DEVELOPMENT OF A PROTOCOL TO ENHANCE PATIENT SATISFACTION WITH REGARD TO NURSING CARE AT HEALTH CENTRES IN MPUMALANGA PROVINCE.

by

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DECLARATION

I declare that the dissertation ‘’Development of a protocol to enhance patient satisfaction with regard to nursing care at the Health Centres in Mpumalanga Province’’ hereby submitted to the University of Limpopo for the degree Master of Nursing Science has not been previously submitted by me for a degree at this or any other institution, is my own work in design and execution, and all material used has been duly acknowledged in both the text and in the list of references.

……. ……

MALUKA E.T Date:

DEDICATION

This dissertation is dedicated to all nurses at Agincourt Health Centre and Thulamahashe Health Centre and my wife Mapuwe Hannah Mamokabe; my mother Mavis Lainah Mokoena, and mostly respondents who took part in this study.

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ABSTRACT

The purpose of the study was to develop a protocol to enhance patient satisfaction with regard to nursing care at Health Centres and to determine factors leading to patient dissatisfaction. A quantitative, descriptive and cross-sectional research design was used for this study. The population of the study for the two Health Centres was: Agincourt Health Centre= 5697 while Thulamahashe Health Centres= 5696. Systemic random sampling method was used to select 400 respondents from each Health Centre. Data were collected through self-developed questionnaire. The questionnaire was pre-tested at Cunningmoore clinic. Reliability was ensured through conducting of a pre-test. Validity was ensured through undertaking extensive literature review.

The questionnaire was also given to the supervisor for content validity. Data analysis was done through descriptive and inferential statistics using SPSS version 22 programme of data analysis. The findings indicated that factors leading to patient dissatisfaction with regard to nursing are: long waiting time, poor communication and information between nurses and patients, shortage of nurses, poor service and environmental condition and shortage of treatment (medication). The study recommends that waiting time should be reduced to less than 3 hours, shortage of nurses should be addressed, workshops and inservice training should be implemented and treatment should be monitored.

Keywords: Patient dissatisfaction, nursing care, protocol, Health Centers.

DEFINITION OF CONCEPTS

Professional nurse

A professional nurse is a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (Nursing Act, 33 of 2005). In this study, a professional nurse means a person who is registered at the SANC, employed at the Health Centres in Mpumalanga Province.

Nursing care

Nursing care refers to assistance provided to a patient when, for some reason he/she cannot provide for the satisfaction of his/her own needs (Abdellah & Levine, 2006). In this study nursing care means the assistance and effort of a professional nurse when caring for patients at the Health Centres in Mpumalanga Province.

Patient's dissatisfaction

Patient's dissatisfaction is the patients' subjective evaluation of their cognitive and emotional reaction as a result of interaction between care providers and their expectations and perceptions regarding nursing care (Ozsoy, Ozgur, & Akyol, 2007). In this study, patient's dissatisfaction means poor or inadequate nursing care resulting to patients complains at the Health Centres in Mpumalanga Province.

Protocol

According to the Oxford mini dictionary and Thesaurus (2008), protocol refers to an official formality and etiquette. In this study, a protocol refers to a written document that helps to enhance patient satisfaction with regard to nursing care at the Health Centres in Mpumalanga Province.

LIST OF ABBREVIATIONS

AHC: Agincourt Health Centre.

AIDS: Acquired Immuno Deficiency Syndrome.

HIV: Human Immunodeficiency Virus.

IBM: International Business Mechine.

NCS: National Core Standard.

NDoH: National Department of Health.

NGO: Non-Governmental Organisation.

OECD: Organization for Economic Cooperation and Development.

SA: South Africa.

SANC: South African Nursing Council.

STI: Sexually Transmitted Infections.

TB: Tuberculosis.

SPSS: Statistical Package of Social Sciences.

WHO: World Health Organization.

THC: Thulamahashe Health Centre

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OVERVIEW OF THE STUDY

1.1 Introduction and background

Globally patient satisfaction with regard to nursing care is an important predictor of overall satisfaction with their clinical care (Otani & Kurtz, 2008). Nursing care is one of the major health care services that contribute significantly to the patient healing process. Care should be of high quality according to clinical, economic or other provider-defined criteria are not ideal if the patient feels dissatisfied (Dzomeku, 2013). Otani and Kurtz (2008) further indicated that what patients believe to be true will determine how they act. If they do not trust the provider or a health facility, they may not follow through with recommended treatment or they may decide to go to another health care facility.

Nursing care is the core factor in the measurement of patient satisfaction given the high levels of nurse-patient contact and nurses' role as the liaison between patients, doctors and other members of the health team. Patients' perceptions of nursing care remain the strongest predictor of behavioural intention and include the likelihood of returning to a particular clinic and to recommending it to others (Aiken, Clarcke & Sloane, 2012). According to Radwin (2012), quality nursing care results when the nurse knows the patient as a unique individual and tailors nursing care to the patient's experiences, behaviours, feelings and perceptions. This includes events that are associated with the illness and condition, as well as the patient's background (Tucker, 2010).

According to Johansson, Oleni and Fridlund (2009), in Africa there is a positive correlation between patient satisfaction and nursing care. Patient satisfaction increases in an organization where more personalised nursing care is given. Johansson et al. (2009) further stated that the socio-demographic background of the patients, their expectations of nursing care, physical environment, communication and information, contribution and participation, interpersonal relationship, technical competence, and structural dimensions of healthcare organization lead to patient’s dissatisfaction with

nursing care. Patient's satisfaction depends on the quality of communication, behaviour and information rendered to a patient during the period that extends from admission to discharge from the hospital or clinic until the results of diagnosis and treatment are achieved (Wallace, Freburger, Darter, Jackson & Cary, 2008). High quality in the communication with the patient is important during medical treatment as well as in nursing care to reach patient satisfaction.

Aiken et al. (2012) indicated that the quality of care from the patient's perspective lists good relations with health professionals and adequate information as important factors for both patients and relatives. Patients increasingly want to learn more about their health conditions and they want to participate in the planning, organization and decision-making of services related to their health (Merkouris, Ifantopoulos, Lanara & Lemonidou, 2008). Well-designed health care delivery system can reduce re-hospitalization, improve quality of life and provide patient satisfaction.

South Africa has a need for continuous improvement of quality and safety in the provision of patient care has become important (Jennings, Heiner, Loan, Hemman & Swanson, 2007). According to Strahan and Brown (2008), patients and their relatives are the only source of information on the dignity and respect with which they are treated and on patient education and pain-management. Assessment, monitoring and exploration of patient complaints and satisfaction data provide one indicator of quality of care that can contribute to clinical care improvement strategies and provide health care consumers input into improvement of health care services and delivery (Stover & Sayers, 2013).

According to the study conducted in Mpumalanga Province by Guadagnino (2013), the way patients perceive nursing care; largely depend on their social status, age, educational level, cultural background, previous hospital experiences, support, and respect from nurses, constant availability of nurses and appropriately given responses. Foebe and Bain (2012) stated that clients' opinions enable nurses to measure existing health care trends and opinions, learn directly from the clients' perceptions of the department and improve nursing care and public relations.

Gerteis, Edgman-Levitan, Daley and Delbanco (2008) stated that patient's dissatisfaction should be a concern to health care planners, policy makers, and managers, because that experience and the technical of quality care will determine how people use the health care system and how they benefit from it. Patient satisfaction should be used for improving health services and patient care, for accreditation requirements and quality assurance of the care provided, as a means of calculating financial incentives, benchmarking and comparing patient satisfaction scores with other hospitals, staff training and implementation of excellence programs in clinical areas (Jennings et al., 2007).

1.2 Research problem

At Agincourt and Thulamahashe Health Centre many patients who used the suggestion box are not satisfied with the nursing care that they receive during their visit at the facilities. Many patients complain about poor services while they are still in the waiting area. The statistics of patients' complaints obtained from the data captures of Agincourt Health Centre and Thulamahashe Health Centre from December 2014 to May 2015 is as follows: Agincourt Health Centre had 187 complaints related to patient dissatisfaction. Thulamahashe Health Centre had 204 complaints related to poor nursing care and long waiting time.

There is a need to find out the factors leading to patients' dissatisfaction from the patients' perspectives, as well as their clinical experiences, views and needs. There is lack of a consensus on what lead to patient dissatisfaction with regard to nursing care and it poses a major challenge for the health services. This has motivated the researcher to undertake the study on development of a protocol to enhance patient satisfaction with regard to nursing care based on the findings from the patients.

1.3 Theoretical Framework

Maslow's hierarchy of needs

The study is based on Maslow's hierarchy of needs. The reason for choosing this theory is that if all the needs starting from physiological needs up to self-actualization level are met patients would be satisfied with the nursing care.

