ISSN:0975-1459
Journal of Pharmaceutical Sciences and Research
www.jpsr.pharmainfo.in

In-Patient Perceptions, Needs, Expectations and Satisfaction within Tertiary Care Settings

Minaa Tahir[1] , Shumaila Nawaz[1], Marrium Zaka Butt[1] , Fatima Amin[1] Khawaja Tahir Mahmood[2]

[1]*Department of Pharmacy, Lahore College Women University, Lahore*
[2]*JIPS-School Of Pharmaceutical Sciences, Lahore, Pakistan*

Abstract- Patient-centered care requires health care providers to recognize and act on patients' genuine needs and expectations. Fulfillment of patients' expectations influences health care utilization, patient satisfaction, and indicates overall quality of care. Most of the patients entering a tertiary care facility have set expectations regarding the nature of treatment, tests, referrals, medications and relevant health care facilities. The present clinical research work aimed at prospectively analyzing factors influencing patient satisfaction at four big teaching hospitals of Lahore, Pakistan. The 492 (82%) responded out of 600 inpatients approached .The patients were extensively interviewed regarding the perceived quality of tertiary care. Only 7.90% of the patients perceived the quality of facilities/information prior to admission as excellent. Quality of medicines and treatment was regarded as satisfactory by 26.29% of the patients. The overall follow up care was perceived as good by 45.63%of the randomly selected patients. Quality of medical treatment was graded excellent with reference to doctoral care (7.88%), nursing care (12.00%) or pharmaceutical care (0%) respectively. Enhanced interaction between different health care providers and patients can significantly improve patient related specific health outcomes. Restructuring of pharmacy services is vital for best patient care based built upon the notion of patient satisfaction which has a single goal of meeting expectations and values of the patients. The time , access and behavior are three most important component in patient satisfaction.The implementation of swift growing patient centered pharmaceutical care definitely augment the patient satisfaction.

Key words: Patient satisfaction ,needs; expectations; tertiary care; pharmaceutical care.

INTRODUCTION

Tertiary care is specialized form of consultative health care, especially for inpatients. Patients but also includes ambulatory as well as emergency patient. Many of these patients are directed to a tertiary care facility on referral from either a primary or secondary health care professional. In the West the term "tertiary care hospital" generally refers to a major hospital that has personnel and infrastructure for advanced medical investigation, diagnosis and treatment. It usually has a full complement of services including pediatrics, obstetrics, general medicine, gynecology, various branches of surgery and psychiatry or a specialty hospital dedicated to specific sub-specialty care. Patients are often referred to a tertiary hospital for major operations, consultations with sub-specialists (e.g. an orthopedic surgeon, neurologist, or neonatologist) and when sophisticated intensive care facilities are required.

The patients are the backbone of any health care system everywhere on the globe.. The nature and interpersonal aspects of medical care emerge as core quality issues for in-patients. Quality of care can be characterized as individualized, patient oriented and related to need [1] Most patients requiring tertiary care have a particular agenda regarding the expected quality of care. Thus "Patient satisfaction" is not a unitary concept but rather a combination of perceptions and values. Perceptions are patients' beliefs regarding the degree to which patients consider particular occurrences to be desirable, expected, or necessary. Patient/Client satisfaction is basically an expression of the gap between the expected and perceived characteristics of a service/treatment or the degree to which care fulfills expectation. Patient satisfaction is associated with adherence to therapy, health care utilization, malpractice litigation, switching of doctors or care plans, and evaluation/comparison of health care systems [2].

The concept of Patient Satisfaction was not extensively researched until the 90's. The number of Medline articles featuring "patient satisfaction" as a key word has increased more than 10-fold over the past two decades (761 in the period 1975 through 1979 to 8,505 in 1993 through 1997)[3,4]. It is a multi-factorial concept. Literature has described patient satisfaction as 'emergent and fluid'.[5] An efficient patient satisfaction system should address individual patient's medical and service needs at the "point-of-care" before the patient leaves the medical facility. Providers or organizations that provide more "personal care" have shown to produce higher levels of satisfaction [5,6.7].

The term "patient needs" is difficult to define due to the inherent complexity of the concept of need. "*Health care need"* should at least include social care, accommodation, health care, finance, education, employment, leisure and transport. Social facilities such as a bus service to arrive at a tertiary care setting, road safety regulations or clean air policies fall under the *health need* banner. The goal of healthcare needs is aimed at achievement of optimal state of health. Wide variations in the description of the term 'needs' directly reflect upon policies intended to meet population's health care needs[8,9,10].

