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DEDICATION

To the One who calls the unworthy, the One who calls the inadequate to adequacy.

To the One who forms the mind, spirit and body for an ordained future.

To the one who hears the inaudible cries when situations become too overwhelming.

To the one who teaches us to dig deeper, knowing full well that treasures are not found on the surface.

To the one who teaches us resilience, the tool against permanent defeat.

To the one who gives us a reason to forge ahead.

ABSTRACT

Client's satisfaction, a measure of outcome of health care provided to patients, is indispensable in the assessment of health care services. In Nigeria, information relating to clients' perception and satisfaction of service delivery at the Accident and Emergency Department (AED) in tertiary healthcare facilities is sparse. This study was, therefore, designed to investigate the perception and satisfaction of clients concerning health service delivery at the AED of the University College Hospital, Ibadan.

A cross-sectional study was adopted and 450 consenting patients and relatives at the AED and wards were purposively selected. An interviewer-administered, semi-structured questionnaire which included questions on socio-demographic characteristics, Clients' Perception (CP) of quality of care, Level of Satisfaction (LS) and service delivery was used for data collection. Clients satisfaction and clients perception were measured on 15-point and 9-point scales respectively. Satisfaction scores (SS) <23 and ≥23 were rated as not satisfied and satisfied respectively. Perception scores (PS) <15 and ≥15 were classified as poor and good respectively. Data were analysed using descriptive statistics and Chi-square test with level of significance set at 0.05.

Age of respondents was 57.9 ± 9.8 years. 50.0% were patients and 50.0% were patients' relatives. 50.2% were males and 62.7% were married. The PS was 14.4±3.71 while SS was 22.3±5.7. Majority (77.3%) of respondents had good perception of health service delivery at the AED. Educational status of the respondents was significantly associated with level of satisfaction, as clients with tertiary education were more satisfied (75.3%) than clients with secondary (64.4%), primary (53.3%) or no formal education (52.1%). A significantly higher proportion of respondents aged 21-40 years (36.3%) were unsatisfied with service delivery compared with those aged 41-60 years (35.1%) and 61-80 years (34.8%). Factors which reportedly accounted for clients' refusal of admission included lack of money (53.3%) and negative attitudes of staff (40.9%). Respondents' suggestions on how to improve services at the AED included; provision of trolleys for moving patients (73.3%) and increase in the amount of attention paid to personal needs (61.1%). Pharmacists were less likely to contribute to poor perception (OR=0.648 95% CI=0.530-0.793) compared to other personnel, while doctors were also less likely to contribute to clients dissatisfaction (OR=0.542 95% CI=0.422-0.697) compared to other personnel.

The level of satisfaction to health service delivery at the Accident and Emergency was inadequate. Patients and relatives still have poor perception about health services in the Accident and Emergency despite the majority having a good perception. Therefore, provision of affordable, readily available and conducive health services should be paramount to the hospital management. In addition, the training of health care providers on interpersonal relationship should be organised regularly to improve the quality of care.

Keywords: Clients perception, Client satisfaction, Quality of care, Service delivery, Accident and Emergency

Word count: 432

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CERTIFICATION

I certify that this project was carried out by Ayokunle Oluwamuyiwa AYENI in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.

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GLOSSARY OF ABBREVIATIONS/ACRONYMS

A&E: Accident and Emergency

CMS: Center for Medicare and Medicaid Services

DAMA: Discharge against Medical Advice

LIC: Low Income Countries

MCC: Moffitt Cancer Center

NHIS: National Health Insurance Scheme

OATH: Obafemi Awolowo Teaching Hospital

SES: Socioeconomic Status

SPSS: Statistical Products and Services Solution

UCH: University College Hospital

U.S: United States

WHO: World Health Organization

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OPERATIONAL DEFINITION OF TERMS

Clients: A person or group that uses the professional advice or services of a professional e.g. a lawyer, Doctor, Accountant etc.

Satisfaction: Satisfaction refers to a state of pleasure or contentment with an action, event or service, especially one that was previously desired and when applied to medical care, patient satisfaction can be considered in the context of patient's evaluation of their desires and anticipation of health care.

Perception: Is the organization, identification and interpretation of sensory information in order to represent and understand the environment.

Health service delivery: This refers to the work done in providing primary care, secondary care and tertiary care as well as in public health practitioners.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the study

The definition of health which is stated as a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity has recently been expanded to include the ability to lead a socially and economically productive life (WHO, 1948 and 1978). Healthcare is an inclusive package of preventive, promotive, curative and rehabilitative health services to the people by the health professionals (Last, Spasoff and Harris, 2000).

Satisfaction is a psychological state resulting when the emotion surrounding disconfirmed expectations is coupled with consumer's prior feelings about the consumption experience (Al-Ehmadi, Falamarzi, Al-Kuwari and Al-Ansari, 2009). Patient satisfaction has also been defined as the degree of congruency between a patient's expectations of ideal care and his /her perception of the real care him /her receives (Aragon and Gesell, 2003).

Satisfaction also refers to a state of pleasure or contentment with an action, event or service, especially one that was previously desired (Hornsby, 2000) and when applied to medical care, patient satisfaction can be considered in the context of patient's evaluation of their desires and anticipation of health care. One of the factors that influence patient satisfaction is efficiency of services rendered to patients (Santillan, 2000). The " efficiency" of service refers to the promptness of the care given to patients, including issues like waiting time before consultation, duration of consultation, amount of time spent with the doctor subsequently, quick response to emergencies, quick dispensation of drugs, fast and accurate laboratory tests (Santillan, 2000).

Patient satisfaction is a factor of health status and a measure of the outcome of care widely used in evaluating distinct dimensions of patients' health care (Donabedian, 1988). It is also one way of assessing communication and information transfer between clinicians and patients and can therefore be a patient's medium of expressing dissatisfaction with the provision of information. The measurement of patients' perceptions relating to the process and quality of health care delivery is increasingly recognized as an important component in the evaluation of health care interventions and for assessing service quality (Crow, Gage, Hampson, Hart, Kimber and Storey, 2002) and it is widely used in assessing experiences with services or care (Sitzia, 1999). Through the evaluation of clients' satisfaction, clinicians are able to investigate the degree to which their services have been able to meet the needs of their clients/patients (Avis,

Bond and Arthur, 1995). One important reason for obtaining patients' views on their experience with care is to facilitate improvement in the services rendered by health care providers since, satisfied patients are more likely to follow treatment instructions and medical advice, probably because they are more likely to believe that treatment will be effective (Hardy, West and Hill,1996). Consumers increasingly regard satisfaction as an essential complement to administrative measures of the quality of health care (Allen, Darling and McNeil, 1994; Dickey, 1996; Sutherland and Dawson, 1998).

Previous studies have related satisfaction to individual consumer experiences and behaviour as well as outcomes of care (Roughmann, Hengst and Zastowny, 1979; Ruggeri and Dall'Agnola, 1993; Kane, Maclejewski and Finch, 1997). However, only a few studies have examined the use of satisfaction measures to compare quality across different hospitals or health care providers (Rubin, Gandek, Rogers, Kosinski, McHorney and Ware, 1993). Olatunji, Ogunlana, Bello and Omobaanu, (2008) assessed patients' satisfaction with the physiotherapy services in a Nigerian Federal Medical Centre where clients were satisfied with physiotherapists' character, the pieces of advice given to them on their health and respect, but were however not satisfied with the small amount of time spent with them and the cost of treatment per session.

Patient satisfaction represents a key marker for the quality of health care delivery and this internationally accepted factor needs to be studied repeatedly for smooth functioning of the health care systems (Almujali, Alshehy, Ahmed and Ismail, 2009). Enhanced focus on improved patient care coupled with achieving high degree of patient satisfaction is due to increasing demand for better care among the public on one hand and the competitive and hostile environment surrounding health care on the other (Rao, 2002). Patient Satisfaction thus encompasses every aspect of the of health services, from system approach perspective (Kumari, Idris, Bhushan, Khanna, Agarwal and Singh, 2009). Improved skills exhibited in the staff-patient communication about the condition of the patient, instructions for care, return visit, Prescription of medicines, pharmacy instructions, a clean and tidy premise, increase the faith and level of satisfaction of the patients (Haldar, Sarkar, Bisoi and Mondal, 2008). The staff should be trained in every possible way in line with the patients needs (Ganguly, Deshmukh and Garg, 2008).

Patient satisfaction is a useful measure to provide a direct indicator of quality in healthcare, hence needs to be measured frequently so that a domesticated and localized healthcare plan could be developed (Farooqi, 2005). Thus, patient's satisfaction is an important issue both for evaluation and improvement of healthcare services (Al-Elsa, Al-Muiar, Radwan

and Al-Terkit, 2005). Patient's assessment, therefore, suggests guidelines for improving the attitudes of doctors and other paramedic staff in better serving the patients thereby improving the health services (Al-Qatari and Haran, 2006). Patient satisfaction is a summation of all the patient's experiences in the hospital (Press, 2006). It derives from the patient's evaluation of how well the provider meets his or her personal and emotional as well as physical needs. Because it is such a complex topic, one of the most accepted ways of studying satisfaction is by using questionnaires in which the questions are organized into different dimensions or domains (Carr-Hill, 1992).

1.2 Statement of the problem

Health care facilities are often poorly utilized in many low income countries (LIC) in Africa and various reasons including poverty, poor access, low literacy levels, inadequate infrastructures and cultural bias have been attributed to this (Ariba, Thanni and Adebayo, 2007) and the amount of time a patient waits to be seen, is also one important factor which affects the utilization of health care services (Fernandes, Daya, Barry and Palmer, 1994; Dos Santos, Stewart and Rosenberg, 1994).

Peoples' satisfaction towards health service delivery in the Accident and Emergency Department of University College Hospital has become an issue of concern in recent times as it has been observed by the author. Majority of people who come for services at the Accident and Emergency either as patients or relatives of patients have shown various reactions towards the way services are been rendered to them and many have actually discharged themselves against medical advice on several occasions because of their dissatisfaction with the way health services are rendered at the facility. Studies conducted by Ariba et al. (2007) had shown that about 39% of patients utilizing the emergency services in a hospital in southwest Nigeria were dissatisfied with the quality of service, while only 17% and 19% reported that they would avoid using the services in future or recommend the services to others respectively.

It is not uncommon to hear people say that they rather die in their homes than come to University College Hospital where they would be subjected to all sorts of tests by different people and people who happen to visit the facility for the very first time already have negative opinion about the facility. Many people also express dissatisfaction because they consider medical treatment difficult to access and expensive. It is therefore a necessity that the reasons for

people dissatisfaction towards health services in the Accident &Emergency Department be studied so as to find ways to improve service delivery.

1.3 Justification of the study

As many people have expressed coming to the University College Hospital as a death sentence, this study has provided the opportunity to explore the perception of clients who visits or bring their relatives for care at the Accident and Emergency Department of University College Hospital which is usually considered as the point of first contact between health providers and most of the health users seen in the hospital. The study found out if clients are satisfied with the ways services are rendered by health workers in the Accident and Emergency Department. The study was also used to determine ways by which services provided to patients can be improved. The findings from the study can also be used to reform the existing service delivery process that would ensure quality assurance of services rendered to the client thereby improving service satisfaction. The University College Hospital authorities can also use the results of this study to revisit the existing policy on service delivery at the Accident and Emergency department in the areas of quality assurance and personnel regulatory reforms as well as staff-patient communication.

1.4 Research questions:

The study provided answers to the following questions:

1. What are the perceptions of clients about health service delivery in the Accident and Emergency Department of UCH?
2. What are the level of satisfaction of clients towards health service delivery at the Accident and Emergency Department of UCH?
3. What are the factors influencing clients satisfaction towards health service delivery?
4. What are the factors that can be put in place to improve clients' satisfaction towards health service delivery at the Accident and Emergency?

1.5 Broad objective of the study:

The broad objective of the study was to investigate the perception and level of satisfaction of clients towards health services provided by health care givers in the Accident & Emergency section of UCH, Ibadan.

1.6 Specific objectives:

The specific objectives that guided the study were to:

1. Identify the perceptions of clients about health service delivery provided in the Accident and Emergency Department of University College Hospital.
2. Determine the level of satisfaction towards health care delivery at the Accident and Emergency amongst clients.
3. Identify factors associated with client's satisfaction towards health service delivery.
4. Determine how the satisfaction of clients can be improved.

1.7 Research Hypothesis:

The research hypotheses for this study were:

1. There is association between socio-demographic variables (educational qualification, age, sex and marital status) and clients' level of satisfaction to health service delivery.
2. There is association between socio-demographic variables (educational qualification, age, sex and marital status) and clients' level of perception towards health service delivery.
3. There is association between level of satisfaction and factors influencing respondents' satisfaction.
4. There is association between level of satisfaction and factors responsible for discharge against medical advice or refusal of admission.
5. There is association between level of perception and factors responsible for refusal of admission or discharge against medical advice.

CHAPTER TWO

LITERATURE REVIEW

2.1 Client Satisfaction: An Operational Definition

Client satisfaction is a concept that has a connection with both the technical and interpersonal aspects of care including the various amenities of care such as attractive physical environment, convenient location and parking Donabedian (1980) points out that a client's assessment of quality, expressed as satisfaction or dissatisfaction, could be remarkably detailed. It could pertain to the settings and amenities of care, to aspects of technical management, to features of interpersonal care, and to the physiological, physical, psychological or social consequences of care.

Client satisfaction has also been defined as the extent to which a program fulfils a client's treatment expectations (Davis and Hobbs, 1989). Davis and Hobbs also identified various components of client satisfaction to allow an accurate measurement. These components were classified into three dimensions of satisfaction:

1. Access to Care (e.g., Signs and direction to treatment facility, waiting room time, clinic hours);
2. Physical Environment (e.g., Cleanliness of reception area, noise level and condition of treatment space); and
3. Care Received (i.e. human, clinical and outcome aspects).

Davis and Hobbs (1989) used this operational definition to devise a conceptual framework from which to design a client satisfaction questionnaire

2.2 Quality in health care

Healthcare quality is more difficult to define than other services because it is the customer himself and the quality of his life being evaluated (Elriz and Figueiredu, 2005). It has been suggested by some authors that healthcare quality can be assessed by taking into account observer, i.e. friends and family perceptions. Moreover, these observer groups represent potential future customers – major influencers of patient healthcare choices (Naidu, 2009). Lim, Tang and Jackson, (1999) postulated two aspects of healthcare quality:

(1) The technical aspect of care, which refers to the competence of the providers as they go about performing their routines. These include thoroughness, clinical and operating skills of the doctors, clinical outcomes.1

(2) The interpersonal aspect of care, which represents the humane aspect of care and the socio-psychological relationships between the patient and the health care providers. This involves explanations of illness and treatment, the availability of information, courtesy and the warmth received.

Quality of health care is the degree of performance in relation to a defined standard of interventions known to be safe and that have the capacity to improve health within available resources and traditionally quality of health care has been measured using professional standards and neglecting the importance of patient perception (Haddad Potvin, Roberg, Pineault and Remondin, 2000). Users' perceptions are now considered to be important source of information in screening for problems and can be applied in the development of an effective plan of action for quality improvement in health care organization (WHO, 2004).

The compliance of clients with treatment and the continuity of patient-physician relationship and hence outcomes is directly influenced by client's perception of care and it also influences utilization and readiness to contribute to financing health services (Akin and Hutchinson, 1999; Kamuzora and Gilson, 2007). Health service should be able to meet both medical and psychosocial needs. However, most often care provided is costly and substandard, and imposes a heavy financial burden on poor households (WHO, 2000). Sometimes patients' expectations are not met by professionals (Jung, Weising and Grol, 1997). Issues of concern to patients include care givers' interaction with patients, accessibility of health services, availability of drugs and equipment, and cleanness (Haddad et al, 2000; Baltussen and Ye, 2006).

