided to the consumers. Nurse educators can also use the findings to formulate needs-based in-service training.

*Policy implementation:* Although this study is not intended to evaluate the implementation of policies, the findings have the potential to inform healthcare managers on the level of compliance of the healthcare professionals with the government transformation agenda.



## **1.7 ETHICAL STATEMENT**

The study was conducted within the universal ethical principles (respect for person, beneficence, non-maleficence, (check spelling) and justice) and the ethics guidelines for postgraduate research prescribed by the University of the Western Cape.

The proposal of this study was approved for its scientific merit by the Scientific Review Committee of the School of Nursing and the Health Higher Degree Committee of the Faculty of Community and Health Sciences of the University of the Western Cape. The ethical clearance to conduct the study was obtained from the Senate Ethics Committee of the University of the Western Cape (see Appendix D). Furthermore permission was granted by the Head of Hospital's Ethics Committee

(see Appendixes A). The process of data collection started after the ethical clearance and the institutional permission.

## **1.8 OPERATIONAL DEFINITION OF KEY CONCEPTS**

### 1.8.1 Batho Pele Principles (BBP)

Batho Pele is a Sesotho expression meaning “People first”. For this study, Batho Pele refers to the principles embedded in the White Paper on Transformation of Public Services published in 1997 to improve public service delivery in South Africa, including the health care services (South Africa 1997). Through the BPP the government intends to ensure that consumers are put at the centre of planning and service delivery and that they are served in an environment that is caring, safe and less restrictive. It is assumed that the adherence to these principles will lead to the provision of quality services to all citizens (South Africa 1997).

### 1.8.2. Care

The concept “care” in this study is defined in terms of the interpersonal (patient-provider interaction) and technical skills of the providers, the nature of the environment of care (physical, food, internal policies and procedures), and the overall experience of care in a psychiatric hospital.

### 1.8.3 Patient and Patient satisfaction

For the purpose of this study, a patient refers to a male or female who was admitted to the target psychiatric hospital for the treatment and management of psychological and psychiatric conditions. Patient satisfaction refers to the patients’ subjective

evaluation of the care received during the hospital stay as defined in point 1.8.2 of this chapter.

#### 1.8.4 Overall satisfaction with care

For the purpose of this study, overall satisfaction with care refers to the patients' overall assessment of care received from the providers (nurses, doctors); and the nature of the environment of care against their expectations as well as their perceived likelihood of future use of the facility or of recommending somebody to the facility.

### **1.9 REPORT OUTLINE**

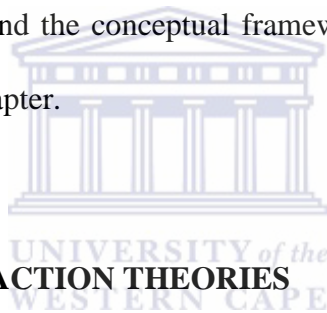
*Chapter One* provides an overview of the study including the background and the rationale, the problem statement, the purpose; the objectives, the significance, operational definitions, and the ethical statement. *Chapter Two* presents the literature on theoretical, empirical and policies related to the topic. It covers the main key concepts and describes the conceptual framework used in this study. *Chapter Three* presents the research design and methodology. *Chapter Four* provides the summary of the findings. *Chapter Five* presents discussions, conclusions and recommendations.

## **CHAPTER TWO:**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

In Chapter 1, a scientific foundation of the study was presented. This chapter focuses on the review of relevant literature. It examines theories of patient satisfaction, previous studies on patient satisfaction with a focus on psychiatric inpatients, the structure of mental health care delivery services in South Africa (SA) and the legal framework guiding the delivery of mental health care delivery in SA. A summary of the literature reviewed and the conceptual framework for the study are included in the conclusion of this chapter.



#### **2.2 PATIENT SATISFACTION THEORIES**

Patient satisfaction is a complex phenomenon which cannot be explained with one single theory (Sitziya & Wood 1997; Johansson et al 2002). Most patient satisfaction theories originate from the marketing field. From a marketing perspective, satisfaction is the outcome resulting from the experience of a consumer with a product or service. It is also suggested that the consumer's satisfaction with the product leads to satisfaction with the organization that produces the product (Newsome & Wright 1999). A review of the commonly used theories described in the literature relating to the healthcare industries follows.

### 2.2.1 Disconfirmation Theory

Disconfirmation Theory is the highly recognised satisfaction model in the marketing industry. This theory argues that consumer's satisfaction is the result of his/her perception of the service which is based on a pre-purchased comparison level or standard. This perception leads to an expectation of an ideal product. The theory suggests that the greater the divergence between the consumer's perception and expectations, the greater his/her satisfaction or dissatisfaction depending on the direction of the divergence (Thompson & Sunol 1995).

Critics argue that raising the expectations of consumers may increase perception even though the service might have been poor. Therefore, expectations can influence satisfaction independently of perceptions (Newsome & Wright 1999). Others argue that the consumer's satisfaction may be increased by lowering the perceived level of performance of the service, expectations likely then exceeds, resulting in increased satisfaction. This has resulted in recommendations of under promising by some organisations so that the likelihood of meeting or exceeding the customer expectations is increased.

### 2.2.2 Expectation Theory

Expectation Theory is based on the understanding that certain individual characteristics can influence the way patients view the actual care they will receive. The researcher felt that the inclusion of the expectation theory will assist in the understanding of the factors that are not related to the health care providers. Zeithaml & Bitner (1996) view expectations as being the level of service the patient hopes to receive (desired service), the minimum tolerable service (adequate service) and

the (predicted service ) which is the level of service the patient is likely to get and implies the objective calculation of the probability of performance. From the perspective of the Expectation Theory (Williams 1994), the knowledge of patients' expectations can tell a great deal about how they will rate the service later. It is argued that patients recognise that the service may vary and that there is a certain level in which they are willing to accept this variation. When dealing with new patients, the expectations might not always be present as new patients may not have the knowledge and the experience to formulate expectations. However these expectations may also develop as the experience of care unfolds or through personal experience which depending on certain socio-demographic factors.

### 2.2.3 Value-precept Disparity Model

Unlike the Disconfirmation Theory, satisfaction is not based on expectations but on an emotional response triggered by a cognitive evaluative process in which one's perception of service is compared to one's values. If the perception meets the consumer's values then satisfaction results and vice versa (Westbrook & Reilly 1983).

### 2.2.4 Social Equity and attribution theory

Social Equity Theory is based on an understanding that people ascertain their opinions and evaluations as being correct through comparing themselves with others. From the marketing perspective, this theory states that consumers compare their gains with those of other consumers and with those of other service provider and satisfaction indicates that the outcome to input ratios are fair (Newsome & Wright 1999).

Attribution theory comes to play when the products or services fall short of consumer expectations. It assumes that people search for causes of events which may be buyer or seller related and the conflict that results from this can in turn lead to dissatisfaction (Folkes 1990).

#### 2.2.5 The Primary Provider Theory

The Primary Provider Theory (PPT) views patient satisfaction as a logical result of the health care professionals' abilities to provide patient-centred services. The PPT explains satisfaction in terms of the clients' assessment/judgement of the care received from *the primary provider and the primary provider assistant*, and *the waiting time*. This judgement is based on what is perceived as an ideal care (expectation) and the actual care received from the primary provider and the primary provider assistant, and the waiting time (Aragon & Gesell 2003). Satisfaction occurs when patients' expectations are met by the actual care provided by the health care services within the expected time. This theory suggests that in a patient-centred approach to health care service delivery, patients will be satisfied with the actual care received from the providers (primary provider and primary provider assistant) and the waiting time (Aragon & Gesell 2003). The professional whose time is consumed the most with the patients' care is regarded as the primary provider, while the one with less amount of time spent with patients' care is referred to as provider assistant. Based on the setting to which the theory is applied, the primary provider may be the nurse, while the doctor might be the primary provider assistant. Waiting time in the context of the PPT refers to the promptness of the providers to attend to the patient and the length of the administrative procedures (Aragon & Gesell 2003).

## **2.3 EMPIRICAL STUDIES ON PATIENT SATISFACTION**

This section explores the concept “patient satisfaction” as used in various studies and quantitative studies on patient satisfaction with special focus on psychiatric inpatients. Several studies have looked at patient satisfaction with health care from the perspective of individual characteristics, interpersonal skills, and policy issues (Johansson et al 2002).

### **2.3.1 Patient satisfaction: the concept**

Globally, there is a shift from reliance on compliance to set standards of care as indicators of health care performance to measure what is reflected in the opinions or views of the users of services. Giving users the opportunity to voice their opinions about the care received is viewed as part of a broader commitment to public and patient participation in planning and delivery of health care services (Olusina et al 2002; Clark et al 2004). Patient satisfaction with the care received has been recognised as the most useful indicator of the quality and people-centred health services (WHO 2001).

Patient satisfaction is extensively used in the literature as a central concept in the assessment of the quality of care, the provision of patient-centred care, and service utilization. Authors (Clark et al 2004; Finnegan & Finnegan 2007; Johansson et al 2002; Sofaer & Firminger 2005; Wood 2006) agree that patient satisfaction is an important indicator of the quality of care and of patient-centred health care delivery services. Patient satisfaction is strongly linked to medication compliance and future utilisation of health services (Newsome & Wright 1999; Wood 2006). For mental health care where clinical outcome is highly dependent on compliance, patient



satisfaction is seen as the ultimate indicator of quality health care provision (Olusina et al 2002).

### 2.3.2. Patient satisfaction and the individual characteristics of patient

Studies have associated patient satisfaction with the individual characteristics of age, gender, race, highest level of education, the duration of the psychiatric illness, and the number of admission in the previous one year.

*Age:* Previous studies have shown a relationship between age and patient satisfaction. Evidence suggests that satisfaction increases as age increases. Older patients are likely to be more satisfied with the health care than young patients (Greenwood 1999; Olusina et al 2002; Ghodse 2004). Johansson et al (2002) attribute this difference to the fact that older patients are likely to be less demanding than younger patients. However, other studies not found an association between age and patient satisfaction (Leavy, King, Cole Hoar and Johnson-Sabine 1997; Middelboe, Schjodt & Byrstring 2001).

*Gender:* Most studies did not find a relationship between patient satisfaction and gender (Leavy et al 1997; Middelboe et al 2001). Few studies (Khayat & Salter 1994; Olusina et al 2004) found that male patients are more likely to be satisfied with care than female patients.

*Race or ethnicity:* Ethnic origin has been seen as one of the most complex determinant characteristic of patient satisfaction. In the United States, studies revealed that Whites are more likely to be satisfied with care than black patients

(Barr 2004). The results of this study reflect that Blacks approach their interaction with the physician with different attitudes and expectations, which are reflected in their lower expressed levels of satisfaction. Physicians may treat black patients differently than white patients in ways that adversely impact patient satisfaction. These differences may reflect the stereotypes and unconscious attitudes which physicians may bring to the racially discordant patient encounter (Barr 2004).

*Highest level of education:* Trends around the world have associated greater satisfaction with lower levels of education (Hall & Dornan 1990; Anderson & Zimmermann 1993). This was attributed to lower expectations from the less educated patients who may not know what the health care providers are expected to deliver. This low expectation may lead to high satisfaction. On the other hand, patients with higher education levels may come with higher expectations knowing what health care providers should deliver. This higher expectation may lead to greater demands on health care resulting in lower levels of satisfaction (Johansson et al 2002).

*Type of admission:* The type of admission is associated with patient satisfaction in psychiatric institutions. Patients subjected to involuntary admissions are less satisfied with the care received than those admitted voluntarily. This association is attributed to the fact that involuntary forms of admission are often associated with a lot of restrictions e.g. locked doors, personal belongings being confiscated, and being subjected to daily ward life imposed by staff (Langle, Baum, Wollinger, Renner, U'ren, Schwarzler & Eschweiler 2003).

*Duration of psychiatric illness:* Authors (Gigantesco, Picardi, Chiaia, Balbi, & Morosini 2001) have found the relationship between the chronicity of mental illness and satisfaction. The chronically ill patients have lower levels of satisfaction than the newly diagnosed patients. However, Middelboe et al (2001) have not found a relationship between duration of psychiatric illness and satisfaction.

### 2.3.3. Patient satisfaction and the health care providers

Previous studies on patient satisfaction have examined at satisfaction in relation to the providers' interpersonal skills (provider-patient interaction) and their technical skills.

*Provider interpersonal skills (Patient-provider interaction):* Several studies have shown the link between patient satisfaction and the way the providers interact with them (Almeida & Adejumo 2004; Clark et al 2004; Myburgh, Solanki, Smith & Lallo 2005; Graham et al 2005; Ozsoy et al 2007). It is argued that most patients are more concerned with interpersonal qualities of the providers than the actual service rendered. Studies indicate that patients are more satisfied when the providers are viewed as friendly, approachable, readily available when needed, sensitive of their culture, and able to communicate in the language they understand better (Bjorkman, Angelman & Jonsson 2008; Clark et al 2004; Olusina et al 2002; Nazan, Arzu, Tacettin & Ismet 2003; Ozsoy et al 2007). Aragon & Gissell (2003) indicate that the availability of primary provider is highly associated with patient satisfaction.

*Technical skills of the providers:* Patients' views on the ability of the health care professionals to provide information related to their care and their competence are

related to satisfaction. Previous studies have shown positive association between patient satisfaction and the provision of information related to their diagnosis, treatment, available services, and treatment routine in the ward (Sitzia & Wood 1997; Gigantesco et al 2001; Johansson et al 2002). This is attributed to the fact that these patients tend to become more involve in their own care and easily influence the decision about their treatment programmes. This active involvement leads to an increased satisfaction (Gigantesco et al 2001; Johansson et al 2002). Previous studies have shown positive association between patients' satisfaction and the quality of nursing and medical care received during their hospital stay (Yellen, Davis, & Ricard 2002).