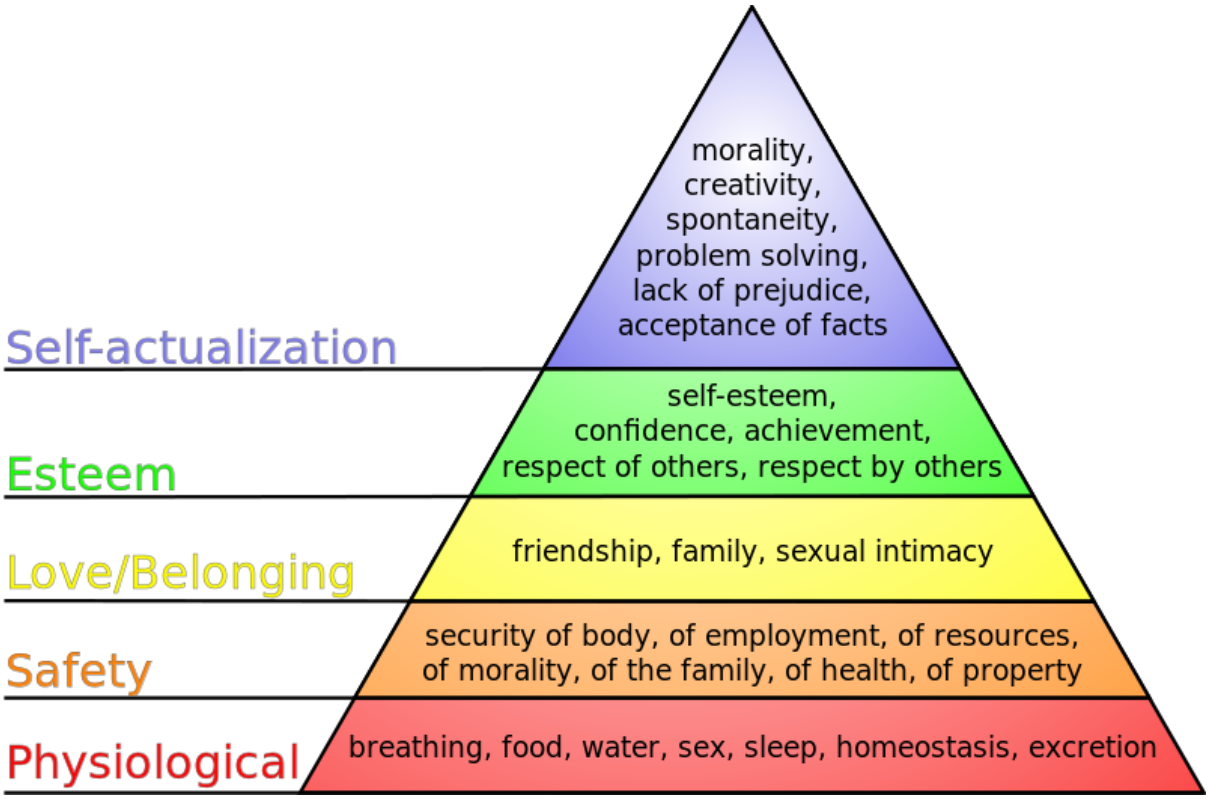

Figure 1.1 Maslow's hierarchy of needs

Maslow's hierarchy of needs is a theory in psychology proposed by Abraham Maslow in his 1943 paper "A Theory of Human Motivation" in Psychological Review (Julia, 2010). Maslow subsequently extended the idea to include his observations of humans' innate curiosity. His theory parallel many other theories of human developmental psychology, some of which focus on describing the stages of growth in humans.

Maslow used the terms physiological, safety, belonging and love, esteem, self-actualization, and self-transcendence to describe the pattern that human motivations generally move through.

Hierarchy of need

Maslow's hierarchy of needs is often portrayed in the shape of a pyramid with the largest, most fundamental levels of needs at the bottom and the need for self-actualization at the top (Cianci & Gambrel, 2012). The pyramid has become the de facto way to represent the hierarchy. The most fundamental and basic four layers of the pyramid contain what Maslow called deficiency needs or d-needs: esteem, friendship and love, security, and physical needs *(*Tay & Diener, 2011).

If these deficiency needs are not met with the exception of the most fundamental (physiological) need, there may not be a physical indication, but the individual will feel anxious and tense (Kenrick, Griskevicius, Neuberg & Schaller, 2010). Maslow's theory suggests that the most basic level of needs must be met before the individual will strongly desire (or focus motivation upon) the secondary or higher level needs. Maslow also coined the term "metamotivation" to describe the motivation of people who go beyond the scope of the basic needs and strive for constant betterment (Julia, 2010).

Physiological needs

Physiological needs are the physical requirements for human survival and they should be met first *(*Tang & West, 2010). If these requirements are not met, the human body cannot function properly and will ultimately fail. Air, water, shelter, ventilation and food are metabolic requirements for survival in all animals, including humans (Torres, 2007).

Safety needs

In the absence of physical safety due to poor working environment, conducive waiting area and consultation rooms, patient may (re-)experience post-traumatic stress disorder or transgenerational trauma (Tang, Ibrahim & West, 2008).

Safety and Security needs include:

- Personal security.
- Financial security.
- Health and well-being.
- Safety net against accidents/illness and their adverse impacts.

Love and belonging

The third level of human needs is interpersonal and involves feelings of belonging. Deficiencies within this level of Maslow's hierarchy due to neglect, nurse's attitude, shunning and ostracism can impact the individual's ability to form and maintain emotionally significant relationships in general, such as friendship (Goebel & Brown, 2009). According to Maslow, humans need to feel a sense of belonging and acceptance among their social groups. Many people become susceptible to loneliness, social anxiety and clinical depression in the absence of this love or belonging element (Julia, 2010).

Esteem

Esteem presents the typical human desire to be accepted and valued by others. People often engage in a profession or hobby to gain recognition (Julia, 2010). These activities give the person a sense of contribution or value. Low self-esteem or an inferiority complex may result from imbalances during this level in the hierarchy. People with low self-esteem often need respect from others; they may feel the need to seek fame or glory (Kremer & Hammond, 2013). Maslow noted two versions of esteem needs: a "lower" version and a "higher" version. The lower version of esteem is the need for respect from others. The higher version manifests itself as the need for self-respect. Deprivation of these needs may lead to an inferiority complex, weakness and helplessness.

Self-actualization

Maslow formulated a more positive account of human behaviour which focused on what goes right. He was interested in human potential and how to fulfill that potential. Maslow describes this level as the desire to accomplish everything that one can and to become the most that one can be (Julia, 2010).

Self-transcendence

Maslow explored a further dimension of needs in his later years, while criticizing his own vision on self-actualization. He believes that the self only finds its actualization in giving itself to some higher goal outside oneself, in altruism and spirituality *(*Yellen, Davis & Ricard, 2011). In this study, patients are not satisfied (deficiency needs) with the nursing care they receive at the Health Centres. The patient's hierarchy of needs physiological, safety, belongingness and love, esteem, self-actualization and Self-transcendence are not met which results in patient's dissatisfaction at the facilities. The patient's hierarchy of needs must be improved to enhance patient satisfaction (Julia, 2010).

1.4 Research questions

The following research questions guided the study:

- What are the factors leading to patient's dissatisfaction with regard to nursing care at Health Centres in Mpumalanga Province, South Africa?
- What protocol can be developed to enhance patient satisfaction with regard to nursing care at the Health Centres in Mpumalanga Province, South Africa?

1.5 Aim of the study

The aim of the study was to develop a protocol to enhance patient satisfaction with regard to nursing care at Health Centres in Mpumalanga Province.

1.6 Objectives of the study

The objectives of the study were to:

- Determine factors leading to patient dissatisfaction with regard to nursing care at Health Centres in Mpumalanga Province, South Africa.
- Develop a protocol to enhance patient satisfaction with regard to nursing care at Health Centres in Mpumalanga Province, South Africa.

1.7 Overview of research methodology

A quantitative method was used to conduct the study. A quantitative descriptive cross-sectional design was used. The population for the two Health Centres was: Agincourt Health Centre =5697 patients and Thulamahashe Health Centre =5696 patients. A systematic random sampling method was used to select respondents at equal intervals. A sample of 400 patients per Health Centre was selected using Solvin's formula. A self-developed questionnaire was used for data collection and it consisted of 34 closed-ended questions.

The IBM SPSS statistics version 22 program was used for data analysis. Descriptive statistics including percentages, frequently distributions, means and standard deviation were calculated. Inferential statistics including t-test was used to determine the demographic information of the variables and the factors leading to patient's dissatisfaction with regard to nursing care at the Health Centres in Mpumalanga Province. Details about research methodology are discussed in Chapter 3 of the study.

1.8 Significance of the study

The study could increase the knowledge and information of the health care management on challenges faced by patients with regard to nursing care. The findings of the study may help to identify strategies to overcome those challenges encountered.

The findings of the study will also help to improve patient satisfaction with regard to nursing care at the Health Centres. The findings could also help the Mpumalanga Department of Health through knowing the factors that affect patients and to formulating strategies on how to solve the identified problems. The formulated strategies could help to enhance patient satisfaction with regard to nursing care at the Health Centres in Mpumalanga Province.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The previous chapter introduced the study and dealt with the research problem, research questions, aim and objectives of the study, overview of research methodology and significance of the study. This chapter discusses the literature review conducted by the researcher on development of a protocol to enhance patient satisfaction with regard to nursing care at Health Centres in Mpumalanga province. This literature review was obtained from nursing research reports, journals, nursing books, articles and internet.

According to Joseph (2006), the purpose of literature review is to:

- Convey what is currently known about patient satisfaction.
- Direct the study.
- Identify gaps which were missed by previous researchers.
- Examine existing research on a protocol to enhance patient satisfaction with regard to nursing care.

2.2 Protocol of the National Core Standard

According to Oxford advanced learner's dictionary (2010), a protocol is the accepted or established code of procedure or behaviour in any group, organization or situation. The National Core Standard (NCS) for health establishments in South Africa was first launched in 2008 and reflect the National Department of health (NDoH) vision for South Africa's health services and focus on what needs to be done to meet that vision. The standards are based on the existing policy environment and are tailored to suit South Africa's health care context, and reflect international best practice and evidence based care (National Department of Health, 2011).

The NCS document reflects what is expected and required to deliver decent, safe, quality care and complemented by a set of measurement tools to assess compliance with these measures. The NCS are structured into cross-cutting domains to reflect a health systems approach, and define the scope or intent of assessing a health area where quality or safety might be at risk. Nurses are being trained since 2011 by the NDoH to implement the NCS, although associated funding, staffing and training requirements have not yet been finalised (National Department of Health, 2011).

2.3 Quality standards for health care establishments

The quality standard for Health care establishment was developed in a form of domains by the National Department of Health (NDoH) in 2011. The Department aimed to provide quality health care to all SA citizens through the Health domains.

Domain 1: Patient's Rights

The domain of patient rights sets out what a hospital or clinic must do to make sure that patients are respected and their rights are upheld, including getting access to needed care and to respectful, informed and dignified attention in an acceptable and hygienic environment, in accordance with Batho Pele principles and the patient's rights charter. Continuity of care must be rendered to patients if necessary.

Domain 2: Patient's Safety

Patient safety, clinical Governance and clinical care domain covers how to ensure quality nursing, clinical care and ethical practice to reduce unintended harm to healthcare users or patients and identify cases of greater clinical risk. Domain 2 also aimed to prevent or manage problems or adverse events, including health care-associated infections and support any affected patients or staff.