The term healthcare quality is multi-faceted (Litvak, Long, Cooper and McManus, 2001). With regards to patient satisfaction, quality from the perspective of a physician, administrator, or clinician is generally judged by clinical outcomes. However, evidence shows that quality from the perspective of the healthcare consumer is rarely judged on the basis of which organization has the best clinical quality, "any more than airlines win the loyalty of their customers on the field of who has the best safety record" (Lee, 2004). In terms of how an institution responds to its patient views on quality, the approach to quality of care encompasses many individual components. Two of the most significant measures of quality of care include quality assessment and quality improvement (Barton, 2003). Quality assessment represents the analytical measure of the important elements of quality of care. For example, in terms of patient/customer satisfaction, quality assessment can be used to analyze the outcomes of interpersonal interactions between the

physician and the patient throughout the care process. Measurement is an essential element of the assessment process (Barton, 2003; Quinn, Jacobsen, Albrecht, Ellison, Newman, Bell, and Ruckdeschel, 2004). Quality improvement is the process used to enhance the delivery of healthcare services provided to healthcare customers in order to best meet their needs and expectations.

The quality improvement process logically follows quality assessment, and utilizes assessment results in order to develop techniques to address those customer concerns defined during the assessment process (Barton, 2003). A prime example of a popular quality assessment tool utilized by various healthcare organizations includes patient satisfaction surveys (Quinn et al, 2004). Patient satisfaction surveys enable organizational leaders to have some clear insights into the inner workings of their healthcare facility. The H. Lee Moffitt Cancer Center and Research Institute at the University of South Florida (MCC) is a prime example of a multidisciplinary institution that encountered issues related to patient satisfaction, and successfully addressed them through a real-time assessment of patient and staff satisfaction for a focused and efficient improvement process. The data generated from their surveys provided a strong foundation in which to evaluate management and staff performance using information directly provided by their healthcare consumers. Their patient satisfaction surveys were instituted as a tool to set goals based upon patient expectations and service quality (Quinn et al, 2004; Ganey and Drain, 1998). They also established patient focus groups and employee interviews to supplement their surveys in order to institute a more comprehensive system directed at coordination of care (Quin et al, 2004). MCC's problem identification-action-feedback approach has become "a method for goal setting and establishing management accountability" (Quinn et al, 2004).

Patient satisfaction in the healthcare field is an important strategic asset for hospital quality improvement as it has been demonstrated in various researches in the past decade (Reichheld, 2003). All healthcare employees in an organization that measures patient satisfaction must understand the value of the patient as a measurement of the success of the organization as the patients come first and therefore measurement needs to be a continuous process so that employees understand that their actions will be held accountable – by patients first, and then by the management (Ganey and Drain, 1998). Patients are now regarded as healthcare customers, recognizing that individuals consciously make the choice to purchase the services and providers that best meet their healthcare needs (Wadhwa, 2002). Consequently, modern consumer

healthcare is driven by the customer demands of a "system that accommodates their busy schedules, provides them with useful information, and involves them in decision-making" (Wadhwa, 2002).

The term *customer* is increasingly been used synonymously with *patient* in characterizing quality in terms of patient satisfaction in the definition of the quality improvement and this has allowed healthcare organizations to bring to the forefront the idea that patients are actually choosing to purchase the healthcare services they desire; stressing the fact that the healthcare delivery system is a highly competitive market (Barton, 2003). Moreover, in order to stay viable in a competitive marketplace, it is important that healthcare organizations and their providers begin to recognize that viewing patients as customers, and improving customer satisfaction, has direct implications on healthcare quality – both in terms of services rendered and the reputation of the institution for best meeting its consumer's needs. Those organizations and providers who recognize this relationship will ultimately develop and maintain a better competitive advantage, and will acquire the benefits associated with a satisfied community of healthcare consumers (Wadhwa, 2002).

In addition to quality assessment and quality improvement, from a patient/customer satisfaction perspective, the concept of quality is addressed in two other distinct manners. First, quality, as it relates to healthcare, represents the overall satisfaction with life *both* during and following an individual's encounter with the healthcare system – its organizations and providers. Quality acts an indicator of satisfaction based upon an individual's experience while receiving medical care. For example, "comfort factors, dignity, privacy, security, degree of independence, decision-making autonomy, and attention to personal preferences" (Shi and Singh, 2005) are all significant attributes of healthcare that are important to most people. These essential factors influence healthcare consumers in making decisions about specific providers and facilities. Second, the term quality can refer to *quality of life* – or an individual's "overall satisfaction with life and with self-perceptions of health, particularly after some medical intervention" and the significance of these two references to quality is that each represents a desirable process during medical treatment, as well as successful outcomes after a healthcare service is rendered (Shi and Singh, 2005). Meeting both standards of quality can help to generate patient volume for a healthcare organization and keep people returning when in need of treatment (Barton, 2003).

It is vital for a healthcare industry to optimize patient/customer satisfaction in the best interest of the patient/customer and it is essential to discuss how vital it is for the actual healthcare provider and healthcare organizational staff (i.e. engineering, facilities, laundry, etc.) to be concerned with maintaining high levels of patient/customer satisfaction. For example, if organizational staff is dissatisfied with a healthcare facility as a place to work, they cannot deliver high quality care. And, vice versa, if a healthcare institution is faced with high staff turnover, that institution risks rendering poor quality care. Both scenarios result in a loss of business creating a red bottom line (Press, 2005). One of the most challenging components to sustaining a successful healthcare organization is trying to keep it operating in the "black", while constantly and consistently providing quality service to patients. Being in the "black" means generating a profit or at least not having to borrow funds, as opposed to being in the "red" which represents an organization in debt. Consequently, the hospital must offer quality care at an affordable price, while remaining competitive in the market (Kim, 2001). Operating in the black is a paramount challenge in itself. Running in the black is at risk when dissatisfied customers no longer seek the services of that organization. If an organization's bottom line is consistently red, it risks being put out of business and, thus, their staffs become unemployed. Customers who are satisfied (patients, employees, and physicians) significantly contribute to the organization operating efficiently and achieving its goals (Press, 2005).

The healthcare delivery system can deal more effectively with the issues of patient/customer satisfaction by examining three key questions: What qualities do healthcare consumers determine to be elements of good healthcare? What, do healthcare consumers, regards as good healthcare provider? And, according to healthcare consumers, what measures do they use to determine good quality healthcare (Safavi, 2006). Taking into consideration the responses to these questions can help healthcare organizations begin to develop or make more effective patient/customer satisfaction programs that best meet their consumer's healthcare needs. In fact, there is a recent history of institutional and scholarly inquiry into the aforementioned questions encompassing the idea of what patients want in terms of healthcare service (Safavi, 2006). To reiterate the aforementioned point, in 2005, a survey conducted of 10,000 households showed that 65 percent of respondents identified that both care and compassion are more important than technical proficiency when receiving medical care (Safavi, 2006; Reichheld, 2003). "When the question is posed specifically in terms of the patients' perception of their hospital experience, the emphasis shifts to issues of respect and communication" (Safavi, 2006).

Moreover, Power and Associates conducted a study in 2004 of 2,350 patients. The results of their study showed that "satisfaction with the hospital experience was driven (in order of importance) by dignity and respect, speed and efficiency, comfort, information and communication, and emotional support" (Safavi, 2006). In both 2004 and 2005, the Agency for Healthcare Research and Quality and CMS (Centers for Medicare and Medicaid Services) assembled 16 separate focus groups in six U.S. cities to determine what healthcare consumers thought to be the most significant characteristics of quality care delivered in hospitals. The results of both studies taken together showed that consumers preferred four qualities: (1) Doctor communication skills; (2) responsiveness of hospital staff; (3) comfort and cleanliness of the hospital environment; and (4) nursing and hospital staff communication skills (Safavi, 2006). The following three factors were determined by the results of the study to be less important characteristics of quality healthcare: (1) Pain management; (2) avoiding problems with medications; and (3) avoiding problems after leaving the hospital (Safavi, 2006). "Are good outcomes really what patients think about when they seek a good care provider for themselves or their family" (Safavi, 2006)?According to research studies, healthcare consumers "determine levels of quality largely on attributes such as respect and compassion, not technical proficiency" (Safavi, 2006)

The modernisation of health care systems and advances in evidence-based healthcare has raised expectations of improvements in the quality of care (Powell, Davies and Thomson, 2003; Sheldon, 2005) and moreover, the growing demand for health care, combined with rising costs and limited resources, has increased the emphasis on the efficient use of health care resources (Campbell, Rowland and Buetow, 2000). A patient's perspective of quality may include their desired health outcome (Mitchell and Lang, 2004; Swan and Boruch, 2004), their relationship with healthcare providers, the qualifications and performance of healthcare providers, and access to and choice of healthcare (Campbell, Braspenning, Hutchinson and Marshall, 2002; Hibbard, 2003).

2.3 Patient satisfaction

One of the most important quality dimensions and key success indicators in health care is patient satisfaction (Pakdil and Harwood, 2005). Zineldin, (2006) defined Satisfaction as an emotional respon... Satisfaction is accepted to be an attitudinal response to value judgments that patients make about their clinical encounter (Kane et al, 1997). As Priporas, Lespa and Kamenidou, (2008) stated, a patient's expectations and perceptions are not simply related

because a medical or health service is not technically comprehensive. The experience of satisfaction may be connected to happiness, wealth, prosperity and quality of life. In its technical attribution, it is a judgment set by the customers of a service, documented after the consumption experience (Priporas et. al., 2008). The earliest studies of patient satisfaction date from the mid-1950s such as: Souelem, (1955) and Klopfer, (1956). The depth and richness of this stream of literature provides physicians and their administrators with adequate knowledge of the measurement of quality of care (Lin and Kelly, 1995).

Patient satisfaction with health care has been argued as a subjective and dynamic perception of the extent to which expected health care is received (Senarath, Fernando and Ishani, 2006). Jackson, Chamberlain and Kroenke, (2001) suggests that patient satisfaction is strongly influenced by patient-doctor communication variables and also influenced by both patient age and functional status. Client satisfaction represents an important aspect in quality of health care and one of the main concerns of any health care units is to achieve a high level of patient satisfaction by providing a better quality service (Torres and Guo, 2004). Client satisfaction with health service delivery organization is influenced by how the patient subsequently evaluates the experience and it is also linked to the patient's overall life satisfaction, another subjective determination (Diener, Suh, Lucas and Smith, 1999). But it cannot be separated from the social and institutional environment in which both patient and provider are embedded. Patient's socioeconomic status (SES) not only reflects their position in society but influences all aspects of their health care experience: which health resources they can attain, their preferences, and their concerns, all based on prior historical interactions. Thus, although it has not yet been proven that SES has a positive effect on patient satisfaction, most researchers nonetheless use a patient's personal characteristics, including both general demographic information and SES, to explain the patterns and the changes that take place from the expectations prior to service to self—reported recovery and final satisfaction (Young, Meterko and Desai, 2000; Linder-Pelz, 1982). Patient satisfaction is regarded as an attitudinal response to value judgments that patients make about their clinical encounter (Kane *et al*, 1997), and an evaluation of specific treatments and related providers (Coulter, 1991). Thus, satisfaction reflects not only the patients' judgment and assessment of the health care experience but also their perception of the gap between what they wanted and what they received

One factor that can account for variation in patient perceptions of hospital care is differences in the measures of satisfaction. The patient satisfaction surveys developed by the Picker Institute focused on "experience of care" and take a problem-oriented approach by asking questions about what did or did not happen during the hospitalization with regard to various aspects of care (Cleary, Edgman-Levitan and Roberts, 1991). Other satisfaction surveys take a "satisfaction with care" approach, asking the individual to rate their satisfaction with various aspects of care while they were hospitalized (Finkelstein, Singh and Silvers, 1998; Kane, et al., 1997). These two approaches to assess patients' views of their hospital experiences may reflect the two complementary but sometimes-conflicting goals for developing such information: quality improvement by hospitals and public reporting for use by consumers. To help hospitals direct their quality improvement efforts, specific questions identifying problem areas have been used (Cleary, et al., 1991; Hargraves, Wilson and Zaslavsky, 2001). Whether results of these questions are more easily understood by the public in a report on hospital quality than questions asking patients to evaluate their satisfaction or rate the care received (e.g., excellent, good, fair, poor) is a methodological issue that has not been resolved.

2.4 Patients' perceptions of quality of care and patient satisfaction

Results from care quality studies showed that the overall view of patients' perceptions of quality of care mostly was good (Wilde Larsson, Larsson, Chanterau, & von Holstein, 2005; Danielsen, Garratt, M. Bjertnæs and Pettersen, 2007), and patient satisfaction was high (Crow, Gage, Hampson, Hart, Kimber, Storey and Thomas, 2002; Jenkinson, Coulter, Bruster, Richards & Chandola, 2002). However, studies have suggested that patient satisfaction scores present a limited and optimistic picture, since questions about specific aspects of patients' experiences showed that inpatients who rated the satisfaction as 'Excellent' at the same time reported several problems (Bruster, Jarman, Bosanquet, Weston, Erens, and Delbanco, 1994; Jenkinson, et al., 2002). One study addressing the paradoxes of patient satisfaction with hospital care found that poor patient experiences with aspects of care did not correlate with low patient satisfaction scores. In fact, the overall patient satisfaction was rated high (Papanikolaou and Niani, 2008). There is a question of whether it may be difficult for patients to criticize the healthcare quality when answering questionnaires with questions with fixed responses, and where there is no space for actual care situations to rate (Rilskjær, Amnertorp and Kofoed, 2011). Other examples of this discrepancy are the coexistence of high levels of patient satisfaction with pain management and high levels of pain (Sauaia, Min, Leber, Erbacher, Abrams and Fink, 2005; Beck, Towsley, Berry, Lindau, Fields and Jensen, 2010). The results from an interview study

examining this discrepancy between high satisfaction rating and high levels of pain intensity indicated that patients expected to have some unrelieved pain after surgery, the healthcare personnel did their best, and the patients did not want to be troublesome to busy personnel (Idvall, 2002). The discrepancy between high scores on patient satisfaction and poor healthcare episodes are a problem when the purpose of healthcare quality research is to improve the quality of care.

2.5 Factors affecting customers' satisfaction in healthcare

Haran, Iqval and Dovlo, (1993) suggested that the main factors, which affect the customer satisfaction in health care are doctors, drug, diagnosis, duration, distance, affordability, and prompt service. These factors are critical to the health care quality system. The higher the efficiency of the quality system, the more will be the satisfaction of customers. A survey carried out by Picker Institute Europe (Coulter, Henderson and Le Maistre, 2004) on patients eligible for the London Patient Choice Scheme asked patients to quantify the relative value of factors influencing their willingness to go elsewhere.

Quality of care deemed to be even more important than fast access, while cleanliness was rated the second highest factor. Many patients were concerned about the risk of infection and information about hygiene standards in alternative hospitals would be likely to influence their decisions about where to be treated. In addition, the healthcare infrastructure and environment can have a direct impact on patient care. There is a general feeling that clinical outcomes are seen as given and that the public will therefore base their choices on their subjective assessment of the environment especially as waiting times are starting to decrease. Patient satisfaction theory has long distinguished patient satisfaction as an attitude (Linder-Pelz, 1982). Due to its evaluative or affective nature, an attitude is distinct from other concepts, such as perceptions.

Additionally, as attitudes are distinct individual states that are affected by upbringing, environment, and beliefs, individuals are expected to differ on their evaluations. Linder-Pelz, (1982) first suggested that patient satisfaction, as an attitude, should be measured by the totalling of objective assessments of the multidimensional attributes associated with the care experience. Numerous studies of patient satisfaction with health care support its depiction as an attitude which can be measured on a multidimensional attributes of care scale (Chisick, 1997; John, 1992; Lewis, 1994; Mittal and Baldasare, 1996; Norcross, Ramirez and Palinkas, 1996; Roter,

Stewart, Putnam, Lipkin, Stiles and Inui, 1997). A premise of social psychological theory strongly suggests that patients' differences influence their attitudes. The underlying premise is that people differ in their orientations towards care because of the broader social, cultural, and otherwise distinctive orientations to which they associate themselves. According to social identity theory, attitudes are moderated by demographic, situational, environmental, and psychosocial factors (Haslam, McGarty, Oakes and Turner, 1993).