#### 2.3.4. Patient satisfaction and the environment of care

The influence of the physical environment or ward atmosphere during the treatment of psychiatric inpatients has been acknowledged for decades (Middelboe et al 2001; Johansson et al 2002). In this current era of deinstitutionalisation, inpatient environment is part of the early rehabilitation for preparing the patient to resume activities of daily living after discharge (Middelboe et al 2001).

Policies related to the environment of care (admission procedures, structure of daily activities, complaints procedures and visiting hours) should be accessible and flexible enough to accommodate the needs of the patients and their families. Aspects of safety, cleanliness, noise levels and food services are also crucial (South Africa 1997; Olusina et al 2002). (Space) According to Bauman (2008), the MHCA emphasises the need for the environment of care to be as less restrictive as possible.

Studies (Taylor & Benger 2004; Thompson & Yarnold 2008) have shown a relationship between waiting time and patient satisfaction. These studies revealed that long waiting time leads to patients' dissatisfaction while satisfaction was increased when the patient perceived the waiting time as reasonable.

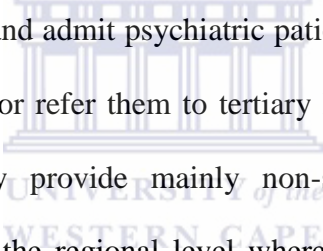
## **2.5 STRUCTURE OF MENTAL HEALTH CARE DELIVERY IN SA**

In SA, the provision of health care services including mental health care services prior to 1994 was characterised by fragmentation and huge disparity mostly on a racial basis. In an effort to correct the imbalances of the past, the new government implemented several measures including an integrated approach to health care service delivery; a decentralised health services management system; and the implementation of a full package of primary health care services. One of the aims of these measures were to ensure reasonable access to effective, efficient and quality health care services to all South Africans in the respective health districts (South Africa 2003).

Mental health care services in the country are provided through the public and private sectors. The private sector serves 20% of the population while the remaining 80% is served by the public sector. The public institutions are funded by government and compelled by law to provide free health care services to all citizens. The National Health Act no 61 of 2003 (NHA) makes provision for equal access to basic health care for unemployed people and people from the lower income groups. It offers opportunity to people who are unable to afford private medical insurance to access free health care services at any clinic or Community Health Care Centre (South Africa, 2003). The private sector is mainly funded by the medical aid schemes

but most patients attending private facilities turn to public sectors as the medical aid gets exhausted (Emsley 2001).

In the public sector, the delivery of the mental health care services is driven by the philosophy of primary health care and structured around the district health system. Within this system, mental health care is integrated into the primary health care delivery services (Van Driel 2005; Mkhize & Kometsi 2008). Mental health users are assessed, diagnosed, treated and rehabilitated at the level closer to them. A greater emphasis at this level is placed on prevention and health promotion (Petersen, Bhana, Campbell-Hall, Mjadu, Lund, Kleintjies, Hosegood, & Flisher 2009).



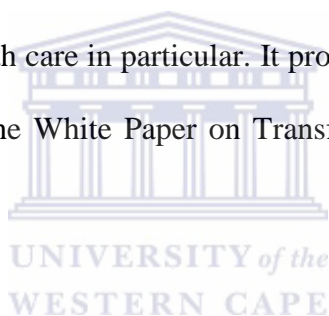
District hospitals assess and admit psychiatric patients as an emergency for 72 hours and thereafter discharge or refer them to tertiary level of care for further treatment and rehabilitation. They provide mainly non-specialized services. Specialized services are provided at the regional level where patients are provided short term inpatient treatment and rehabilitation. Patients needing long-term treatment or more specialized care are referred to provincial hospitals where a wide range of specialities and subspecialties e.g. forensic, child and adolescent, mental retardation and psycho geriatric services are provided (Lund, Kleintjies, Kakuma & Flischer 2010).

Reports suggest that mental health services in South Africa (SA) like in many other low and middle income countries are under-resourced and unequally distributed between the provinces and within rural-urban areas in the same province. For example there is a greater concentration of mental health services and mental health professionals in the Western Cape and Gauteng while other provinces are still

lagging behind. Urban areas are more privileged than the rural areas resulting in the access of psychiatric services for the latter being inadequate if not non-existent (Lund et al 2010).

## **2.6 LEGAL FRAMEWORK FOR MENTAL HEALTH CARE DELIVERY IN SA**

Mental health care delivery services like any other form of service delivery in SA are guided by laws and legislation related to the delivery of services to the public. This section provides an overview of three key policies guiding the delivery of public services and mental health care in particular. It provided an overview of the Patients' Rights Charter (PRC), the White Paper on Transformation of Public Services, and the MHCA.



### **2.6.1 Patients' Rights Charter**

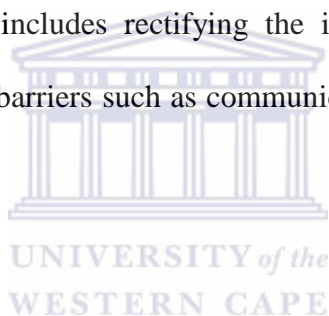
In 1999, SA introduced the PRC in order to ensure access to health care services (South Africa 2002). These include the right to safety and security, freedom of speech to express dissatisfactions with service delivery, a clean and hygienic hospital environment, be addressed in a language of understanding and respect of culture, information about diagnosis as well as consent to treatment and rehabilitation, participate in decision making regarding health, access to health care relating to the patient's need, information regarding the availability and the use of health service, and continuity of health care after discharge. Patients should be awarded an opportunity to complain about the health service they receive (Van Rensburg 2004).

## 2.6.2 The White Paper on Transformation of Public Services

The White Paper on Transformation of Public Services in South Africa also known as Batho Pele White paper aims to ensure consumer-centred approach to service delivery through eight principles: increasing access, consultation, setting service standards, openness and transparency, redress, ensuring courtesy, providing information, and value for money. A short description of the above principles is given below (South Africa 1997).

### *Increasing access:*

This principle aims to ensure that all citizens have equal access to services to which they are entitled to. It includes rectifying the inequalities in the distribution of services and removal of barriers such as communication, attitudes and socio-cultural to access services.



### *Consultation:*

This principle entails the involvement of users in the planning and provision of health care services and wherever possible, providing them with choices for alternative services.

*Setting service standard:* This principle reinforces the need for benchmarking the services and constantly measuring the extent to which consumers are satisfied with the quality of service they receive. It requires managers to outline the service standards and make those standards public so that consumers can align their expectations with those standards and take an informed decision.



*Openness and transparency:*

Service providers should inform users about the way national, provincial and local government institutions operate, how well they utilise the resources they consume, and who is in charge. It is assumed that users will take this opportunity to make suggestions for improvement of service delivery mechanisms, and to make service providers accountable and responsible for failure to deliver the expected services.

*Ensuring courtesy:*

Service providers should empathize with the users and treat them with as much consideration and respect, as they would like for themselves. They should be committed to continuous, honest and transparent communication with the users.

*Providing information:*

This principle requires that information about services that are accessible to users is presented in a language that is understandable to them. They should be given information that would enable them to understand the services they are entitled to receive.

*Redress:*

This principle involves an effective approach to dealing with complaints, as well as identifying and redressing poor quality of services. Service providers are expected to welcome complaints and view them as an opportunity to improve service.

*Value for money:*

In terms of this principle providers should put in place measures that would prevent unnecessary wastage of resources including time.

### 2.6.3 The Mental Health Care Act No. 17 of 2002 (MHCA)

This Act provides excellent legislation that serves as an advocate for the management and treatment of mental health users in the country. The Act provides guidelines on the provision of appropriate care, treatment and rehabilitation as well as the protection of patients' rights and those of their communities. Unlike the previous legislation, the Act puts the patient at the centre of service delivery, emphasising treatment rather than detention (Baumann 2008). The severity of the disturbed state and the insight of the patient determine the procedures to be followed regarding hospitalisation hence the various forms of admission status i.e. voluntary admissions, section 27 (assisted admissions) and section 33 (involuntary admissions). The MHCA emphasises and compels mental health care practitioners to inform patients of their rights which include the right to privacy, respect, human dignity. Information about the care the patients are to receive and their consent to this is crucial as they need to be involved (South Africa 2002). The Act makes provision of a Review Board to be established at each province. The Review Board has the main responsibility of ensuring that the provision of the mental health services are in the best interest of the patients, the accreditations and qualifications of the mental health care practitioners providing the necessary assessment is taken into consideration, as well as the provision of the least restrictive environment (South Africa 2002).

The Mental Health Review Board has played a significant role in prescribing the minimum standards for mental health care. These revolve around patients' right to dignity, choice, autonomy, confidentiality, privacy, complaints as well as the appropriateness of the environment in which care is rendered (Muller & Flisher

2005). In response to these guidelines, mental health care managers are compelled to develop internal policies for the improvement of the quality of care. Such policies should incorporate the principles outlined in the MHCA, the Batho Pele White Paper, and the Primary Health Care (PHC). However critics argue that compliance to standards does not mean quality of care. Standards should be supported with strategies that ensure the implementation of patient-centred care. From the patients' perspective, quality involves the reduction of symptoms, carrying on with daily activities, treatment with respect and independent decision making. Quality improvement therefore requires the alignment of policy and legislation with active participation of the users (Draper, Lund, Kleintjies, Funk, Omar & Flischer 2009).

## **2.7 CONCEPTUAL FRAMEWORK FOR THE STUDY**

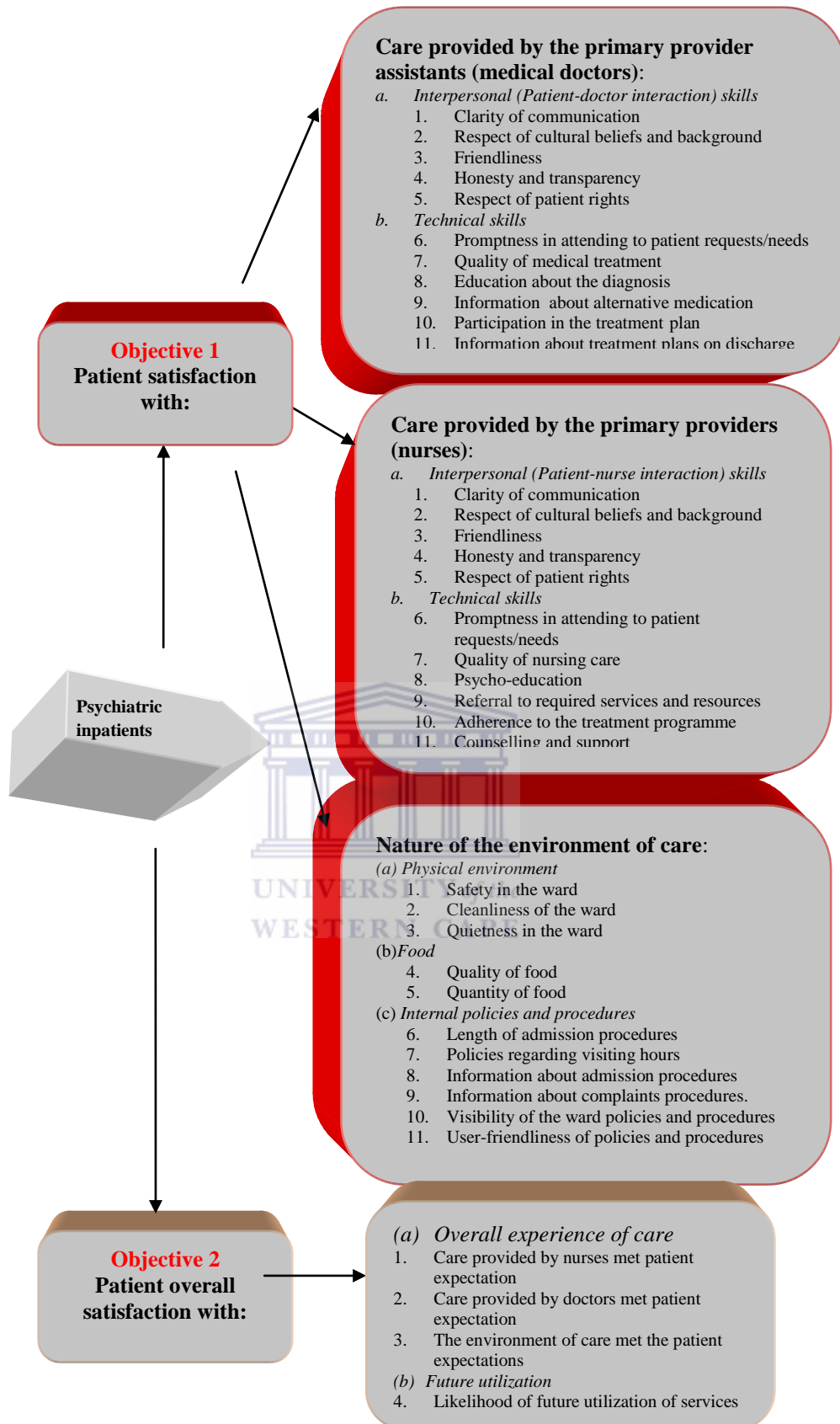
Most studies on patient satisfaction use the marketing conceptual models as framework but critics argue that the marketing conceptual models do not really fit the health care context (Newsome & Wright 1999). The conceptual framework used in this study is derived from the Primary Provider Theory (PPT) and the Batho Pele principles (BPP). It consists of four key concepts (primary provider, primary provider assistant, environment of care, and experience of care) and 37 measurement indicators (see Figure 1).

