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A Study Of Patient Satisfaction In Ipd At A Tertiary Care Hospital In India

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I. ABSTRACT

During a patient's stay in the hospital, patient comes in contact with the various clinical and non-clinical services offered by the Hospital. So, the problems like delayed services, incompetent staff, inadequate communication, physical environment, etc play a major role in influencing the patient's experience at the Hospital. Since, patient-centred care is a fundamental tenet of Quality Healthcare, it is the need of the hour to deliver services which respond to and are sensitive to the needs and wishes of the patients (consumers). Hence, measurement of quality of care as per the patients' perspective and service redesign in accordance with it, would help the Organisation (Hospital) to achieve its goal i.e. to provide highest quality of patient care.

The objective of this study is to measure the patient satisfaction in the In-Patient Department and to provide measures towards improving it. The study was conducted to identify issues faced by patients at the root level and provide solutions.

Keywords – Patient Satisfaction, Quality Healthcare, IPD, Tertiary Hospital India, Expectations

II. PATIENT SATISFACTION & LITERATURE

Many studies have been conducted on the customer satisfaction. An attempt has been made to present in brief, a review of literature on customer satisfaction in general as well as on the customer satisfaction from hospital services.

Health services have always been an essential human requirement because all the human beings need them for curative, preventive and rehabilitative purpose. It is good quality health service than can confer healing, and only the attainment of quality service for health can physically and psychologically satisfy the patient. Patient satisfaction is persons' feeling of pleasure or disappointment resulting for comparing a service's perceived performance or outcome in relation to his/her expectations.

2.1 Theories of Patient Satisfaction in Healthcare

The major patient satisfaction theories were published in the 1980s with more recent theories being largely "restatements" of those theories (Hawthorne, 2006). Five key theories can be identified:

1) Discrepancy and transgression theories of Fox and Storms (1981) advocated that as patients' healthcare orientations differed and provider conditions of care differed, that if orientations and conditions were congruent then patients were satisfied, if not, then they were dissatisfied.

(2) Expectancy-value theory of Linder-Pelz (1982) postulated that satisfaction was mediated by personal beliefs and values about care as well as prior expectations about care. Linder-Pelz identified the important relationship between expectations and variance in satisfaction ratings and offered an operational definition for patient satisfaction as "positive evaluations of distinct dimensions of healthcare" (p578). The Linder-Pelz model was developed by Pascoe (1983) to take into account the influence of expectations on satisfaction and then further developed by Strasser et al. (1993) to create a six-factor psychological model: cognitive and affective perception formation; multidimensional construct; dynamic process; attitudinal response; iterative; and ameliorated by individual difference.

(3) Determinants and components theory of Ware et al. (1983) propounded that patient satisfaction was a function of patients' subjective responses to experienced care mediated by their personal preferences and expectations.

(4) Multiple models theory of Fitzpatrick and Hopkins (1983) argued that expectations were socially mediated, reflecting the health goals of the patient and the extent to which illness and healthcare violated the patient's personal sense of self.

(5) Healthcare quality theory of Donabedian (1980) proposed that satisfaction was the principal outcome of the interpersonal process of care. He argued that the expression of satisfaction or dissatisfaction is the patient's judgment on the quality of care in all its aspects, but particularly in relation to the interpersonal component.

III. PATIENT SATISFACTION IN DEVELOPING COUNTRIES

A critical challenge for health service providers in developing countries is to find ways to make them more client-oriented. Indifferent treatment of patients, unofficial payments to providers, lack of patient privacy, and inadequate provision of medicines and supplies are common, yet are rarely acknowledged by traditional quality assessment methods. Assessing patient perspectives give users a voice, which, if given systematic attention, offers the potential to make services more responsive to people's needs and expectations, important elements of making health systems more effective. The main beneficiary of a good health-care system is clearly the patient. As a customer of health care, the patient is the focus of the health care delivery system. Customers who are merely satisfied often do not come back and organisation operating under this discipline of satisfaction outperformed the firms that did not provide satisfaction. The long-term survival of hospitals depends on loyal patients who come back or recommend the hospital to others. The concept of patient satisfaction is rapidly changing to customers' delight which means the patient is not only cured of his ailment during the hospital stay. The degree of patient satisfaction can be used as a means of assessing the quality of health care and the personnel. It reflects the ability of the provider to meet the patients' needs. Satisfied patients are more likely than the unsatisfied ones to continue using the health care services, maintaining their relationships with specific health care providers and complying with the care regimens. A very important aspect on which patient satisfaction depends is nursing care' because nurses are involved in almost every aspect of client's care in hospital. It is assumed that these patients have formed a positive attitude with regard to the service performance of the provider based on prior use of services. Patients carry certain expectations before their visit and the resultant enormous number of new valuable or evidence-based insights, techniques and procedures are published each year; innovations that claim to contribute to patient care. Changing and improving patient care and making it effective and efficient to prove to be a complex but challenging.

