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Assessing Patient Satisfaction with Nursing Care in Federal Tertiary Hospitals: A Study in Enugu, Southeast Nigeria

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The satisfaction of patients with the care they receive from healthcare providers has become one of the most important approaches to the measurement of the quality of care in recent times as against the predominantly clinical and administrative approaches. This is because patients' satisfaction could serve as index for compliance and non-compliance with care regimen. The study was to determine helpless patients' satisfaction with quality of care received at tertiary hospitals in Enugu. A descriptive survey research design was used for the study. A total population of 105 helpless patients (those that need assistance with the activities of daily living) were studied. Tools for data collection were questionnaire and interview guide. Data were analyzed using descriptive statistics. Results showed that helpless patients were satisfied with physical and psychological care but satisfaction with spiritual care was marginal. Nurses seemed to lack skills for meeting spiritual needs of the patients. Patients' satisfaction with nurses attitude was marginally positive. The study showed that there was need for improvement in the care nurses provide for helpless patients in the spiritual dimension. Opportunities for continuing education programme in spiritual care and in interpersonal relationship need to be addressed.

Key words: Helpless patients, satisfaction, quality, nursing care, tertiary hospitals.

INTRODUCTION

Changes in the health care industry brought about by globalization, technological and scientific developments have and will continue to greatly influence the education, theory and practice of nursing as in other health professions. Nursing, therefore, must continue to examine its practice in the face of these developments in order to ensure that its practice is in consonance with global standards and the satisfaction of its consumers (patients/clients) in order to maintain its relevance in the healthcare industry and the society. The aspect of these changes and developments which has become the rallying point for today's society is the demand for quality in all spheres of life of which health care delivery is not an exception.

The public is becoming increasingly interested in, and knowledgeable about health and health promotion activities through motivation from information technology (Berman et al., 2008). Computers, the internet and World Wide Web have now made access to medical/nursing information easy to clients that they are now more health conscious and have come to believe that quality health care constitutes a basic right rather than a privilege for a chosen few (Creel et al., 2009, 2002). Indeed access to quality care has become enshrined in most national constitutions as the right of every individual, as is reflected in Section 42 of the Nigerian constitution. Factually technology has a high price tag in these days of consumerism, where clients are better able, than at any other time to demand quality for the price they pay.

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Davis (1994) defined quality as a continuous striving for excellence and conformity with specifications or guidelines. The goal in healthcare is to maximize desirable health outcomes. Quality care therefore, means care provided in a technically appropriate manner that is beneficial and meets the expectations of the population. Quality of care is thus defined in the light of both technical standard and clients' expectations since both consumers and providers have vested interest in it (Davis, 1994). Factually, there is a direct link between performing a quality job or service for an individual or group and professional survival (Jonas, 2002). Nurses therefore, must provide quality service to individuals and groups in order to guarantee the survival of the profession.

The objective and systematic evaluation of care for quality has become a priority in nursing profession given the present day consumers (patients/clients) of care awareness and demand for quality. There is every need to ensure that quality of care given by nurses to patients/ clients meets pre-determined standards with resultant satisfaction of all (consumers and providers). This is what quality assurance in nursing is all about. Makers (1998) in George et al. (2007) states that Quality Assurance in nursing is defining nursing practice through well written nursing standards and the use of these standards as basis for evaluation on improvement of the client care. It is a dynamic process through which nurses are accountable for quality of care they provide as well as guarantee that services provided are regulated by members of the profession to ensure client's / patient's safety and satisfaction. Donabedian (1985) described three components of quality for the purpose of measurement which he termed structure, process and outcome. These have been widely accepted and embraced in developing standards for measurement of care. Thus the evaluation of the structure, process and outcome of care in relation to the nursing process has become the basic approach to quality assurance.

According to the American Nurses' Association (ANA) (1999), structure considers the purpose of the institution, agency or programme. It includes organizational characteristics, fiscal resources and management, qualification of health care workers and physical facilities. Process focuses on the nature, sequence of events and the extent to which they help the client meet specified health care goals. The primary approaches used for process evaluation include peer review and client satisfaction surveys among others. Outcome refers to the end result of nursing care and measureable changes in the state of the clients' health. Other criteria for evaluating outcome include client disposition, personnel/client safety, client/personnel satisfaction, malpractice suits, documentation of care, and effectiveness/efficiency of services among others.