Based on the PPT, nurses are regarded as the primary providers while the medical doctors are primary provider assistants. The concept of the environment of care derived from the Batho Pele White Paper which emphasizes the quality of the environment of care and includes the indicators of the concept waiting time from

PPT. All the measurement indicators derived from the BPP are indicated in Table 1 below.

**Table 1: Application of Batho Pele principles in the study**

| <b>Principles</b>                | <b>Related Measurement Indicators</b>  | <b>Related component of the study</b> |
|----------------------------------|--|---------------------------------------|
| <b>Increasing access</b>         | 1. Language of communication<br>2. Respect of cultural beliefs and background              | Interpersonal skills of providers     |
| <b>Consultation</b>              | 3. Information about alternative medication<br>4. Choice of alternative treatment modality | Technical skills of providers         |
| <b>Setting service standard</b>  | 5. Quality of nursing and medical care   | Technical skills of providers         |
|                                  | 6. Information regarding management of side effects  |                                       |
|                                  | 7. Information about the diagnosis   |                                       |
|                                  | 8. Promptness in attending to patients' requests/needs                                     |                                       |
|                                  | 9. Safety in the ward<br>10. Cleanliness of the ward<br>11. Quietness in the ward          | Physical environment                  |
| <b>Openness and transparency</b> | 12. Quality and quantity of food   | Food services                         |
|                                  | 13. Length of admission procedures   | Internal policies and procedures      |
|                                  | 14. Adherence to ward programmes   |                                       |
| <b>Ensuring courtesy</b>         | 15. Information regarding visiting hours   | Internal policies and procedures      |
|                                  | 16. Information about admission procedures   |                                       |
|                                  | 17. Accessibility of ward programmes   |                                       |
| <b>Providing information</b>     | 18. Friendliness of providers  | Interpersonal skills                  |
|                                  | 19. Respect of patients' rights by providers   |                                       |
|                                  | 20. Continuous communication   |                                       |
| <b>Redress</b>                   | 21. Information about services available in the hospital                                   | Technical skills of the providers     |
|                                  | 22. Information about complaints procedures  |                                       |
| <b>Value for money</b>           | 23.  | Internal policies & procedures        |
|                                  | 23. Appropriate referral to services   |                                       |



**Figure 1: Illustration of the conceptual framework of the study**

**(Prof Ganga-Limando & Marepula)**

## 2.8 CONCLUSION

This chapter focused on the literature relating to the mental health care delivery services in SA, the theoretical foundation of patient satisfaction, and previous studies on patient satisfaction with a focus on factors associated with psychiatric inpatients. The literature reviewed suggests that mental health care delivery services in the country is driven by the philosophy of primary health care and structured around the district health system. It is also suggested that mental health care services are integrated within the general health care delivery system. In addition to legislation guiding the delivery to public services which includes health services, mental health care delivery in the country is mainly guided by the MHCA and the PRC. Finally, the literature also illustrates that the private sector provides around 20% of mental health care services in the country.

The literature examined indicates that patient satisfaction is a key indicator for quality of care. Furthermore, Satisfaction Theories evolved from the marketing field. Several other theories were reviewed and these all seem to explain patient/consumer satisfaction in terms of the interaction between the consumer's perception of ideal service and his/her experience of the actual service. In addition, satisfaction is influenced or associated with several factors including socio-demographic, the provider-consumer interaction or the interpersonal skills of the provider, the technical skills of the provider as well as environmental factors. However, previous studies on psychiatric inpatients' satisfaction have been conducted in developed countries where health care institutions are run as profit-making institutions and the users are treated as consumers. In SA, the public institutions are the main providers of the mental health services and the users do not pay for services received from

these institutions. Would this influence the quality of care and therefore patient satisfaction? Would this influence the users' expectations and consequently their satisfaction? These are some of the questions that this study intends to answer as the existing literature does not provide enough information related to the current research settings.



## **CHAPTER THREE: RESEARCH METHODOLOGY**

### **3.1 INTRODUCTION**

The purpose of this study was to describe psychiatric inpatients' satisfaction with the care received in a psychiatric hospital in Cape Town. This chapter outlines the research methodology used to investigate the above purpose. It specifically describes the research setting, the research design, the population, the sample and sampling techniques, the research instrument, the data collection process, data analysis, and ethical considerations.

### **3.2. RESEARCH DESIGN**

A research design may be defined as a blueprint of how the planned research will be conducted. It gives the researcher greater control and improves the validity of the study (Burns & Grove 2007:17). In this study, the researcher used a quantitative descriptive survey design by means of a self-completion questionnaire. A quantitative research is a formal method of collecting information systematically and objectively under controllable conditions. A standardized data collection instrument is used and the results quantified to answer the research questions (Burns & Grove, 2007:17; De Vos, 2007:73).

In a descriptive design, the researcher obtains information concerning the current status of the phenomena of interest in order to describe "what exists" with respect to



variables or conditions in a specific situation or setting (Kelley, Clark, Brown & Sitzia 2003). For this study, patient satisfaction was the phenomenon of interest. The researcher's main interest was to describe the status of patients' satisfaction with the care they received during their hospitalization within the context of the Primary Provider Theory and the Batho Pele principles. In descriptive studies the relationships amongst variables aid to present an overall picture of the phenomenon under study (Burns & Grove 2007). In the context of this study, certain socio-demographic characteristics and previous psychiatric history of the patients were used to present an overall picture of the phenomenon of interest.

The use of a self-completion questionnaire in a survey has the advantage of providing the respondent with the opportunity to complete the questions at their own convenience without fear of victimisation (Bless & Higson-Smith 2004; Kelley, et al 2003). This was most appropriate as the researcher happened to be a manager of one of the care units of the psychiatric hospital under the study.

### **3.3 RESEARCH SETTING**

The study took place in a public psychiatric teaching hospital in Cape Town. The hospital has a bed capacity of 276 and admits males and females from all racial groups between the ages of 18 and 60. The hospital consists of various units with psychiatric patients at different levels of recovery. The hospital's catchment area which is predominantly coloured includes all the Southern suburbs of Cape Town. All patients admitted at this hospital are followed up at the Outpatients Department of the hospital for a period of six to 12 months before they get referred to their

respective community clinics. In terms of the types of admission, the majority of patients are admitted under section 33 of the MHCA (Involuntary admission).

### **3.4 POPULATION OF THE STUDY**

A study population refers to the set of elements that the research focuses upon and to which the results obtained should be generalized (Burns & Grove 2007). The population for this study constituted of all the patients discharged from the research setting between January 1st and June 30th 2011. The official records of the target hospital showed that a total of 1,160 patients were discharged during the above period. This number was therefore considered as the study population.

### **3.5 SAMPLE AND SAMPLING TECHNIQUES**

According to Burns & Grove (2007) a sample is a subset of the population that is selected for the study. Generally, 10% of the study population is generally considered as a representative sample (Polit & Beck 2004). A simple random sampling technique was used to select 150 patients. In simple random sampling, participants are chosen randomly and entirely by chance, so that each individual has the same probability of being chosen at any stage during the sampling process, and each subset of the sampling frame has the same probability of being chosen for the sample. Quantitative descriptive design often uses a sampling frame from which the eligible participants will be selected (Burns & Grove 2007).

In this study, the researcher compiled a sampling frame which consisted of an alphabetical list of the discharged patients with full contact addresses including

telephone numbers and/or no re-admittance after being discharged during the selected period. The researcher selected every fifth patient from the sampling frame and telephonically contacted every selected patient requesting if she/he would be willing to participate in the study. This process was followed until the researcher reached 150 participants. The researcher was satisfied with this number which represented more than 10% of the study population (n=1,160).

### **3.6 DATA COLLECTION INSTRUMENT**

#### **3.6.1 Description of the instrument**

The researcher designed a questionnaire based on the conceptual framework of this study (see Figure 1). The questionnaire was divided into three sections. The first section consisted of close-ended questions related to the respondents' age, gender, race, highest level of education, the duration of the psychiatric illness, and the number of admissions in the previous one year. The second section consisted of 33 statements related to the first objective of the study. Of these 33 statements, 22 were related to the interpersonal and technical skills of nurses and medical doctors and 11 related to the nature of the environment of care. The third section of the questionnaire comprised of 4 statements related to the second objective of the study. Three of these statements were related to the overall experience of care and one to the likelihood of future utilization of the hospital services (see Appendix E).

A four point Likert-scale ranging from always, sometimes, never, and not sure was used to evaluate the 33 statements included in the second section of the questionnaire

while a five point Likert-scale ranging from strongly agree, agree, disagree, and strongly disagree was used to evaluate the 4 statements included in the third section of the questionnaire. Authors (Clark et al 2004; Vagias 2006) view Likert-scales as the most appropriate measurement tool for people's opinions and experiences.

### **3.6.2 Validity and reliability of the instrument**

The validity of an instrument determines the extent to which it measures what it is supposed to measure (Polit & Beck 2004). Validity of an instrument can be achieved through face validity and content validity. Face validity refers to whether the instrument looks as though it is measuring the appropriate construct and can persuade the people to participate in the study (Polit & Beck 2004). Content validity is concerned with the degree to which an instrument contains an appropriate sample of items for the construct being measured and adequately covers the construct domain (Polit & Beck 2004). Reliability refers to the consistency and accuracy of measures i.e. an instrument has the potential to produce the same results if used to measure the same phenomenon. According to Bless & Higson-Smith (2004) a reliability coefficient score of 0.7 is the most recommended score in social sciences.

For this study, the researcher used a conceptual framework to enhance the content validity of the instrument. In addition, the developed instrument was scrutinized by the research supervisor and two other experts in psychiatry (one psychiatrist and one academic). They both felt that the questionnaire was simple and relevant to the objectives of the study. The questionnaire was also tested with 10 respondents who were not part of the study. They felt that all questions were clear, relevant to the study and easy to complete. No changes were made to the original questionnaire.

### **3.7 DATA COLLECTION PROCESS**

The questionnaires were posted to 150 participants with a return postage envelope. Participants were also offered an option to drop the completed questionnaire in a sealed box which was made available at the waiting area of the Outpatients Department. A participant's information sheet and a consent form were attached to each questionnaire. To enhance the response rate, the researcher made follow-up calls one week after the mailing of the questionnaire. Data collection period lasted for four weeks.

### **3.8 DATA ANALYSIS**

The process of data analysis in a quantitative study involves sorting the collected information into components or elements in order to test the hypothesis or answering the identified research problem. Statistical analyses are conducted to assist the researcher in this process (De Vos, Strydom, Fouche, & Delpont, 2005; Pallant 2005).

In this study, the researcher scrutinized each return questionnaire to ascertain that all questions were answered as expected. The Statistical Package for the Social Sciences (SPSS Version 19) was used for data capturing, editing and analysis. Each questionnaire was given a unique number identifying it to facilitate error tracking where necessary. Variables were given value numbers e.g. 1 for male and 2 for female. The data was screened and checked for errors and these were corrected where possible in the data file.

Summary descriptive statistics were conducted to describe and summarize data. For the purposes of analyses and reporting, the four-point Likert scale (always, sometimes, never, not sure) was captured and analysed as highly satisfied for always, moderately satisfied for sometimes, and unsatisfied for never and not sure. While the five-point Likert scale (strongly agree, agree, undecided, disagree, and strongly disagree) was captured and analysed as agree for the two levels of agreement (strongly agree and agree) and disagree for the two levels of disagreement (strongly disagree and agree). The researcher used graphs, frequency tables and percentage distribution as well as the mean score to describe the results.

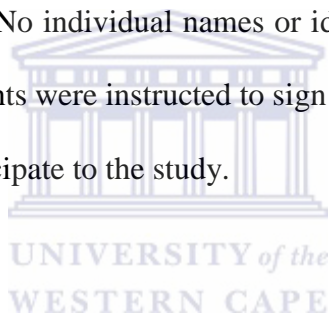
### **3.9 ETHICAL CONSIDERATIONS**

The study was conducted within the universal ethical principles (respect for person, beneficence, non-maleficence, and justice) and the ethics guidelines for postgraduate research prescribed by the University of the Western Cape.

The proposal of this study was approved for its scientific merit by the Scientific Review Committee of the School of Nursing and the Health Higher Degree Committee of the Faculty of Community and Health Sciences of the University of the Western Cape. The ethical clearance to conduct the study was obtained from the Senate Ethics Committee of the University of the Western Cape (see Appendix D). Furthermore permission was granted by the Head of Hospital's Ethics Committee (see Appendix A). The process of data collection started after the ethical clearance and the institutional permission were granted.

Participation to the study was voluntary and the researcher ensured that the participants were fully informed about the study. The initial information was given telephonically and thereafter in the Patient Information Sheet attached to the

questionnaire. Participant Information Sheet contained information about the purpose and the scope of the study, the participants' benefits for participating in the study and their right to withdraw if they wish to. They were ensured that should they refuse to participate there would be no consequences (see Appendix B). Each respondent was requested to sign a written consent form which was attached to the questionnaire (see Appendix C). This study did not have any potential for physical, mental and social harm to the respondents. However, the researcher structured data collection instruments in a manner that was not harmful to the participants. The questionnaires did not contain any information that could be traced back to the participants. The returned envelopes were destroyed and the completed questionnaires were locked away by the researcher. No individual names or identifier mechanisms were used in the report. The respondents were instructed to sign the consent form as a reflection of their willingness to participate to the study.



### **3.10 CONCLUSION**

This chapter examined the research methodology in terms of the research design, the setting, the population, the sample and sampling techniques, data collection instruments, data collection process, data analysis, and ethical considerations. The next chapter describes and discusses the results of the findings.