3.1 IN INDIA

The quality of healthcare in India in both the private and public health sector is unsatisfactory. The problems include non-availability of staff and medicines as well as the rude behaviour of the staff. Studies in the private sector have shown that practitioners tend to prescribe unnecessary and even harmful medicines. Recent policy documents also acknowledge the lack of quality in the Indian health services. One of the recommended strategies is to introduce demand-side financing, specifically community health insurance. There are three possible mechanisms whereby CHI can improve the quality of care. One of the mechanisms is when the organizer of the CHI scheme strategically purchases health care from the provider. Strategic purchasing includes among other facets, a mandate to set quality standards of care. This could include the following activities: gate keeping, contracting out with specific providers, maintaining a provider profile and monitoring the quality and financial performance, conducting utilization reviews, quality assurance, introducing generic medicines and implementing

standard treatment protocols. To summarise, the organizer of the scheme can negotiate with the provider for 'better quality of care' because they control the funds and are ultimately responsible for paying the provider. Yet another mechanism is by empowering the community. In any health insurance scheme, there is an element of 'service guarantee' i.e. once the insured pays the premium, the insurer has to guarantee the promised services. This can then give the insured patient the authority to 'demand' the services from the provider. Thus, ideally the insured patient can access the care that is required. A third mechanism is from the provider side. Especially in the Indian milieu where the private practitioners compete with each other for patients, providers would be happy to empanel themselves with a CHI scheme and have a captive community of patients who would use their services. This would ensure that they receive a steady income over time. They would thus be willing to improve their standard of care, to ensure that they remain empanelled with the CHI scheme. Thus, insured patients should hypothetically receive better quality of care from these providers.

However, there is very little evidence that this relationship between CHI schemes and improved quality of care actually exists. Ranson showed that some insured women at self Employed Women's Association (SEWA) were exposed to 'dangerous' hospital conditions while undergoing hysterectomy. A study in China also documented that insured patients under the New Comprehensive Medical Scheme were exposed to over prescribing compared to uninsured patients. This suggests that community health insurance could potentially lead to patients using facilities that provide poor quality care.

IV. PATIENT SATISFACTION

4.1 Introduction:

The relationship between patients and the providers of health care is changing radically. Patients today are demanding more from Hospitals than ever before. They want more information about their health, they want to be involved in the planning and selection of alternate care regimens and their relative costs, as well as to take an active part in decisions that affect health outcomes. The media promote rapid dissemination of information about new technologies and scientific research that affect health care. The results are a more informed patient population that can be expected to ask quite relevant health-related questions, even about cost/benefit ratios for services provided.

Often, the patients are better educated than ever before concerning health problems and practices; yet they continue to express increased dissatisfaction with the amount of health information provided by physicians. A current trend in hospital administration is to define a cost mechanism which allows nursing care to be charged separately. An increase in the organizational power base is sought by identifying distinct revenues generated by the nursing staff. If observable beneficial outcomes, both physical and fiscal, can be identified, nursing's influence and power will likely expand. As the concept of patient satisfaction is identified as part of these beneficial outcomes.

It is essential to have an overview of theoretical notions of satisfactions and expectations of the customers, generalities in planning intensive care units, social system, doctor patient relationships, physician role and behaviour, nurse behaviour patient role and opinions. An organization exists to achieve its goal, the goal of hospital, whatever one may say, is always primarily to provide highest quality of patient care and other objectives are secondary. There are various factors which influence customer's expectations of services. They include efficiency, confidence, helpfulness, personal interest reliability. These are intrinsic factors. They influence the response of the hospital staff to the patient and his relatives. Intrinsic factors are susceptible to training. They can be improved by training when the performance does not reach the set standards. Accordingly, external factors exist. These are the outside reasons given by the employee. They include media influence, experience of others and contribute to customers' expectations.