Further, interpretations of these factors are moderated by individual beliefs, perceptions, and frames of reference that affected by cultural orientations. Patients' attitudes towards the care that they receive are potentially complex and multifaceted. As a result, discernible social and psychological differences between patients and providers, as well as physiological differences, can be expected to influence variations in patients' attitudes. Glassman and Glassman (1981) found that women used personal experience and peer recommendations to select a physician, and patient satisfaction was determined primarily by physician controlled factors such as providing sufficient relevant information about what to expect during pregnancy and offering continuity of care. Manthei, Vitalo and Ivey, (1982) manipulated patients' choice of health center and then measured patient satisfaction. Surprisingly, the subjects did not differ in their satisfaction ratings across three choice conditions.

In later studies, Manthei, (1983) found that, when allowed the opportunity, patients demonstrated a strong desire to choose their caregiver. In a 1988 study, Manthei found that allowing patients to choose their own health care provider enhanced the patient commitment to the therapy which raised expectation for the outcome and improved ratings for services received (Manthei, 1988). Curbow (1988) investigated the impact of restricted choice on patient perceptions of a medical plan. Positive perceptions occurred when patients had a choice, had more choices than expected, or had a restricted choice. Having no choice created the strongest negative perceptions. Weymuch (1996) found that patients who saw their own physician were significantly more satisfied than patients who saw another physician. Schmittdiel, Selby, Grumbach and Quesenberry, (1997) surveyed 10,205 HMO patients and found that patients who chose their personal physician were as much as 20 % more likely to rate their satisfaction as "Excellent" or "Very good" than were patients who were assigned a physician. In the literature on quality and quality-related issues, the theme of patient satisfaction has been taken up by numerous authors even though their attention has mainly been focused on questions of quality management and control and less emphasis has been placed on customer satisfaction itself.

Thus, an analysis of the patient satisfaction concept requires a re-examination of the studies concerning quality issues. Parasuraman, Zeithami and Berry, (1985) developed SERVQUAL as an instrument for measuring service quality. There have been other attempts too to develop models and mechanisms to measure quality and patients satisfaction. Nagel and Cilliers (1990) developed an integrated model for the management of what is called "total service satisfaction". In this model all service attributes can be managed on an integrated basis, irrespective of whether the service is offered to in-patient or out-patient customers. This approach seeks to optimize the performance of the service delivery system as a whole. To provide a context for the review of existing hospital patient satisfaction public reports and to add to the understanding of the advantages and disadvantages of different methodological approaches, a systematic search and review of the literature was conducted.

Several papers have described the general problem of language barriers and communication in health care (Chang and Fortier 1998; Tomes 1998). Various studies show that language barriers are associated with lower access to health care and error rates were higher when physician and patient spoke different languages (Gandhi, Burstin, Cook, Puopolo, Haas, Brennan and Bates, 1998). Patient's abilities to follow provider instructions and adhere to treatments may also be reduced due to language barriers (David and Rhee 1998; Manson 1988) or to comply with instructions for follow-up care (Manson, 1988). Poorer medical outcomes among patients with hypertension and diabetes were also associated with language barriers (Perez-Stable, Napoles-Springer nnd Miramontes, 1997; Tocher and Larson 1998). However, the relationship between language barriers and adherence is not consistent (Kaplan, Greenfield and Ware 1989). Language barriers may also lead doctors to sending patients for additional tests and procedures that increase costs of care and may carry additional risks to the patient (David and Rhee 1998, Lee and Rosenberg 1998).

Research comparing English and non-English speaking patients reveal that language barriers were associated with lower patient satisfaction among non-English speaking patients (David and Rhee 1998; Morales,Cunningham, Brown, Liu and Hays, 1999). Findings from a mail survey by Morales et al. (1999) report significantly greater dissatisfaction with provider communication among Spanish-speaking respondents. Another survey of patients who sought care in an emergency department found that while over 70% of English-speaking patients were satisfied, only 52% of non-English speaking patients were satisfied (Carrasquillo, Orav, Brennan and Burstin, 1999). Non-English speakers were also less willing to return to the same emergency

department for care and also reported more problems with communication. Other research shows that patient satisfaction increased when interpreter services were available and helped to reduce language barriers (Baker, Haynes and Fortier, 1998).

The role of culture in medical care is related to the Health Belief model (Rosenstock, 1966), which defined cultural barriers to care as "primarily internal, subjective beliefs" (D'Avanzo, 1992). The effects of cultural differences on health care use are similar to those of language: cultural differences often translate into cultural barriers that lower access to health care. Oomen, Owen and Suggs, (1999) studied cultural barriers in health care by comparing Latino patients interacting with non-Hispanic White physicians, and report lower quality of care for Hispanic women related to cultural norms. Dibble, Vanoni and Mlaskowski, (1997) compared Black, Asian, White, Latina, and Pacific Islander women on ethnic (cultural) differences in rates of breast cancer screening, with lower rates among Latina and Asian women related to embarrassment during the procedure.

Unfamiliarity with the U.S. health care system also discourages health care use and leads to misunderstanding between providers and patients, which further discourage use by culturally different patients (Hoang and Erickson, 1982). For example, many Vietnamese refugees experienced health care in a "crisis-oriented system of care" (Hoang and Erickson, 1982) and do not understand the U.S. system of scheduled appointments and preventive care. Cultural preferences for using traditional treatments can also be associated with reduced use of health care (Kleinman, Eisenberg and Good, 1978). Researchers have shown that many culturally different patient populations turn to traditional treatments first, then turn to Western medicine, or employ traditional treatments in conjunction with Western medical (Buchwald, Carolis, Gany, Hardt, Muecke and Putsch, 1992). Culturally diverse patients' lack of knowledge about Western medical procedures can contribute to poorer medical care. For example, being sent for an X-ray procedure such as a mammogram or X-ray of a potentially broken bone may be misinterpreted as treatment and the patient may expect to recover from the procedure alone. Such patients then fail to comply with follow-up care, which, in turn, is misinterpreted by physicians as lack of interest in caring for themselves (Grizzell, Savale, Scott and Nguyen, 1980).

Another important factor affecting patients satisfaction with health care services is health literacy which is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (National Center for Health Statistics, Healthy People 2010). Health literacy as a

patient characteristic can affect the effectiveness of communication for all patients but is expected to play a larger role for patients who are culturally and linguistically different from the physician, for several reasons. Health literacy is inversely associated with socioeconomic status, and a higher proportion of the foreign born population is poor and have lower educational attainment (Rudd, Colton and Schacht, 2000). Medical concepts and their expressions are influenced by culture, as discussed above. The effect of low health literacy in reducing communication effectiveness can therefore be multiplied for patients from different cultural and language backgrounds.

There is a fairly extensive literature on health literacy (see Rudd et al.'s [2000] annotated bibliography, and updates by Zobel, 2002). However, there is a lack of research on the relationship between English language proficiency, cultural diversity, health literacy, and physician-patient communication. Health literacy is distinct from English language proficiency and culture, and it will be challenging for researchers to include measures of health literacy in studies of language and cultural barriers in physician-patient communication.

As discussed above, many researchers use race and ethnicity as proxy measures of culture, and attribute differential health treatments to cultural barriers. A different but related area of research is to examine racial concordance as a predictor of patient satisfaction and other measures of health care quality. Cooper-Patrick, Gallo, Gonzales, Vu, Powe, Nelson and Ford (1999) compared African American and White patients and physicians on physicians' participatory decision-making styles and found that physician-patient race concordance was associated with higher ratings of physician decision-making as more participatory. Greater patient participation in health care is seen as beneficial, by increasing patient satisfaction and leading to better health outcomes. This study also examined gender concordance as a factor but did not find a similar result.

Saha, Komaromy, Koepsell and Bindman (1999) also investigated the effect of physician-patient racial concordance on patient satisfaction and use of health care with a sample of Black, Hispanic, and White respondents drawn from the 1994 Commonwealth Fund's Minority Health Survey. Their findings confirm the effect of racial and Hispanic origin concordance between physician and patient on greater patient satisfaction. Van Ryn and Burke (2000) examined data provided by physicians on post-angiogram physician-patient encounters to evaluate the effects of patients' race and socioeconomic status on physicians' perceptions and beliefs about patients. The researchers found that physicians (in this sample, 84% of physician

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were White) tended to perceive African Americans and patients from low and middle socioeconomic status more negatively: Black patients were more likely to be seen at risk for noncompliance with cardiac rehabilitation, substance abuse, and having inadequate social support. In addition, physicians rated Black patients as less intelligent than White patients, even when patient sex, age, income and education were controlled. Physicians also report less affiliative feelings toward Black patient (Van Ryn and Burke, 2000).

The most typical doctor-patient relationship seen in hospitals is one where the physician dominates the encounter and has high control and this high control style is also characterized by frequent interruptions of the patient (Platt and McMath 1979). Communicative behaviour can also be categorized as instrumental (or task-oriented) and affective (or socio-emotional) behaviour. Instrumental behaviour refers to "technically based skills used in problem solving, which composes the base of 'expertness' for which the physician is consulted" (Hall, Roter and Katz, 1987). Examples of instrumental behaviour include speech that provides information to the patient, discussing tests and procedures, and explaining reasons for treatment options.

Affective behaviour refers to a broader range of behaviour, including a physician's behaviour and speech that are directed towards the patient as a person instead of as a case, and communication that is designed to establish empathy and a positive relationship with the patient. (Ben-Sira, 1980; Hall et al., 1987). Examples of physician affective behaviour include introducing self to patient, providing verbal encouragement and support, non-verbal communication such as touching the patient, and engaging in small talk.

A study of the relationship between physician interaction style and health by Kaplan et al (1989) found that physician behaviours that reinforce patients' self-confidence, motivation, and positive view of their health status may therefore indirectly influence patients' health outcomes. Roter et al. (1997) report a positive association between physician's instrumental behaviour (especially physicians' information-giving behaviour) and patient satisfaction. Physicians' expression of affective behaviour was positively associated with patient satisfaction while doctors who communicated in a controlling dominant mode produced less patient satisfaction (Bensing, 1991; Buller and Buller, 1987).

Most studies of the relationship of patient characteristics to hospital satisfaction scores have found that several key variables were significantly related to reports of satisfaction, most consistently patient age and self reported health status. Virtually every study reviewed found these two characteristics to be strongly related to hospital satisfaction, and this finding held for

VA hospital patients (Rosenheck, Wilson and Meterko 1997; Young, Meterkor and Desai 2000). for obstetrical patients (Finkelstein, et al., 1998) and in different countries (Thi, Briancon, Empereur and Guillemin, 2002). In general, older patients tended to report greater satisfaction, and sicker patients tended to be less satisfied (Finkelstein, et al., 1998; Hargraves, et al., 2001; Rogut, Newman and Cleary, 1996; Rosenheck, et al., 1997; Thi et al., 2002; Young, et al., 2000).Other patient characteristics that have been significantly related to hospital patient satisfaction include: race/ethnicity (Finkelstein, et al., 1998; Rogut, et al., 1996; Young, et al., 2000), gender (Hargraves, et al., 2001; Rosenheck, et al., 1997), education level (Hargraves, et al., 2001), insurance status (Finkelstein, et al., 1998; Rogut, et al., 1996), income (Rogut, et al., 1996; Young, et al., 2000), having a regular physician (Rogut, et al., 1996), and past hospital experience (John, 1992).

2.6 Patient empowerment—a patient-centred approach to improve care

Patient empowerment in the health care context means to promote autonomous self-regulation so that the individual's potential for health and wellness is maximised. Patient empowerment begins with information and education and includes seeking out information about one's own illness or condition, and actively participating in treatment decisions. Empowerment requires an individual to take care of one's self and make choices about care from among the options identified by the doctor (Funnell, Anderson and Arnold, 1991).

Multiple studies have demonstrated that patients who are involved with decisions about their care and the management of their conditions have better outcomes than those who are not involved (Wagner, Glasgow and Davis, 2001; Greenfield, Kaplan and Ware, 1985).

Physician's views on patient empowerment are also positive, in that encouraging patients to be partners will lead to faster shared understanding, greater patient satisfaction, and improved health outcomes. The concept of 'patient as partner' is essential for efficient doctor-patient consultations, in which mutual understanding leads to rapid diagnosis and negotiated treatment options that are more likely to be adhered to (Taylor, 2000).

Informed consent is considered a tool for patient empowerment. Edge and Groves (1994) identify the stages that characterise informed consent as including:

(1) disclosure—the patient should be informed of the nature of the condition, the various options, potential risks, the professional's recommendation, and the nature of consent as an act of authorisation;

(2) understanding—information is provided at the patient's level of understanding, using appropriate language;

(3) voluntaries—the patient must be in a position to practise self-determination free from any coercion, manipulation, or constraint;

(4) competence—based on the patient's past experience, maturity, responsibility, and capacity for independent decision making; and

(5) consent—a freely given authorisation to the medical or nursing intervention

2.7 Determinants of patient satisfaction with physician interaction

Only a minority of persons who perceive themselves to be sick visit their doctor (Zola, 1973; Blaxter, 1985; Ingham and Muller, 1986; Egan and Beaton, 1987). Previous experience with a doctor seems crucial to whether or not people choose to consult a doctor (Pendleton, 1983). For every patient, a medical consultation forms part of a continuing process of coping with illness. Patients have expectations when they visit their doctors; the degree to which these expectations are met influences patients' perception of the quality of that experience and, thus, patient satisfaction, which is defined as the nature of an individual's experience compared with his or her expectations (Pascoe, 1983).

There is a strong positive association between a patient's consultation experience and actual health outcomes (Ong, De Haes, Hoos, and Lammes, 1995; Joos et al, 1996; Wooley, Kane, Hughes and Wright, 1978). There is a positive correlation between effective physician-patient interaction and patient adherence to scheduled appointments and other physician instructions (DiMatteo, Hays and Prince, 1986). Improvement in physician-patient communication can result in better patient care and help patients adapt to illness and treatment (Lee, Back, Block and Stewart, 2002).

In health care provision all over the world, client satisfaction is gaining more and more importance. Outcomes as assessed from the patient's perspective have been accepted as valid, important and standard indicators of quality of care (Loblaw, Bezjak and Bunston, 1999; Cotinsky, Bates and Davis, 1996). Patients often fail to disclose their problems and anxieties

when they are not satisfied with the doctor's attitude. Doctors are often unaware of whether or not patients are satisfied with a consultation because, whatever their views, patients tend to retain a deferential attitude in the medical encounter. Problems in physician-patient interaction, especially communication barriers, are common: these adversely affect patient management (Steine, Finset and Laerum, 2001). Reports from the United States suggest that over 90% of medical litigation is prompted by patients' perception that the doctor did not care about them (Beckman, Markakis, Suchman and Frankel, 1994; Levinson, Roter, Mullooly, Dull and Frankel, 1997). While litigation is uncommon in the Nigerian environment, dissatisfied patients suffer disadvantages from recourse to quacks, self-medication or delays in seeking medical assistance.

A high satisfaction with physician-patient interaction is associated with increased adherence, better continuity of care, client participation in important treatment decisions and even beneficial/positive adjustment (Loblaw et al, 1999). It influences promptness in seeking help and increases patients' understanding and retention of information (Barker, Shergill and Higginson, 1996). Communication skills, often not sufficiently emphasised during medical training, make a huge difference in patient satisfaction and health outcomes (Doyle and Ware, 1997).