## **CHAPTER FOUR:**

### **PRESENTATION AND DISCUSSION OF THE RESULTS**

#### **4.1 INTRODUCTION**

Chapter three described the methodology followed in this study. This chapter presents and discusses the results of the analysis of the data generated from the study. At the end of four weeks data collection period, a total of 120 questionnaires out of 150 were returned and considered for analysis. The presentation and discussion of the results are introduced by the characteristics of the respondents. The researcher used the objective of the study to structure the presentation and discussion of the results. As stated in chapter one, the objective of the study was to describe the psychiatric patients' satisfaction with the care received during their hospitalization in a psychiatric hospital in terms of their views on the:

- Interpersonal (patient-provider interaction) and technical skills of nurses;
- Interpersonal (patient-provider interaction) and technical skills of doctors;
- Nature of the environment of care;
- Overall experience of care (quality of care received from nurses, quality of care received from doctors, the nature the environment of care, and the likelihood of future utilization of the hospital services).

#### **4.2 CHARACTERISTICS OF THE RESPONDENTS**

The respondents were described in terms of the socio-demographic factors (age, gender, highest level of education; race) and the individual psychiatric history (duration with the psychiatric illness, and number of admissions in the last 12 months). The results are summarized in Table 2.



#### **4.2.1 Socio-demographic characteristics**

Of the 120 respondents, 16.7% (n=20) were between 25-29 years old, 16.7% (n=20) were between 35-39 years old, 15.8% (n=19) were between 20-24 and 40-44 years old respectively, 13.3% (n=16) were between 20-24 years old; 10.0% (n=12) were between 45-49 years old; 5.8% (n= 7) and 5.0% (n= 6) were between 50-54 years old and less than 20 years old respectively. One respondent (0.8%, n=1) was above 54 years old (see Table 2). In general, 62.5% (n=75) of the respondents were between 20-39 years old and 25.8% (n=31) were in their forties (40-49).

In terms of gender, 51.7% (n=62) of the respondents were males and 48.3% (n=58) were females. As indicated in Table 2, 55.0% (n=66) of the respondents were classified as Coloureds; 21.7% (n=26) as Blacks; 19.2% (n= 23) as Whites; and 4.2% (n=5) as Indians. All the respondents have attended formal education. Of the 120 respondents, 47.5% (n= 57) went up to the high school; 25.0% (n=30) completed or went up to the college; 19.2% (n=23) went up to or have a university qualification; and 8.3% (n=10) had only primary education level.

#### **4.2.2 Psychiatric history of the respondents**

Of the 120 respondents, 63.3% (n=76) were diagnosed with mental illness for less than one year, 25.0% (n=30) between one to five years; and 11.7% (n=14) for more than five years. In terms of the number of admissions into a psychiatric hospital in the past one year, 63.3% (n=76) of the respondents were admitted once; 20.0% (n=24) were admitted twice; and 16.7% (n=20) were admitted three times.

**Table 2: Socio-demographic characteristics of the respondents**

| <b>Individual characteristics</b>                 | <b>Frequency</b> | <b>Percentage (%)</b> |
|---|------------------|-----------------------|
| <b><i>Socio-demographic:</i></b>                  |                  |                       |
| <b>Age (in year):</b>                             |                  |                       |
| <b>Less than 20</b>                               | 06               | 5.0                   |
| <b>20-24</b>                                      | 19               | 15.8                  |
| <b>25-29</b>                                      | 20               | 16.7                  |
| <b>30-34</b>                                      | 16               | 13.3                  |
| <b>35-39</b>                                      | 20               | 16.7                  |
| <b>40-44</b>                                      | 19               | 15.8                  |
| <b>45-49</b>                                      | 12               | 10.0                  |
| <b>50-54</b>                                      | 07               | 5.8                   |
| <b>55 and over</b>                                | 01               | 0.8                   |
| <b>Gender:</b>                                    |                  |                       |
| <b>Male</b>                                       | 62               | 51.7                  |
| <b>Female</b>                                     | 58               | 48.3                  |
| <b>Race:</b>                                      |                  |                       |
| <b>Blacks</b>                                     | 26               | 21.7                  |
| <b>Coloureds</b>                                  | 66               | 55.0                  |
| <b>Indians</b>                                    | 05               | 19.2                  |
| <b>Whites</b>                                     | 23               | 4.2                   |
| <b>Highest level of education:</b>                |                  |                       |
| <b>Primary school</b>                             | 10               | 8.3                   |
| <b>High school</b>                                | 57               | 47.5                  |
| <b>College</b>                                    | 30               | 25.0                  |
| <b>University or tertiary</b>                     | 23               | 19.2                  |
| <b><i>Psychiatric History:</i></b>                |                  |                       |
| <b>Duration of psychiatric illness:</b>           |                  |                       |
| <b>Less than one year</b>                         | 76               | 63.3                  |
| <b>One to five years</b>                          | 30               | 25.0                  |
| <b>More than five years</b>                       | 14               | 11.7                  |
| <b>Number of admissions in the past one year:</b> |                  |                       |
| <b>One time</b>                                   | 76               | 63.3                  |
| <b>Two times</b>                                  | 24               | 20.0                  |
| <b>Three times</b>                                | 20               | 16.7                  |

### **4.3. PRESENTATION OF THE RESULTS**

#### **4.3.1 Patients' satisfaction with the interpersonal and technical skills of nurses**

Eleven statements were used to describe the interpersonal (five statements) and technical (six statements) skills of nurses. The respondents expressed their views on each of the statements using a four-point Likert-Scale ranging from always, sometimes, never, and not sure. For the purpose of the objective of this study, the views expressed by the respondents were captured and analysed as “highly satisfied” for always, “moderately satisfied” for sometimes, and “unsatisfied” for never and not sure. The results are summarized in Table 3.



##### ***4.3.1.2. Satisfaction with the interpersonal skills of nurses***

The respondents used the following five statements to express their views on the interpersonal skills of nurses:

- clarity of communication during the interaction (communicate in a language which is well understood by the patient);
- respect of cultural beliefs and background of patient;
- friendliness toward patient;
- honesty and transparency during the interaction; and
- respect of patient rights.

Figure 2 illustrates the frequency distribution of the respondents' satisfaction with the interpersonal skills of nurses.

Of the 120 respondents, 79.0% (n=95) were highly satisfied with the clarity of nurses' communication, 15.0% (n=18) were moderately satisfied, while 6.0% (n=7) were unsatisfied. In terms of the respect of the patients' cultural beliefs and background, 56.0% (n=68) of the respondents were highly satisfied, 24.2 % (n=26) were moderately satisfied, while 19.2% (n=23) were unsatisfied. Of the 120 respondents, 61.7% (n=74) were highly satisfied with the friendly aspect, 34.2% (n=41) were moderately satisfied, 3.4% (n=4) while were unsatisfied; With regards to the honesty and transparency of nurses, 40.8% (n=49) of the respondents were highly satisfied, 36.7% (n=44) were moderately satisfied, while 22.5% (n=27) were unsatisfied. As for respect of the patients' rights, 65.0% (n=78) were highly satisfied, 30.0% (n=36) were moderately satisfied, 5.0% (n=6) while were unsatisfied.

The mean score of the five statements showed a score of 3.71 for the clarity of communication, followed with a score of 3.60 for the friendliness of nurses, 3.55 for nurses' respect of patients' rights, 3.27 for nurses' respect for cultural beliefs and background of patients, and 3.12 for the honesty and transparency of nurses during their interactions with patients (see Table 3).

#### ***4.3.1.2. Satisfaction with the technical skills of nurses***

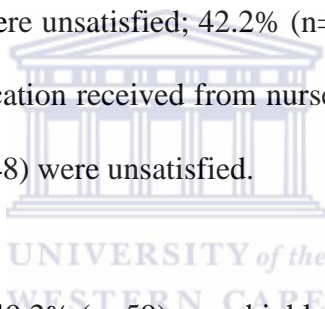
The respondents used the following six statements to express their views on the technical skills of nurses:

- promptness of nurses in attending to the patients' requests/needs;
- quality of the direct nursing care;
- provision of psycho-education;

- provision of appropriate referral to required services;
- level of adherence to ward programme; and
- provision of counselling and support.

Figure 3 illustrates the frequency distribution of the respondents' satisfaction with the interpersonal skills of nurses.

The results showed that of the 120 respondents, 50.0% (n=60) were highly satisfied with nurses' promptness in attending to their requests, 37.5% (n=45) were moderately satisfied, 12.5% (n=15) were unsatisfied; 58.3% (n=71) were highly satisfied with the quality of direct nursing care, 33.3% (n=40) were moderately satisfied, 8.3% (n=10) were unsatisfied; 42.2% (n=51) were highly satisfied with the provision of psycho-education received from nurses, 17.5% (n=21) were moderately satisfied, and 40.3% (n=48) were unsatisfied.



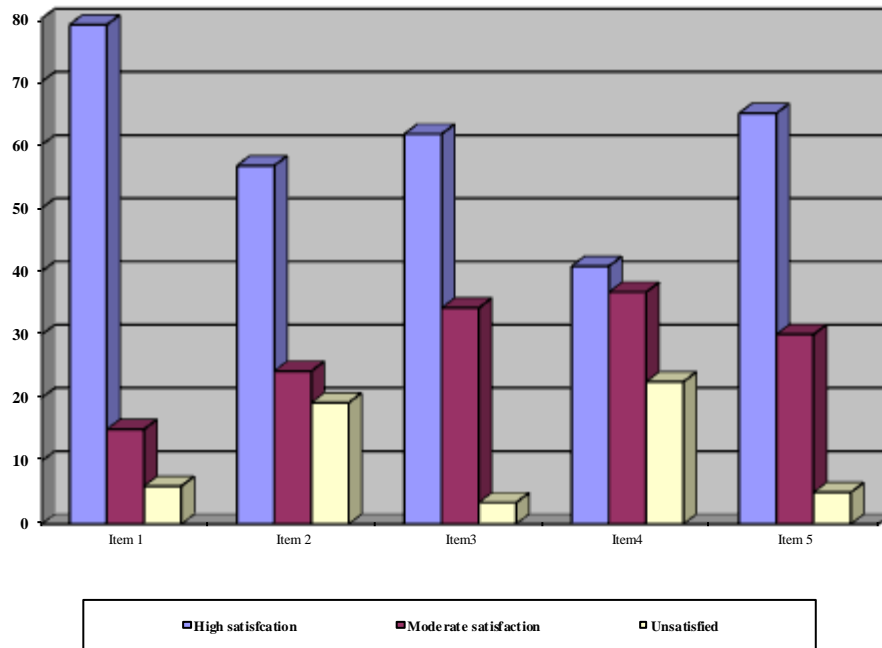
Of the 120 respondents, 49.2% (n=59) were highly satisfied with the ability of nurses to appropriately refer them to the required services, 25.0% (n=30) were moderately satisfied, and 25.8% (n=31) were unsatisfied; 64.2% (n=77) of the respondents were highly satisfied with nurses' level of adherence to the ward programme, 25.8% (n=31) were moderately satisfied, and 10.0% (n=12) were unsatisfied. With regard to the provision of counselling and support, 55.8% (n=67) of respondents were highly satisfied, 36.7% (n=44) were moderately satisfied, and 7.5% (n=9) were unsatisfied.

The mean score of the five statements showed a score of 3.48 for nurses' level of adherence to the ward programme, followed with a score of 3.47 for the provision of counselling and support, a score of 3.45 for the quality of direct nursing care, a score

of 3.32 for the promptness of nurses in attending to patients' requests/needs, and a score of 3.21 for the appropriateness of the referral to required services. The mean for the respondents' satisfaction with the provision of the psycho-education was the lowest with 2.93.

**Table 3: Satisfaction with interpersonal and technical skills of nurses**

| Measurement indicators                                    | Highly satisfied (%) | Moderately satisfied (%) | Unsatisfied (%) | Mean |
|---|----------------------|--------------------------|-----------------|------|
| <i>Interpersonal skills</i>                               |                      |                          |                 |      |
| 1. Clarity of communication                               | 95<br>(79.0)         | 18<br>(15.0)             | 7<br>(6.0)      | 3.71 |
| 2. Respect of cultural beliefs and background             | 68<br>(56.7)         | 29<br>(24.2)             | 23<br>(19.2)    | 3.27 |
| 3. Friendliness   | 74<br>(61.7)         | 41<br>(34.2)             | 4<br>(3.4)      | 3.60 |
| 4. Honesty and transparency                               | 49<br>(40.8)         | 44<br>(36.7)             | 27<br>(22.5)    | 3.12 |
| 5. Respect of patients' rights                            | 78<br>(65.0)         | 36<br>(30.0)             | 6<br>(5.0)      | 3.55 |
| <i>Technical skills</i>                                   |                      |                          |                 |      |
| 6. Promptness of nurses in attending to request/need      | 60<br>(50.0)         | 45<br>(37.5)             | 15<br>(12.5)    | 3.32 |
| 7. Quality of direct nursing care                         | 70<br>(58.3)         | 40<br>(33.3)             | 10<br>(8.3)     | 3.46 |
| 8. Provision of psycho-education                          | 51<br>(42.2)         | 21<br>(17.5)             | 48<br>(40.3)    | 2.93 |
| 9. Provision of appropriate referral to required services | 59<br>(49.2)         | 30<br>(25.0)             | 31<br>(25.8)    | 3.21 |
| 10. Level of adherence to the ward programme              | 77<br>(64.2)         | 31<br>(25.8)             | 12<br>(10.0)    | 3.48 |
| 11. Provision of counselling and support                  | 67<br>(55.8)         | 44<br>(36.7)             | 9<br>(7.5)      | 3.47 |