Domain 3: Clinical Support Services

The Clinical Support Services domain covers specific services essential in the provision of clinical care. Clinical Support Services domain includes the timely availability of medicines and efficient provision of diagnostic, therapeutic and other clinical support services and necessary medical technology, as well as systems to monitor the efficiency of the care provided to patients.

Domain 4: Operational Management

The Operational Management domain covers the day-to-day responsibilities involved in supporting and ensuring delivery of safe and effective patient care, including management of human resources, finances, assets, consumables and records. Operational management should also be ensured through development of staff, wellness, supply chain management, transport, and fleet management.

Domain 5: Facilities and Infrastructure

The Facilities and Infrastructure domain covers the requirements for clean, safe and secure physical infrastructure (buildings, plant, machinery, equipment) and functional, well managed hotel services, and effective waste disposal. Facilities and Infrastructure domain includes proper buildings, grounds, safety and security, cleanliness, linen and laundry, hygiene and food services.

2.4 Nursing care

The factors leading to patient dissatisfaction have been widely studied and discussed within nursing. Suhonen, Valimaki and Leino (2008) provide evidence on the effectiveness of nursing care on patient outcomes. These outcomes include patient satisfaction, better knowledge level about health and illness, adherence to care regimen and health related quality of life.

South Korea has undergone changes in health care services since the National Health Insurance system was introduced in 1989. Although South Korea has achieved a remarkable expansion of acute hospital services, the quality of health care has been rated lower than the average of the Organization for Economic Cooperation and Development Member Countries (OECD, 2012). According to recent comparisons of nurse-rated quality of care in nine countries—the United States, China, South Korea, Thailand, Japan, New Zealand, the United Kingdom, Canada, and Germany—South Korean nurses were more likely than nurses in other countries to report that the quality of care on their unit was only fair or poor (Aiken, 2011).

South Africa has the least nurses as compared to developed countries such as South Korea per 10,000 populations and by far the worst patient outcomes (NDoH, 2011). It is well recognized within the Republic of South Africa (RSA) that there are differences in resources, including nurse workforce resources between private and public hospitals but the consequences of such resources result in poor quality of care, patient safety and patient's satisfaction.

The persistent shortage of nursing staff which results in inadequate nurse to patient ratio to meet all the demands, socio-demographic characteristics and the patient's health status are all factors which affect satisfaction with nursing care (Soleimanpour, 2011). According to Aiken et al. (2012), less nurses' staffing was strongly associated with patient's mortality rate, while more staffing contribute to nurse's job satisfaction. Aiken et al. (2012) further indicated that nurses had more knowledge, were better motivated, implemented policies more often, acted consciously towards nursing goals and collaborated better.

Extended work shifts of twelve hours or longer are common and even popular with hospital nursing staff, but little is known about how such extended hours affect the care that patients receive or the well-being of nurses (Vahey, 2011). However, as the proportion of hospital and clinic nurses working shifts of more than thirteen hours increased, patients' dissatisfaction with care also increased.

The extended work shift may result in burnout and job dissatisfaction and to intend to leave the job (Wolf, Lehman, Quinlin, Zullo & Hoffman, 2008). Extended shifts undermine nurses' well-being, may result in expensive job turnover, and can negatively affect patient care (Wagner & Bear, 2009).

2.5 Working environment

According to De Lucia, Otto, and Palmier (2009), internationally there is a shortage of nurses and one of the reasons for this shortage is due to the work environment in which nurses practice. The empirical human factors and ergonomic literature specific to nursing performance, nurses were found to work in generally poor environmental conditions. De Lucia et al. (2009) further said the profession of nursing as a whole is overloaded because there is a nursing shortage and individual nurses are overloaded. A pleasing and well-equipped clinical environment can be facilitating factors for quality patient care and good patient outcomes.

According to Worthington (2008) an inadequate nurse work environment refers to a work environment lacking in adequate resources, strong nurse leadership, collegial relationships between nurses and physicians, ardent nurse participation in hospital and clinic affairs. A solid nursing foundation for quality of care also appears to negatively affect both nurses and patient’s satisfaction (Twardon & Gartner, 2008). Poor work environments make it difficult for nurses to perform their professional roles. Vahey (2011) further indicated that in terms of nurse workforce outcomes, more favourable practice environments and lower patient to nurse workloads have been shown to be related to greater nurse workforce outcomes.

2.6 Education and training

The increased level of nurses in terms of education and training, skills and knowledge, experience and perceived support for clinical working will improve quality nursing care

(Wadhwa, 2010). Firstly, education and training have been found to be important driving forces for individualised patient care (Suhonen, Valimaki & Leino, 2008).

Curry and Stark (2012) identified that a lack of knowledge and training in alternative approaches to team work may limit the successful provision of individualised care and there is need for flexible ways of working, which should be facilitated by education and training. According to Waters and Easton (2008) nurses' skills and knowledge level are positively related to their ability to provide quality care and patients satisfaction. Waters and Easton (2008) further indicated that nurses need skills to act as educators, advocates, promoters, safeguards and supporters for different patients at different times.

2.7 Supervision and support

According to Berg and Danielson (2007) a perception of received supervision promotes quality care. Berg and Danielson (2007) further indicated that to promote individualised care there is a need for a support system, such as clinical supervision that focuses on the type of clinical work.

Staff attitudes and values may be the key forces to promote and develop patient's satisfaction with nursing care (Curry & Stark, 2012). The effective leadership and management of nursing work helps to enhance the implementation of nursing care, and this could be facilitated by ward sisters or staff nurses who act as coordinators, facilitators and supervisors as well as interpreters of the nursing care in the units (Vinagre & Neves, 2008).

2.8 Patient's waiting time

Waiting times has an impact on patient satisfaction. In a study conducted by Westaway, Rheeder, Van Zyl and Seager (2014) in South Africa it is reported that in respect of a country setting (developed or not developed), the highest levels of dissatisfaction ware

with waiting time. Patients do not like to be left alone for a long time (Hasin, Seeluangsawat & Shareef, 2011).

Ericksson and Svedlund (2007) point out that long lines and waiting times for services and care are “a waste of time” have detrimental effects on patient’s satisfaction. Patients also express dissatisfaction with inflexible administrators that leave them not knowing who to contact (Ericksson & Svedlund, 2007). These are some of the organizational factors that play a key role in determining patient satisfaction.

2.9 Nurse’s attitude

Nurse burnout and dissatisfaction lead to poor quality of patient care, lower patient satisfaction and worse patient outcomes, including mortality (Aiken, 2011). The relationship between the patients and the nurse is a determinant of patient satisfaction. According to Shattell, Starr and Thomas (2007) interpersonal relationship include honesty trust, respect, understanding, empathy, knowing individuals as a person, touch, friendliness and feeling connected.

Characteristics of good relationships also included honesty, cooperation and humour (Irvine & Compass, 2007). Shattell et al. (2007) affirm that knowing the individual as a person, not a patient, number or diagnosis or set of diagnoses is important also to enhance patient satisfaction. Jennings et al. (2007) report incidents where patients complained of health care providers who were “rude” and “snotty”, doctors who “blew patients off” and nurses who were “impatient” and altogether unsympathetic. These relationships provide a crucial emotional element which is important for the patient to respond positively to medical treatment plans and ultimately have satisfaction (Vista, 2010).

2.10 Communication and information

Information to the patient is of fundamental importance. Patients need information regarding their care and condition as they feel anxious and vulnerable during their hospitalization (Strahan & Brown, 2008).

Walsh and Walsh (2009) affirm that adequate information giving is a necessary condition for patient empowerment and will reduce the risk of legal action when things have gone wrong. Two-way communication is seen as one of the most important characteristics of good quality care as well as being necessary for the development of good staff relationship (Attree, 2012).

Eriksson and Svedlund (2007) report that sometimes patients were misunderstood or not taken seriously because of one-way communication and that the communication they received was delivered in a technical language that was hard to understand. Bankauskaite and Saarelma (2007) report that lack of information provided to the patient about disease, its causes, perspectives and way of treatment was found to be a source of dissatisfaction.

2.11 Fast track to quality

The vision of the National Department of Health and social services indicates clearly the commitment to providing quality services at all levels. The provision of quality services is a legitimate expectation in a democratic society and is an essential yardstick for ensuring that the communities are protected, respected, treated fairly and has equal access to health services. All South African residents have a constitutional right to receive services that meet their expectations (NDoH, 2011).

The premise of provision of quality services denotes the commitment to exceed the people's expectations. Services that do not meet the patient's needs call for the citizens to exercise their right to complain as outlined in the Patients' Right Charter. The National Core Standards have been developed in 2009 as a tool for management to

guide their expected practice and assess whether they are in line with what is required (includes the requirements of the Patients' Rights Charter). They will also serve to benchmark all establishments against the same expected standards and will form basis for external inspections to certify whether or not they are complaint (NDoH, 2011).

Over time, the process of monitoring compliance will result in significant improvements in the effectiveness and quality of the health system as a whole. The National Department of Health (2011) has developed a protocol to reduce patient dissatisfaction. The most focus is on the six most critical/priority areas for patient-centreed care. The six priority areas are as follows:

a. Caring health staff and the feeling of being cared for.
b. Cleanliness of the facility.
c. Waiting time to receive care.
d. Safety from accidental harm or medical errors.
e. The risk of being infected in hospital.
f. Shortage of health resources.

2.11.1 Caring health staff and the feeling of being cared for

Health workers are far too often rude and uncaring to their patients. Patient complaints and patient satisfaction surveys both highlight this problem; patients don't feel they have been treated well or in a caring manner at all times. Health workers tell patients about their feeling of demotivation and a lack of recognition for their efforts.

2.11.2 Cleanliness of the facility

Most health facilities in South Africa are found to be dirty, untidy and unhygienic, showing that the staff do not care or respect their patients or their colleagues'. Shortage of resources such as cleaning materials, equipment's and maintenance reinforce poor condition of the health facilities.

2.11.3 Waiting time to receive care

Patients are forced by circumstances to wait for hours to get their files, to see the nurse or doctor, and then to get their medication. There are frequently reports of patients having to come back the next day to be seen. There may be delays in referring patients needing urgent attention.