HCPs tend to focus on a medical model of health care. This ignores the more comprehensive approach which states that "Health is a state of complete physical mental and social wellbeing and not merely an absence of disease or infirmity"[11]. Geographic variations, socio-economic

factors, political pressures and population attitude influence *demand* for health care, while medical guidelines and effectiveness of interventions may affect health care *availability*. Fulfilling social needs direct impacts upon community health status, which eventually indicates the "holistic nature" of needs. Target-driven practices in the domain of health care facilities can replace the concept of clinical need. This shift in clinical care warrants a re-evaluation of health care outcomes. The goal of therapy is becoming more patient oriented than product oriented. Provision of care for 'optimal health' can ascertain individual patients' health care needs and influence medical tailor services accordingly.

Patients' perceptions of both quality of medical care and quality of life are associated with the clinicians' ability to transfer key information to their patients effectively. More personal care results in better communication and more patient involvement, and hence better quality of care[12]. Overall quality of patient care consists of integrated domains of medical care, nursing care, and pharmaceutical care. Healthcare consumers are demanding excellence in care and services from care providers, and stakeholders are following in their expectations. Demonstration of quality outcomes and consumer satisfaction with services are now a priority and the primary competitive edge in healthcare [13,14].In the broader sense, the decisions and action of HCPs must focus on clinical or technical aspects that emphases "what" the patient receives and process performance that explains "how" health care services are delivered to patients [15].

Quantifying the impact of patient satisfaction with pharmacist consultation is a relatively new development[16].There are limited studies in this regard. Pharmacists can play a crucial role in medication adherence, monitoring issues, problem solving, reinforcement, and improving patient satisfaction[17,18].An urgent intervention is needed to ensure that patients are made aware of the existence of pharmacists and the concept of pharmaceutical care and their justified right to have access to clinical/hospital pharmacists in order to rationalize drug treatment and therapy. Hurdles to effective role of clinical/hospital pharmacist need to be identified and addressed in future improvement efforts [19].

Pharmaceutical care gives answers to many questions about reprofessionlization of pharmacy profession b ased upon responsibility and accountability in pharmacotherapy.The term "pharmaceutical care" was first used in 1975 by Michael but the definition put forward by Hepler and Strand, 1990 is widely accepted and quoted. "Pharmaceutical care (PC) is the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life". The outcomes are cure of a disease, elimination or reduction of a patient's symptomatology, arresting or slowing of a disease process; or prevention of a disease or symptomatology. PC is a patient-centered practice in which the practitioner assumes responsibility for a patient's drug-related needs and is held accountable for this commitment. Pharmaceutical care is how a practitioner applies expert pharmacotherapeutic knowledge in practice to benefit the patient. The identification, resolution, and prevention of drug therapy problems or drug related problems (DRP) are the heart and soul of pharmaceutical care practice. Pharmaceutical care has many benefits that may include but are not limited to: decreased medication errors; increased patient compliance in medication regimen; better chronic disease state management; strong pharmacist-patient relationship; and decreased long-term costs of medical care. Pharmaceutical care practice is applicable in all setting (including ambulatory care) under all circumstances.[20,21,23,24]

In review of patient satisfaction literature, it has been established that satisfied patients are more likely to continue using health care services, adhere with health care plans, participate in effective decision making and cooperate with their health care providers. From a clinical perspective, this can facilitate the provision of pharmaceutical care. Clinical outcomes will be superior owing to improved concordance/adherence. The quality patient experience doesn't happen by chance but by standardized practice. It is not just a matter of attitude or positive intent but a matter of design and continuous quality improvement. To create an exceptional patient experience, personalized care and service for patients and attendants must be focused. HCPs can sustain impressive levels of patient satisfaction if they effectively hold themselves as accountable regarding their respective roles and responsibilities.[25,26,27]

METHODS

The course of research work consisted of comprehensive interrogation of randomly selected in-patients regarding their perceptions/ expectations for tertiary care. A comprehensive questionnaire was formulated which dealt with major aspects of patient expectations form the time of initial referral till patient discharge and follow up care. Patients at the four different tertiary care hospitals of Lahore, Pakistan were included in the study. (i.e. Mayo Hospital, Services Hospital, Ganga Ram Hospital, Jinnah Hospital)