**Figure 2: Satisfaction with the interpersonal skills of nurses**

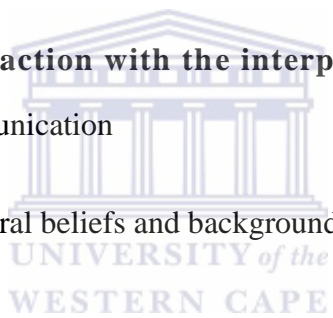
Item 1-Clarity of communication

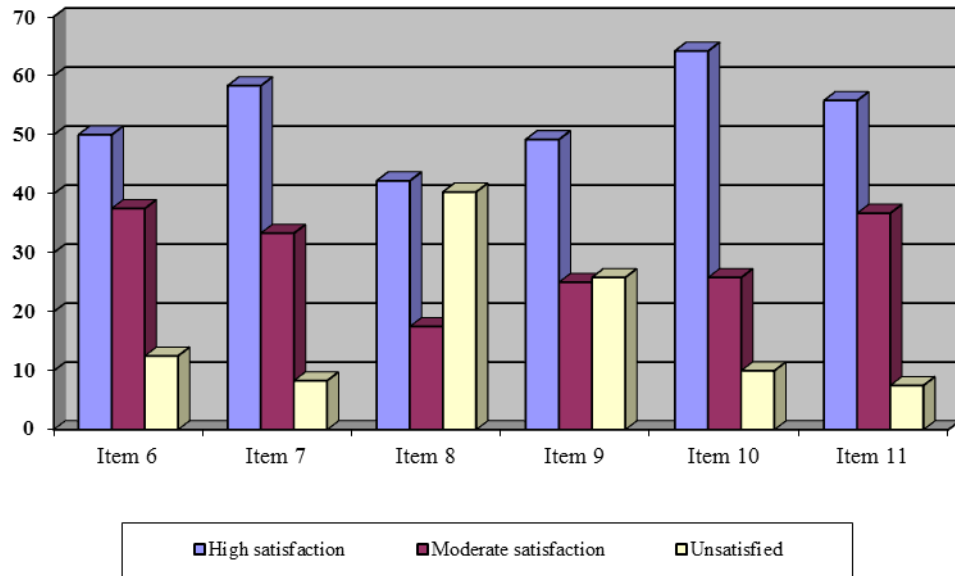
Item 2 – Respect of cultural beliefs and background

Item 3 –Friendliness

Item 4 – Honesty and transparency

Item 5 – Respect of patients’ rights





**Figure 3: Satisfaction with the technical skills of nurses**

Item 6 – Promptness of nurses in attending to requests

Item 7 – Quality of direct nursing care

Item 8 – Provision of psycho-education

Item 9 – Provision of appropriate referral to required services

Item 10 – Level of adherence to the ward programme

Item 11 – Provision of counselling and support

#### **4.3.2 Patients’ satisfaction with the interpersonal and technical skills of doctors**

Eleven statements were used to describe the interpersonal (five statements) and technical (six statements) skills of doctors. The respondents expressed their views on each of the statements using a four-point Likert-Scale ranging from always, sometimes, never, and not sure. For the purpose of the objective of this study, the views expressed by the respondents were captured and analysed as “highly satisfied”



for always, “moderately satisfied” for sometimes, and “unsatisfied” for never and not sure. The results are summarized in Table 4.

#### ***4.3.2.1 Satisfaction with interpersonal skills of doctors***

The respondents used the following five statements to express their views on the interpersonal skills of doctors:

- clarity of communication during the interaction (communicate in a language which is well understood by the patient);
- respect of cultural beliefs and background of patient;
- friendliness toward patient;
- honesty and transparency during the interaction; and
- respect of patient rights.

Figure 4 illustrates the frequency distribution of the respondents’ satisfaction with the interpersonal skills of doctors.

With regards to the clarity of communication, 89.2% (n=107) of the respondents were highly satisfied, 9.2% (n=11) were moderately satisfied, and 1.7% (n=2) were unsatisfied. Of the 120 respondents, 67.5% (n=81) were highly satisfied with the medical doctors’ respect to their cultural beliefs and background, 17.5 % (n=21) were moderately satisfied, and 15.0% (n=18) were unsatisfied; 74.2% (n=89) were highly satisfied with the friendliness of the medical doctors, 23.3% (n=28) were moderately satisfied, and 1.7% (n=2) were unsatisfied; With regard to the honesty and transparency of the medical doctors, 80.0% (n=96) were highly satisfied with the honesty, 16.7% (n=20) were moderately satisfied, and 3.3% (n=4) were unsatisfied; 80.9% (n=97) were highly satisfied with the medical doctors’ respect of their rights

as patients, 18.3% (n=22) were moderately satisfied, and 0.8% (n=1) were unsatisfied.

On average the respondents were satisfied with the interpersonal skills of medical doctors with the highest mean of 3.87 for the clarity of communication; followed by respect of patients' rights with 3.79; honesty and transparency with 3.74; friendliness with 3.73; and respect of cultural beliefs and background of patients with 3.44.

#### ***4.3.2.1 Satisfaction with interpersonal skills of doctors***

The respondents evaluated the technical skills of medical doctors in terms of:

- the promptness of medical doctors in attending to their requests/needs;
- the quality of medical treatment;
- the provision of education about the diagnosis;
- the provision of information about alternative medication;
- participation in selecting the treatment modality or medication; and
- information about treatment plan after discharged.

Figure 5 illustrates the frequency distribution of the respondents' satisfaction with the technical skills of doctors.

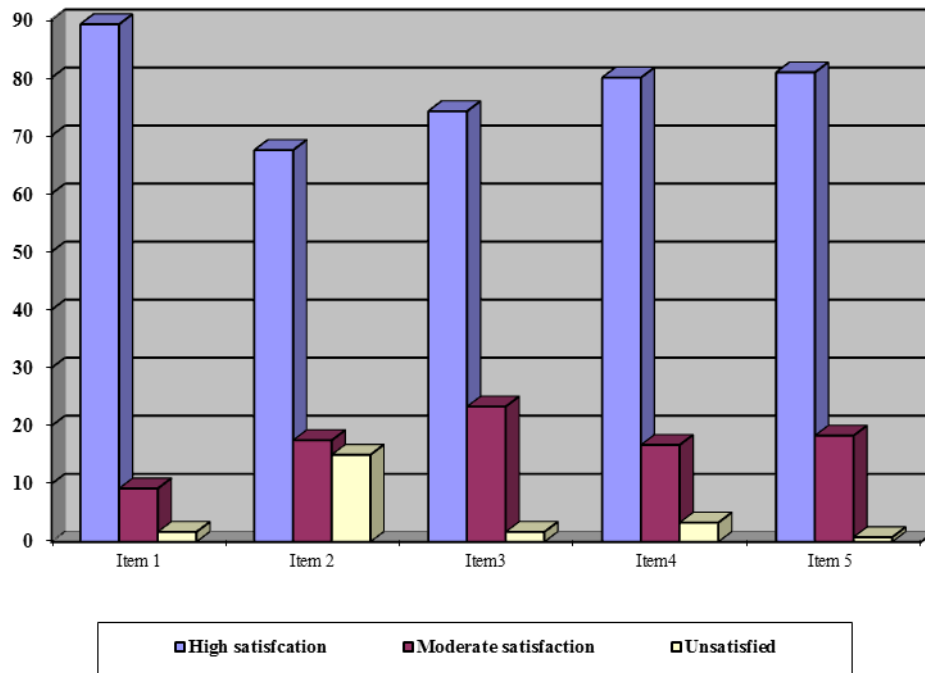
Of the 120 respondents, 60.0% (n=72) were highly satisfied with doctors' promptness in attending to their requests, 23.3% (n=28) were moderately satisfied, and 16.7% (n=20) were unsatisfied; 72.5% (n=87) were highly satisfied with the quality of medical care, 13.3% (n=16) were moderately satisfied, and 13.3% (n=16) were unsatisfied; 69.2% (n=83) were highly satisfied with the information given by doctors regarding their diagnosis, 15.8% (n=19) were moderately satisfied, and 15.0% (n=18) were unsatisfied.

With regard to information about alternative medication, 54.2% (n=65) of the respondents were highly satisfied, 14.2% (n=17) were moderately satisfied, and 31.6% (n=38) were unsatisfied. The results in Table 6 illustrate that 48.3% (n=58) of the respondents were highly satisfied with their participation in selecting the treatment modality or medication, 12.5% (n=15) were moderately satisfied, and 39.2% (n=47) were unsatisfied; 69.2% (n=83) of the respondents were highly satisfied with information given by doctors regarding their treatment plans after discharged, 15.0% (n=18) were moderately satisfied, and 15.8% (n=19) were unsatisfied.

On average the respondents were satisfied with the technical skills of medical doctors with the highest mean of 3.50 for the quality of medical care, followed by the education about the diagnosis with 3.48, the provision of information about the treatment plans after discharge with 3.40, the promptness of medical doctors in attending to patients' requests/needs with 3.38, the provision of information about alternative medication with 3.15, and patients' participation in selecting treatment modality and medication with 3.03.

**Table 4: Satisfaction with the interpersonal and technical skills of doctors**

| <b>Measurement indicators</b>                                   | <b>Highly satisfied (%)</b> | <b>Moderately satisfied (%)</b> | <b>Unsatisfied (%)</b> | <b>Mean</b> |
|---|-----------------------------|---------------------------------|------------------------|-------------|
| <b><i>Interpersonal skills</i></b>                              |                             |                                 |                        |             |
| 1. Clarity of communication                                     | 107<br>(89.2)               | 11<br>(9.2)                     | 2<br>(1.7)             | 3.87        |
| 2. Respect of cultural beliefs and background                   | 81<br>(67.5)                | 21<br>(17.5)                    | 18<br>(15.0)           | 3.44        |
| 3. Friendliness   | 89<br>(74.2)                | 28<br>(23.3)                    | 2<br>(1.7)             | 3.73        |
| 4. Honesty and transparency                                     | 96<br>(80.0)                | 20<br>(16.7)                    | 4<br>(3.3)             | 3.74        |
| 5. Respect of patient rights                                    | 97<br>(80.9)                | 22<br>(18.3)                    | 1<br>(.8)              | 3.79        |
| <b><i>Technical skills</i></b>                                  |                             |                                 |                        |             |
| 6. Promptness of doctors in attending to request/need           | 72<br>(60.0)                | 28<br>(23.3)                    | 20<br>(16.7)           | 3.38        |
| 7. Quality of medical treatment                                 | 87<br>(72.5)                | 16<br>(13.3)                    | 16<br>(13.3)           | 3.50        |
| 8. Education about the diagnosis                                | 83<br>(69.2)                | 19<br>(15.8)                    | 18<br>(15.0)           | 3.48        |
| 9. Provision of information about alternative medication        | 65<br>(54.2)                | 17<br>(14.2)                    | 38<br>(31.6)           | 3.15        |
| 10. Participation in selecting treatment modality or medication | 58<br>(48.3)                | 15<br>(12.5)                    | 47<br>(39.2)           | 3.03        |
| 11. Information about treatment plans after discharge           | 83<br>(69.2)                | 18<br>(15.0)                    | 19<br>(15.8)           | 3.40        |



**Figure 4: Satisfaction with the interpersonal skills of doctors**

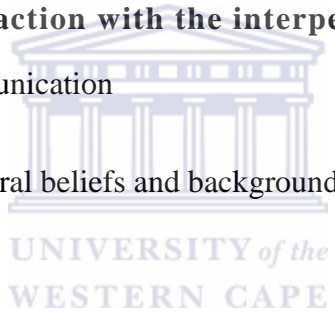
Item 1 -Clarity of communication

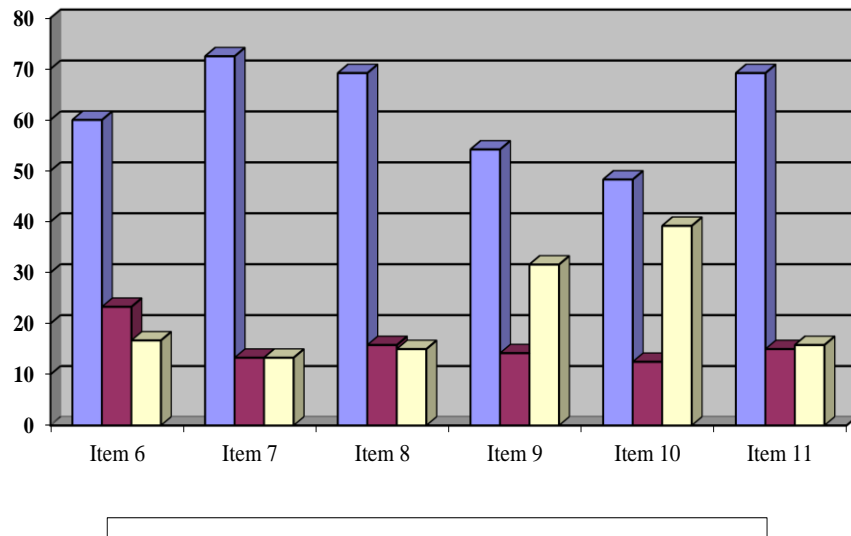
Item 2 – Respect of cultural beliefs and background

Item 3 –Friendliness

Item 4 – Honesty and transparency

Item 5 – Respect of patients' rights





**Figure 5: Satisfaction with the technical skills of doctors**

Item 6 – Promptness of doctors in attending to requests/need

Item 7 – Quality of medical treatment

Item 8 – Education about the diagnosis

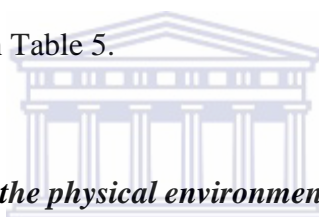
Item 9 – Provision of information about alternative medication

Item 10 – Participation in selecting treatment modality or medication

Item 11 – Information about treatment plans after discharge

### 4.3.3 Patients' satisfaction with the nature of the environment of care

Eleven statements were used to describe the nature of the environment of care. Of the eleven statements, three were related to the physical environment, two to the food service, and six to the internal policies and procedures. The respondents expressed their views on each of the statements using a four-point Likert-Scale ranging from always, sometimes, never, and not sure. For the purpose of the objective of this study, those views were captured and analysed as “highly satisfied” for always, “moderately satisfied” for sometimes, and “unsatisfied” for never and not sure. The results are summarized in Table 5.