2.11.4 Safety from accidental harm or medical errors

It is a common finding that even simple guidelines and protocols are not implemented and patient's harm or injuries are due to negligence or malpractice of the health staff. Patients and staff in a facility are the major concern against medico legal harzard.

2.11.5 The risk of being infected in hospital (nosocomial infection)

One every specific area of harm that is directly under the staff control is that of preventing the spread of infection in the facility. In this respect many of the basic rules and practices of hygiene are found not to be observed. Essential professional knowledge is not applied, procedures are not followed adequately and management does not prioritise this, with inadequate supplies of essential disinfectants, equipment and often problems with the proper disposal of medical waste.

2.11.6 Shortage of health resources

Shortage of medicines and supplies has become more common across South Africa. The problem with suppliers may be budget related, lack of payment or failure to place order in time. Patients who are unable to receive their treatment they need on the day they come to collect it suffer not just the inconvenience and costs but possibly also the worsening of their condition.

2.12 Patients' rights

In line with the Government's endeavor to instill fundamental human rights in South African society and through its commitment to provide caring and effective services in

which health rights are being upheld, in 1999 the Department of Health introduced the National Patients' Rights Charter into the national health system (Muller, 2009). A charter is written grand of rights; it is also known as an agreement or contract.

A right is that which is morally or socially correct, and just for faith so it many therefore be legally or morally claimed. The patient has the right to a healthy and safe environment, access to healthcare, confidentiality and privacy, informed consent, second opinion, exercise choice in healthcare, continuity of care, to complain, participate in decision making, treated by a named healthcare provider, refuse treatment and knowledge of healthcare insurance/medical aid scheme.

2.13 Batho-Pele principles

Batho Pele means people first (Muller, 2009). The South African public service will be judged by one criterion above all: its effectiveness in the delivery of services which meet the basic needs of all South African citizens. Improving service delivery is therefore the ultimate goal of the public service transformation programme. The profession of nursing should be acquainted with these principles and the unit manager should design a strategy to ensure compliance with these principles: Consultation, service standards, access, courtesy, information, redress and value for money.

- Consultation: Patients should be consulted about the level of quality of the public service they will receive and where possible, should be given a choice about the services that are offered.
- Service standards: Service standards must be published and displayed at the point of delivery and communicated as wisely as possible to all users so that they can know what level they are entitled to expect, and can complain if they don't receive it.
- Access: Patients should have equal access to the services to which they are entitled.
- Courtesy: The public services should specify the standards regarding the way in which patients should be treated.

- InformationL: The health care information should be provided in a variety of media and languages to meet the different needs of patients.
- Redress: Establish ways of measuring all expression and dissatisfaction, and regulate strategies to overcome the problems.
- Value for money: All national and provincial departments will be required, as part of their service delivery improvement programs to identify areas where efficiency savings will be sought, and the service delivery improvements which will results from achieving the savings.

2.14 Patient Satisfaction

Asnani (2009) has developed a protocol or core elements to enhance patient satisfaction, this include:

- Expectations: Healthcare workers should provide an opportunity for the patients to tell their expectations.
- Communication: Patient satisfaction increased when members of the healthcare team took patients' problems seriously, explained information clearly, and tried to understand the patient's experience and their viable options.
- Control: Patient satisfaction is improved when patients are encouraged to express their ideas, concerns and expectations.
- Decision-making**:** Patient satisfaction increased when the importance of their social and mental functioning as much as their physical functioning was acknowledged.
- Time spent: Patient satisfaction rates improved as the length of the healthcare visit decreases.
- Clinical team**:** Although it is clear that the patient first concern is their clinician, they also value the team for which the clinician works.
- Continuity of care**:** Patient satisfaction increases when they receive continuing care from the same healthcare provider(s).

- Dignity**:** As expected, patients who are treated with respect and who are invited to partner in their healthcare decisions report greater satisfaction.

2.15 Conclusion.

This chapter presented factors leading to patient's dissatisfaction namely: nursing care, working environment, education and training, supervision and support, patients' waiting time, nurse's attitudes, communication and information. Fast track to quality, patients' rights and Batho Pele principles were also discussed in this chapter. The next chapter describes the methodology used for the research study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research methodology. The research methodology consists of study site, research method, study design, population, sampling, inclusion and exclusion criteria, data collection, data analysis, reliability and validity. Ethical considerations consist of ethical clearance, permission to collect data, informed consent, confidentiality and anonymity, right to privacy and right to self-determination.

3.2 Study site

The study was conducted in two Health Centres of Mpumalanga Province at Ehlanzeni district, namely Agincourt Health Centre which is situated in the Southern side of Bushbuckridge, 40 kilometers away from Bushbuckridge complex. Thulamahashe Health Centre which is also situated in the Southern side of Bushbuckridge, 30 kilometers away from Bushbuckridge complex in Mpumalanga province, South Africa. Both Health Centres are 24 hours' facilities providing the following services: reproductive health, maternal care, minor ailments, HIV and AIDS, STI, occupational health, oral health, victim empowerment, environmental health, youth and adolescence health, welfare services, chronic and geriatric services, rehabilitation and disability care.

Agincourt Health Centre has 10 bed occupancies and 9 consultation rooms including antenatal, labour and post-natal room. Thulamahashe Health Centre has 12 bed occupancies and 10 consultation rooms including antenatal, labour and post-natal room. The staff members and villages served by each Health Centre are discussed in Table 3.1.

Table 3.1 Staff members and villages of the Health Centres

Health Centre	Villages	Population	Operational Manager	Professional Nurse	Assistant nurse	clerk	Data capturer	General Assistant
Agincourt	Agincourt	6926	1	15	6	2	2	7
	Croquetlawn	4512						
	Dumphries A	6290						
	Ireagh	7608						
	Khayalami	2555						
	Newington	5740						
Thulamahashe	Darkcity	3281	1	19	10	2	2	8
	Dumphries B	4952						
	Kumani	3793						
	Landela	3920						
	Mambumbu	4267						
	M.P Stream	5821						
	New Forest	2901						
	Rolle A	2616						

3.3 Research method.

The quantitative approach was used to conduct this study. According to Given, (2009) quantitative research refers to the systematic empirical investigation of social phenomena via statistical, mathematical or computational techniques. In this study statistical information about patient's dissatisfaction with regard to nursing care was obtained from the patients through data collection using self-developed questionnaires.

3.4 Study design

According to Brink, Van Der Walt and Van Rensburg (2012) cross-sectional study is used to examine data at one point in time. In this study, a cross-sectional study was chosen because it enabled the researcher to collect data from two Health Centres on different respondents of different age group and conditions. Data were collected from different respondents at the Health Centres, rather than on the same respondent at several points in time, therefore this study design was suitable to obtain relevant information about factors leading to patient's dissatisfaction with regard to nursing care at the Health Centres, in Mpumalanga Province.

3.5 Population

According to Brink et al. (2012) a population is a complete set of persons or subjects that possesses the characteristics that are of interest to the researcher. The population of the study was all patients who came at the Health Centres on the day of data collection. The total monthly population of the two Health Centres for both males and females was as follows: Agincourt Health Centre = 5697 while Thulamahashe Health Centre = 5696.

3.6 Sampling

According to Burns and Grove (2009), sampling is a process of selecting a sample from the population in order to obtain information about a phenomenon in a way that represents the population of interest. A sample is a subset of the population that is selected to represent the population (Brink et al., 2012).

In this study, Solvin's formula was used to select the sample size and it is written as follows: n = N / (1 + Ne^2)

Sample size of Agincourt Health Centre

n = Number of samples=unknown?
N = Total population=5697 per month
e = Error tolerance which is =0.05

n = N / (1 + Ne^2)

=5697 / (1 + 5697× 0.05^2)

= 399, 9

399, 9 was the sample size but it was converted to 400 because we were dealing with human beings not numbers.

Sample of Thulamahashe Health Centre

n = N / (1 + Ne^2)

n = Number of samples=unknown?
N = Total population=5696 per month
e = Error tolerance which is =0.05

n = N / (1 + Ne^2)

=5696 / (1 + 5696× 0.05^2)

= 399, 9

399, 9 was the sample size but it was converted to 400 because the study was dealing with human beings not numbers. The sample of 400 patients per Health Centre was selected to represents the whole population according to Solvin's formula. A systematic random sampling method was used to select respondents at equal intervals. All patients who came at the facility were given numbers at the gate by securities according to their time of arrival. The researcher used patient's number to select respondents. Every third patient who came at the facility on the day of data collection was selected to participate in the study.

3.7 Inclusion and exclusion criteria

Inclusion and exclusion criteria increases the likelihood of producing reliable and reproducible results, minimizes the likelihood of harm to the subjects and guards against exploitation of vulnerable persons (Given, 2009).

3.7.1 Inclusion criteria

All patients that are more than 18 years of age who came at the facility on the day of data collection were included in the study because the researcher needed a large sample size of 400 per Health Centre.

3.7.2 Exclusion criteria

Patients less than 18 years of age were excluded because they were not eligible to give consent. Mental health care users and known Tuberculosis (TB) patients were also excluded because they are infectious.

3.8 Data collection

Data collection is the gathering of information that describes some situation from which conclusions can be drawn (Brink et al., 2012). The data were collected at Agincourt and Thulamahashe Health Centres using self-developed questionnaires which consisted of 34 closed ended questions. Data were collected for two months with one month for each Health Centre from Monday to Friday as weekends are only for emergencies. The selected respondents were separated from other patients and they had their own waiting area according to their numbers given at the gate. The questionnaires were handed in the private room and the researcher used self-administered questionnaires to collect data. The researcher was wearing casual clothes and off duty on the day of data collection to avoid bias or to reduce vulnerability of respondents.

The questionnaires were divided into 2 sections namely Section A and Section B. Section A consist of 6 questions on demographic data while section B consist of 28 questions on factor leading to patient dissatisfaction. The questionnaires were translated in the language that the patient understands namely Xitsonga. Completion of the questionnaire took about 20 minutes.

3.9 Data analysis

According to Babbie and Mouton (2007), quantitative analysis is the numerical representation and manipulation of observations for the purpose of describing and explaining the phenomenon that those observations reflect. Babbie and Mouton (2007) further indicated that data analysis is the breaking up of data into manageable patterns, trends and relationships. In this study, the returned questionnaires were coded and then captured using the Microsoft Excel program.