2.8 Conceptual Framework

PRECEDE Model:

The PRECEDE-PROCEED model is a cost-benefit evaluation framework proposed in 1974 by Dr Lawrence W. Green, that can help health program planners, policy makers, and other evaluators analyze situations and design health programs efficiently. It provides a comprehensive structure for assessing health and quality of life needs, and for designing, implementing, and evaluating health promotion and other public health programs to meet those needs. It guides planners through a process that starts with desired outcomes and works backwards to identify a mix of strategies for achieving objectives. The model views health behavior as influenced by both individual and environmental forces, it has two distinct parts: an "educational diagnosis" (PRECEDE) and an "ecological diagnosis" (PROCEED). The PRECEDE acronym stands for Predisposing, Reinforcing, Enabling Constructs in Educational/Environmental Diagnosis and Evaluation. For the scope of the research focus on Educational and Ecological Assessment, the practitioner identifies antecedent and reinforcing factors that must be in place to initiate and sustain change. According to the framework, any behaviour is caused by some behavioural

antecedents. These antecedents could be differentiated into three typologies-pre-disposing, enabling and reinforcing factor.

Predisposing factors are any characteristics of a person or population that motivates behaviour prior to or during the occurrence of that behaviour. They include an individual's knowledge, beliefs, values and attitudes. Within the context of this study, the perception and belief of patients and their relatives towards health service seeking behavior and the influence of other people and environment of making decision to seek health services at the A&E department of UCH. The model explains if clients perceive health service delivery at the A&E department of UCH as unsatisfactory, their health seeking behaviour towards the facility will be poor. The perception and belief of clients will determine if they will seek health care at the A&E if they have a positive belief that seeking health service delivery at the A&E will provide the satisfaction they seek in health care.

The enabling factor enable persons to act on their predispositions. these factors include available resources, supportive policies, assistance, services, facilities, hospital and clinics, money and access to health care in the environment. The presence or absence of any of these variables has potential for influencing the behaviours of people relating to seeking health services.

The Reinforcing factors, which come into play after behaviour has been initiated, they encourage repetition or persistence of behaviors by providing continuing rewards or incentives. Social support,peer support, family support, praise, conducive environment, availability of affordable services and symptom relief might all be considered reinforcing factors. This help to understand if clients who have gone for health services at the A&E in the past will still seek further care at the facility in the future or encourage their relatives or friends to go for health service delivery at the same facility.

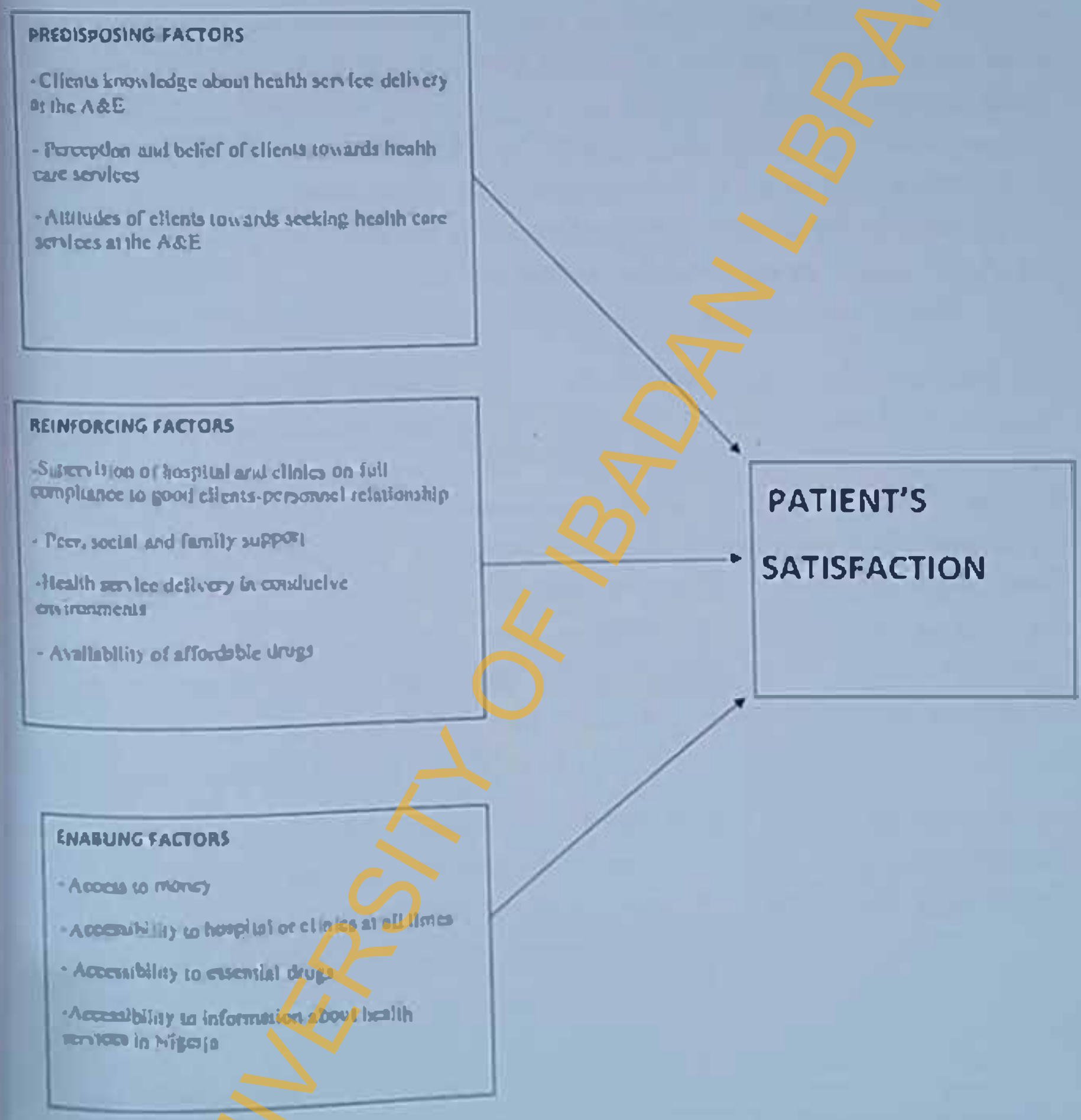

Figure 2.1: Application of PRECEDE Model to Factors influencing intention towards patient's satisfaction.

CHAPTER THREE

METHODOLOGY

3.1 Study area

The study was conducted in the Accident and Emergency Department of the University College Hospital (UCH) Ibadan, Oyo State, Nigeria. The University College Hospital, Ibadan was established in November 1952 in response to the need for the training of medical personnel and other healthcare professionals for the country and the West African Sub-Region. The University College Hospital (UCH) was strategically located in Ibadan, then the largest city in West Africa which is also the seat of the first University in Nigeria. The University College Hospital was initially commissioned with 500 bed spaces. Presently the Hospital has 850 bed spaces and 163 examination couches, current bed occupancy rates ranges from 55-60%.

The Accident and Emergency is the unit that receives emergency cases from within Oyo State and referrals from other parts of the country. The facility has a reception which is manned by Nurses and Doctors to receive in clients and to triage cases, a pharmacy store where drugs and other essentials are procured, payment point, registration room where casualty cards are opened for new clients or retrieved for old clients, a medical store where medical materials are procured, an X-Ray unit, a resuscitation room for critically ill patients, a dressing room, consultation rooms and eight cubicles where patients are admitted to before they are transferred to their respective wards. Others include: a Servicom office, Medical Social worker office, offices for Medical and Surgical Consultants, mini theatre, mini laboratory, plaster room and call room for the Casualty Doctors.

The facility runs 24 hours each day of every week including weekends and public holidays and the staffs run shifts. The facility attends to all emergency cases except paediatric cases that are not due to trauma and some cases are solely managed at the facility while the majority are referred to various specialties within the hospital.

3.2 Study design

The study was a descriptive cross sectional survey and it was aimed at investigating the perception of clients towards health service delivery and how satisfied they were with service

delivery at the Accident and Emergency Department of the University College Hospital (UCH) Ibadan.

3.3 Study population

The study population was made up of both male and female patients who were on admission for 24 hours or more at the A&E and have been discharged but still in A&E or have been transferred to other wards within UCH and followed up to these wards and relatives of patients who accompanied and stayed with their relatives in the hospital.

3.4 Sample size determination

The sample size for the study was estimated using the formula developed by Daniel (1999), which states that:

$$n = \frac{z^2 p(1-p)}{d^2}$$

Where:

n= Sample size

z= Constant variable with critical value of 1.96 at 5% (95% confidence interval)

p= Expected prevalence or proportion. This is the proportion (prevalence) that is going to be estimated by the study. For this study, the value for p will be assumed to be 63.3% i.e. 0.633 (Abioye, Bello, Olaleye, Ayeni and Amedi, 2010)

p+q= 1

q= 1-0.633

q= 1-0.633

= 0.367

d= Precision limit which for this study will be considered at 95% confidence interval, therefore the precision limit will be 100-95= 5%(0.05)

The sample size (n) = $\frac{(1.96)^2 \times (0.633) \times (0.367)}{(0.05)^2}$

n = 356.98

The sample size was increased by 20% in order to make room for non-response bias and for those who may not return the questionnaire.

Therefore 20% of 356.98= 71.196

Thus sample size = 356.98 + 71.196

= 428.176

Approximated to 450 clients in a ratio of 1:1 i.e. 225 patients and 225 relatives

3.5 Sampling technique

An Exit interview in which clients that have been discharged but still in the A&E and those that have been transferred to other wards within UCH and followed up to these wards was conducted amongst respondents who consented to participate in the study.

3.6 Inclusion and exclusion criteria

Inclusion criteria: Clients who have been on admission for 24hours or more and are about to be discharged home or that have been discharged but still in the A&E and those that have been transferred to other wards within UCH were recruited for the study.

Exclusion criteria: Clients who have not been on admission for up to 24hours, those who discharge themselves against medical advice, unconscious patients and those lacking cognitive competence.

3.7 Instrument for data collection

The study employed the use of semi-structured questionnaire which had closed ended questions to conduct an exit interview on clients that have been discharged home but still in the A&E or transferred to the wards. The questionnaire was also provided in Yoruba language for respondents who were not literate.

The items on the questionnaire were divided into six sections – labelled sections A, B, C, D, E and F. Section A consisted of questions for documenting the demographic characteristics of the respondents while sections B and C were used to assess respondents' perception and level of satisfaction respectively. Section D contained questions that were used to determine the factors influencing satisfaction. Factors responsible for refusal of admission or discharge against medical advice were assessed using questions in Section E. Questions in Section F were used to document respondents' areas that needs improvement at the A&E (Appendix I). In formulating the questionnaire, close-ended questions were used. The questionnaires were interviewer-administered.

3.8 Validity and Reliability

3.8.1 Validity:

In order to ensure construct validity of the instruments for data collection, the questionnaire was written in simple English and Yoruba languages for easy comprehension and understanding by the respondents. The content validity of the questionnaire was strengthened through the review of literature in related areas in health care delivery. The validity of the instruments was also assured through the review of literature. The input of project supervisor, other lecturers in the Department of Health Promotion and Education and senior colleagues were used to enhance the validity of the instruments. The questionnaire was also pre-tested amongst 10% of the sample size i.e. 45 clients at the Obafemi Awolowo Teaching Hospital Ile-Ife, Osun State.

3.8.2 Reliability

After the pre-test, the questionnaire was revised and ambiguous questions were rephrased. This activity helped to screen for potential problems in the questionnaire, to detect errors and ambiguities and take appropriate measures to rectify this before collecting the data using the instrument. The instrument also went through measures of internal consistency with the use of Cronbach's Alpha model technique to determine the reliability of the questionnaire. This is a model of internal coefficiency based on the average inter-item correlation. Result showing a correlation coefficient greater than 0.50 using the technique is said to be reliable and in this study the result was 0.72, which is greater than 0.50, thereby confirming its high degree of reliability.

In addition to reliability and validity processes, a recruitment of research assistants and training programme was conducted to ensure that they had adequate understanding and knowledge of the instruments prior to the commencement of data collection. The training focused on the objective of the study, sampling processes of distribution of questionnaire to respondents, ethical consideration, basic interviewing skills and how to review instrument to ensure proper completeness of the questionnaires.

3.9 Training of research Assistants

Two research assistants were recruited and trained to participate in the quantitative data collection. They were trained to have adequate understanding of the instrument and the methods to be used in collecting the data prior to the commencement of data collection. The research assistants were also involved in pre-testing of the questionnaire at Obafemi Awolowo University Teaching Hospital, Ile-Ife, in other to facilitate a better understanding of the study.

3.10 Data Collection process

This was carried out within the period of eight weeks from the month of April to June. Two research assistants, one male and one female were employed for the data collection.

The data collection process involved the following:

The identification of patients/relatives who had been admitted for 24hours in the A&E was carried out a day before the distribution of the questionnaires and after which identification and visits to the various wards where patients are transferred to from the A&E was done. The identification of each wards matrons for formal introduction and to seek for permission to conduct the study was also carried out the same day. On the day of the questionnaire administration, establishment of rapport with the eligible participants in each of the wards, including a disclosure of the nature of the study, its objectives and any inconveniences that maybe involved was discussed and consent to participate in the study was taken from the participants after which the administration of the questionnaires to the participants was commenced. All the questionnaires were collected and reviewed for completeness each day of the exercise until the study was completed.

3.11 Data management and analysis

Cleaning and editing of the questionnaires was done on the field and necessary corrections were made. A coding guide was developed after a careful and meticulous review of responses to facilitate coding and data entry. The copies of the questionnaire were coded and entered into the computer using the serial number that had been pre-assigned to each questionnaire. A template was designed on the Statistical Products and Services Solution (SPSS version 16) software for entry of the coded data and analysis. The data entered into the computer were subjected to descriptive and inferential statistical treatment and all these were used to run a Chi-square.

Clients satisfaction and clients perception were measured on 15 and 9-point scales respectively. Satisfaction scores (SS) of <23 and ≥23 were rated as not satisfied and satisfied respectively. Perception Scores (PS) <15 and ≥15 were classified as poor and good respectively.Information obtained were summarized and presented in tables.

3.12 Ethical consideration

Ethical approval for the study was obtained from the University College Hospital Ethical Review Committee Ibadan (Appendix 2) and the permission to carry out the study was also obtained from the Head of Department of Accident and Emergency. The respondents' verbal consent (Appendix 3) was obtained after provision of adequate and clear information about the study. The respondents were also informed of their right to withdraw from the study at any point they felt like.

CHAPTER FOUR

RESULTS

4.1 Respondents' socio-demographic characteristics

The socio-demographic characteristics of the respondents are presented in Table 4.1. It shows that 50.0% of the respondents were patients and 50.0% relatives. The tables showed that 42.9% of the respondents were between 21-40 years of age, this is followed by 34.3% in the 41-60years age bracket, followed by 14.7% of the respondent in the 61-80years age bracket and the lowest proportion of 8.2% was noted among the respondents aged 1-20years. The mean age of the respondents was 57.9±9.8 and 50.2% of the respondents were male and 49.8% were females. Of all the respondents, 47.8% were Yorubas, 33.3% were Igbos, 18.7% were Hausas and the lowest proportion 0.2% were from others ethnic groups. 56.7% were Christians, followed by 43.1% who were Muslims, and the lowest proportions of 0.2% were among other religions. Of the 450 respondents 55.6% had secondary education, 21.6% had tertiary education, 16.2% had no formal education and 6.7% had primary education 62.7% of the respondents were married, 23.3% were single, this is followed by 10.7% who were separated and 3.3% were divorced.

Table 4.1 Socio- demographic Characteristics of the Respondents (N=450)

Variable	Frequency (n)	Percentage (%)
Category of Respondents		
Patients	225	50.0
Relatives	225	50.0
Age (Years)		
≤20	37	8.2
21–40	193	42.9
41- 60	154	34.2
61-80	66	14.7
Sex		
Male	226	50.2
Female	224	49.8
Ethnic Group		
Yoruba	215	47.8
Ibo	150	33.3
Hausa	84	18.7
Ibibio	1	0.2
Religion		
Christianity	255	56.7
Islam	194	43.1
Traditional	1	0.2
Level Of Education		
Primary	30	23.3
Secondary	250	62.7
Tertiary	97	10.7
None	73	3.3
Marital Status		
Single	105	3.3
Married	282	62.7
Separated	48	10.7
Divorced	15	3.3

4.2: Patients' Perception of Quality of Care at the Accident and Emergency Department.