#### 4.3.3.1 Satisfaction with the physical environment and food services

The respondents used the following statements to express their views with the physical environment of care and the food services:

- safety in the ward;
- cleanliness of the ward;
- quietness of the ward environment;
- quality of the food served; and
- quantity of the food served.

Figure 6 illustrates the frequency distribution of the respondents' satisfaction with the physical environment of care and the food services.

Of the 120 respondents, 61.7% (n=74) were highly satisfied with the safety in the ward, 24.2% (n=29) were moderately satisfied, and 14.2% (n=17) were unsatisfied;

75.8% (n=91) were highly satisfied with the cleanliness of the ward, 19.2% (n=23) were moderately satisfied, and 5.0% (n=6) were unsatisfied; 43.3% (n=52) were highly satisfied with the quietness in the ward, 42.5% (n=51) were moderately satisfied, and 14.2% (n=17) were unsatisfied.

Of the 120 respondents, 50.0% (n=60) were highly satisfied with the quality of food served in the hospital, 40.0% (n=49) were moderately satisfied, and 9.2% (n=11) were unsatisfied; 76.7 % (n=92) were highly satisfied with the quantity of food served, 19.2% (n=23) were moderately satisfied, and 3.3% (n=4) were unsatisfied.

With regards to mean score, the results showed that on average, the respondents were satisfied with the physical environment of the ward with the highest mean of 3.69 for the cleanliness of the ward, followed by the safety in the ward with a mean of 3.43 and the quietness in the ward with a mean of 3.28. With regard to the food services, the mean score was higher with the quantity of the food served (mean score of 3.74). The mean score of the quality of food was 3.40.

#### ***4.3.3.2 Satisfaction with the internal policies and procedures***

Satisfaction with internal policies and procedures was assessed in terms of;

- the length of admission procedures;
- the policy on visiting hours;
- the information about the admission procedures;
- information about the complaints procedures;
- visibility of the ward policies and procedures; and
- the user-friendliness and adherence to policies and procedures.



Figure 7 illustrates the frequency distribution of the respondents' satisfaction with the internal policies and procedures.

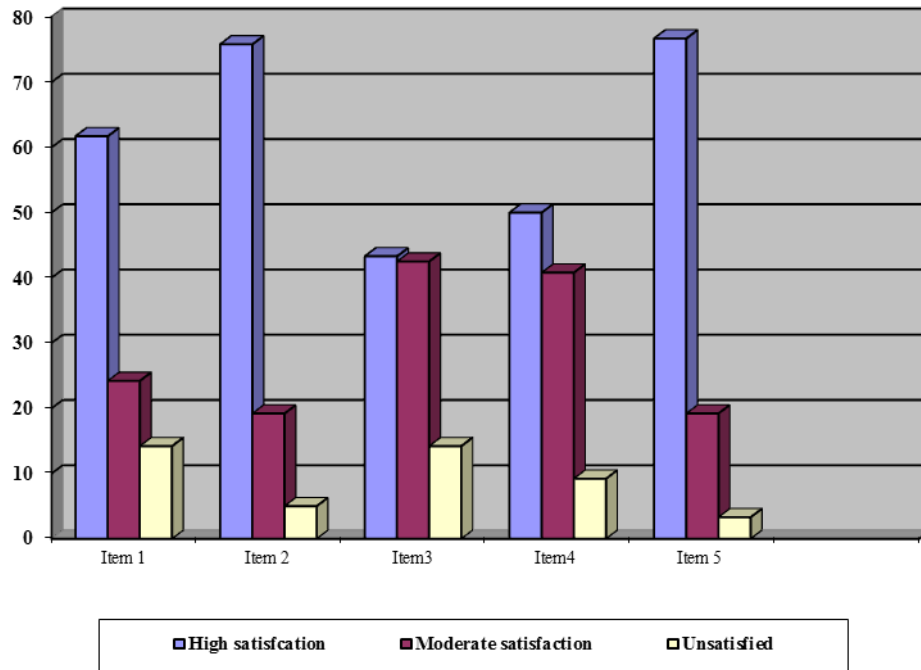
Of the 120 respondents, 66.7 % (n=80) were highly satisfied with the length of the admission procedure, 18.3% (n=22) were moderately satisfied, 15.0% (n=18) were unsatisfied; 56.0% (n=68) were highly satisfied with the visiting hours policies, 15.8% (n=19) were moderately satisfied, 27.5% (n=33) were unsatisfied; 57.5% (n=69) were highly satisfied with the information given to them regarding the admission procedures, 17.5% (n=21) were moderately satisfied, and 16.0% (n=50) were unsatisfied.

With regards to information about the complaints procedures, 55.8% (n=67) of the respondents were highly satisfied, 16.7% (n=20) were moderately satisfied, and 27.5% (n=33) were unsatisfied. As shown in Table 8, 69.2% (n=83) of the respondents were highly satisfied with the visibility of the ward procedures and policies, 20.8% (n=25) were moderately satisfied, and 10.0 % (n=12) were unsatisfied; 56.7% (n=68) of the respondents were highly satisfied with the user-friendliness and adherence to the ward policies and procedures, 19.2% (n=23) were moderately satisfied, and 24.1% (n=29) were unsatisfied.

On average the respondents were satisfied with the internal policies and procedures in the wards with the highest mean of 3.56 for the visibility of the ward policies and procedures, 3.38 for the length of admission procedure, 3.23 for the provision of information about the admission procedures, 3.21 for the visiting hours policies, 3.18 for the user-friendliness and adherence to policies and procedures, and 3.14 for the information about the complaints procedures.

**Table 5: Satisfaction with the nature of the environment of care**

| Measurement indicators   | Highly satisfied (%)       | Moderately satisfied (%)   | Unsatisfied (%)            | Mean        |
|--|----------------------------|----------------------------|----------------------------|-------------|
| <b><i>Physical environment</i></b>                             |                            |                            |                            |             |
| <b>1. Safety in the ward</b>                                   | <b>74</b><br><b>(61.7)</b> | <b>29</b><br><b>(24.2)</b> | <b>17</b><br><b>(14.2)</b> | <b>3.43</b> |
| 2. Cleanliness of the ward                                     | 91<br>(75.8)               | 23<br>(19.2)               | 6<br>(5.0)                 | 3.69        |
| 3. Quietness in the ward                                       | 52<br>(43.3)               | 51<br>(42.5)               | 17<br>(14.2)               | 3.28        |
| <b><i>Food service</i></b>                                     |                            |                            |                            |             |
| 4. Quality of food   | 60<br>(50.0)               | 49<br>(40.8)               | 11<br>(9.2)                | 3.40        |
| 5. Quantity of food  | 92<br>(76.7)               | 23<br>(19.2)               | 4<br>(3.3)                 | 3.74        |
| <b><i>Internal policies and procedures</i></b>                 |                            |                            |                            |             |
| 6. Length of admission procedure                               | 80<br>(66.7)               | 22<br>(18.3)               | 18<br>(15.0)               | 3.38        |
| 7. Visiting hours policies                                     | 68<br>(56.0)               | 19<br>(15.8)               | 33<br>(27.5)               | 3.21        |
| 8. Information about admission procedures                      | 69<br>(57.5)               | 21<br>(17.5)               | 30<br>(25.0)               | 3.23        |
| 9. Information about complaints procedures                     | 67<br>(55.8)               | 20<br>(16.7)               | 33<br>(27.5)               | 3.14        |
| 10. Visibility of the policies and procedures                  | 83<br>(69.2)               | 25<br>(20.8)               | 12<br>(10.0)               | 3.56        |
| 11. User-friendliness and adherence to policies and procedures | 68<br>(56.7)               | 23<br>(19.2)               | 29<br>(24.1)               | 3.18        |



**Figure 6: Satisfaction with the nature of the environment of care and food services**

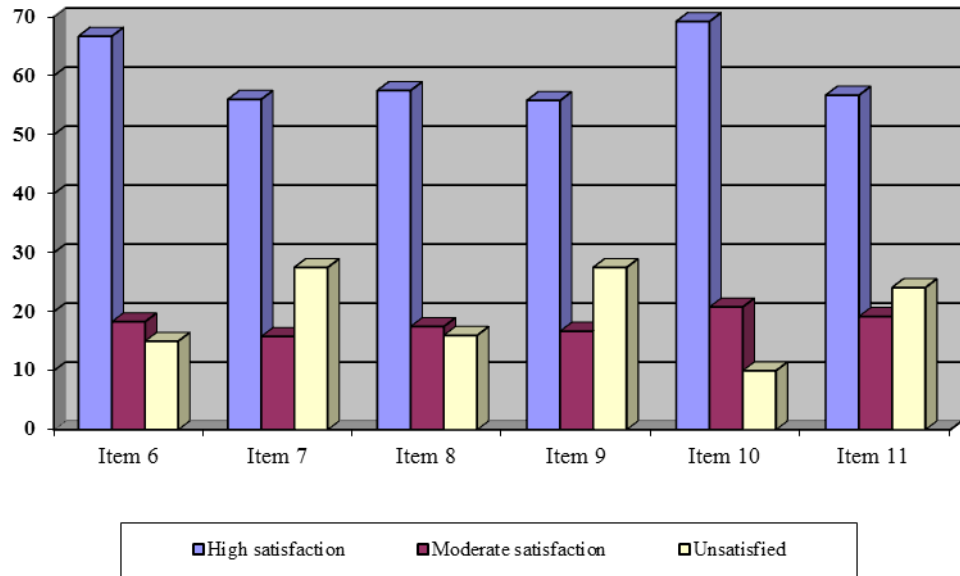
Item 1 – Safety in the ward

Item 2 – Cleanliness of the ward

Item 3 – Quietness in the ward

Item 4 – Quality of food

Item 5 – Quantity of food



**Figure 7: Satisfaction with the internal policies and procedures**

Item 6 – Length of admission procedures

Item 7 – Visiting hours policies

Item 8 – Information about admission procedures

Item 9 – Information about complaints procedures

Item 10 – Visibility of the policies and procedures

Item 11- User-friendliness and adherence to policies and procedures

#### **4.3.4 Patients' satisfaction with the overall experience of care**

The respondents' satisfaction with the overall experience of care was measured in terms of:

- the quality of care received from the nurses;
- the quality of care received from doctors;

- the environment of care; and
- their likelihood of future use of the hospital services.

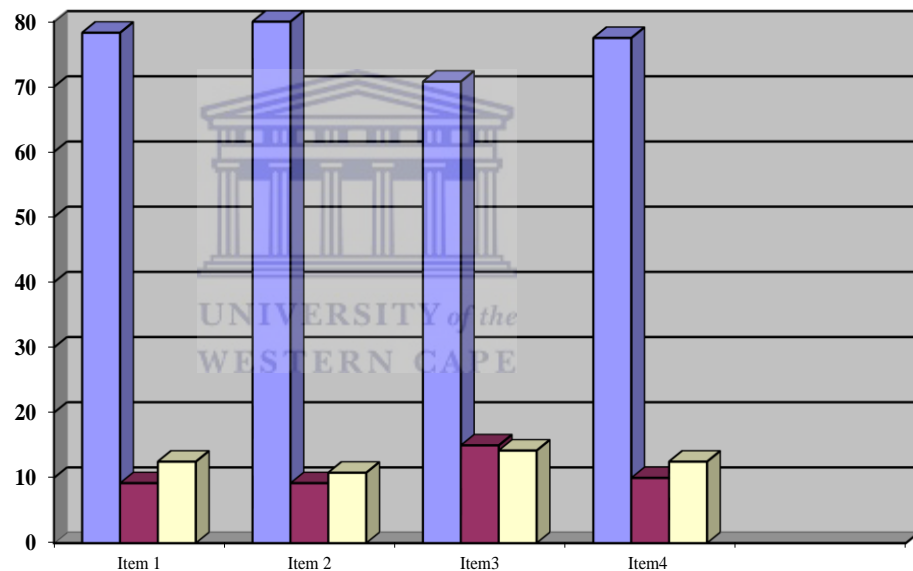
These items were reflected in four statements. The respondents expressed their views on each of the statements using a four-point Likert-Scale ranging from strongly agree, agree, undecided, disagree, and strongly disagree. For the purpose of the objective of this study, strongly disagree and agree were captured and analysed as “agree”, while disagree and strongly disagree were captured and analysed as “disagree”. The results are summarized in Table 6. Figure 8 illustrates the frequency distribution of the respondents’ satisfaction with the internal policies and procedures.

Of the 120 respondents, 78.3% (n=94) agreed that the quality of care provided by nurses met their expectations, 9.2% (n=11) disagreed with that statement, and 12.5% (n=15) were undecided; 80.0% (n=96) of the respondents agreed that the quality of care provided by medical doctors met their expectations, 9.2% (n=11) disagreed with that statement, and 10.8% (n=13) were undecided; 70.8% (n=85) of the respondents indicated that the environment of care met their expectations, 15.0% (n=18) of the respondents disagreed, and 14.2% (n=17) were undecided.

With regards to the likelihood of future utilization, of the 120 respondents, 77.5% (n=93) agreed that they will not hesitate to come back or to recommend people to the facility because of their experiences, 10.0% (n=11) disagreed, and 12.5% (n=15) were undecided.