Client satisfaction is then one of the approaches to measuring quality of care and thus can be assessed using interviews and questionnaires. Satisfaction surveys are used to assess care received during an admission to a specific agency to assess a client's personal nursing care; or to assess the total care that the client received from all services (Stanhope and Lancaster, 2004). These authors further stated that satisfaction surveys are essential aspect of quality. The surveys may measure the interventions used for client care, attitudes about the care and the providers, and perceptions of the situation (environment) in which the care was received. Clients are often more critical of interpersonal and situational components of care than of the interventions of care. Data from client satisfaction surveys provide clues to reasons for client compliance or non-compliance with plan of care. Although consumers may not view quality in the same light as the health professional, client satisfaction surveys provide data about health-seeking behaviours, the probability of malpractice litigation and the likelihood of continuing client-provider agency relationship (Stanhope and Lancaster, 2004). Therefore, to a large extent satisfaction with the service provided in both the process and outcome of service has been identified as a determinant of the effectiveness of nursing care provided.

The recipients of nursing care are in the current dispensation referred to as consumers (patient/client). A consumer is an individual or a group that uses a service or commodity produced by another. A client is a person that engages the counsel or services of another who is qualified to provide this service. The term according to Berman et al. (2008), presents the individual as collaborator in the care. The health status of the client is therefore the responsibility of the individual in collaboration with health care professionals. Both terms "consumers" and "client" are active words that connotes somebody with choices and contributions. However, the word patient has traditionally been used to refer to recipients of healthcare.

A patient is a person waiting for or receiving treatment and care from a qualified provider because of illness or injury. The word is believed to imply passiveness on the part of the sick or injured person. He is expected to accept decisions and services of health professionals, without making inputs (Berman et al., 2008). This is no more acceptable in this era of consumerism and increased awareness of the public to health matters.

Statement of problem

When a patient becomes helpless, he is invariably unable to carry out most of his self care activities such as bathing, feeding, exercising, recreation, and grooming health deviation requisites which result from illness. Such

a person weakened by illness or injury require assistance with self-care activities. Self-care deficit results when self care organization is not adequate to meet the known self care demand. It is at this point of deficit according to Orem (1971) that the nursing profession comes in to help. A helpless patient usually lacks motivation to make behavioural changes.

Helplessness normally would result when individuals over time find that they cannot control the outcome of events affecting their lives, even if there is effort, there may not be commensurate goals attainment. This is the kind of situation that manifests when patients are incapacitated through debilitating illness or/and injury. In such a situation, it becomes quite easy for the nurse not to ensure that the services provided meet required standards, since a helpless patient may hardly have any choice or contribution to make towards his/her care. Nurses, being the professionals who are mostly in contact with the patients have the responsibility (more than other members of the health team) to provide optimum quality care that will be both safe and satisfying to all patients especially the helpless ones.

Findings from this study will show how helpless patients assess the care they receive which will serve as a necessary feedback that is very important to and much required by nurses. Such a feedback could give an impetus for the much needed improvement in the quality of patient care. Improving quality of care among other things will attract more clients for the service provider thereby establishing the relevance of nursing profession in the healthcare system and the society at large. The purpose of this study therefore, was to determine helpless patients' satisfaction with the quality of nursing care received from nurses in federal tertiary institutions in Enugu State. The specific objectives were to (1) determine helpless patients' satisfaction with the physical care received from nurses in the hospitals studied, (2) determine helpless patients' satisfaction with psychological care received and (3) determine their satisfaction with spiritual care received in the hospitals studied.

Review of literature

The concept of quality is complex and value laden. It is a multifaceted subject which can be viewed from different angles. Different stakeholders may define quality differently depending on their various perspectives. There is, however, a general agreement that the goal of quality should be that of maximizing outcomes which may also vary depending on who is defining quality. In healthcare, the definition of quality largely rests on the perception of the client, the provider, the care manager, the receiver, the payer and so forth (Wold, 2005). Whereas the client expects the best care possible, hospital administrators and managers focus on clinical outcomes such as length of stay and the cost involved. Caregivers (nurses for example) place higher premium on professional knowledge and skills. For each of these however, quality still represents a degree of excellence or a high standard of service or of a product when compared to others.