4.2 Aspects of patient experiences:

- *Waiting times* — The issue is not actual waiting times but patients' assessment of how problematic those waiting times were. The experience of having admissions dates changed could also be assessed.
- *Admission processes* — Waiting to be taken to a room/ward/bed — again the issue is not actual waiting times but patient assessment of how problematic that waiting was.
- *Information/Communication* — Focusing on patient assessments of the adequacy of information provided about the condition or treatment, and the extent to which patients believed they had opportunities to ask questions.
- *Involvement in decision making* — Focusing on patient assessments of the adequacy of their involvement in decision making.
- *Treated with respect* — Patients' views on whether hospital staff treated them with courtesy, respect, politeness and/or consideration. These questions could be split to focus specifically on doctors versus nurses. Patient assessments of the extent to which cultural and religious needs were respected could also be included.
- *Privacy* — Patient assessments on the extent to which privacy was respected.
- *Responsiveness of staff* — Most surveys include a patient experience question related to how long nurses took to respond to a call button. Related questions concerning availability of doctors is included in several surveys.
- *Information provided related to new medicines*
- *Physical environment* — Patient assessments of cleanliness of rooms and toilets/bathrooms, quietness/restfulness, quality, temperature and quantity of food.
- *Management of complaints* — Patient assessments of how complaints were handled.
- *Discharge* — Information provided at discharge on to how to manage the patient's condition.

4.3 Mechanisms to measure performance of health care from a patient perspective:

Patient-centred care is fundamental tenet of quality healthcare, which necessarily involves delivering services which respond to and are sensitive to the needs and wishes of the consumers or patients. Assessing whether health care is patient-centred will require the measurement of the quality of care from patients' perspectives, and service redesign in accordance with the results.

4.4 Issues with the measurement of patient satisfaction include:

- The ambiguity of the concept of 'satisfaction' which is a multidimensional construct, though often measured as if it were one-dimensional.
- Patient level biases, including a tendency for patients to treat medical professionals uncritically as experts, and a disinclination to be critical because of their gratitude or not wanting to jeopardize their treatment
- Satisfaction being determined largely by factors other than the care an individual receives, including age or educational attainment
- Satisfaction being related only marginally to experience, and more to public events like media portrayals, the opinion of political leaders, and even national events that are not directly related to health
- Findings from satisfaction surveys being too non-specific to use to improve the quality of care Delivered.

4.5 As citizens, the public expects:

- Affordable treatment options, which are free at the point of care.
- Safety and quality built into their health system.
- Health promotion and preventive health built into standard service delivery.
- Accessible local services, as well as access to national centres of excellence.
- Universal health coverage, and equity in the structure of service delivery.

4.6 When individuals are in the role of patients, their priorities are:

- Fast access to reliable health services, and longer opening hours
- Effective treatment options, by competent health professionals (including revising treatment to be delivered by a non-medical professionals)
- Clear comprehensible information which enables self-care
- Attention to their physical and environmental needs
- Emotional support, empathy and respect

4.7 Difficulties in Defining Patient Satisfaction:

Despite its centrality, there is no agreed definition of the concept of patient satisfaction. It has been conceptualized in a myriad way in different studies with various objectives: even in studies which share the same objective, conceptual diversity is evident. Carr-Hill questions the utility of trying to establish a single, absolute definition.

In part difficulties of conceptualization occur because satisfaction is multi-dimensional. Hall and Dornan's meta-analysis of the literature identified the following dimensions of patient satisfaction with health care: overall satisfaction, access, cost, overall quality, humaneness, competence, informativeness, bureaucratic procedures, physical facilities, the handling of psychosocial problems, continuity of care and the outcome of care, while factor analysis by the Health Policy Advisory Unit has suggested that patient satisfaction is largely predicated on six underlying dimensions, namely medical care and information; food and physical facilities; non-tangible environment; quantity of food; nursing care and visiting arrangements. Patients may prioritize issues and, when analysing the data, individual items can be weighted according to their perceived importance in order to achieve a measure of overall satisfaction