**Table 6: Overall satisfaction with the experience of care**

| Statements   | Agree (%) | Disagree (%) | Undecided (%) |
|--|-----------|--------------|---------------|
| 1. The quality of care provided by nurses met my expectations.   | 94 (78.3) | 11 (9.2)     | 15 (12.5)     |
| 2. The quality of care provided by doctors met my expectations.  | 96 (80.0) | 11 (9.2)     | 13 (10.8)     |
| 3. The environment of care in this hospital met my expectations.   | 85 (70.8) | 18 (15.0)    | 17 (14.2)     |
| 4. I will not hesitate to come back or recommend somebody to this hospital because of my experience of care. | 93 (77.5) | 11 (10.0%)   | 15 (12.5)     |



**Figure 8: Satisfaction with the overall experience of care**

Item 1 – The quality of care provided by nurses met my expectations

Item 2 - The quality of care provided by doctors met my expectations

Item 3 – The environment of care in this hospital met my expectations

Item 4 – I will not hesitate to come back or recommend somebody to this hospital because of my experience of care

## **4.4. DISCUSSION OF THE RESULTS**

### **4.4.1 Satisfaction with the interpersonal and technical skills of nurses**

Satisfaction with the care provided by nurses as indicated in Table 3 and Figures 2 and 3 showed that generally the respondents were satisfied with the care received from nurses. Greater satisfaction was observed on aspects of nurse-patient interactions. This is in line with the findings Hansson 1989, Middleboe et al 2001; Olusina et al 2002; Ghodse 2004; Myburgh et al 2005). These authors concluded that interpersonal interactions are the core of practise and have a positive influence on mental health care. This is not surprising as the psychiatric inpatients value interactions the most. Further Kagan (1985) mentions that teaching of interpersonal skills forms the basis in one form or another for much of the psychiatric nursing training while technical skills are less focused on due to the nature of the job.

Interpersonal aspects of nurses were measured in terms of patients' views on the clarity of communication (communicate in a language which is well understood by the patient); respect of cultural beliefs and background; friendliness; honesty and transparency; and respect of patients' rights. Honesty and transparency seem to have scored the lowest and this could be due to honesty regarding diagnosis and psycho education on medication which is an aspect of technical skills.

However the satisfaction ratings on the aspects of technical skills were lower than those related to nurse - patient interaction. This could be explained by the focus on interpersonal skills, the core of psychiatric training (Kagan 1985). These aspects were promptness in attending to requests, quality of direct nursing care, provision of

psycho-education on medication and diagnosis, provision of referral to required services, counselling and support, and adherence to the ward programme. This can be explained by the fact that there is a shortage of nurses in psychiatric hospitals and these aspects of care are time consuming as they relate to nurse availability. The information regarding side effects of medication reflects the lack of psycho education and is consistent with the study by Kuosmanen, Hatonen, Jyrkinen, Katajisto and Valimaki (2006). Availability of nurses is related to staffing and is an important element as it ensures that patients' problems are attended to (Ware et al 1977; Yellen, Davis & Ricard 2002). Similar findings regarding lack of education on medication were observed on the study by Howard and El-Mallakh (2011) but on the contrary staff was able to talk to patients about their problems when needed. These findings are consistent with other studies done on patient satisfaction where satisfaction with nursing care ranged between 50% and 98% with interaction aspects rating the highest (Middelboe et al 2001; Johansson et al 2002; Clark et al 2004; Almeida & Adejumo 2004, Ozsoy et al 2007).

#### **4.4.2 Satisfaction with the interpersonal and technical skills of doctors**

As indicated in Table 4 and Figures 4 and 5 medical doctors seem to have scored the highest on aspects of interaction and this could be due to the fact as claimed by Sitzia and Wood (1997) doctors have a higher power regarding competence and knowledge than nurses resulting in nurses rating badly on communication aspects, elements that respondents gave the highest scores. Further nurses are often in close contact with patients during the process of enforcing ward rules which is associated with restrictions, a situation that could make them unpopular or less popular than medical doctors. Furthermore the BBP of Openness and Transparency as well as Consultation



have been adhered to. Interpersonal aspects for medical doctors included clarity of communication, respect for cultural beliefs, friendliness, honesty and transparency and respect of patients' rights.

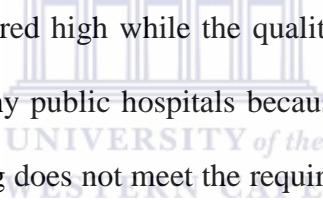
Doctors scored high on aspects relating to technical skills as illustrated in Table 6. This could be due to the fact that their training concentrates more on aspects of technical skills and that they tend to have higher levels of competence than nurses (Sitzia & Wood 1997). Further there is a common understanding that patients tend to trust medical doctors more when it comes to technical aspects of care. This is in line with the findings of Olusina et al 2002; Clark et al 2002 and Ozsoy et al 2007, who in their studies of determinants on patient satisfaction found the above mentioned technical aspects crucial to patients being satisfied. In addition to this, findings on patient satisfaction in Sweden UK and USA revealed that quality of medical services is crucial in hospital settings as it ensures that patients' problems are attended to (Ware et al 1977; Yellen, Davis & Ricard 2002). These aspects were promptness of doctors in attending to requests, quality of medical treatment, education about the diagnosis, information about treatment plans after discharge, information on alternative medication, and participation in selecting the treatment modality. The results showed that doctors were prompt in attending to patients and this could be attributed to the fact that this is a provincial hospital which admits booked patients referred from the district hospitals and admissions are planned based on the waiting list with an agreed number of patients per day. This finding is in line with the BBP of Access which requires that services of the health care professionals are made available to the patients (Khoza 2010). Access to information about plans after

discharge, crucial for compliance to treatment was adhered to. This was in line with the findings of Ware and Davis-Avery (1977) which emphasised that in order for continuity of care to occur, doctors should communicate discharge plans to psychiatric patients.

However doctors scored lowest on provision of information about alternative medication and consultation on choice of treatment options and this indicates that patients are not fully involved in their treatment plan, something that is crucial in psychiatry. This could be due to the fact that patients in this hospital are involuntary and are usually admitted while in a psychotic state which could impair their judgement and insight regarding choice of medication and their involvement might delay their recovery. This finding is crucial and not in line with literature which emphasises consultation and patient involvement in treatment choice and is linked to positive clinical outcomes such as improved adherence to therapeutic regime, compliance to medication, reduced anxiety, and enhanced ability to cope with symptoms and to ensure patient involvement in care (Sitzia & Wood 1997; Gigantesco et al 2001), a situation that has a positive influence on satisfaction. Furthermore this finding is in contradiction with the provisions of the MHCA 17 of 2002 which emphasises and compels mental health care practitioners to inform patients of their treatment and give them alternatives to choose from (South Africa 2002). The results show that the BBP of Consultation seem to have been compromised as respondents were not given treatment alternatives to choose from. The respondents seem to have placed more importance on interpersonal aspects. An argument by Sitzia and Wood (1997) questions the ability of psychiatric patients to assess patient care and further argue that these patients are more concerned with personal qualities than the actual service rendered.

#### **4.4.3 Satisfaction with the nature of the environment of care**

The results in Table 5 as illustrated in Figures 6 and 7 showed that respondents were satisfied with physical environment even though psychiatric patients place less importance on the characteristics of the environment and more on the interpersonal aspects. These aspects were safety, cleanliness and quietness in the ward. These results mirror those of Olusina et al 2002; Samuels; Hall and Parkes (2007) but contradict those of Khoza (2010) who discovered that respondents were dissatisfied with safety. Low satisfaction scores were noticed on quietness in the ward, an indication that there were instances of high noise levels in the ward environment. This is consistent with the study by Olusina et al (2002).



The quantity of food scored high while the quality of it scored low. The latter is a common problem in many public hospitals because of the difficulty of catering for varied tastes. This finding does not meet the requirements of inpatient satisfaction by Sitzia and Wood (1997) who found food to be the most common determinant factor for inpatients with regards to satisfaction.

With regards to internal policies and procedures, the respondents were generally satisfied. Respondents were satisfied with the length of admission procedures and visibility of the policies and procedures. This could be attributed to the fact that in this hospital there are no emergencies. Admissions are planned based on the waiting list and only a certain amount of patients can be admitted per day. This contradicts studies on patient satisfaction and waiting times by Taylor and Bengner (2004) as well as Thompson and Yarnold (2008) who reported dissatisfactions with waiting times.

These studies were however based on emergency departments. These findings are in line with the provisions of the BBP of service standards which expects the ward environment to reflect policies and procedures related to the patients e.g. admission procedures, structure of daily activities, complaints procedures and visiting hours.

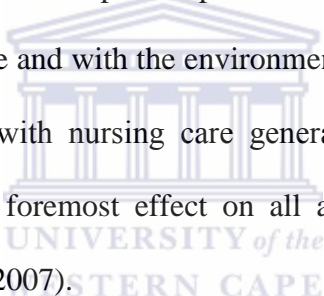
However the ratings were lower in information about admission procedures which could be explained by the fact that patients are often admitted in a psychotic state and could therefore not be offered these explanations. This reflects the failure of the mental health care providers to give information in this regard as required by the BBP of Information (South Africa 1997). This is a concern as patients who receive information not only show satisfaction but they become more involved in their own care and cope more effectively with their illness. This is consistent with the study findings on information sharing of Lowry 1998; Kampman, Poutanen and Leinonen 2003; Kuosmanen, et al 2006; and Khoza 2010. This further confirms that the provisions of MHCA and the BBP which focus on patients' rights are not being adhered to and further contradict the stance of SA and the rest of the world on the affirmation of the right to information through the PBR (Gigantesco et al 2001, South Africa 2002, South Africa 1997). Insufficient information has been shown by Johansson et al (2002) as the major cause of dissatisfaction.

There is a concern with regards to flexibility in this hospital as the score on visiting was low. This then poses the issue of freedom for psychiatric patients which was viewed by other studies as a cause for dissatisfaction as it impacts negatively on therapeutic environments Olusina et al (2002) and further contradicts the MHCA

which expects psychiatric patients to be treated in the least restrictive environment as possible (Bauman 2008).

#### **4.4.4 Satisfaction with the overall experience of care**

As shown in Table 6 and illustrated in Figure 8 the respondents were generally satisfied with their overall experience of care. This is supported by various studies done in developed and developing countries which revealed that the majority of psychiatric patients expressed satisfaction with their care with a few responding negatively (Middelboe et al 2001; Olusina et al 2002, Almeida & Adejumo 2004). The overall satisfaction with hospital experience is judged on the satisfactions with nursing care, medical care and with the environment of care (Aragon & Gisell 2003). In addition satisfaction with nursing care generally determines patients' hospital experience, and has the foremost effect on all aspects of satisfaction (Mailan & Fahad 2005; Ozsoy et al 2007).



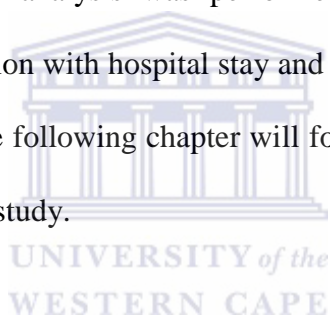
Furthermore, the study has demonstrated that our theoretical framework (PPT) has been upheld which holds the stance that fulfilment of expectations based on the difference between the ideal and the actual care received (Thompson & Sunol 1995; Johansson, et al 2002; Aragon & Gesell 2003). The respondents' expectations were met in all categories of care.

Finally there is evidence that expectations vary according to knowledge and prior experience and could change with the accumulation of experience resulting in a

situation where increasing satisfaction may raise expectations, a situation which could lead to lower levels of satisfaction in the future (Sitzia & Wood 1997).

#### **4.7 CONCLUSION**

In this chapter the respondents' satisfaction with nursing care, medical care and environment of care were presented, described and discussed fully. Further, a multivariate analysis has been presented to demonstrate the relationship between patient characteristics and satisfaction with nursing care, medical care and the environment of care which could help explore the factors associated with patient satisfaction. A bivariate analysis was performed to determine the relationships between overall satisfaction with hospital stay and nursing care, medical care and the environment of care. The following chapter will focus on the conclusions drawn and recommendations of the study.



## **CHAPTER FIVE:**

### **CONCLUSIONS, RECOMMENDATIONS, AND LIMITATIONS**

#### **5.1 INTRODUCTION**

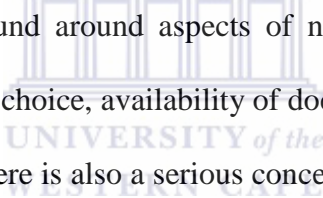
Chapter 4 presented, described and discussed the perceptions of psychiatric inpatients with the care provided in a psychiatric hospital in accordance with the objectives of the study. This chapter will focus on the conclusions and will present recommendations as drawn from the study.

#### **5.2 CONCLUSION**

The objectives of the study which were to (1) describe the psychiatric inpatients' satisfaction with the care provided in a psychiatric teaching hospital in terms of their views on the: care provided by nurses (interpersonal/nurse-patient interaction and technical skills); care provided by doctors (interpersonal/doctor-patient interaction and technical skills); and the nature of the environment of care, and (2) to describe the psychiatric inpatients' overall satisfaction with the care received in a psychiatric teaching hospital in terms of the: quality of care received from nurses and doctors; nature of the environment of care; and the likelihood of future utilization of the hospital services, and if these have been fulfilled.

Generally respondents were satisfied with the care received at the public psychiatric hospital. Greater satisfaction was observed on aspects related to provider-patient interactions. Doctors seem to have scored higher than nurses on aspects of interaction. Technical aspects of care for nurses received lower satisfaction levels.

The effect of patient satisfaction with interpersonal aspects of care has been displayed to be sufficiently powerful to overcome some areas of dissatisfaction with nurses, doctors, and environment of care, resulting in a positive experience with the hospital stay. One would then argue that the hypothesis that states that patient satisfaction with the primary provider has the greatest influence on the overall service satisfaction. This finding is further supported by the theory that states that nurses are the major determinants of satisfaction with the overall experience with hospital stay. The above results indicate that the PPT can be used to guide the measurement of patient satisfaction, identify gaps and implement patient satisfaction plans.