The traditional approach has been mostly to define quality at a clinical level (from the point of view of providers) and hospitals. However, this quality often involves offering technically competent, effective, safe care that contributes to the clients well being (Creel et al., 2009). The current trend now is to measure quality from the perspective of consumers (patients/clients) – the client oriented approach. Issues such as patient satisfaction with care and perceptions of care have taken the centre stage of defining quality of service. They are now regarded as very important indicators in assessing quality of care (Sahin and Tatar, 2006; Creel et al., 2009; 2002; Taylor and Benger, 2004).

Several studies have been carried out on the issue of patients' satisfaction with care in many countries globally. For example Hutchison et al. (2003) conducted a study on patient satisfaction and quality of care in walk-in clinics, family practice and emergency department in the Ontario health care system. This was a comparative study on utilization, cost and quality of service in walk-in clinics with those provided in family physicians' offices and emergency departments. A questionnaire was used to assess the satisfaction of 433 patients with patient-centred communication, physician attitude and any delay in waiting time. Results showed that the adjusted mean quality of care scores were significantly higher for emergency department and walk-in clinics than for family practice with scores of 73.1, 69.9 and 64.1% respectively. It was also found that walk-in clinic patients were significantly more satisfied than emergency department patients on all 3 satisfaction scales, and family practice patients were more satisfied than emergency department patients on all three satisfaction scales, but this difference was only significant for satisfaction with waiting time. Both family practice and walk-in clinics were perceived more positively than emergency department on all 3 dimensions of satisfaction.

Sahin and Tatar (2006) analysed factors affecting patient satisfaction among asthma patients in Ankara, Turkey. They grouped the satisfaction items into five dimensions: a doctor competency, provision of information, quality of care, waiting time, and hospital quality. Findings showed that the five satisfaction dimensions were all significantly correlated with each other and that patients' general satisfaction was also significantly correlated with all five satisfaction dimensions. The study found that the levels of patient care were influenced by

provider characteristics rather than patient characteristics and that only 32.4% of general patient satisfaction was explained by the variables used in the study. The conclusion was that there are still very important gaps in our understanding of factors affecting patient satisfaction.

The importance of interpersonal and situational components of care rather than the interventions of care have also been highlighted in studies and articles. All the three dimensions of patient satisfaction measured in the Ontario study by Hutchison et al (2003) were of the interpersonal and situational types. They measured perceptions of patient-centred communication, perceptions of physician's attitude, and delay in the waiting room. Bruce and Jain (1990) included information given to patients and interpersonal relationships in their framework for basic definition of quality of care. Jha et al. (2008) in the study of patient's perception of hospital care in the United States also examined performance with respect to patients' experiences such as communication with physicians, and communication with nurses. In their findings, 79% of patients reported that doctors and nurses always communicated well with them. The domains of patients' experiences were highly correlated over all. The correlation between communication with nurses and adequate pain control was particularly high (0.84). However, they reported that there was room for improvement on most of the measures.

In their findings, they reported that (delete only) 89% of patients rated their hospitals/services as 70% or more, very few hospitals received the highest ratings up to 90% or more of their patients, though only a small percentage of patients were seriously dissatisfied. Liu and Wang (2007) also examined patient satisfaction with nursing care and factors influencing satisfaction in a teaching hospital in China. Their findings showed a relatively high degree of satisfaction with nursing care. Patient's age, educational background, occupation, method of payment and hospital wards were the main factors that influenced satisfaction with nursing care.

From the literature reviewed, not much work has been done on helpless patients' satisfaction with reference to physical care, psychological care and spiritual care hence the relevance of this study.

MATERIALS AND METHODS

A descriptive survey design was used for the study. All helpless patients in the two federal tertiary hospitals in Enugu State – the University of Nigeria Teaching Hospital (UNTH) Ituku-Ozalla and National Orthopaedic Hospital Enugu (NOHE) were included in the study. These two hospitals have an extended catchment area for their services, extending to various other states of Nigeria such as Abia, Anambra, Benue, Cross River, Delta, Imo State among others. Each of them has training schools for the training of different cadre of health personnel, various specialist units as well as serves as referral centre's for primary and secondary level health facilities in Enugu State and its environs.