IBM SPSS statistics program was used for data analysis (Statistical Package of Social Sciences) version 22. Descriptive statistics including percentages, frequency distributions, means and standard deviations were calculated. Inferential statistics were

used to analyse correlations between variables such as gender, age, place of residence and educational level. The data were analysed with the assistance of a statistician.

3.10 Reliability and validity

3.10.1 Reliability

Reliability is the consistency and dependability of a research instrument in measuring a variable (Brink et al., 2012). In this study reliability was ensured by conducting a pre-test of the questionnaire at Cunningmoore clinic and doing literature review.

3.10.2 Validity

Validity is the ability of an instrument to measure the variable it is intended to measure (Brink et al., 2012). In this study validity was ensured by doing literature review to get the variables regarding the factors leading to patient's dissatisfaction with regard to nursing care.

3.10.3 Face validity

Face validity is the extent to which a test is subjectively viewed as covering the concept it purports to measure (Brink et al., 2012). It helped the researcher to find potential flaws of the questionnaire before face validity was ensured by doing literature review and submitting the questionnaires to the supervisor and co-supervisor.

3.10.4 Content validity

According Brink et al. (2012), content validity refers to how accurately a measurement tool tabs into various aspects of the specific construct in questions. Content validity was ensured by giving the questionnaires to the experts in quantitative research and the statistician for review.

3.11 Pre-testing

Pre-testing of the research instrument involves determining the feasibility of using an instrument in a formal study. It provides an opportunity to try out the technique or instructions that will be used with an instrument, especially if it has never been used with a specific population (Brink & Wood, 2006). Pre-testing of the questionnaires was done at Cunningmoore clinic which is situated in the same local area with Agincourt Health Centre just 24 kilometers away from where the study was conducted. Ten (10) respondents were selected to participate in the pre-test to assess the reliability of those instruments. It was found that option 7 of question 5 on ‘’place of residence’’ was omitted. A typing error was also identified in question 6 on ‘’level of education’’ where option 1 and 2 were written in both English and Xitsonga. Both identified errors were corrected.

3.12 Bias

Bias refers to any influence that possesses a distortion or myth representation of an outcome of particular findings in the study (Given, 2009). Pre-test was done in different facility not where the research study was conducted. Respondents were given consent forms and the questionnaires inside the private room one after another. The questionnaires were not discussed with the respondents until they were in the private room. The clinic and the patient(s) who took part in the pre-test did not form part of the study.

3.13 Ethical considerations

Whenever human subjects are used for research purposes, as is the case in this research study, special attention was paid to the rights of these individuals. The researcher conducted the study in an ethical manner. According to Polit, Beck and Hungler (2008) ethics is defined as a system of moral values. Research ethics comprises principles, values and standards that guide appropriate conduct related to

research decisions and actions (Cottrell, Girvan & Mckenzie, 2009). Ethical considerations addressed in this study was ethical clearance and permission to collect data**,** informed consent, confidentiality and anonymity, right to privacy and right to self-determination.

3.13.1 Ethical clearance and Permission to collect data

The ethical clearance was obtained from Turfloop Research Ethics Committee. Permission to collect data was obtained from Mpumalanga Department of Health and the Operational managers of Agincourt and Thulamahashe Health Centres.

3.13.2 Informed consent

Informed consent is the prospective respondent's agreement to participate in the study Polit, Beck and Hungler (2008). Informing is the transmission of essential ideas and content from the researcher to the prospective respondents (Burns & Grove, 2009). Respondents were informed about what is expected from them, how their information and names would be treated confidentially and how they will benefit from the study. Respondents were told that participating in the study would not cost their time.

The following information was given to the respondents namely: the purpose of the research, the objectives of the research, the duration of the study, the type of participation expected from the subjects, how results will be published, how confidentiality, anonymity and privacy would be maintained, the identity and qualifications of the researcher and supervisors of the dissertation. Respondents were requested to sign the consent form to take part in the study.

3.13.3 Confidentiality and Anonymity

In this study confidentiality was maintained whereby names and identification of the respondents were not written in the questionnaires, and Information provided by the respondents would be kept confidential. Information from the respondents was not divulged to unauthorised people. Anonymity is the right to assume that the data

collected will be kept confidential (Burns & Grove, 2009). Anonymity was maintained by providing the respondents with code numbers such as respondent number one (1) on data entry.

3.13.4 Right to privacy

Privacy is the freedom an individual has to determine the time, extent and general circumstances under which private information will be shared with or withheld from others (Burns & Grove, 2009). The respondents were given questionnaires to answer in a private room and they came one after the other to maintain privacy. Information gathered was not disclosed or made available to any unauthorised person.

3.13.5 Right to self-determination

The right to self-determination is based on the principle of respect for persons, and indicates that humans are capable of controlling their own destiny (Burns & Grove, 2009). Right to self-determination was maintained by informing the respondents that they have a right to refuse to participate or withdraw from the study at any time without being penalised.

3.14 Conclusion

This chapter described the research methodology used in the study. The research methodology consists of study site, research method, study design, population, sampling, inclusive and exclusive criteria, data collection, data analysis, reliability and validity, pre-test and bias. The ethical considerations were also discussed and consisted of ethical clearance and permission to collect data, informed consent, confidentiality and anonymity, right to privacy and right to self-determination. Chapter 4 will deal with data discussion and interpretation of the results.

CHAPTER 4
INTERPRETATION AND DISCUSSION OF THE RESULTS

4.1 Introduction

The previous chapter discussed the research methodology used in this study. This chapter focuses on interpretation and discussion of the results. The aim of the study was to develop a protocol to enhance patient satisfaction with regard to nursing care at the Health Centres in Mpumalanga Province.

4.2 Section A: Respondents demographic data

Respondents who participated in this study were 800 from Agincourt and Thulamashe Health Centre. Agincourt Health Centre had 400 (50%) and Thulamahashe Health Centre also had 400 (50%) respondents.

4.2.1 Respondents' gender

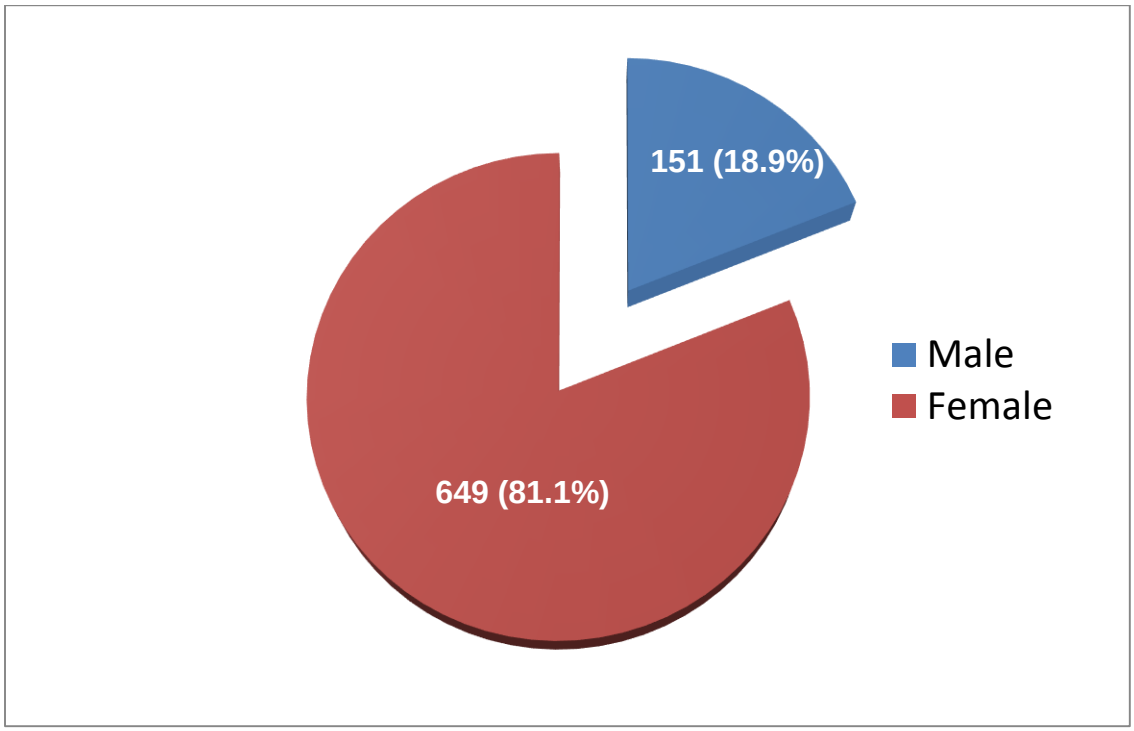

Figure 4.1: Respondents' Gender

According to the findings in figure 4.1, 151 (18.9%) respondents were male and 649 (81.1%) were female. There is a huge gap between males and females who attend the Health Centres. Adherence to the traditional male gender role may result in negative attitudes toward help-seeking (Good, 2006). Traditionally, men are viewed as strong, independent and emotionally controlled, while women are seen as weak and emotionally expressive. Good (2006) further indicated that men seek medical advice very late, and the stereotype is that men 'overreact' to small symptoms and 'underreact' to severe symptoms, the latter leading to a poorer prognosis.

According to Kessler (2008) women are more sensitive to subtle bodily cues than men which may account for the higher rates of formal medical care utilisation among women. However, when men actually seek medical help, they often present with no complaints or general complaints about their health, hoping that they will be asked appropriate questions by health workers to uncover the underlying reasons for their visit (Kessler, 2008). According to Thi, Brian, Empereur, and Guillemin (2014) women are not only key decision makers of their own health care but for immediate and extended families as well. Therefore, women have a role in the health status, the family and significant others. Women are associated with less satisfaction in the Health facilities as compared to man (Cheng & Yang, 2008). This could be the reason for women to predominate and most respondents dissatisfied in this study.