Dissatisfactions were found around aspects of noise, information sharing, patient involvement in treatment choice, availability of doctors and psycho education on side effects of medication. There is also a serious concern around the BPP as principles of information, openness and transparency, consultation, access, and redress do not seem to have been adhered to.

It is interesting to note that despite the above positive findings, Sitzia and Wood (1997) cautioned that they should not be seen at face value if the significance of the study is to improve patient care. More focus should be placed on the areas of dissatisfaction if the significance of the study is to inform the health care managers about the level of compliance of the health care professionals with the government transformation agenda. Furthermore other variables e.g. demographic characteristics should also be taken into consideration.



The study has demonstrated that patient satisfaction studies remain a useful indicator in monitoring the patient care and in the evaluation of changes in the organisations. The literature has been supportive in the aspects discussed in this study. These findings offer valuable information for developing and maintaining the quality of services and implementing client-centred methods in psychiatric hospital. Further, they are in line with international declarations and recommendations about mental health and psychiatric inpatient care.

General inpatient satisfaction in psychiatric hospital care was good. However, more innovative methods for improvement in the areas of dissatisfaction need to be developed. Special attention should be given to the implementation of the Batho Pele Principles and the protection of the patients' rights.

### **5.3 RECOMMENDATIONS**

The issues resulting from this study that would help to improve the quality of care delivered are listed below:

- In-service education programmes for nurses is necessary to reinforce aspects of technical skills as these appear to have scored low in this study e.g. giving psycho education on side effects of medication, provision of referral to required services and informing patients about the complaints procedures and patients' rights.
- Special attention should be focused on methods to improve patients' access to information to fulfil the provisions of the MHCA, PRC and the BBP.

- Hospital management should take into consideration the factors associated with patient satisfaction when designing psychiatric inpatient care.
- The implementation of the BPP and the adherence to the provisions of the MHCA should be an important element of human resource development programmes and care should be taken that all categories of staff are conversant about these aspects as the study showed that the principles of information, consultation openness and transparency, access, and redress were not adhered to.
- Focus should not only remain on the areas of dissatisfaction but should be extended to include the more positive aspects so that the satisfaction levels reflected in this study are maintained if the significance of the study is to inform the health care managers about the level of compliance of the health care professionals with the government transformation agenda.
- Qualitative studies are warranted to explore details on areas of satisfaction and dissatisfaction from the patient perspective.
- Further studies should be done to determine unknown expectations of the patients, essentially thus demanding that more qualitative studies be done to explore these.
- The literature which forms the basis for our discussion is of western origin and it is therefore important that more studies be done in the African continent as it is lacking at the moment.
- To complement the results of this study, further studies should concentrate on the rest of mental health care professionals as these were excluded.

#### 5.4 LIMITATIONS OF THE STUDY

- The study did not take into consideration the fact that patients were hospitalised in various units where nurses, doctors and environment of care could vary, a situation that could have caused confusion for respondents with regards to ratings as experiences would not be the same.
- The study was only limited to nurses, doctors and the physical environment of care and excluded other areas of care and other mental health care practitioners, something that could have had a positive or negative impact on the respondents' ratings of the overall hospital stay.



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APPENDIX A: LETTER OF PERMISSION TO COLLECT DATA



DEPARTMENT  
of HEALTH  
Provincial Government of the Western Cape

Research & Ethics Committee

Valkenberg Hospital, P/B X1, Observatory, 7935

REFERENCE:

ENQUIRIES:

S. Z. Kaliski / P Milligan

Tel: +27 21 4403195

Sean.Kaliski@uct.ac.za; [PMilligan@pgwc.gov.za](mailto:PMilligan@pgwc.gov.za)

Ms Lindiwe Marepula

Valkenberg Hospital, Observatory

**RE:** "Patient satisfaction with the care provided in a psychiatric hospital in Cape Town"

**Dear Ms Marepula,**

Thank you for your submission to conduct the above mentioned study at this hospital. We are happy to inform that we have approved the study.

However we do require that you give us a copy of the questionnaire that you will be using, and an assurance of how you will ensure that the identities of those who participate in the study remain anonymous.

Yours sincerely,

PROF S KALISKI  
Principal Specialist

DR P MILLIGAN  
Principal Specialist

DATE: 29 August 2011

APPENDIX B: PARTICIPANT INFORMATION SHEET



UNIVERSITY OF THE WESTERN CAPE  
Private Bag X 17, Bellville 7535, South Africa  
Tel: 0214403107, 0829275801, Fax: 0214403199  
E-mail: lomarepula@yahoo.com

**INFORMATION SHEET**

Lindiwe Marepula  
11 Hamilton Park  
27 Hamilton Road  
Plumstead  
Telephone: 0217978799 (h), 0214403107 (w)  
Fax: 0214403199

2011/09/01



UNIVERSITY of the  
WESTERN CAPE

Dear Participant.

I am a Master Student at the University of the Western Cape. I am conducting a research project to measure the level of satisfaction of patients with the service at the hospital.

You are kindly requested to participate by filling in a questionnaire. Your participation can ensure that a difference is made in the way patients are treated. The information is confidential and your name will not appear on the questionnaire. The participation is voluntary and there will be no consequences should you refuse to participate. If you so wish, you may discontinue filling in the questionnaire at any time during this process.

If you have any questions you can contact Prof. O Adejumo directly at this number 0219593024.

Signed at (place) ..... on (date) ..... 2011.

Signature of participant

.....

Declaration by investigator

I (name) ..... Declare that:

- I explained the information in this document.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (If an interpreter is used then the interpreter must sign the declaration below.

.....

Signature of investigator



APPENDIX C: CONSENT FORM



UNIVERSITY OF THE WESTERN CAPE  
Private Bag X 17, Bellville 7535, South Africa  
Tel: 0214403107, 0829275801, Fax: 0214403199  
E-mail: lomarepula@yahoo.com

**CONSENT FORM**

TITLE OF THE RESEARCH PROJECT: PATIENT SATISFACTION WITH THE  
CARE PROVIDED IN A PSYCHIATRIC HOSPITAL IN CAPE TOWN

PRINCIPAL INVESTIGATOR: LINDIWE MAREPULA



Declaration by the participant:

By signing below I agree to participate in the study. I have been informed of the purpose of the study and my rights as a participant.

Signature of the participant.....

Date.....

APPENDIX D: APPROVAL HIGHER DEGREE COMMITTEE





## APPENDIX E: RESEARCH INSTRUMENT

### SURVEY QUESTIONNAIRE

Patient Satisfaction with the care provided in a psychiatric hospital in Cape Town

Questionnaire Code       Date of completion

**Note:** The completion of this questionnaire is voluntary.



**SECTION A: GENERAL INFORMATION**

Please complete by ticking (√) in the box next to the corresponding answer

|  |                       | (√) | Office use-code |
|--|-----------------------|-----|-----------------|
| Your age (in years)  | Less than 20          |     |                 |
|  | 20-24                 |     |                 |
|  | 25-29                 |     |                 |
|  | 30-34                 |     |                 |
|  | 35-39                 |     |                 |
|  | 40-44                 |     |                 |
|  | 45-49                 |     |                 |
|  | 50-54                 |     |                 |
|  | 55-59                 |     |                 |
|  | 60-64                 |     |                 |
|  | Above 65              |     |                 |
| Your gender  | Female                |     |                 |
|  | Male                  |     |                 |
| Your highest level of education  | Never been to school  |     |                 |
|  | Primary school        |     |                 |
|  | High school           |     |                 |
|  | College               |     |                 |
|  | University/Tertiary   |     |                 |
| Race   | Black                 |     |                 |
|  | Coloured              |     |                 |
|  | Indian                |     |                 |
|  | White                 |     |                 |
| How long have you had psychiatric illness?   | Less than one year    |     |                 |
|  | 1-5 years             |     |                 |
|  | More than 5 years     |     |                 |
| How many times have you been admitted to a psychiatric hospital in the past 12 months? | None                  |     |                 |
|  | One time              |     |                 |
|  | Two times             |     |                 |
|  | Three times           |     |                 |
|  | More than three times |     |                 |

**SECTION B: SATISFACTION WITH THE CARE RECEIVED DURING THE HOSPITAL STAY**

**I: Satisfaction with the care provided by nurses**

The statements contained in the table below are related to the way nurses interacted with you and to the care you received from them during your last hospitalization. Please indicate your views regarding each of the statements by ticking (√) against the box that best reflects your opinion.

**Notes:**

- Tick (√) in only one box per statement
- There are no wrong or right answers as this reflects your personal view and not what others think

| <b>Statements</b>  | 4<br>Always | 3<br>Sometimes | 2<br>Never | 1<br>Not sure |
|--|-------------|----------------|------------|---------------|
| <b><i>Your interaction with nurses</i></b>   |             |                |            |               |
| Nurses' communication to me was clear (They spoke to me in a language and manner that I could easily understand)   |             |                |            |               |
| Nurses respected my cultural beliefs and background during my interaction with them  |             |                |            |               |
| Nurses were friendly   |             |                |            |               |
| Nurses were honest and transparent in their communication  |             |                |            |               |
| Nurses respected my rights as a patient during our interaction   |             |                |            |               |
| <b><i>Nursing care (Technical skills)</i></b>  |             |                |            |               |
| Nurses responded to my request/need in a reasonable time   |             |                |            |               |
| I received quality care from nurses  |             |                |            |               |
| Nurses provided me with information regarding my diagnosis, medication, side effect of medication and how to manage the side effect of medication (psycho-education) |             |                |            |               |
| Nurses referred me to the appropriate services in the hospital when needed   |             |                |            |               |
| Nurses followed the ward programme throughout my hospital stay   |             |                |            |               |
| Nurses provided me with counselling and support when needed  |             |                |            |               |

## II: Satisfaction with the care provided by doctors

The statements contained in the table below are related to the way doctors interacted with you and to the care you received from them during your last hospitalization. Please indicate your views regarding each of the statements by ticking (✓) against the box that best reflects your opinion.

### Notes:

- Tick (✓) in only one box per statement
- There are no wrong or right answers as this reflects your personal view and not what others think

| Statements  | 4<br>Always | 3<br>Sometimes | 2<br>Never | 1<br>Not sure |
|---|-------------|----------------|------------|---------------|
| <b><i>Your interaction with doctors</i></b>   |             |                |            |               |
| Doctors' communication to me was clear (They spoke to me in a language and manner that I could easily understand) |             |                |            |               |
| Doctors respected my cultural beliefs and background during my interaction with them                              |             |                |            |               |
| Doctors were friendly   |             |                |            |               |
| Doctors were honest and transparent in their communication  |             |                |            |               |
| Doctors respected my rights as a patient during our interaction   |             |                |            |               |
| <b><i>Nursing care (Technical skills)</i></b>   |             |                |            |               |
| Doctors responded to my request/need in a reasonable time   |             |                |            |               |
| I received quality care from doctors  |             |                |            |               |
| Doctors provided me with information regarding my diagnosis   |             |                |            |               |
| Doctors provided me with information regarding alternative medication   |             |                |            |               |
| Doctors gave me options and opportunities to choose my medication or treatment                                    |             |                |            |               |
| Doctors informed me about my treatment plans after discharge  |             |                |            |               |

### III: Satisfaction with the environment of care

The statements contained in the table below are related to the ward you stayed in during your last hospitalization. Please indicate your views regarding each of the statements by ticking (√) against the box that best reflects your opinion.

**Notes:**

- Tick (√) in only one box per statement
- There are no wrong or right answers as this reflects your personal view and not what others think

| <b>Statements</b>   | 4<br>Always | 3<br>Sometimes | 2<br>Never | 1<br>Not sure |
|---|-------------|----------------|------------|---------------|
| <b><i>Physical environment</i></b>  |             |                |            |               |
| The ward was clean  |             |                |            |               |
| The ward was quiet  |             |                |            |               |
| I felt safe in the ward   |             |                |            |               |
| <b><i>Food service</i></b>  |             |                |            |               |
| The food was of good quality  |             |                |            |               |
| The food was enough   |             |                |            |               |
| <b><i>Internal policies and procedures</i></b>  |             |                |            |               |
| On admission I was attended to within a reasonable period of time                       |             |                |            |               |
| Visiting hours were flexible and visible  |             |                |            |               |
| I was informed about the admission procedures   |             |                |            |               |
| I was informed about the complaints procedures  |             |                |            |               |
| The ward policies and procedures related to patients were well displayed and accessible |             |                |            |               |
| The ward policies and procedures were user-friendly and adhered to                      |             |                |            |               |

**SECTION C: SATISFACTION WITH THE OVERALL EXPERIENCE OF CARE DURING THE HOSPITAL STAY**

The statements contained in the table below are related to your overall experience of care during your last hospitalization. Please indicate your views regarding each of the statements by ticking (√) against the box that best reflects your opinion.

**Notes:**

- Tick (√) in only one box per statement
- There are no wrong or right answers as this reflects your personal view and not what others think

| <b>Statements</b>  | 5<br>Strongly<br>agree | 4<br>Agree | 3<br>Undecided | 2<br>Disagree | 1<br>Strongly<br>disagree |
|--|------------------------|------------|----------------|---------------|---------------------------|
| The quality of care provided by nurses met my expectations   |                        |            |                |               |                           |
| The care provided by doctors met my expectations   |                        |            |                |               |                           |
| The environment of care in this hospital met my expectations   |                        |            |                |               |                           |
| I will not hesitate to come back or recommend somebody to this hospital because of my experience of care |                        |            |                |               |                           |