This section shows the perception of respondents to the quality of care at the Accident and Emergency (table 4.2). This tables shows that 377(83.3%) of the respondents agreed that the Accident and Emergency Department is a complex area while 326(72.4%) of the respondents agreed that the Accident and Emergency Department is easily located during emergencies. A large number 364(80.9%) of the respondents agreed that the Accident and Emergency Department doctors listen to patients complaints adequately while 333(74.0%) agreed that the nurses listen to patients complaints adequately. In the same view, 302(67.1%) agreed that the nurses are always polite. Mjority, 270(60.0%) of the respondents agreed that the Accident and Emergency Department provides adequate privacy during examination of patients while 274(60.9%) agreed that the Accident and Emergency Department provides adequate support to patients care.

Table 4.2: Patients' Perception of Quality of Care at the Accident and Emergency Department. (N=450)

Varinbles	Patients' Perception		
	Agree n(%)	Disagree n(%)	Undecided n(%)
Accident and Emergency is a complex area	377(83.8)	46(10.2)	27(6.0)
Accident and Emergency is easily located during emergencies	326(72.4)	100(22.2)	24(5.3)
Accident and Emergency environment is comfortable	268(59.6)	131(29.1)	51(11.3)
Accident and Emergency Doctors listen to your complaints adequately	364(80.9)	57(12.7)	29(6.4)
Accident and Emergency Nurses listen to your complaints adequately	333(74.0)	77(17.1)	40(8.8)
Accident and Emergency Nurses are always polite to you	302(67.1)	78(17.3)	70(15.6)
Accident and Emergency Pharmacy has all the prescribed medications	263(58.4)	130(28.9)	57(12.7)
Accident and Emergency provides adequate privacy during examination of patients	270(60.0)	133(29.6)	47(10.4)
Accident and Emergency provides adequate support to patients care	274(60.9)	111(24.7)	65(15.5)

4.3: Level of Perception of Respondents

Out of the 450 respondents 77.3% had a good perception and the 22.7% had a poor perception with the health service delivery in the Accident and Emergency unit.

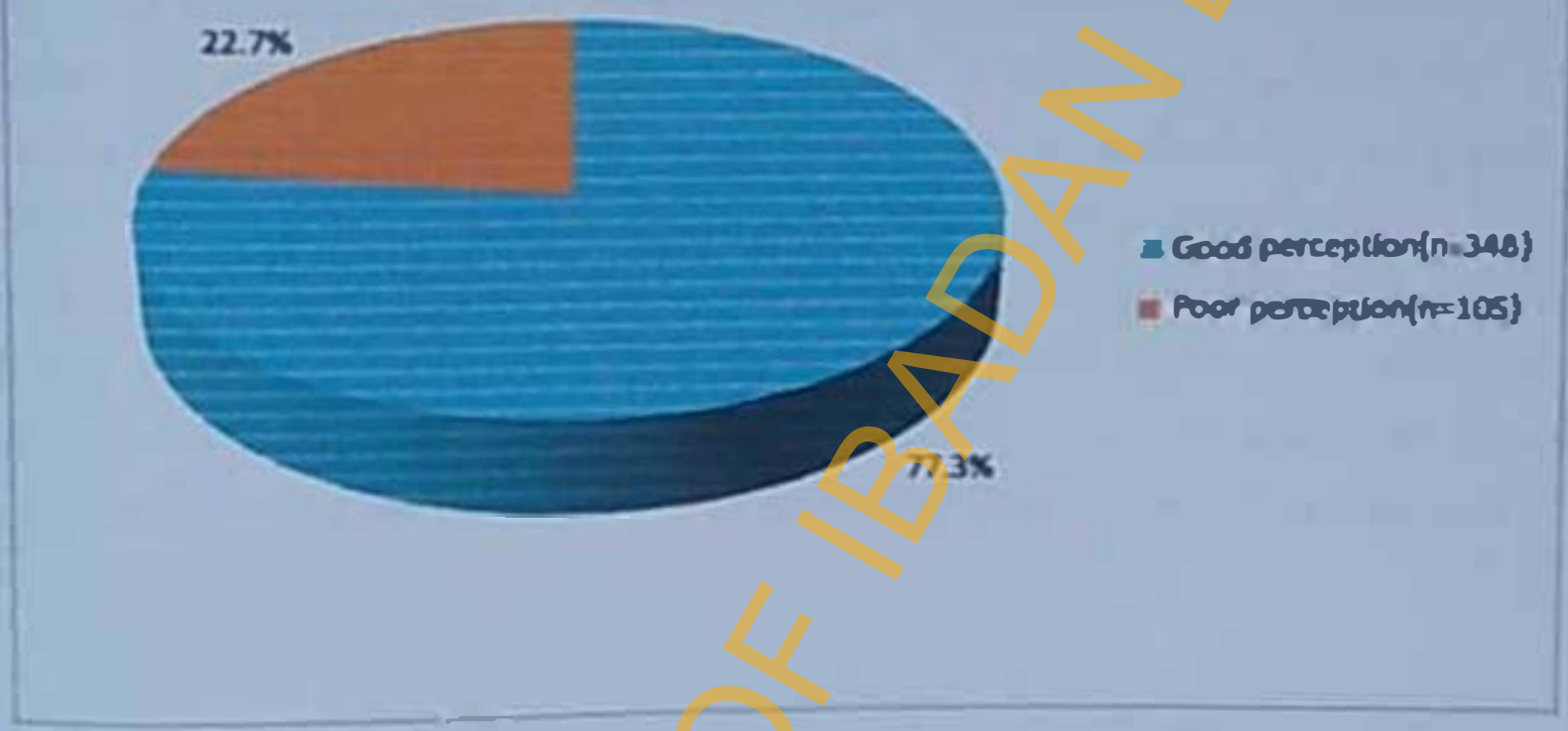

Figure4.1: Pie chart of respondents' level of perception

4.4: Level of Satisfaction of Care at the Accident and Emergency

The satisfaction of respondents to factors such as courtesy of staffs, comfort of the waiting rooms etc are shown in this section.

The table 4.3 shows that 274(60.9%), 244(54.2%) and 278(61.8) of the respondents were respectively satisfied with courtesy of staff in the registration area, courtesy of security staff and courtesy of staff who transfer the patients. Also 249(55.3), 212(47.1%) of the respondents were respectively satisfied with comfort and pleasantness of the waiting area and comfort and pleasantness during examination. Also 280(62.2%) and 240(53.3%) of the respondents were respectively satisfied with friendliness/courtesy of the care provider and length of waiting before going to an examination room. In same view, 252(56.0%), 270(60.0%) and 291(64.7%) of the respondents were respectively satisfied with explanations the care provider gave about you or your relatives condition, concern the care provider showed for your questions or worries, care provider's efforts to include you in decisions about treatment options respectively

In another view 280(62.2%), 232(51.6%),267(59.0%) and 267(59.0%) were respectively satisfied with instructions the care provider gave you or your relative about follow-up care degree to which care provider talked with you using words you could understand, amount of time the care provider spent with you or your relative and frequency of visit by physicians

Table 4.3: Level of Satisfaction of Care at the Accident & Emergency (N=450)

Varinbles	Respondents level of satisfaction		
	Satisfied n(%)	Not satisfied n(%)	Not sure n(%)
Courtesy of staff in the registration area	274(60.9)	144(32.0)	32(7.1)
Comfort and pleasantness of the waiting area	249(55.3)	166(35.9)	35(7.8)
Comfort and pleasantness during examination	212(47.1)	163(36.2)	75(16.6)
Courtesy of security staff	244(54.2)	147(32.7)	59(13.1)
Courtesy of staffs who transfer the patients	278(61.8)	122(27.1)	50(11.1)
Length of waiting before going to an examination room	240(53.3)	148(32.9)	62(13.7)
Friendliness/courtesy of care Provider	280(62.2)	125(27.8)	45(10.0)
Explanations the care provider gave about you or your relatives condition	252(56.0)	141(31.3)	57(12.6)
Concern the care provider showed for your questions or worries	270(60.0)	135(30.0)	45(10.0)
Care provider's effort to include you in decisions about treatment options	291(64.7)	121(26.9)	38(8.4)
Information the care provider gave about medications	280(62.2)	133(29.6)	37(8.2)
Instructions the care provider gave about follow-up care	285(63.3)	126(28.0)	39(8.7)
Degree to which care provider talked with you using words you could understand	232(51.6)	164(36.4)	54(12.0)
Amount of time spent with the care giver	267(59.0)	137(30.4)	46(10.3)
Frequency of visit by physicians	267(59.0)	137(30.4)	46(10.3)

4.5 Factors Influencing Satisfaction at the Accident and Emergency

The various factors that influence clients' satisfaction with service delivery are shown in table 4.4. Majority 64.4% of the respondents rated the reception offered by doctors in the Accident and Emergency Department as very good, 25.8% rated the reception as good, 5.1% gave average rating, 2.7% gave a fair rating and 2.0% gave a poor rating for the reception offered by doctors in Accidents and Emergency. 43.6% gave a very good rating to the perception given by nurses, 36.0% gave a good rating, 8.9% gave average rating, 7.3% gave fair and 4.2% gave poor rating of the reception by nurses. The reception given by pharmacists were rated as been very good by 41.3% of respondents, 33.6% rated the reception as good, 18.4% gave average rating, 4.2% gave a fair rating while 2.4% rated the reception as been poor. Reception offered by laboratoty scientists showed that 35.6% of respondents gave a very good rating, 33.8% gave good rating, 19.6% gave average rating, 6.7% gave a fair rating and 4.4% gave a poor rating. The ratings of the reception given by radiology staffs, ward maids, porters, cashiers and security men are also highlighted in table 4.2

Table 4.4: Factors Influencing Satisfaction at the Accident and Emergency

Reception by staff	Very good n (%)	Good n(%)	Average n (%)	Fair n(%)	Poor n (%)
Reception by Doctors	290 (64)	11(25.8)	23(5.1)	12(2.7)	9(2.0)
Reception by Nurses	196(43.6)	162(36.0)	40(8.9)	33(7.3)	19(4.2)
Reception by Pharmacist	186(41.3)	151(33.6)	83(18.4)	19(4.2)	11(2.4)
Reception by Lab. Scientist	160(35.6)	152(33.8)	88(19.6)	30(6.7)	20(4.4)
Reception by Radiology	152(33.8)	143(31.8)	88(19.6)	38(8.4)	29(6.4)
Reception by Ward maid	117(26.0)	111(24.7)	116(25.8)	76(16.9)	30(6.7)
Reception by porters	161(35.8)	35(33.8)	76(16.9)	38(8.4)	23(5.1)
Reception by cashiers	106(23.6)	112(24.9)	130(28.9)	71(15.8)	31(6.9)
Reception by security men	113(25.1)	85(18.9)	98(21.8)	106(23.6)	48(10.7)

4.6: Level of Perception nnd Satisfaction of Respondents

Of the 450 respondents, 64.0% were satisfied while 36% were not satisfied with the health delivery systems in the accident and emergency unit.

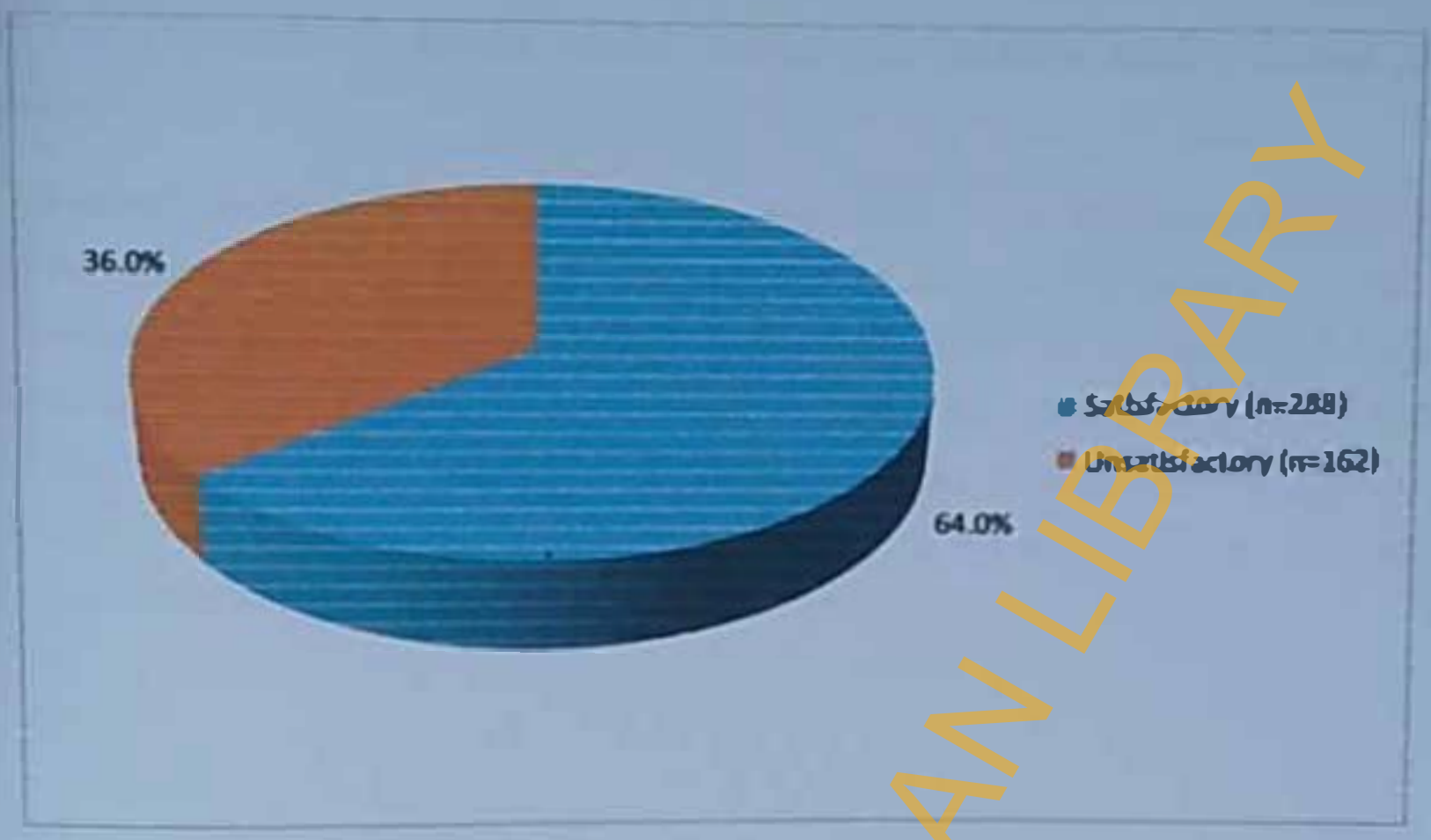

Figure4.2: Pie chart of respondents' level of satisfaction

4.7: Factors Responsible for the Refusal of Admission/ discharge against medical advice (DAMA)

Factors responsible for the refusal for admission or DAMA as enumerated by respondents include attitude of the attending staff (46.9%), lack of money among patients (53.3%) and services being expensive (51.3%). Also 47.6% of the respondents claimed that one of the factors responsible for the refusal for admission/ DAMA was due to lack of privacy and 39.6% claimed that the treatment given to patients is ineffective. Other factors enumerated were the unconducive nature of the hospital beds and wards (43.3%) and non-availability of prescribed drugs and other medical materials (43.8%).

Table 4.5: Factors Responsible for the Refusal of Admission/ Discharge against medical advice

(N=450)

Variable	Frequency (n)	Percentage (%)
Attitude of attending staff		
Yes	211	46.9
No	151	33.6
No idea	88	19.6
Lack of money		
Yes	240	53.3
No	162	36.0
No idea	48	10.7
Lack of privacy		
Yes	214	47.6
No	159	35.3
No idea	77	17.1
Services are expensive		
Yes	231	51.3
No	153	34.0
No idea	66	14.7
Treatment not effective		
Yes	178	39.6
No	195	43.3
No idea	77	17.1
Hospital bed and ward are unconducive		
Yes	195	43.3
No	149	33.1
No idea	106	23.6
Non-availability of prescribed drugs and other medical materials		
Yes	197	43.8
No	137	30.4
No idea	116	25.8

4.8: Respondents Perceived Areas in the Accident and Emergency Department that needs Improvement.