4.2.2 Respondents' Age (in years)

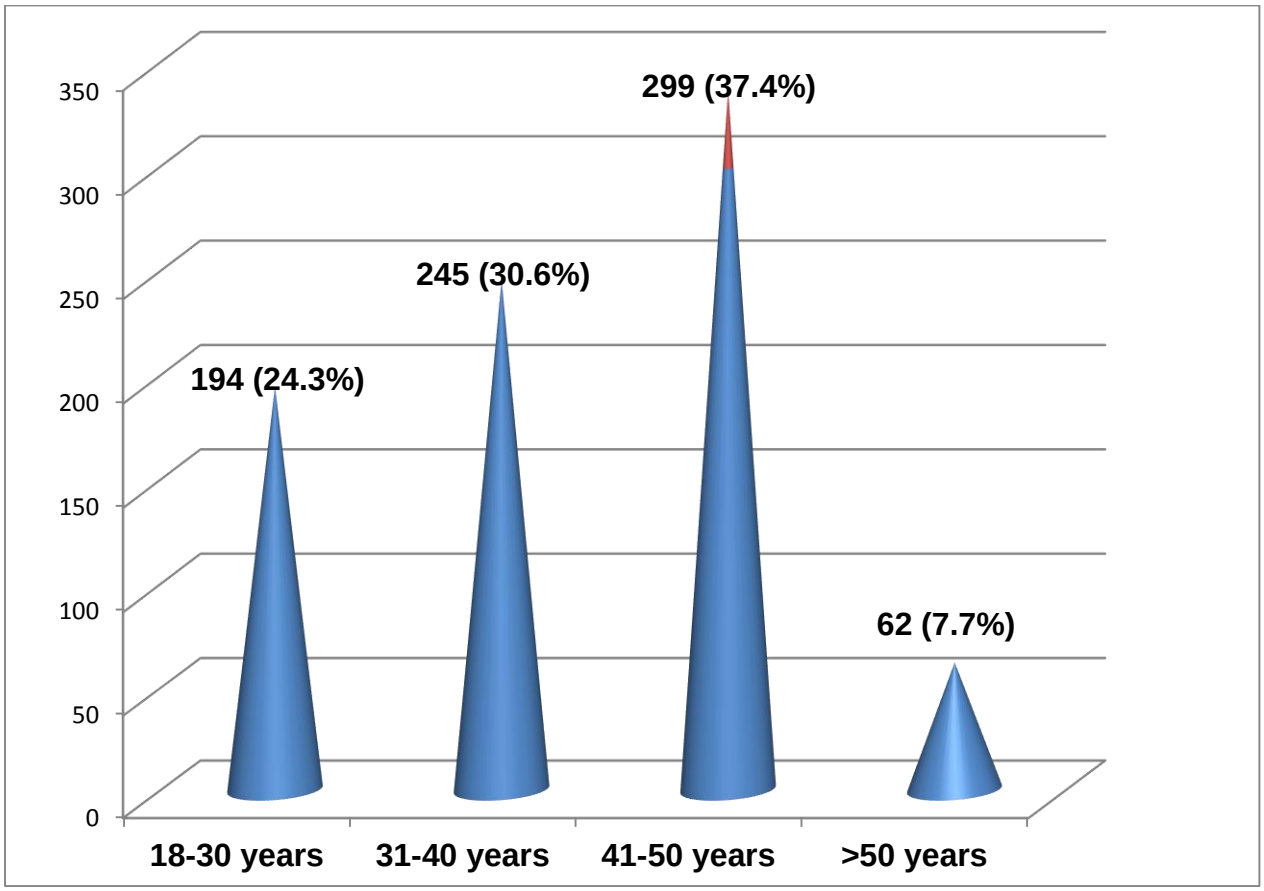

Figure 4.2: Age of respondents

The respondents' age ranged from 18 years to 50 years and older. Figure 4.2 shows that 194 (24.3%) respondents were from 18 - 30 years, 245 (30.6%) were 31 - 40 years, 299 (37.4%) were 41 – 50 years and 62 (7.7%) were 50 years and older. The two Health Centres are dominated by respondents of between 41 – 50 years of age. According to Young and Meterko (2009), respondents' age has a significant relationship with their satisfaction with regard to nursing care. The mean satisfaction level increase with an increase in age and higher satisfaction level was found in older age patients.

4.2.3 Marital status for respondents

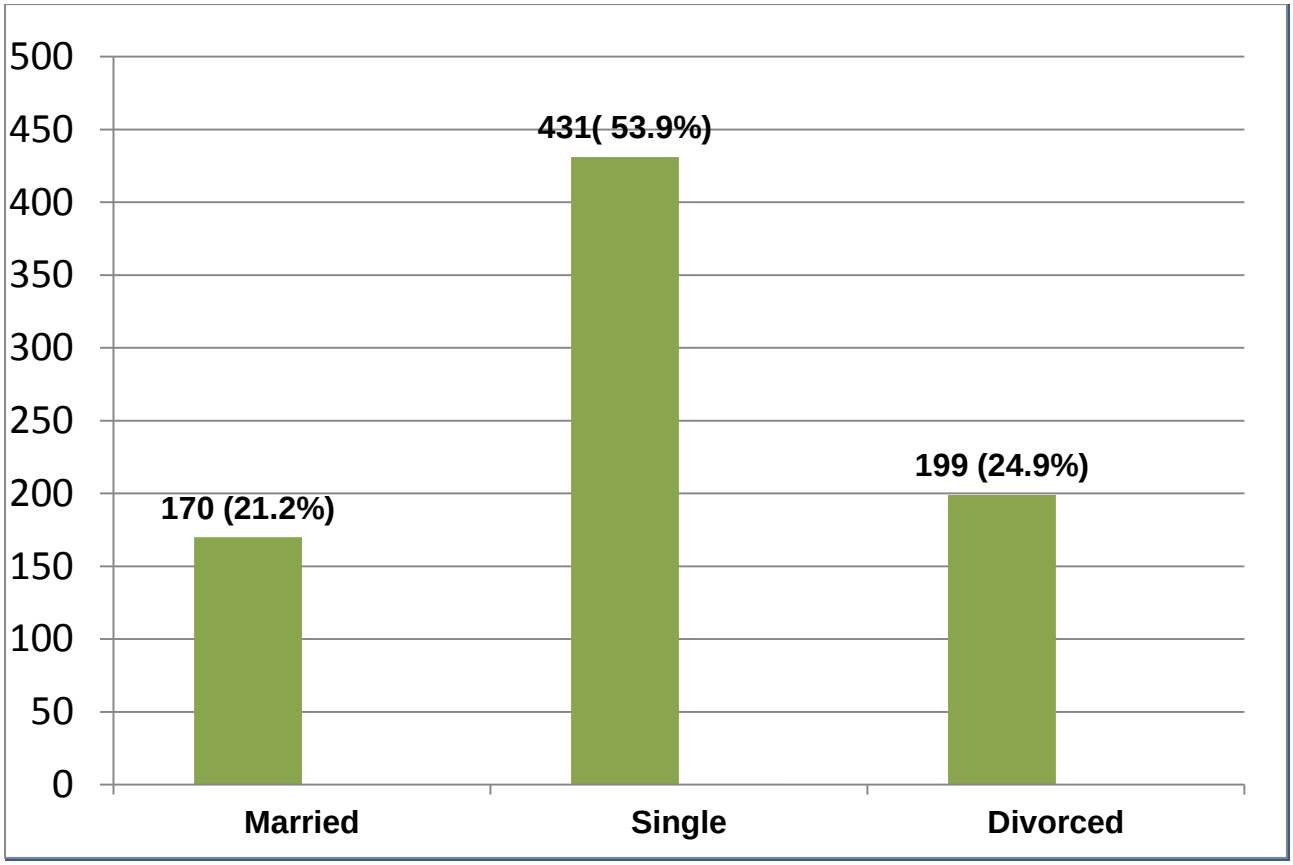

Figure 4.3: Respondents' marital status

The results in figure 4.3 shows that 170 (21.2%) of the respondents were married, 431 (53.9%) were single and 199 (24.9%) were divorced. In this study, majority of respondents were single followed by divorced rate. A study conducted by Lumby and England (2010), indicated that single persons uses public health services than married and divorced persons. Single patients had significantly less satisfaction level as compared to married and divorced.

4.2.4 Place of residence for respondents

Table 4.1 Respondent's place of residence

Place of residence	frequency	%
Agincourt	103	12.9
Croquetlawn	71	8.9
Dark City	68	8.5
Dumphries A	50	6.3
Dumphries B	50	6.3
Ireagh	32	4.0
Khaya lami	44	5.5
Kumani	73	9.1
Landela	70	8.8
Mambumbu	22	2.8
Mp Steam	81	10.1
New Forest	49	6.1
Newington	37	4.6
Rolle A	34	4.3
Other	16	2.0
Total	800	100.0

Table 4.1 reflects the frequency and percent of respondents' place of residence. The study was dominated by respondents from Agincourt village (12.9%), while Mambumbu village had the smallest number of respondents (2.8%). Respondents who are not part of the villages served by the two Health Centres contributed 2%.