Type of study: Prospective

Inclusion criteria: Tertiary care patients irrespective of age and gender

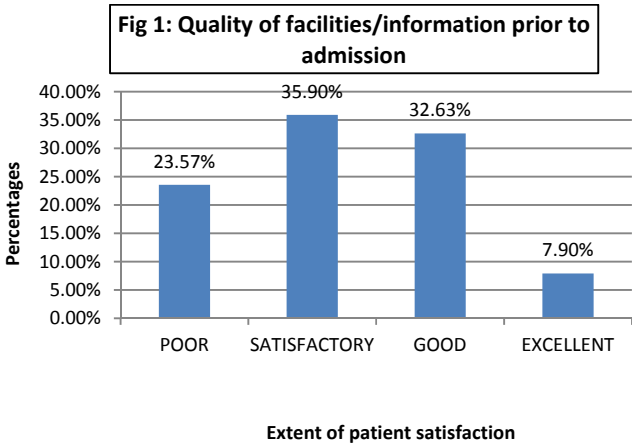
Exclusion criteria: Patients requiring primary or secondary care

Duration of study: 3 months

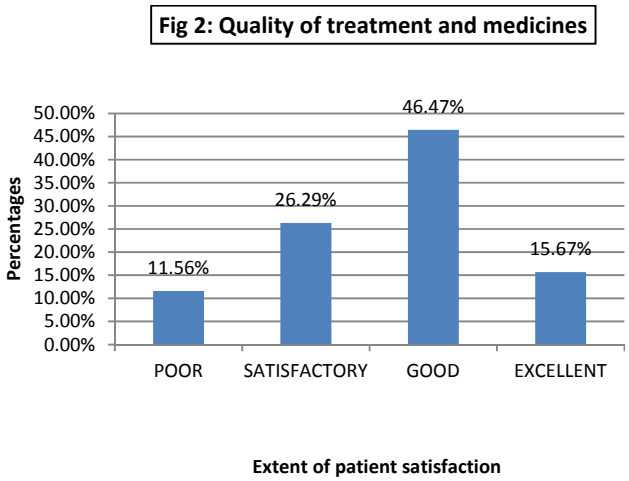
Plan of work: A total of 600 inpatients were randomly selected. Response rate was 82% These in-patients were prospectively queried. Perceptions/expectations of patients about the inpatient department services, logistic arrangements, waiting time, facilities, performance/behavior of staff, appointment system, support services and quality of follow up were analyzed. Appropriateness of each study parameter concerning patient needs, expectation, perception and satisfaction was determined on the basis of information provided by the patient or his attendant.

RESULTS& DISSCUSSION

Thoughts, feelings, and moods can have a significant effect on the onset of some diseases, the course of many, and the management of nearly all. The economic and psychological benefits underlying evaluation of patient satisfaction make this assessment an important exercise. The **n = 492 in all the graphs** Patient satisfaction was evaluated with reference to the quality of facilities/information prior to admission as depicted in figure 1.

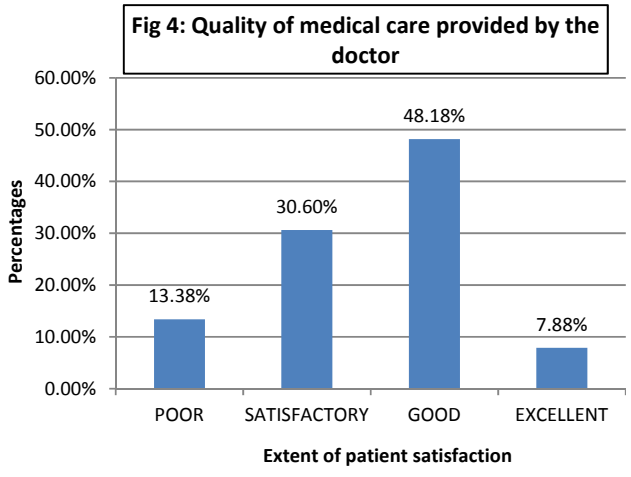


Most of the patients had to travel long distances to reach a particular health/tertiary care facility. There were complaints regarding the facilities being offered in the waiting room area with reference to cross ventilation, seating arrangement and sanitation conditions. However people were satisfied with the information and greetings being offered prior to admission. Adequate directions had been provided before being admitted into the inpatient wards or private rooms.