However, the multi-dimensional nature of satisfaction raises issues not so easily resolved. Although the National Consumer Council has drawn up seven consumer principles including access, choice, information, redress, safety, value for money and equity, applying these to health care is problematic and Carr-Hill argues that patient satisfaction studies are unsuitable for addressing questions of equity and fail to focus on issues of choice, safety, redress, psychological problems or outcome. Fitzpatrick also argues that studies often neglect patients' opinions on outcome while Hall and Dornan note that some aspects of satisfaction are less frequently addressed, in particular the structural aspects of health care, such as cost and facilities, which may be viewed by investigators as less open to change and less important to consumers

4.8 Risk:

Principal risk in use of patient satisfaction and complaints as a measure of ‘quality’ or ‘performance’ is the issue of attribution. Misuse of this tool carries significant risk to the organization’s relationship with senior doctors.

- State-of-the-art, sophisticated technology
- Apart from world class medical facilities, it is Human Touch & Care by which we have been able to gain trust of people

V. PATIENT SATISFACTION MEASUREMENT:

(THIS INFORMATION IS BEING COLLECTED FOR A PROJECT AND IN NO WAY WILL IT BE USED AGAINST ANYONE UNDER ANY CIRCUMSTANCES. IT WILL REMAIN PURELY CONFIDENTIAL)

Name (optional): Age:

Gender: Education:

Is this your first visit to the hospital?

Yes No

What factors influenced your choice of this hospital?

Referral by another patient
Referral by friends or family members
Close to home or workplace
Local papers

Indicate your level of agreement with the following statements:
(*Agree AND disagree)*

	Agree	**disagree**
It is important to me that the hospital is open 24/7	23	27
I was satisfied the way staff welcomed me	20	30
The staff at the registration and admission counter was courteous and prompt	19	31
I was assisted properly to the hospital	25	25
The staff heard my complaints patiently and attentively	20	30
I got sufficient time with the doctor	24	26
It was easy to get appointment to see the doctor	19	31
The doctors treat me in a friendly and courteous manner	40	10
The doctor was good about explaining the reason for medical tests	42	8
I was offered a chance to ask questions and be involved in my treatment	20	30
The doctor explained the medical terms which he was using	10	40
I was happy with the way my consultation notes were forwarded to me	15	35

I was happy with the continuity of care provided to me (eg; in case of test results or follow up after a surgery)	23	27
Doctors did not ignore what I told them	22	28
The doctor was careful to check everything while examining me and treating me	22	28
The doctors are easily accessible	20	30
The hospital respects my right to privacy	19	31
I did not have to wait for a long time for the doctors to call me for my check up	18	32
The waiting area is clean and comfortable	30	20
It is easy to get medical care in emergency	25	25
The nurses provide a good care	17	33
I am happy with the cleanliness of the hospital	23	27
I am satisfied with the amenities available (e.g.; newspapers, magazines, quality of refreshments)	20	30
The quality of food provided in the hospital is satisfactory	22	28
I am satisfied by the behavior of the food serving staff	30	20
The security services provided by the hospital are satisfactory	21	39
I am satisfied with the charges	22	28
In event of illness in the future I would like to visit this hospital for medical care	20	30

50 patients were interviewed and asked to fill the above-mentioned form for the purpose of this study.

VI. FINDINGS & CONCLUSION:

Out of 50 patients, 46% are satisfied with the functioning of hospital and 54% are dissatisfied. The reason of 40% of patients to be dissatisfied is mentioned below:

- Most of the room do not have call bell wire, and nurses are not responding to the call bell promptly.
- The major problem that patient is facing in IPD is that nursing staff is not communicating well with patients and their attendants. International patient also complained that they are not understanding what the nurses are trying to say because they do not understand English.
- The other major problem is that the patient's bedding is not changed daily and if the patient soils one, there is no extra bed sheet to be changed. Only one blanket is provided to patient from their admission up to their discharge from the hospital.
- There is a delay in the services of nursing staff most of the time.
- Discharge process is quite lengthy. Patient file contain discharge summary which is made by doctor and need signature of doctor. Discharge summary is not completed on time. So, patient has to wait unnecessary for discharge summary thereby resulting in frustrated patient/attendant.

VII. BIBLIOGRAPHY

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