4.2.5 Educational level

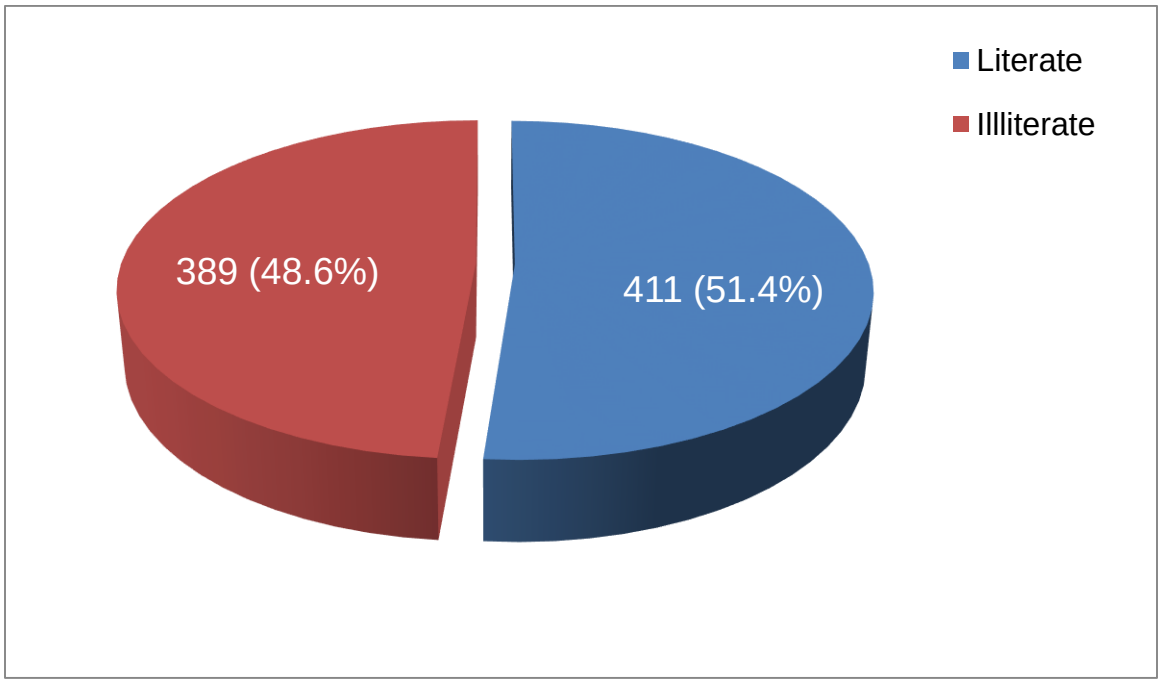

Figure 4.4: Respondents' educational level

Figure 4.4 represent the educational status of the respondents. According to the findings, 411 (51.4%) respondents were literate while 389 (48.6%) illiterate. Education at all levels remains a top priority of SA government (South African Department of Education, 2014). The education level of patients may influence patient satisfaction with care; greater satisfaction is associated with less education (Gerteis, 2009). Cooper, Beach, Johnson, and Inuli (2006) indicated that patients with less education do not know what they are entitled to or what constitutes good quality care. This study is dominated by illiterate respondents which resulted to more patients being dissatisfied with regard to nursing care.

4.2.6 Employment status

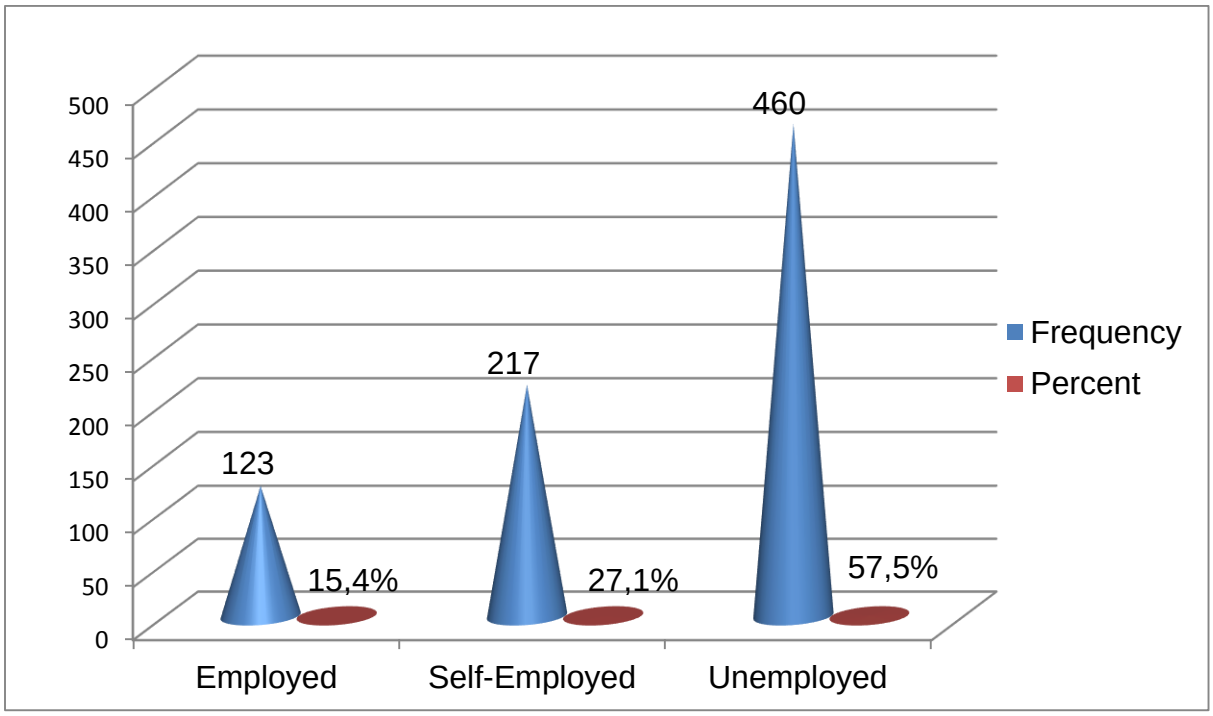

Figure 4.5: Employment status

Figure 4.5 shows the employment status of the respondents. The findings in the figure 4.5 shows that 123 (15.40%) respondents were employed, 217 (27.10%) were self-employed and 460 (57.50%) were unemployed. According to the findings, more than 50% of the respondents were unemployed. High and persistent unemployment increases the economic inequality and has a negative effect on subsequent long-run economic growth (Chaaya, Rabal, Morou & Kaiss, 2014).

Unemployment can harm growth not only because it is a waste of resources, but also because it generates redistributive pressures and subsequent distortions, drives people to poverty, erodes self-esteem, promoting social dislocation, unrest and conflict (Robert & Shille, 2013). According to Richard (2007), unemployment increases susceptibility to cardiovascular disease, anxiety, depression, and suicide. Unemployed people have higher rates of medication use, poor diet, physician visits, tobacco smoking, alcoholic consumption, drug use, and lower rates of exercise (Michaels, 2007).

Employed patients are associated with high satisfaction with regard to nursing care as compared to unemployed and self-employed.

Demographic information of the respondents

According to the findings in this study, 800 respondents were selected to participate. Each Health Centre contributed 50% of respondents. Majority (81.1%) of respondents were female. The study dominated by respondents aged from 41 - 50 years (37.4%) and 53.9% respondents were single. Amongst all villages participated in the study, Agincourt village had most respondents (12.9%). Nearly half (48.6%) of the respondents were Illiterate and 57.5% were unemployed.

4.3 Section B: Factors leading to patient dissatisfaction with regard to nursing care.

4.3.1 Respondents' number of visits in the two Health Centres per month

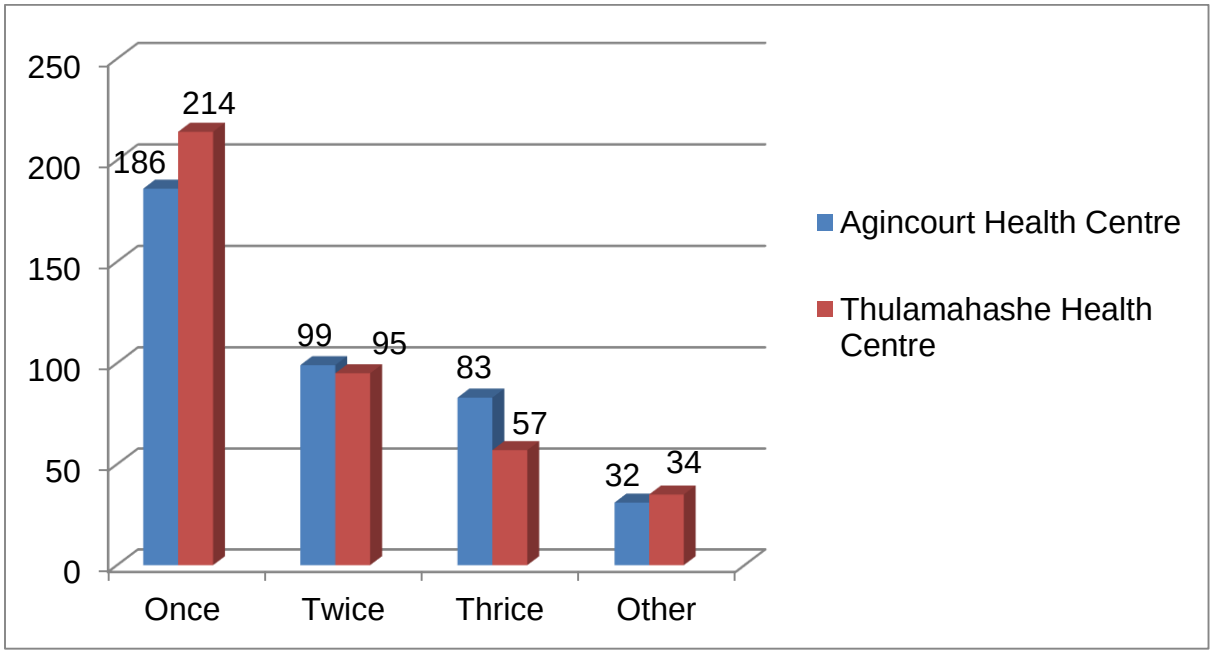

Figure 4.6: Respondents' number of visits

The frequency at which patients consult at the Health Centres is indicated in figure 4.6. The findings show that many patients (400= 50%) visit the Health Centres once per month. The ‘’other’’ above represent respondents who visit the Health Centres more than three times and those who visit not frequently. The first time visitors are indicated by the figure ‘’others’’. Agincourt Health Centre had 186 (46.5%) of respondents who visit once, 99 (24.8%) visit twice, 83 (20.7%) visit thrice and other is 32 (8%) while Thulamahashe Health Centre had 214 (53.5%) of respondents who visit once, 95 (23.8%) visit twice, 57 (14.2%) visit thrice and 34 (8.5%) is others.

More than half (53.5%) of respondents from Thulamahashe Health Centre visit the facility once per month as compared to Agincourt Health Centre (46.5%). The length of stay as well as previous experiences during hospitalisations also influenced patient satisfaction. Patients with more experience of hospitalization have more realistic expectations and are therefore easily satisfied (Ramhqvist, 2011).