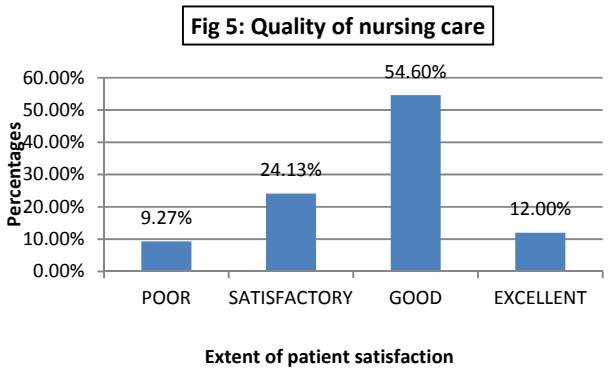
Patient satisfaction was evaluated with reference to the quality of treatment and medicines as depicted in figure 2. Most of the services were regarded to be adapted to the latest scientific developments. People are satisfied with the quality of the medicines being provided free of cost under the budget of the hospital. Patients complained of low privacy during treatment since there were frequent interruptions by other patients and visitors during consultation with the doctors. Patients were satisfied with the frequency, quality and validity of all tests performed within the hospital. Rarely, patients were referred to an external facility for lab testing

Patient satisfaction was evaluated with reference to the quality of follow up care as depicted in figure 3. Patients were effectively counseled regarding the medication but meager knowledge was disseminated regarding self-care. Most of the patients regarded the treatment outcome as good. Quality of care during follow up was also regarded satisfactory by most of the patients. However, the quality of accommodation services with references to cleanliness, sanitation and restroom facilities was mostly regarded as poor.

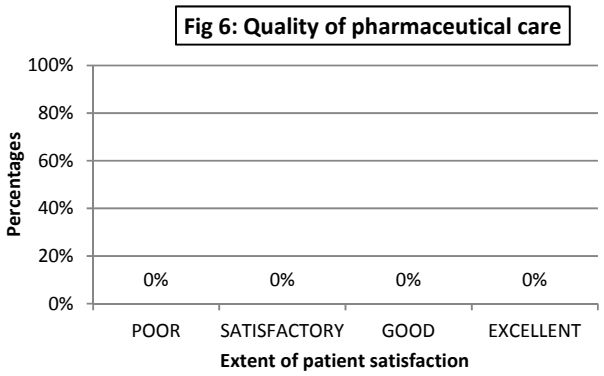


Patient satisfaction was evaluated with reference to the quality of medical care provided by doctor as depicted in figure 4.There was no definite trend behind the choice of a doctor on the basis of age, gender, race or medical specialty. However for intimate examinations, the majority of patients

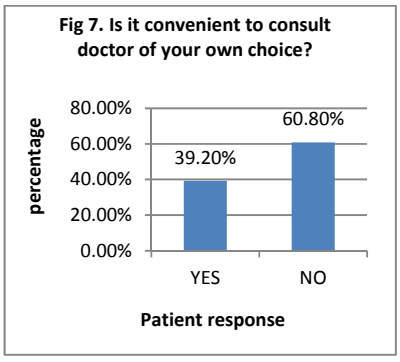
prefer a female practitioner whether they are a nurse or medical practitioner. The number of years in practice is related to patient satisfaction. Minority patients, especially those not proficient in English, are less likely to engender empathic response from physicians, establish rapport with physicians, receive sufficient information, and be encouraged to participate in medical decision making[22]. Most of the patients were satisfied with the attitude of the senior consultant doctors as being respectful and empathetic as opposed to the indifferent behavior of young junior doctors.

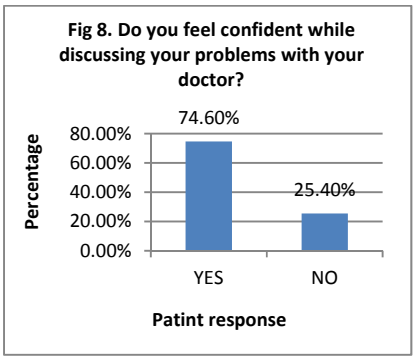


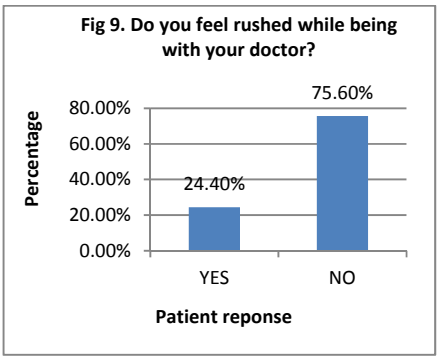
Patient satisfaction was evaluated with reference to the quality of nursing care as depicted in figure 5. Most of the people were satisfied with the quality of nursing care but complained of being told off and rude behavior of over worked nurses