The study population consisted of 105 adult helpless patients, who need some form of help with their activities of daily living (ADL). These included hospitalized patients with severe chronic illness, post-operative patients (24 to 72 h); patients on traction, patients with amputation of any of the limbs and some burns patients. The criteria for inclusion into the study were as follows: patient must be conscious and well oriented. He must be an adult. All the patients who met these inclusion criteria in the two hospitals within the period of study were included in the study. Data were collected by means of a 24-item questionnaire developed by the researchers with guidance from literature search, and interview guide to meet the objectives of the study. Some of the questions were structured (close-ended) while some were unstructured (open-ended).

A letter of approval was obtained from the ethical committees of the hospitals studied. Oral permission was then secured from the unit heads of each of the units where the patients studied were admitted. An informed consent was signed voluntarily by each of the respondents having understood the total package of the study before the administration of the instrument. Those who needed assistance either because of their conditions or illiteracy were helped to complete the questionnaire by the researchers or the assistants. The questionnaires were collected. All copies administered were retrieved giving a response rate of 100%. However, five (5) copies were not correctly completed so data analysis was based on 100 copies.

Data analysis was by descriptive statistics and presented in tables. The modified 3-point likert type satisfaction scale was analyzed using criterion mean. A mean score of above 2 was accepted as positive.

RESULTS

Table 1 show that 48% of the respondents were 41 years and above; while 62% were males and 38% were females. 64% had secondary education and above. All respondents were Christians and 49% were married while 3% were divorced. Table 2 shows the satisfaction with physical care received by the patients in descending order of frequency where the highest was medication (84%), while bed bathing was the least 14%. Satisfaction with psychological care showed that informing the patient before any procedure scored the highest while the lowest was attitude of the nurses while carrying out the procedures. In spiritual care dimension majority of the respondents did not respond to the questions (72%). The few (28%) that responded showed that 18% stated that nurses asked their relatives to pray for them while only 4% invited the priests to pray. Table 3 shows that 66% were very satisfied with physical care provided by the nurses while 12% were not satisfied.

In the area of psychological care, 64% of the respondents were very satisfied with psychological care while 8% were not satisfied. In spiritual dimension, 55% were very satisfied while 14% were not satisfied. The reasons elicited from respondents through interview for not being

Table 1. Demographic characteristics of the respondents

Variables	Frequency	Percentage
Age (yrs)		
21 to 30	31	31
31 to 40	21	21
41 to 50	19	19
50+	29	29
Sex		
Male	62	62
Female	38	38
Educational background		
Non formal education	16	16
Primary education	20	20
Secondary and above	64	64
Religion		
Christianity	100	100
Others	-	-
Marital Status		
Single	39	39
Married	49	49
Widowed	9	9
Divorced	3	3

satisfied with psychological care were narrated as follows; “I don’t like the way nurses address me” 37.5%; “The nurses are harsh” 37.5%; Some of the nurses do not show fulfillment about their duties” 12.5%; “Some of the nurses are not responsive to calls” 12.5%. Satisfaction with physical and psychological care were positive while satisfaction with spiritual care was marginally positive. Table 4 shows the mean satisfaction with physical care 2.56; psychological care 2.54; spiritual care 2.11 and perception of nurses’ attitude 2.44.

DISCUSSION

The findings of the study showed that helpless patients were satisfied with the physical care they received, though a few expressed lack of satisfaction. It was also found that the commonest physical care these patients received was medication, followed by bed-making and wound dressing. Others, such as bed bathing, oral care, etc were not commonly given. A lot of factors may have been responsible for this – for example, medication and bed making may be the procedures that every patient must receive while they variously received other physical care according to their needs. Nevertheless the number of respondents that received bed pans and bed bathing were too low considering the fact that these were helpless patients.

Some patients however reported being fairly satisfied with physical care received. This agrees with the findings of Sahin and Tatar, 2006 and Jha et al. (2008) where few patients were fairly satisfied. Probably there were still important gaps in the understanding of all the factors that affect patients’ satisfaction. The results also showed similarity to the findings of Jha et al. (2008) where only 12% of patients reported not being satisfied, while 66% reported being very satisfied. This suggests that there is still room for improvement even though much has been achieved. Those respondents who reported dissatis-faction anchored their reasons on nurses’ attitude to them or to the care they neglected such as ignoring their calls, or avoiding some procedures while concentrating on just a few. This is consistent with reviewed literature on the influence of staff attitude and the fact that clients are often more critical of interpersonal components than procedural components of care (Stanhope and Lancaster, 2004).