The various areas perceived by respondents that needed improvement in the Emergency department are shown in Table 4.6. Out of 450 respondents (77.3%) suggested that areas that needs improvement were the hospital trolleys used for moving patients and 67.6% pointed to the communication between staff and patients as one of the areas that needs to be improved.

Majority, (71.1%) of the respondents suggested that the cleanliness of the wards at the Accident and Emergency needs improvement while 67.6% suggested that the response time of doctors and nurses to patient's needs improvement. Also, 66.9% suggested that the privacy given to patients needs to be improved while 64.9% viewed that courtesy and respect of staff to patients also should be improved.

Table 4.6: Respondents Perceived Areas in Accident and Emergency Department that needs Improvement.

(N=450)

Areas in A&E that needs improvement	Frequency (n)	Percentage (%)
The hospital trolleys for moving patients	330	73.3
Communication between staff and patients	304	67.6
Cleanliness of the wards	320	71.1
Response time of Doctors and Nurses	304	67.6
Privacy for patients	301	66.9
Courtesy and Respect of staff	292	64.9
Availability of prescribed drugs	295	65.6
The overall quality of care	290	64.4
Nurses attitude towards request	282	62.7
Amount of attention paid to personal and specials needs	275	61.1

4.9: Tests of Hypothesis

4.9.1:Hypothesis1: Association between Respondents' Demographic Variables and Clients Level Of Satisfaction

There is no association between socio-demographic variables (kind of educational qualification, age, sex and marital status) and clients' level of satisfaction to health service delivery.

Table 4.8 shows there is no significant association between age group of respondents and their satisfactory level (p =0.933). Majority of the respondents who were aged between 21-40 years 63.7% were more satisfied followed by those between41-60years 64.9%. Also there is no significant association between sex of respondents and their satisfactory level. Out of the 450 respondent, 145 males (64.2%) were satisfied followed by the 143 females (63.2%) compared to those who were notsatisfied among the respondents, this was not significant at (p= 0.944).

There was statistical significant association between marital status and level of respondents satisfaction at p=0.033. The respondents level of satisfaction showed that 64.2% of the respondents that are married, (62.9%) of the single, (75.0%) of the separated and (33.3%) of the divorced were satisfied.

There was statistical significant between the educational level of respondents and level of satisfaction at p=0.01. It shows that respondents with formal level of education were more satisfied than those with no format education.

In view of the fact that there was a significant relationship between respondents' educational qualification, marital status and level of satisfaction, the null hypothesis was rejected. On the other hand, there was no significant relationship between respondents' age, sex and level of satisfaction, therefore the null hypothesis failed to be rejected.

Table 4.7: Association Between Respondents' Demographic Variables and Clients Level of Satisfaction at Emergency Department.

Socio-demographic characteristic	Level of satisfaction: Unsatisfactory n(%)	Satisfactory n(%)	χ^2	p-value
Age				
≤ 20	15(40.5)	22(59.5)		
21-40	70(36.3)	123(63.7)	0.434	0.933
41-60	54(35.1)	100(64.9)		
61-80	23(34.8)	43(65.2)		
Sex				
Male	81(35.8)	145(64.2)	0.006	0.944
Female	81(36.8)	143(63.2)		
Educational level				
None	35(47.9)	38(52.1)		
Primary	14(46.7)	16(53.3)	11.355	0.01*
Secondary	89(35.6)	161(64.4)		
Tertiary	24(24.7)	73(75.3)		
Marital Status				
Single	39(37.1)	66(62.9)		
Married	101(35.8)	181(64.2)	8.707	0.033*
Separated	12(25.0)	36(75.0)		
Divorced	10(66.7)	5(33.3)		

*Significant

4.9.2:Hypothesis 2: Association Between Respondents' Demographic Variables And Clients Level of Perception.

There is no association between socio-demographic variables (kind of educational qualification, age, sex and marital status) and clients' level of perception towards health service delivery.

Table 4.9 shows that the association between social demographic characteristics of respondents and their level of perception. There was no significant association between age group and clients level of perception . But higher proportion of the respondents within the age groups had good perception with ≤20 years old at 62.2%, 21-40 at 79.8%, 41-60 years old at 77.9% and 61-80years to those that had poor perception among the respondents.

There was no significant association between the sex of respondents and the level of perception. The proportion of female with good perception was 79.5% which was a little higher than the proportion of male respondents with good perception (75.2%).

There was a significant association between educational status and level of the respondents perception. In line to the finding, 88.7% of tertiary education who were the highest proportion had good perception.

There was a significant association between marital status and level of the respondents perception at. In line to the finding 87.5% of separated had the highest proportion more than the other groups.

In view of the fact that there was a significant relationship between respondents' educational qualification, marital status and level of perception, the null hypothesis was rejected. On the other hand, there was no significant relationship between respondents' age, sex and level of perception, therefore the null hypothesis failed to be rejected.

Table 4.8: Association of Demographic Data and Clients Level of Perception of Service Delivery at Emergency Department.

Socio-demographic characteristic	Level of Perception			
	Poor perception n(%)	Good perception n(%)	χ^2	p-value
Age				
≤20	14 (37.8)	23(62.2)		
21-40	39(20.2)	154(79.8)	5.555	0.135
41-60	34(22.1)	120(77.9)		
61-80	15(22.7)	51(77.3)		
Sex				
Male	56(24.8)	170(75.2)	1.155	0.282
Female	46(20.5)	178(79.5)		
Educational level				
None	18(24.7)	55(75.3)		
Primary	10(33.3)	20(66.7)	10.127	0.018*
Secondary	63(25.2)	187(74.8)		
Tertiary	11(11.3)	86(88.7)		
Marital Status				
Single	20(19.0)	85(81.0)		
Married	69(24.5)	213(75.5)		
Separated	6(12.5)	42(87.5)	9.066	0.028*
Divorced	7(46.7)	8(53.3)		

*Significant

4.9.3: Hypothesis 3: Association Between Level of Satisfaction and Factors Influencing Satisfaction of the Respondents.

There is no association between level of satisfaction and factors influencing respondents' satisfaction.

Table 4.10 below showed that reception offered by Doctors in Accident and Emergency was significantly associated with level of satisfaction (p-value=0.00) with 89.8% satisfied and 10.2% unsatisfied. Reception offered by nurses in Accident and Emergency unit was significantly associated with level of satisfaction (p-value= 0.000) with 78.9% satisfied and 21.1% unsatisfied. Reception offered by Pharmacists in Accident and emergency unit was significantly associated with level of satisfaction (p-value=0.00) with 72.9% satisfied and 27.1% unsatisfied. Reception offered by Laboratory scientist in Accident and emergency unit was significantly associated with level of satisfaction (p-value=0.00) with 68.7% satisfied and 31.3% unsatisfied. Reception offered by Radiology staff in Accident and emergency unit was significantly associated with level of satisfaction (p-value=0.00) with 64.7% satisfied and 35.3% unsatisfied.

Reception offered by ward maid in Accident and emergency unit was not significantly associated with level of satisfaction (p-value=0.850) with 49.6% satisfied and 50.4% unsatisfied. Also there was no significant association between level of satisfaction and the reception given by the cahiers (p=0.278).

The null hypothesis failed to be rejected since there was no significant relationship between reception offered by the ward maids, cashier and level of satisfaction. For the other characteristics that were significant (reception by doctors, nurses, pharmacists, lab scientist), the null hypothesis was rejected.

Table 4.9:. Association between Level of Satisfaction and Factors Influencing Satisfaction of the Respondents

Factors influencing Satisfaction	Level of Satisfaction			
	Satisfactory n(%)	Unsatisfactory n(%)	χ^2	p-value
Reception by doctors	404(89.8)	46(10.2)	289.29	0.000*
Reception by nurses	355 (78.9)	95(21.1)	154.74	0.000*
Reception by pharmacist	328(72.9)	122(27.1)	104.819	0.000*
Reception by lab. Scientist	309(68.7)	141(31.3)	64.51	0.00*
Reception by radiology	291(64.7)	159(35.3)	41.47	0.000*
Reception by ward maid	223(49.6)	227(50.4)	0.026	0.850
Reception by porters	306(68.0)	144(32.0)	64.47	0.000*
Reception by cashier	213(47.3)	237(52.7)	4.178	0.278
Reception by security	195(43.3)	255(56.7)	7.27	0.007*

*Significant

4.9.4: Hypothesis 4: Association Between Level of Satisfaction and Factors Responsible for Refusing Admission or Discharge Against Medical Advice

There is no association between level of satisfaction and factors responsible for discharge against medical advice or refusal of admission.

From table 4.11 below, there was no significant association between the level of satisfaction and factors responsible for refusing admission or discharge against medical advice such as the attitude of attending staff (p =0.069). Though 33.6 % were unsatisfied and 66.4% were satisfied.

There was significant association between the level of satisfaction and factors responsible for refusing admission or discharge against medical advice such as lack of money by the respondents (p=0.00), however 27.1% who agreed were unsatisfied and 72.9% were satisfied.

There was no significant association between the level of satisfaction and factors responsible for refusing admission or discharge against medical advice such as lack of privacy for the respondents (p =0.063). however 31.8 % who agreed were unsatisfied and 68.2% were satisfied.

There was no significant association between the level of satisfaction and factors responsible for refusing admission or discharge against medical advice such as treatment is not effective for the respondents (p =0.099). however 30.3% who agreed were unsatisfied and 69.7% were satisfied.

There was not significant association between the level of satisfaction and factors responsible for refusing admission or discharge against medical advice such as Hospital bed and wards are not conducive (p =0.264). however 31.8% whoagreed were unsatisfied and 68.2% were satisfied.

The null hypothesis failed to be rejected since there was no significant relationship between level of satisfaction and attitude of staff, lack of privacy, non effective treatment unconducive hospital beds and wards, and non-availability of prescribed medication. For the other characteristics that was significant (lack of money), the null hypothesis was rejected.

Table 4.10 Association Between Level of Satisfaction and Factors Responsible for Refusing Admission or Discharge Against Medical Advice.

Factor responsible for refusing Admission or DAMA	Unsatisfactory n(%)	Satisfactory n(%)	χ^2	p-value
Attitude of attending staff				
Yes	71 (33.6)	140(66.4)		
No	50(33.1)	101(66.9)	5.337	0.069
No idea	41(46.6)	47(53.4)		
Lack of money				
Yes	65(27.1)	175(72.9)		
No	76(46.9)	86(53.1)	17.908	0.00*
No idea	21(43.8)	27(56.3)		
Lack of privacy				
Yes	68(31.8)	146(68.2)		
No	58(36.5)	101(63.5)	5.538	0.063
No idea	36(46.8)	41(53.3)		
Treatment is not effective				
Yes	54(30.3)	124(69.7)		
No	80(41.0)	115(59.0)	4.620	0.099
No idea	28(36.4)	49(63.6)		
Hospital bed and wards are conducive				
Yes	62(31.8)	133(68.2)		
No	59(36.9)	90(60.4)	2.6647	0.264
No idea	41(38.9)	65(61.3)		
Non availability of prescribed drugs and other medical materials				
Yes	63(32.0)	134(68.0)		
No	51(37.2)	86(62.8)	2.928	0.231
No idea	48(41.4)	68(58.6)		

*Significant

4.9.5: Hypothesis 5: Association Between Level of Perception and Factors Responsible for Refusing Admission or Discharge Against Medical Advice.

There is no association between level of perception and factors responsible for refusal of admission or discharge against medical advice.

Table 4.12 below showed that there was significant association between the level of perception and factors responsible for refusing admission or discharge against medical advice such as the attitude of attending staff (p =0.00). though 20.6 % and 76.6% who agreed had poor perception and good perceptions respectively.

There was significant association between the level of perception and factors responsible for refusing admission or discharge against medical advice such as lack of money by the respondents (p-value =0.00), however 14.2% and 85.8% who agreed had poor perception and good perceptions respectively.

There was significant association between the level of perception and factors responsible for refusing admission or discharge against medical advice such as lack of privacy for the respondents (p =0.00), however 14.2% and 85.8% who agreed had poor perception and good perception respecively. There was significant association between the level of perception and factors responsible for refusing admission or discharge against medical advice such as treatment is not effective for the respondents (p =0.005), however 18.0% and 82.0% who agreed had poor perception and good perception respectively.

There was no significant association between the level of perception and Hospital bed and wards not being conducive (p =0.126), however 19.0% and 81.0% who agreed had poor perception and good perception respectively.

The null hypothesis failed to be rejected since there was no significant relationship between level of perception and non conducive hospital beds and wards. For the other characteristics that was significant (attitude of staffs, lack of money, lack of privacy, ineffective treatment), the null hypothesis was rejected.

Table 4.11: Association Between Measure of Perception and factors Responsible for Refusing Admission or Discharge Against Medical Advice.

Factor responsible for refusing Admission or DAMA	Poor Perception n(%)	Good Perception n(%)	χ^2	p-value
Attitude of attending staff				
Yes	43 (20.6)	168(76.6)		
No	20(13.2)	131(86.8)	31.811	0.000*
No idea	39(43.3)	46(55.7)		
Lack of money				
Yes	31(14.2)	206(85.8)		
No	43(26.5)	119(73.5)	34.977	0.000*
No idea	25(52.1)	23(47.9)		
Lack of privacy				
Yes	30(14.0)	181(86.0)		
No	34(21.4)	125(78.6)	31.811	0.00*
No idea	38(49.4)	39(50.6)		
Treatment is not effective				
Yes	32(18.0)	146(82.0)		
No	42(21.5)	131(78.5)	31.811	0.005*
No idea	28(36.4)	49(63.6)		
Hospital bed and wards are conducive				
Yes	37(19.0)	158(81.0)		
No	34(22.8)	115(77.2)	2.911	0.126
No idea	31(29.2)	75(70.8)		
Non availability of prescribed drugs and other medical materials				
Yes	37(18.8)	160(81.2)	29.811	0.002*
No	25(18.2)	112(81.8)		
No idea	40(34.5)	76(65.5)		

*Significant

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This chapter is organized into the following sections: socio-demographic characteristics, satisfaction with interaction with health service providers, factors influencing discharge against medical advice or refusal of admission, improving health service delivery. The chapter ends with conclusion and recommendation.

5.1 Socio-demographic characteristics of respondents

The mean age of respondents in the study was 57.9±9.8. There were a slightly higher number of male respondents (50.2%) than the females (49.8%) and this could be attributed to the fact that the emergency department receives all forms of emergency cases involving both male & females in all aspects of medicine.

The study also revealed that respondents with a tertiary level of education that present at the emergency wards were fewer (10.7%) than respondents with either primary (23.3%) or secondary (62.7%) levels of education. A reason that could be given for this is that people with a higher level of education tend to have a good health seeking behaviour which makes them to take responsibility for their health in preventing diseases or accidents and also seeking medical care on time.

The study also revealed that respondents in the older age groups were more satisfied with service delivery than respondents in the younger age group and this finding was similar to a study conducted by Sara and Emre, 2009. Also, Faxelid, Ahlber, Maimbolwa, 1997, in a study on examining patients' perception of care, it was revealed that older patients tended to be more satisfied than younger patients. In a related study on patient satisfaction with primary health care services in the United Arab Emirates age was statistically significant for the domains of comprehensiveness. Older people felt that the clinic service was more comprehensive than younger people (Margolis, Almarzougi, 2003).

Respondents with tertiary level of education were found to have a lower level of satisfaction compared to other respondents with lower level of education and this result was similar to a study by Blumenthal, (1996) which showed that people with higher levels of education felt that the clinic service was less effective than those who were less educated. This

could be due to the fact that the more educated a client is, the more the expectations they would expect in contrary to the less educated who may not have an idea about their rights and standard of care at a tertiary hospital like the University College Hospital.