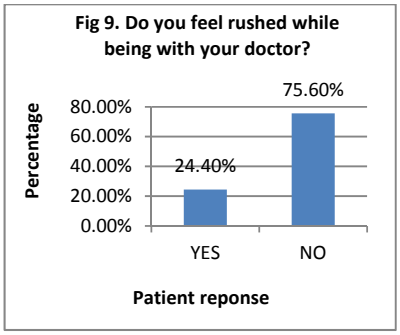


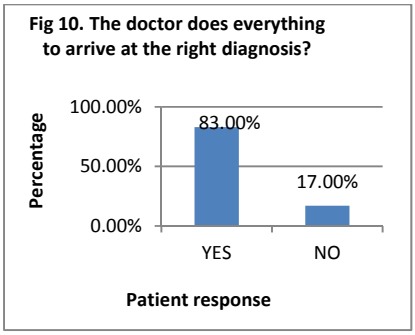
Patient satisfaction was evaluated with reference to the quality of pharmaceutical care as depicted in figure 6. The extent of patient satisfaction with reference to quality of pharmaceutical care was also evaluated and resulted in many unfortunate findings. Patients failed to recognize their needs regarding the provision of consultative tertiary care by clinical pharmacists. Patients are unaware about pharmacists' roles such as "responsible behavior," "creating a patient-centered relationship," and "interpersonal communication"[23]. Thus, the role of clinical pharmacist in meeting patients' genuine needs/expectations and the subsequent patient satisfaction with reference to pharmaceutical care was impossible to evaluate. Patient specific factors influencing expectations within tertiary care settings are explained in fig 7-22.