The findings also revealed a similar picture of level of

Table 2. Patients' satisfaction with physical, psychological and spiritual care received

Responses	Frequency	Percentage
Satisfaction with Physical care		
Medication	84	84
Bed making	72	72
Wound dressing	61	61
Feeding	26	26
Turning in bed	20	20
Giving of bedpan	19	19
Treatment of pressure area	18	18
Bed bathing	14	14
Satisfaction with psychological care		
Inform them of procedure before they commence	92	92
Discuss with them how to cope with their illnesses	84	84
Respect to patients during care/provision of privacy	82	82
Encouraging patients to make demands freely	74	74
Conveying positive attitude to patients during procedures	54	54
Satisfaction with spiritual care		
Nurse asked the patients' relative to pray for them	18	18
Nurse prayed for the patients	6	6
Nurse invited the priests to pray	4	4
No response	72	72

Table 3. Patients' level of satisfaction with physical, psychological and spiritual care received

Responses	Frequencies	Percentages
Level of satisfaction with Physical care		
Very satisfied	66	66
Fairly satisfied	22	22
Not satisfied	12	12
Total	100	100
Level of satisfaction with psychological care		
Very satisfied	64	64
Fairly satisfied	28	28
Not satisfied	8	8
Total	100	100
Level of satisfaction with spiritual care		
Very satisfied	55	55
Fairly satisfied	14	14
Not satisfied	14	14
No response	31	31
Total	100	100

satisfaction with psychological care received with 64% of clients reporting being very satisfied, while majority of the respondents (92%) reported that they were satisfied with care. The content of psychological care included

Table 4. Mean satisfaction summary table

Option	Mean score	Acceptance
Satisfaction with physical care	2.56	Accepted
Satisfaction with psychological care	2.54	Accepted
Satisfaction with spiritual care	2.11	Accepted
Perception of nurses attitude	2.44	Accepted

informing patients of procedures before commencement, discussing how to cope with their illnesses, encouraging patients to make demands, respect for patients during care/provision of privacy, and conveying positive attitudes to patients while carrying out procedures. The scores were quite high for each of the components varying from 74 to 92% except for conveying positive attitudes which was reported by only 54% of patients. Reasons for non-satisfaction among the 8% that were dissatisfied were still related to that of physical care - poor nurses' attitudes.

Patients' satisfaction with spiritual care received showed that majority of respondents (72%) did not respond to the question while 28% who responded reported that nurses were not skilled in providing spiritual care which showed in their response to the demand of patients to spiritual help, 18% of the respondents stated that nurses asked their relatives to attend to them, 6% prayed for the patients while only 4% invited the priests to attend to the patients spiritual needs. One would have expected a reversal in the order of priority in the intervention given by nurses. However, the mean satisfaction score was very marginally positive (2.11) as shown in Table 4. There is therefore evidence that there is room for improvement in this aspect of care by the nurses. For as many as 72% not to respond to the question constitutes a significant concern also.

CONCLUSION AND RECOMMENDATION

Helpless patients' satisfaction with care received from nurses in the federal tertiary hospitals studied in Enugu was found to be fairly high especially with regards to physical and psychological care. Satisfaction with spiritual care was low evidenced by the fact that nurses did very little to meet the perceived spiritual needs of patients. The content of physical care given was not com-prehensive. Most of the patients studied reported that they just received medication, bed making and dressing procedures. The other types of physical care such as bed bathing, feeding and providing for elimination (giving bed pan and urinal) were not provided by the nurses yet; these are core areas of need for helpless patients.

The patients' response to the content of psychological care was higher and more comprehensive except for the low percentage recorded for nurses' attitude which was consistent in all the three dimensions of care studied. It is therefore, recommended that nurses should be exposed to some training/workshop sensitization about the influence of interpersonal relationship on the care they give and visa-vis on patient satisfaction. The need for attitudinal change among nurses needs to be emphasized in order to improve the satisfaction of this category of patients to the care nurses provide during the training workshop sessions.

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