The majority of the respondents were Yoruba's (47.8%) and this could be attributed to the fact that the study was carried out in the South West region of the Country that is inhabited majorly by various Yoruba ethnic groups.

5.2 Level of satisfaction at the A&E

The amount of time a patient waits to be seen, is one factor which affects the utilization of health care services (Fernandes et al., 1994; dos Santos et al., 1994) and this study shows that 53.3% of respondents were satisfied with the period of time they had to wait before being attended to by the examining doctor and this would infer that patients do not have to wait too long before an health care provider attends to them. The waiting time of clients in the hospital is an important factor that determines if there would be dissatisfaction or not and previous studies have shown that a short waiting time is crucial to clients satisfaction. The study however shows that 35.9% of respondents were not satisfied with the period of time they had to wait before being attended to by the examining doctor and this could be due to the imbalance in the doctor – patient ratio. The commonest reason adduced by our respondents for the long waiting time was, few doctors to attend to the large number of patients on the queue. This is a common finding in most health care centres' across Nigeria due to the shortage of medical doctors and other health care providers. patients perceive long waiting times as barriers to actually obtaining services (Kurata, Nogawa, philips, Hoffman, Werblum, 1992) and excessive patient waiting undermines the quality of care and leads to patient dissatisfaction. and this may result in loss of patronage in a competitive healthcare delivery system, and a hospital that cannot offer quick service might lose customers because patients will have a wider choice of healthcare providers (Anderson, Camacho, Balkrishnan, 2007).

The study revealed that 56.0% of respondents were satisfied with the explanations the care providers gave about their ailments and clients show a high level of satisfaction to service delivery when they are listened to attentively by health care givers who in turn carefully explains their conditions to them. This was similar to the finding in Central Ethiopia where 576 (75.0%) of the respondents were of the opinion that health care providers told them enough about how to manage their diseases (Birhanu, Assefa, Woldie and Morankar, 2010). However in another survey of patient satisfaction with obstetric ultrasound service in a Nigerian teaching hospital

results showed that majority of patients (66%) were not given adequate information required to make a knowledgeable decision about their scan (Eze and Okaro. 2006).

Also the study showed that 63.3% of the respondents were satisfied with the instructions given to them about follow-up care and this was similar to a study by Sambo and Lewis. (2010) in which it was found that 62% of respondents were informed about the next appointment date. Providing patients with adequate information about their next appointment or follow-up helps in preventing patients being lost to follow-up and also provides an avenue to assess the outcome of the care a patient is been given.

The study also revealed that health care providers provide adequate information on how to use medication as shown by 62.2% of respondents who were satisfied with the information provided and this was similar to the study carried out by Sambo *et al.* (2010) in North Central Nigeria, in which majority (83%) of the respondents were informed on how to take their drugs. This finding however differs from a study on the rationality of drug prescriptions done in Burkina Faso which revealed that about one-third of health workers did not give adequate information to patients on how long the drugs prescribed to them had to be taken (Doubova, Perez-Cuevas and Zepeda-Arias, 2009). Providing adequate information about how a Patient should use his or her medications goes a long way in ensuring compliance with the medication and also preventing drug abuse amongst patients.

The study revealed that 64.7% of respondents were satisfied with being included in making a decision about treatment options available for their ailment and not been compelled to just agree with whatever treatment options provided by the doctors and seeking patients' opinion while providing treatment improves their responses to respective treatment (Ahmed, Amir and Ilaan, 2004).

This study however also shows that 32.0%, 32.7% and 27.1% of the respondents were not satisfied with the services provided by the staffs at the registration point, security staffs and the porters who transfer patients respectively. This could be explained by the fact that patients and their relatives sometime spend long periods on the queue before they could be registered and seen by the doctor. Also some patients and their relative may not appreciate the way the security personnel at the entrance to the Accident & Emergency order them about parking their vehicles and also the lack of assistance in moving a patient from the vehicle into the emergency room. Some patients also feel dissatisfied with the way the porters move the trolleys used to move them

inside the emergency room and also the dilapidated states of some of the trolleys used in moving patients.

5.3 Factors influencing Discharge against medical advice or refusal of admission

Discharge against medical advice can be defined as a situation in which a patient chooses to leave the hospital before the managing physician recommends discharge (Onyiriuka, 2007). Several factors have been implicated as causes or contributing to DAMA, some of which are financial constraints, lack of health insurance, deteriorating clinical condition of patient, problematic doctor-patient relationship and substance abuse (Berger, 2008 and Aliyu, 2002).

The study revealed that majority (53.3%) of respondents believe that one of the factors responsible for DAMA or refusal of admission was the high cost of receiving care at the Accident & Emergency and the prevailing harsh economic environment in Nigeria, and the infantile age of the National Health Insurance Scheme, with its expected impact on individuals' healthcare financing largely being awaited, partly explains this (Federal Republic of Nigeria: National Health Insurance Scheme (NHIS) 1999 and Aricde, 2003).

About 39.6% of the respondents also fill that not receiving treatment to their own satisfaction is another reason given for the refusal of admission or DAMA and this could be explained by the fact that patients tend to become uncomfortable with the treatment being received when they are also being used as subjects of training by their caregivers to other health workers.

Also, poor response to treatment, as judged by the patient or their relations, often leads to DAMA. This is often due to ineffective communication between the attending physician and the patient with regards to the natural history of disease, its prognosis, potential complications, and outcomes of available treatment options (Devitt, Devitt and Dewan, 2000).

Also, 46.9% of respondents fill that the DAMA or refusal of admission was as a result of the attitude of staffs. This could be explained from the perspective that health seekers will always want 100% attention from health care givers when they present at the hospital and anything short of that will be dissatisfaction on the part of the patients. This may be because of the large number of patients on admission or new patients with more serious ailments such that a doctor on duty at that time may not be disposed at the moment a patient needs his attention because he is attending to another patient. This was also in line with a study carried out in

Calabar, Nigeria. Etuk et al found out that poor attitude of health staff was a major area of dissatisfaction that patients have (Oyo-ilo and Etuk, 2007).

Dissatisfaction with the hospital environment has been variously attributed to patients' emotional dispositions, psychosocial factors like anger and fear (Anis AH, Sun, Guh, Palepu and Schechter, 2002) and this was reflected in the study, in which 43.3% of the respondents point to unconducive hospital wards and beds and 47.6% pointing to the lack of provision of adequate privacy as the reason for refusal of admission or DAMA.

The study also revealed that due to the unavailability of some prescribed drugs and other medical materials within the hospital premises, about 43.8% of respondents will refuse admission or DAMA and this could be explained by the fact that patients always appreciate procuring all the drugs and other materials needed for their care at the hospital where they have presented for health care and dissatisfaction will arise when they are been told to go to other pharmacists outside the hospital to procure medications because it adds an additional burden on them.

5.4 Improving health service delivery

The overall evaluation of the level of satisfaction and dissatisfaction is an important tool in assessing areas that needs improvement and many previous studies have developed and applied patient satisfaction as a quality improvement tool for health care providers. Thus, patient satisfaction is an important issue both for evaluation and improvement of healthcare services Al-Eisa, Al-Mutar, Radwan, Al-Terki, 2005 .This study highlights a number of areas where respondents perceived as needing improvement.

Majority of respondents (73.3%) identified the hospital trolleys in used in moving patients as one of the areas that needs improvement and this was not surprising as many of the trolleys used are in dilapidated states, with patients at times placed on these trolleys which are made of metals without any foam or coverings which further causes more discomfort to the patients. Also, majority of patients spend a long period of time at the emergency wards before they are transferred to specific wards and having to stay for several hours or even days on these metal trolleys adds to the dissatisfaction towards the level of care being received.

Another 71.1% of the respondents however identified the cleanliness of the wards as an area that also needs improvement because the hospital wards are expected to be clean and free of contaminants. This is similar to what was reported in Calabar, Nigeria (Oyo-Ita et al., 2007)

where dissatisfaction with care was mostly attributed to poor sanitation. Different studies in Abia (Iloh, Ofoedu, Njoku, (2012).) and Kano (Iliyas, Abubakar, Abubakar, (2010).) states of Nigeria however reported patients' satisfaction with the sanitation and cleanliness of the hospital.

Patients' satisfaction with nursing care has been reported as the most important predictor of the overall satisfaction with hospital care and an important goal of any health care organization (Mrayyan, 2006). Therefore, dissatisfaction with the nursing care services may further lead to lower utilization of the nursing care services by the patients (Yunus, Nasir, Nor Afiah, Sherin & Faizah, (2001)). It is a known fact that nurses spend more time with the hospital patients than the attending physician and therefore has a significant impact upon patient's perception about their hospital experience (Crow et al, 2003), this study however shows that 62.7% of respondents want an improvement in the attitude of the nurses and the explanation that could be given for this could be the burden which the nurses face in attending to a large number of patients at the emergency room compared to the fewer number of nurses.

The area of communication is also a vital aspect in health care delivery and the "clinician must communicate with the patient or a proxy (e.g., a family member) to learn about the patient's problems, needs, and concerns and to convey information and offer recommendations about care" (Homberger et al, 1996). This study shows that communication between staffs of the emergency ward and patients' needs improvement as indicated by 67.6% of the respondent and this would imply that healthcare providers will have to pay more attention to the area of interpersonal relationship with patients.

5.5 Implications for Health Promotion and Education

The following are the findings from the study that have several health education implications:

1) There is a knowledge deficit among health workers at the Accident and Emergency in the provision of quality health care.

2) There is still a communication gap between health workers in the Accident and Emergency which plays a part on how patients are satisfied with service delivery.

3) The major reason for discharge against medical advice among clients was the high cost of receiving health care in the Accident and Emergency.

There is no gainsaying that the findings from this study have health promotion and education implications and imply the need for multiple interventions directed at tackling the phenomenon. Thus, health education and promotion principles, strategies and methods can be employed in addressing these problems in the following ways:

Health education interventions such as training/workshops for health workers in the Accident and Emergency on how to provide quality health care services needs to be implemented and carried out on regular basis for both new and older health workers at the Accident and Emergency. Secondly, there should be regular seminars and conferences conducted for the health care givers working in the Accident and Emergency to train them on how to further empower their patients on good health seeking behaviours and not just providing emergency care.

The importance of good communication between health workers and clients cannot be undermined. Therefore, sessions should be provided on communication and communication skills which would go a long way in improving how the Accident and Emergency staffs interact with clients and also in providing quality health delivery to clients. In addition, there should be posters available around the Emergency complex that will help patients understand the structure of the complex in order to make it easier to find their way around the complex.

Also the effective use of communication and technology by health care and public health professionals can bring about an age of patient- and public-centered health information and services. By strategically combining health IT tools and effective health communication processes, there is the potential to:

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- Improve health care quality and safety.
- Increase the efficiency of health care and public health service delivery.
- Improve the public health information infrastructure.
- Support care in the community and at home.
- Facilitate clinical and consumer decision-making.
- Build health skills and knowledge.

There is also a need for a review on the policy guarding the running of the Accident and Emergency in terms of the provision of services during emergencies in which clients will have to pay first before care is giving with many deciding to take their patients away due to the high cost of care. Therefore, the UCH authorities must employ the use of the National Health Insurance Scheme. The health insurance scheme holds the promise of ensuring a guaranteed pool of funds for health, improving the efficiency of management of health resources and protecting people against catastrophic expenditure for health

5.6 Conclusion

The research explored the perception of respondents towards health care delivery and how satisfied respondents were with service delivery at the Accident and Emergency Department of the University College Hospital. Overall the study showed a moderate level of satisfaction of patients with services obtained from the Accident and Emergency. However, a number of potential barriers and facilitators that may influence patient satisfaction were discovered such as the poor states of the hospital trolleys, the lack of adequate cleanliness of the wards, the lack of adequate privacy, unfriendly attitude of nurses towards patients request, non-availability of prescribed medications and the high cost of receiving health care.

These negative factors can affect future patients and adversely affect the image of the hospital and these factors were also responsible for the poor perception respondents had about service delivery at the A&E. The fact that some patients expressed dissatisfaction with the services indicates that health care providers need to do more in the drive towards improving service windows in order to improve efficiency, minimize patient waiting times and provide for patient comfort. Periodic patient satisfaction survey should be institutionalized to provide feedback for continuous quality improvement.

Therefore improvement on areas where services are deficient must be made so as to ensure the delivery of quality health services which will go a long way in increasing clients' satisfaction and also changing the negative perception of clients towards the A&E of UCH.

5.7 Recommendations

1. The hospital management needs to organise orientation programmes for the hospital staff to ensure a more friendly and effective services.

2. Attention must be paid to the amenities in the health facilities, as these affect the patients' satisfaction and this includes strengthening and strictly enforcing regular washing of the toilets and bathrooms, linens, bed sheets in the wards and cleaning of the wards.

3 The hospital management through the SERVICOM department should develop a quality of health care assessment tool and carry out periodic evaluation of the level of satisfaction of clients, with services provided at various departments of the hospital.

4. There should also be adequate number of Doctors, Nurses and other health staffs in order to cope with the large number of clients who visit the A&E.

5. There should be availability of sign boards and postings which would direct people to the complex easily and the security personnel's at the hospital gates should also be trained in assisting people in locating the complex or any other department they seek within the hospital.

6. There should be adequate and regular funding of the hospital by the Government in order to reduce the cost of health service delivery and also there should be more public-private partnership in the running of some of the services at the Accident and Emergency department.

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APPENDIX I

Questionnaire

PERCEPTION AND SATISFACTION OF CLIENTS TOWARDS HEALTH SERVICE DELIVERY IN THE ACCIDENT AND EMERGENCY DEPARTMENT OF UNIVERSITY COLLEGE HOSPITAL IBADAN, OYO STATE

Dear respondents,

I am a Post Graduate Student in Public Health, University of Ibadan and I am conducting a research on the above topic in partial fulfilment of the requirements for an MPH in Health Promotion and Education. Please kindly complete this research instrument as truthfully as possible as your participation will be very helpful in obtaining accurate information

All information will be treated with utmost confidentiality and will not be disclosed or released for any other purposes without your prior consent, except as required by law.

Section A. Socio-demographic data

1. Category: Circle one please- 1. Patient 2. Relative
2. How old are you now?

(Write out the number of years).....

3. Sex: 1. Male 2. Female
4. What is your Ethnic group?

1.Yoruba 2.Ibo 3.Hausa 4.Others please specify

5. What is your religion?

1.Christianity 2.Islam 3.Others please specify

6. What is your level of education?

1.Primary 2.Secondary 3.Tertiary 4.None

7. What is your marital status?

1.Single 2.Married 3.Separated 4.Divorced

8. What is your occupation?

Please specify .....

Section B: Patients perception of quality of carent the Accident & Emergency (A&E)

SN	Statement	Agree	Disagree	Undecided
8	The Accident & Emergency Department is a complex area			
9	The Accident & Emergency Department is easily located during emergencies			
10	The Accident & Emergency environment is comfortable			
11	The Accident & Emergency Doctors listen to your complaints adequately			
12	The Accident & Emergency Nurses listen to your complaints adequately			
13	The Accident & Emergency Nurses always polite to you			
14	The Accident & Emergency Pharma has all the prescribed medications			
15	The Accident & Emergency provide adequate privacy during examinatio of patients			
16	The Accident & Emergency provide adequate support to patients care			

Section C. Level of satisfaction

Rate the following services or practices satisfactory, not satisfactory or not sure

17. Courtesy of staff in the registration area

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

18. Comfort and pleasantness of the waiting area

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

19. Comfort and pleasantness during examination

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

20. Courtesy of security staff

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

21. Courtesy of staff who transfer the patients

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

22. Length of waiting before going to an examination room

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

23. Friendliness/courtesy of the care provider

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

24. Explanations the care provider gave about you or your relatives condition

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

25. Concern the care provider showed for your questions or worries

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

26. Care provider's efforts to include you in decisions about treatment options

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

27. Information the care provider gave you or your relative about medications

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

28. Instructions the care provider gave you or your relative about follow up care

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

29. Degree to which care provider talked with you using words you could understand

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

30. Amount of time the care provider spent with you or your relative

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

31. Frequency of visit by physicians

Satisfactory.....1 Not satisfactory.....2 Not sure.....3

Section D. Factors influencing satisfaction

32. How can you describe the reception offered by the Accident & Emergency staff

	Very Good	Good	Average	Fair	Poor	
Doctors						
Nurses						
Pharmacist						
Laboratory Scientists						
Radiology Staff						
Ward maid						
Porters						
Cashiers						
Security m						

Section E. Factors responsible for refusing admission or DAMA

33. Which of the following do you think is responsible for people refusing admission or discharging against medical advice?