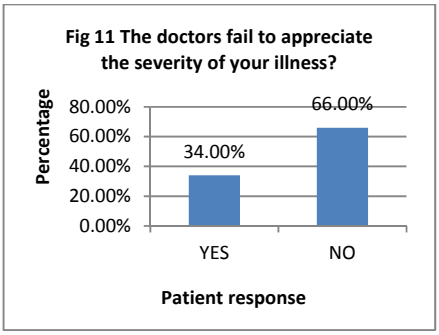


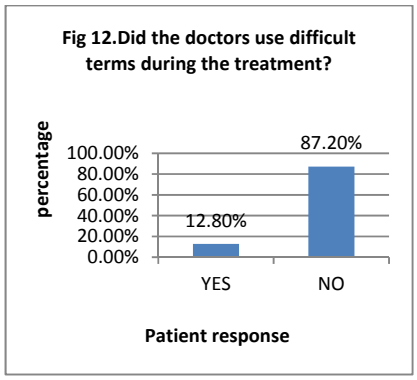


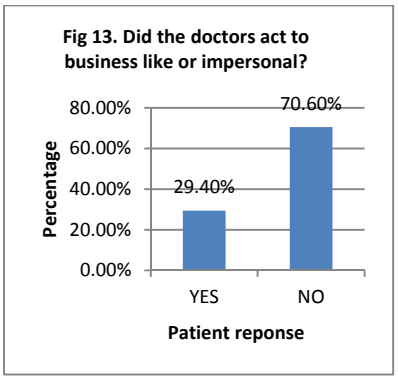


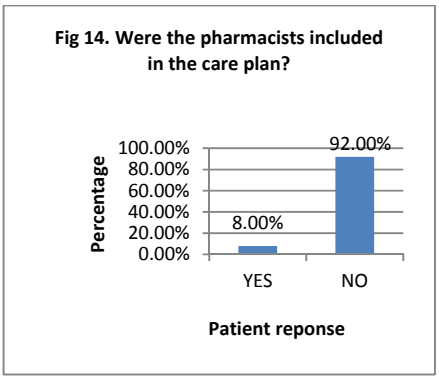


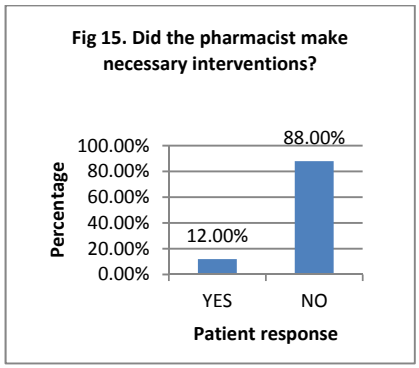


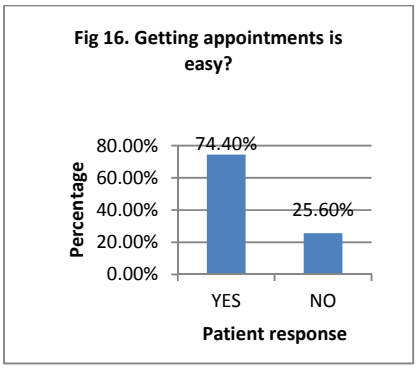


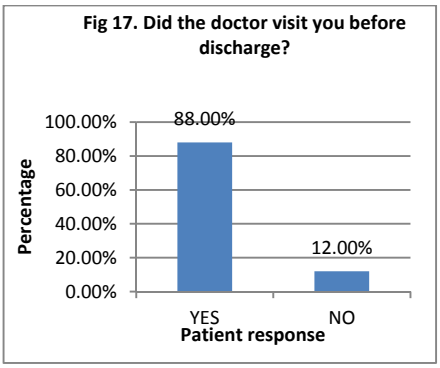


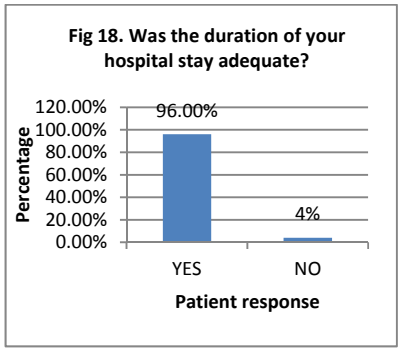


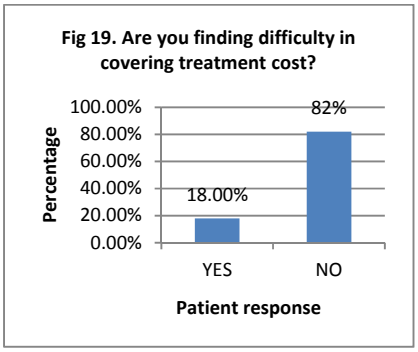


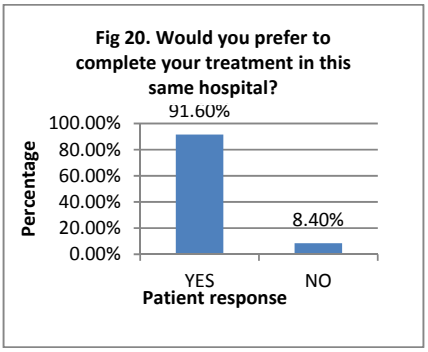


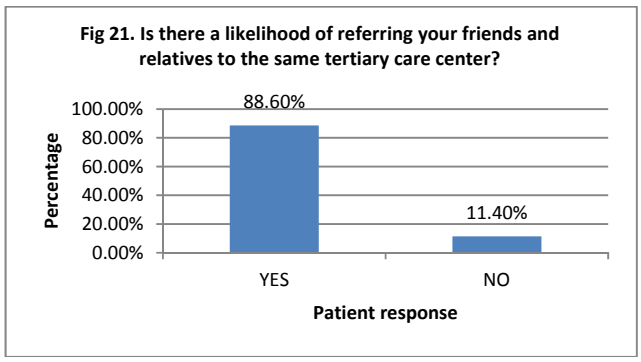


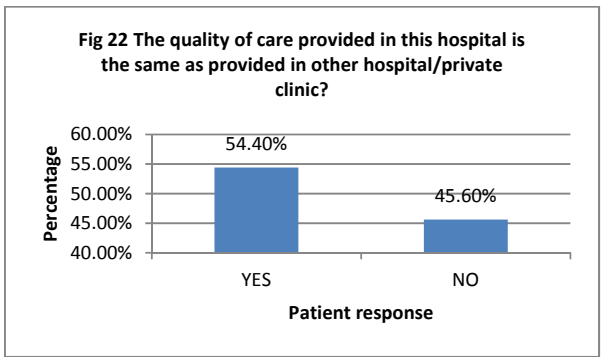












39.2% of the patients feel that it is convenient to consult doctor of their own choice (fig 7). 74.6% of the patients feel confident while discussing their problems with their doctor (fig 8). 24.4% of the patients reported to have been rushed while being with your doctor (fig 9). Most of the of the patients i.e. 83.0% believe that the doctor does everything to arrive at the right diagnosis (fig 10).However, 34.0% of the patients complained that the doctors fail to appreciate the severity of their illness (fig 11).12.8% failed to understand the terms used by the doctors during the treatment (fig 12). 29.4% reported that the doctors acted business like or impersonal (fig 13). Unfortunately in 92.0% of the cases,

pharmacists were not included in the care plan (fig 14). 88.0% reported that pharmacists were not seen to have been making any necessary interventions during the treatment. The rest of the 12.0% patients explained the role of pharmacists to be centered on dispensing or administration activities but not revolving around the patient (fig 15). 74.4% of the patients had experienced that getting appointments is easy (fig 16). 88.0% of the patients were visited by the doctor before discharge (fig 17). 96.0% of the patients believed that the duration of their hospital stay was adequate (fig 18). Only 18.0% of the patients were finding difficulty in covering the cost of their treatment while the treatment cost of the rest of the patients was being managed under the hospital budget (fig 19). 91.6% of the patients preferred to complete treatment in this same hospital (fig 20). The likelihood of referring friends and relatives to the particular tertiary care center was 88.6% (fig 21). The quality of care provided in a particular tertiary care center was found to be same as provided in other hospital or private clinic by 54.4% of the patients (fig 22).

The patient's perceived efficacy of medical care and greater continuity of care have significant correlations with patient satisfaction. However the criterion for patient satisfaction is not homogenous. The quality of treatment or service that is satisfying for one patient may not be fulfilling another patient needs with higher level of expectations. There is no limit to human desires but the threshold level for genuine patient needs and requirements should be met. Patients with lower levels of education are generally most satisfied and have lower expectations[24]. There is a dire need that physicians should view the relationship as patient-physician partnership collaboration than the relationship as being physician controlled in order to have greater levels of patient satisfaction. More personal care will result in better communication and more patient involvement, and hence better quality of care.

Generally ,the patient is a person who possess a unique set of needs, values, beliefs and behavior that brought to an interaction with a health care providers whereas . Oliver , defines satisfaction as ; “an individual judgment about the extent to which a product or service provides a pleasurable level of consumption.” Dr. Donebedian is right when he had stated that “Satisfying patient is one of the important indicators of quality care, because it demonstrates the ability of provider to meet expectations and values of the patients**”.** Patient satisfaction is a subjective term. There are no universal standards for defining, evaluating and quantifying this wide ranging subject. The quality of a treatment parameter deemed excellent by a particular patient may be regarded as satisfactory relative to another patient. Patient demographics, perceived severity of illness, patient literacy, utilization of medical services, cost of therapy and attitude of health care providers greatly influence patient needs and expectations at tertiary level. However, characteristics of providers or organizations that result in more "personal" form of tertiary care are associated with higher levels of patient satisfaction. Dissatisfaction can rise alarmingly on account of rude/harsh behavior of nurses or doctors. Unfortunately in Pakistan patients fail to recognize their needs regarding the provision of consultative tertiary care by clinical pharmacists. The environment of tertiary care settings needs to be made “pharmacist friendly” and conducive for implementing Pharmaceutical Care which is the primary role of an empathetic pharmacist who care for patient under all settings cattering all types of patients.