	Yes	No	No idea	
Attitude of attending staff				
Lack of money				
Lack of privacy				
Services are expensive				
Treatment is not effective				
Hospital beds & wards are not conducive				
Non-availability of prescribed drugs/ other medical materials				

Section F. Improvement of service delivery

Tick yes or no against the areas in the Accident & Emergency you think needs improvement

34. The hospital trolleys for moving patients 1. Yes 2. No

35. Communication between staff and patient 1. Yes 2. No

36. Cleanliness of the wards 1. Yes 2. No

37. Response time of Doctors and Nurses 1. Yes 2. No

38. Privacy of patients 1. Yes 2. No

39. Courtesy and respect of staff 1. Yes 2. No

40. Availability of prescribed drugs 1. Yes 2. No

41. The overall quality of care 1. Yes 2. No

42. Nurses attitude towards your requests 1. Yes 2. No

43. Amount of attention paid to your personal and special needs 1. Yes 2.No

IWOYE ATI ITELORUN OLUGBATOJU NIPA ETO ILERA NI EKA TO N SE AMOJUTO IJANBA ATI PAJAWIRI NI ILE IWOSAN ORITA MEFA

(UNIVERSITY COLLEGE HOSPITAL IBADAN, OYO STATE)

Olukopa Owon,

Emi ni akeko onimo ijinle ti ilera gbogbogbo (Public Health) ti ile eko giga university Ibadan.

Mo n se ise iwadi lori akori "iwoye ati itelorun olugbatoju nipa eto ilera ni eka to n se amojuto ijanba ati pajawiri ni ile iwosan orita mefa" ni apakan ninu amuye lati gba oye Imo ijinle (MPH in Promotion Health and Education) E jowo e fi tokantokan dahun awon ibeere yii pelu otito

IPIN KINNI:

1. Isori: Jowo fala si okan 1. Alaisan 2. Molebi
2. Omo odun melo ni yin (e ko iye odun yin) .....
3. Okunrin ni yin tabi obinrin: 1. Okunrin 2. Obinrin
4a. Eya wo ni yin?
   1. Yoruba 2. Ibo 3. Hausa 4. Omiran, jowo salaye .....
4b. Elesin wo ni yin?
   1. Onigbagbo 2. Musulumi 3. Omiran, jowo salaye .....
5. Iwe melo ni e ka?
   1. Alakobere 2. Girama 3. Ile eko giga 4. Mi o ko rara
6. Kini Ipo Igbeyawo yin lowo?
   1. Apon 2. Loko-laya 3. Ngbe lotooto 4. Ikosile
7. Iru ise wo ni e n se?
   E jowo e salaye .....

IPIN KEJI: IWOYE AWON ALAISAN LORI IKU-OJU-OSUNWO ITOJU

S/N	Gbolohun	Mo fara mo	Mi o fara mo	Mo o le so

8	Eka A & E je ibi ti o le [redacted]			
9.	A le tete ri eka A&E ni igba pajawiri			
10.	Nje ayika A&E te yin lorun			
11.	Awon dokita A&E maa n feti sil[illegible] esun tabi farabale lati gbo alaye [illegible] daradara			
12.	Awon nooosi A&E maa n feti si [illegible] tabi farabale lati gbo alaye yin daradara			
14.	Eka apogun A&E ni gbogbo oog[illegible] ti won ko fun yin			
15.	Eka A&E ni ibi ti o pamo ti o [illegible] igba ayewo fun awon alaisan			
16.	Eka A&E maa n se atileyin ti o [illegible] fun itoju awon alaisan			

IPIN KETA: IPELE ITELORUN

Gbo awon ise tabi ise wonyi le ori esunwon. O te mi lorun, Ko te mi lorun, Ko daju

17. Oyaya awon osise ni ibi iforukosile
O te mi lorun.....1 Ko te mi lorun.....2 Ko daju.....3

18. Iura all idenun ibi iduro
O te mi lorun.....1 Ko te mi lorun.....2 Ko daju.....3

19. Iura all idenun ni igba ayewo
O te mi lorun.....1 Ko te mi lorun.....2 Ko daju.....3

20. Oyaya awon osise elelo abo
O te mi lorun.....1 Ko te mi lorun.....2 Ko daju.....3

21. Oyaya awon osise to n gbe awon alaisan lo ibomiran

O te mi lorun.....1 Ko te mi lorun..... 2 ko daju.....3

22. Ibe akoko iduro ki a to lo si yara ayewo

O te mi lorun.....1 Ko te mi lorun..... 2 ko daju.....3

23. Oyaya ati Ikonimora nwon to n olutoju

O te mi lorun.....1 Ko te mi lorun..... 2 ko daju.....3

24. Alaye ti olutoju se nipa ipo re tabi ti molebi re

O te mi lorun.....1 Ko te mi lorun..... 2 ko daju.....3

25. Bi olutoju se fi iye si awon ibere re si tabi si awon ohun to n ba o lero

O te mi lorun.....1 Ko te mi lorun..... 2 ko daju.....3

26. Akitiyan awon olutoju lati fi o sinu ipinu won nipa Ilana itoju

O te mi lorun.....1 Ko te mi lorun..... 2 ko daju.....3

27. Awon alaye tabi oro ti olutoju ba o so tabi molebi re so nipa oogun Ilo

O te mi lorun.....1 Ko te mi lorun..... 2 ko daju.....3

28. Awon alaye ti olutoju se lori o tabi molebi re nipa_wiwa Iun iyewo dede

O te mi lorun.....1 Ko te mi lorun..... 2 ko daju.....3

29. Bi olutoju se ba o soro si. to n lo awon oro ti o ye o

O te mi lorun.....1 Ko te mi lorun..... 2 ko daju.....3

30. Iye akoko ti olutoju lo pelu re tabi molebi re

O te mi lorun.....1 Ko te mi lorun..... 2 ko daju.....3

31. Bi awon dokita se n ba o mi si

O te mi lorun.....1 Ko te mi lorun.....2 ko dju.....3

IPIN KERIN: AWON OHUN TO N SE OKUPA ITELORUN

12. Bawo lo se le se apejuwe bi awon osise A & B se gba owole

	O dara pupo	O dara	Iwotunwonsi	Ko buru	Ko dara	
Owita						
Nawi						
Olopongun						
Deinerijimle asayewo						
Awon osise to n awonan ara						
Awon olumulowo No						
Awon olasana						
Alowe owo						
Alaabo						

IPIN KARUN: Awon nkan ti a fa kiko lati maa je ki won dawon duro si ile iwosan tabi ki won pinnu lati maa lo bi o tile je pe awon olutoju so pe ki won maa se be

13). Kinni o ro pe o fa ninu awon nkan wonyi ti awon eniyan fi maa n ko lati maa je ki won dawon duro si ile iwosan tabi ki won pinnu lati maa lo bi o tile je pe awon oluwosan so pe ki won maa se be

	Ikeni	Ikeko	Ni o mo	
Iwa awon osise to n da won lohun				
Aini owo				
Aini ibi ti o pamo				
Ireju won pupo				
Ireju ko mu [illegible] (poyi)				
Iberu ile iwosan ati awon yara ko dara				
Ko si [illegible] ongbon ti won ko ati awon ol				

elo ise isegun miran				

PIN KEFA:

Fun si Beeni tabi Beeko ni awon aye ti o ro pe o ye ki A&E se atunse si

34.	Keke ile iwosan ti won maa n fi n gbe alaisan	1.Beeni	2. Beeko
35.	Ibara eni soro laarin Awon osise ati alaisan	1.Beeni	2. Beeko
36.	Imototo inu yara (woodu)	1.Beeni	2. Beeko
37.	Akoko ti awon dokita ati noosi fi n dahun	1.Beeni	2. Beeko
38.	Bi won se fun alaisan ni ibi ipamo si	1.Beeni	2. Beeko
39.	Oyaya ati bi awo osise se n bowo fun awon eyan	1 Beeni	2. Beeko
40.	Bi awon oogun ti won ko se wa si	1.Beeni	2. Beeko
41.	Bi gbogbo itoju se munadoko (peye) si	1.Beeni	2. Beeko
42.	Iwa awon Noosi si awon ebe re	1 Beeni	2. Beeko
43.	Bi won se fi lye si awon ohun to se pataki ti o nilo	1.Beeni	2. Beeko

INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IAMRAT)

COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN. IBADAN, NIGERIA.

Director: Prof. A. Ogunniyi, B.Sc(Hons), MBChB, FMCP, FWACP, FRCP (Edin), FRCP (Lond)

Tel: 08023038583, 08038094173

E-mail: aogunniyi@comui.edu.ng

UI/UCH EC Registration Number: NIUREC/05/01/2008a

NOTICE OF EXPEDITED REVIEW AND APPROVAL

Re: Clients Perception and Satisfaction with Health Services Delivery in the Accident and Emergency Department of the University College Hospital, Ibadan, Oyo State

UI/UCH Ethics Committee assigned number: UI/EC/12/0163

Name of Principal Investigator:	Ayokunle O. Ayeni
Address of Principal Investigator:	Department of Health Promotion & Education, College of Medicine, University of Ibadan, Ibadan

Date of receipt of valid application: 15/06/2012

Date of meeting when final determination on ethical approval was made: N/A

This is to inform you that the research described in the submitted protocol and other participant information materials have been reviewed and *given expedited approval by the UI/UCH Ethics Committee.*

This approval dates from 20/12/2012 to 19/12/2013. If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the UI/UCH EC assigned number and duration of UI/UCH EC approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. No changes are permitted in the research without prior approval by the UI/UCH EC except in circumstances outlined in the Code. The UI/UCH EC reserves the right to conduct compliance visit to your research site without previous notification.

UCH EC
20 DEC 2012
APPROVED
COLLEGE OF MEDICINE, U.I.

Professor A. Ogunniyi
Director, IAMRAT
Chairman, UI/UCH Ethics Committee
E-mail: uiuchirc@yahoo.com

APPENDIX 3

Informed Consent form for patients/relatives

IRB Research approval number:

This approval will elapse on:

Title of the research: PERCEPTION AND SATISFACTION OF CLIENTS TOWARDS HEALTH SERVICE DELIVERY IN THE ACCIDENT AND EMERGENCY DEPARTMENT OF UNIVERSITY COLLEGE HOSPITAL IBADAN, OYO STATE

This study is being conducted by a student of the Health Promotion and Education Department, College of Medicine University of Ibadan, Oyo State, Nigeria The purpose of this study is to find out the perception of clients and their level of satisfaction towards health service delivery at the Accident and Emergency Department of the University College Hospital.

I will be recruiting 450 Participants into the study which will include clients who have been discharged but are still present in the A&E, those that are about to be discharged and those that have been transferred to other wards from the A&E. The selected participants must have been admitted at the A&E for 24hours or more to meet the inclusion criteria for the study. Semi-structured questionnaires will be given to clients who are willing to participate in the study. There are no physical risks associated with participation in this study. Your participation in this research is absolutely voluntary and will not cost you anything. There are no direct and immediate benefits for participation in this study but your responses will help in determining ways by which health service delivery can be improved at the A&E Department.

All information collected cannot be linked to you in any way as your name will not be collected. As part of my responsibility only the researcher, members of the researcher's staff and representatives from the Universities of Ibadan and/or UCH Ethical Committees may have access to study records. They are required to keep your identity confidential.

Statement of person giving consent:
Now that the study has been well explained to me and I fully understand the content of the study process. I hereby agree to allow my child/ward to be part of the study.

DATE: _____ SIGNATURE: _____

NAME: _____

Detailed contact information

This research has been approved by the Ethics Committee of the University of Ibadan and the Chairman of this committee can be contacted at Biode Building, Room 110, 2nd Floor, Institute for Advanced Medical Research and Training, College of Medicine, University of Ibadan, Telephone: 08033397793. Email: ctuchier@yahoo.com. In addition if you have any questions about your participation in this research, you can contact the principal investigator. You can also contact the Supervisor of this project or the Faculty of Public Health, University College Hospital, Ibadan.

IWE IFOWOSO ALAISAN / MOLEBI

Nomba ifowosi ti ise iwadi IRB

Ifowosi yi yoo dopin ni:

AKORI ISE IWADI: IWOYE ATI ITELORUN OLUGBATOJU NIPA ETO ILERA NI EKA TO N SE AMOJUTO IJANBA ATI PAJAWIRI NI ILE IWOSAN ORITA MEFA

Ise iwadi yii ni ti okeko ti eka Health Promotion and Education ni ile eko giga imo isegun University Ibadan, Ipinle Oyo, Nigeria. Erongba ise iwadi yii ni lati se awari iwoye ati gbedeke itelorun awon olugbatoju lori itoju ti n won gba ni eka ijamba ati pajawiri (Accident and emergency) ni ile ikose isegun orita Mefa (UCH).

Mo ma gba awon akopa ti o to 450 si ise iwadi yii. nimu eyi ti o je pe awon olugbatoju ti won ti da sile sugbon ti won si wa ni A & E, awon ti won sese fe dasile ati awon ti won ti gbe lo si wodu(yara) miran lati eka A & E. Awon olukopa gbodo je awon to won ti gba wole ni eka A & E fun wakati merinlelogun tabi ju be lo lati je ki won kun oju osuwon lati kopa. Iwe ibere ti a ti seto ni a maa n fun olukopa ti o ba nife lati kopa ninu iwadi yii. ko si ewu Kankan to wa ninu kikopa ninu ise iwadi yii. Kikopa yin ninu ise iwadi yii gbodo je lalokanwa. ko si ni naa yin ni ohun Kankan. Ko si ere tabi anfani oju ese ti e o ri gba nitu kikopa ninu ise iwadi sugbon awon idahun yin yoo se iranlowo lori bi a se le se ipinnu lati se amugboro bi a se le maa se itoju awon alaisan ni eka A & E. Gbogbo awon alaye ti e ba se fun wa ni a ko ni le fi da yin mo tabi se awari yin nitoripe a ko ni gba oruko yin sile.

Gege bi ojuse mi: on ise iwadi nikan, awon osise ati awon asoju ile eko giga ti University Ibadan tabi awon igbimo to n se akose iru ise bee ni ogba UCH le ni anfani si akosile ise yii. Won ko gbodo fi ohun idanimo yin han enikankan.

Ore Ifowosi Lati Enu Olukopa

Iyi bayi ti won ti salaye ise iwadi yi fun mi. Ti mo si ti ni oye gbogbo ohun ti o wa ninu ise iwadi naa mo gba lati kopa ninu ise iwadi yii

Date: ..... Sign:

.....

Oruko:

.....

Ise iwadi yii ni awon igbimo to n se akoso ise iwadi ni University Ibadan ti fi owo si. E si le kan si alaga igbimo yii ni Biode Building Room T10, 2nd floor, Institute of Advance Medical /Research and Training, College of Medicine, University of Ibadan. Tel 08032397993 E-mail: uiuchire@yahoo.com.Ni afikun, tie ba ni ibere Kankan lori kikopa ninu ise iwadi yii, e le kan si eni tin se iwadi na. Bakanna e le kan si oludari/alamojuto ise iwadi yii labi Faculty of Public Health, University College Hospital,Ibadan