REFERENCES

1. Atree M. Patients’ and relatives’ experiences and perspectives of ‘Good’ and ‘Not so Good’ quality care. J Adv Nurs. 2001 ;33(4):456-66.
2. Peck BM, Ubel PA, Roter DL, Goold SD, Asch DA, Jeffreys AS, Grambow SC, Tulsky JA. Do Unmet Expectations for Specific Tests, Referrals, and New Medications Reduce patients' Satisfaction? J Gen Intern Med. 2004; 19(11): 1080–1087.
3. Kravitz RL. Patient Satisfaction with Health Care, Critical Outcome or Trivial Pursuit? J Gen Intern Med. 1998; 13(4): 280–282.
4. Pascoe GC. Patient satisfaction in primary health care: a literature review and analysis. Eval Program Plann. 1983; 6(3-4):185-210.
5. Meredith J, Wood N. The development of the Royal College of Surgeons of England’s patient satisfaction audit service. Journal Quality in Clinical Practice 1995;15:67-74.
6. Cleary PD, McNeil BJ. Patient satisfaction as an indicator of quality care. Inquiry 1988; 25(1):25-36.
7. Dimatteo MR, Hays R. The significance of patients' perceptions of physician conduct: a study of patient satisfaction in a family practice center. Journal of Community Health 1980; 6(1):18-34.
8. RK, Steward CA. Sinacore JM. A comparative study of seven measures of patient satisfaction. Med Care. 1995; 33(4):392-406.
9. Asadi-Lari M, Packham C, Gray D. Unmet health needs in patients with coronary heart disease: implications and potential for improvement in caring services. Health Qual Life Outcomes. 2003;1:26.
10. Need for redefining needs Mohsen Asadi-Lari, Chris Packham, and David Gray Health Qual Life Outcomes. 2003; 1: 34.
11. Godlee F. What is health?, BMJ 2011; 343:d4817.
12. Kravitz RL. The Physician-Patient Relationship Measuring Patients' Expectations and Requests. MSPH 2001; 134 (9) Part 2: 881-888.
13. Weng HC. Does the physician's emotional intelligence matter? Impacts of the physician's emotional intelligence on the trust, patient-physician relationship, and satisfaction. Health Care Manage Rev. 2008;33(4):280-8.
14. Abramowitz S. Analyzing patient satisfaction: a multianalytic approach. QRB 1987; 13(4):122-30.
15. Marley KA, Collier DA, Goldstein SM. The Role of Clinical and Process Quality in Achieving Patient Satisfaction in Hospitals. Decision Sciences 2004; 35(3):349–369.
16. Williams SJ, Calnan M. Convergence and divergence: assessing criteria of consumer satisfaction across general practice, dental and hospital care settings. Soc. Sci. Med.1991; 33(6):707-716.
17. Bultman DC, Svarstad BL. Effects of pharmacist monitoring on patient satisfaction with antidepressant medication therapy. J Am Pharm Assoc (Wash). 2002;42(1):36-43.
18. Ning Yan GU, Yunwei GAI, Joel W. HAY The effect of patient satisfaction with pharmacist consultation on medication adherence: an instrumental variable approach. Pharmacy Practice 2008;6(4): 201-210.
19. Tasneem A, Shaukat S, Amin F and Mahmood KT. J. Patient satisfaction ; a comparative study at teaching versus DHQ level hospital in Lahore, Pakistan, Pharm. Sci. & Res 2010;2(11):767-774.
20. R.J. Cipolle, L.M. Strand, and P.C. Morley(, 2004.). Pharmaceutical Care Practice: the Clinicianûs Guide, McGraw-Hill, New York
21. Hepler C and Srand L. Opportunities and responsibilities in pharmaceutical care. Am J Hosp Pharm 1990; 47: 533-43
22. Phantipa S (2007) Comparative analysis of pharmaceutical care and traditional dispensing role of pharmacy Thai J. Pharm. Sci. 31 100-104
23. Sitzia J, Wood N. Patient satisfaction: A review of issues and concepts, Social Science & Medicine1997;45(12): 1829–1843.

24. Soh G. Patient satisfaction with physician care. Hawaii Med J. 1991;50(4):149-52.
25. Ferguson WJ, Candib LM. Culture, language, and the doctor-patient relationship. Fam Med. 2002;34(5):353-61.
26. Worley MM,' Schommer JC, Brown LM, Hadsall RS, Ranelli PL, Stratton TP, Uden DL. Pharmacists' and patients' roles in the pharmacist-patient relationship: Are pharmacists and patients reading from the same relationship script? Research in Social and Administrative Pharmacy, 2007;3(1):47–69.
27. Anderson LA, Zimmerman MA. Patient and physician perceptions of their relationship and patient satisfaction: a study of chronic disease management. Patient Educ Couns. 1993;20(1):27-36
28. Hatamizadeh N, Jafary P, Vameghi R, Kazemnezhad A. Factors Affecting Client Satisfaction and Dissatisfaction in Out-Patient Rehabilitation Centers in Kurdistan Province in Iran.Iran Red Crescent Med J. 2012; 14(2): 119–120