4.3.2 Patients’ waiting time

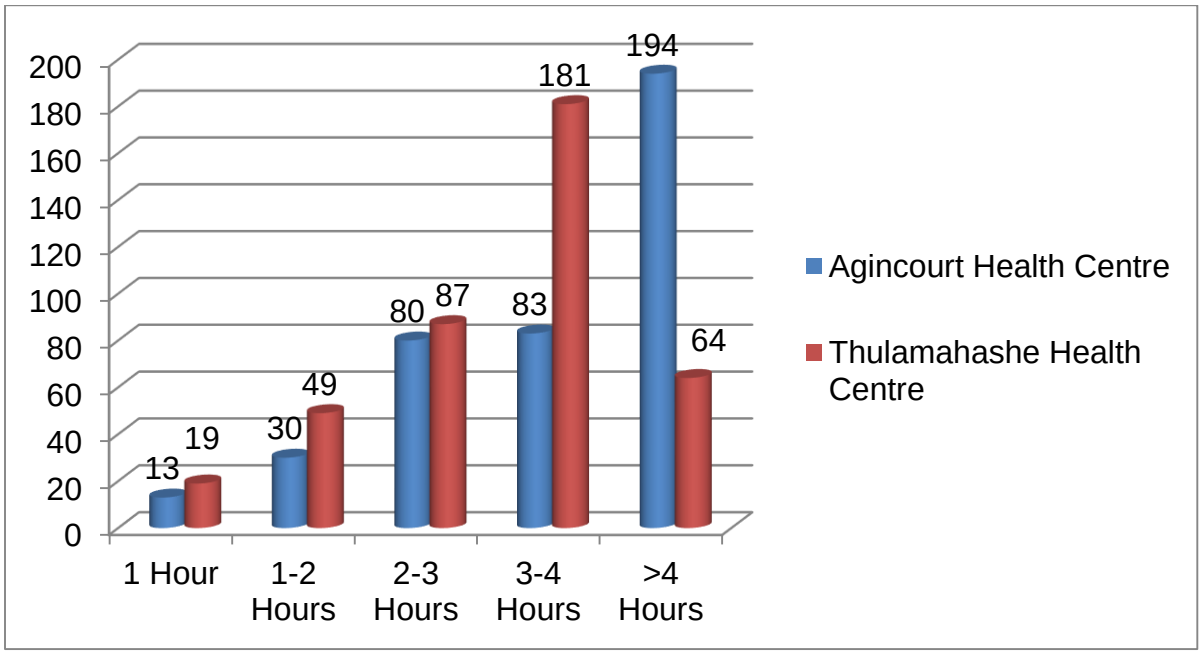

Figure 4.7: Patients’ waiting time

Figure 4.7 indicate the waiting time for respondents before consultation. At Agincourt Health Centre respondents who wait for 1 hour were 13 (3.3%), 1 – 2 hours were 30 (7.5%), 2 – 3 hours 80 (20%), 3 – 4 hours 83 (20.8%), more than four hours were 194 (48.5%) while respondents at Thulamahashe Health Centre who wait 1 hour 19 (4.8%), 1 – 2 hours 49 (12.3%), 2 – 3 hours 87 (21.8%), 3 – 4 hours 181 (45.3%) and more than 4 hours 64 (16%). The results displayed in figure 4.8 shows that respondents wait three hours and more before they get inside the consultation room and those who wait about an hour to consult were less. Respondents from Agincourt wait for many hours as compared to Thulamahashe Health Centre. T-test was calculated and the value was t=0.06. The results of a t-test show that there is no significance difference on waiting time between the two Health Centres.

Based on the results of the t-test, respondents from the two Health Centres were not happy with the waiting time. The vision of the National Department of Health and social services indicates that the commitment to providing quality services at all levels and patients are required to wait less than three hours in Health Centres and clinics (NDoH, 2011). The results show that the two Health Centres are not in line with the vision of the National Department of Health.

4.3.3 Respondents' satisfaction with waiting time

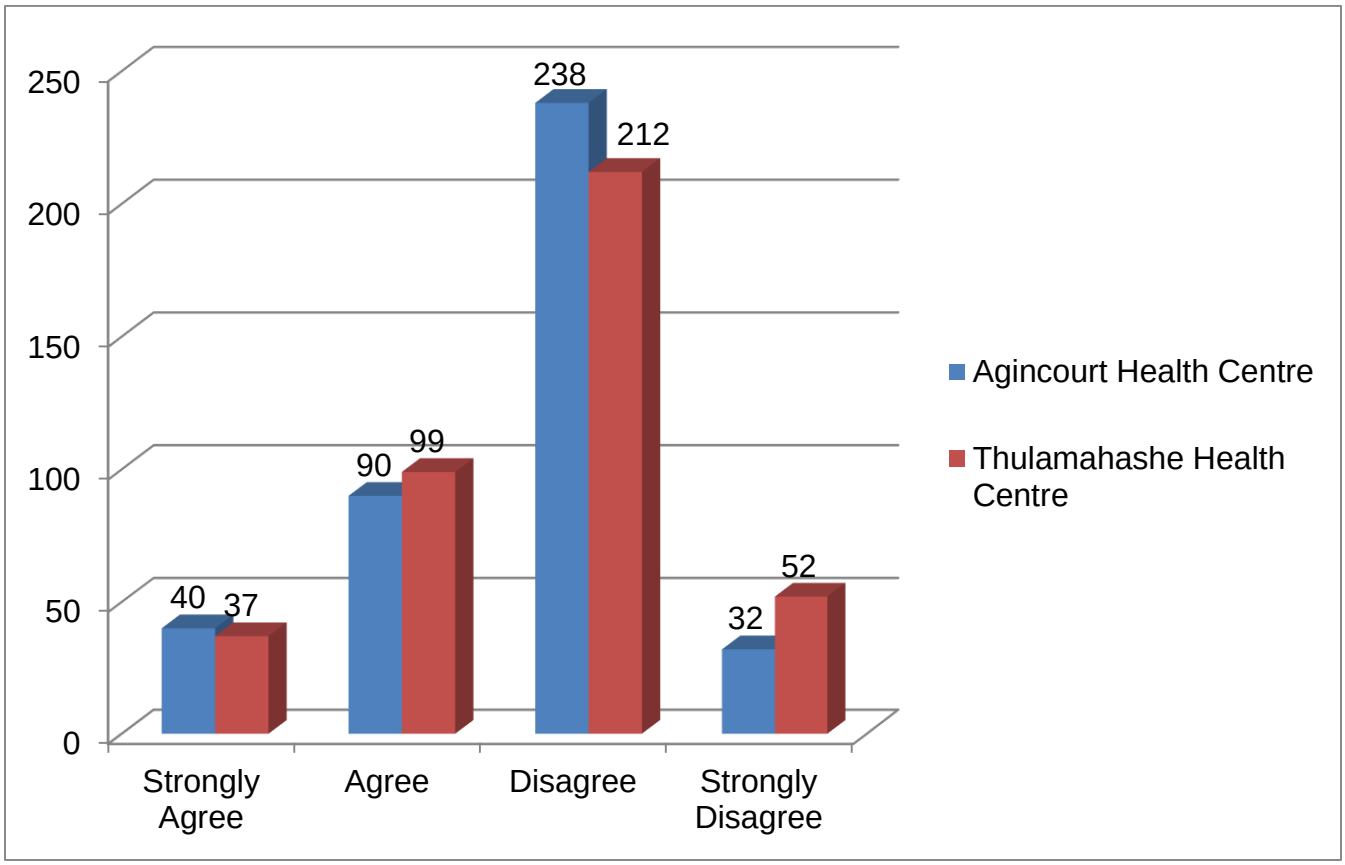

Figure 4.8: Satisfaction with waiting time

Figure 4.8 shows the Responds on satisfaction with waiting time from the two Health Centres. Respondents from Agincourt who strongly agree with the waiting time were 40 (10%), agree 90 (22.5%), disagree 238 (59.5%) and strongly agree 32 (8%), while respondents from Thulamahashe Health Centre who strongly agree were 37 (9.3%), agree 99 (24.7%), disagree 212 (53%) and strongly disagree 52 (13%). Respondents from both Health Centres are not satisfied with the time the wait before consultation. The value of the T-test was t=0.0 and it means there is a significant difference between Agincourt and Thulamahashe Health Centre. Agincourt had more respondents (59.5%) who disagree with the time they wait before consultation than Thulamahashe Health Centre which had (53%).

The results indicate that respondents are not satisfied with the time they wait before consultation. All South African residents have a constitutional right to receive services that meet their expectations. Long waiting time may cause delays in referring patients that need urgent attention (NDoH, 2011). According to Ericksson and Svedlund (2007) long lines and waiting times for services and care are “a waste of time” and have detrimental effects on patient’s satisfaction.

4.3.4 Communication and information

Table 4.2 Responses on communication and information

	AGINCOURT HEALTH CENTRE					THULAMAHASHE HEALTH CENTRE			
ITEMS	**SA**	**A**	**D**	**SD**		**SA**	**A**	**D**	**SD**
1.1 Are you informed about the waiting time before consultation?	13 (3.3%)	62 (15.5%)	292 (73%)	33 (8.2%)		32 (8%)	88 (22%)	242 (60.5%)	38 (9.5%)
1.2 Do nurses give you enough information?	22 (5.5%)	218 (54.5%)	137 (34.3%)	23 (5.7%)		38 (9.5%)	134 (33.5%)	194 (48.5%)	34 (8.5%)
1.3 Do nurses inform you about any procedures to be done on you?	46 (11.5%)	234 (58.5%)	95 (23.8%)	25 (6.2%)		44 (10.8%)	133 (33.3%)	177 44.3%)	46 (11.6)

1.4 Are you given time to explain at the consultation?	26 (6.5%)	251 (62.8%)	93 (23.2%)	30 (7.5%)		39 (9.7%)	162 (40.5%)	167 (41.8%)	32 (8%)
1.5 Are explanations about diagnosis and treatment done clearly?	97 (24.3%)	287 (71.7%)	12 (3%)	4 (1%)		63 (15.7%)	291 (72.8%)	32 (8%)	14 (3.5%)
1.6 Do nurses make any follow-up after diagnosis and treatment?	26 (6.5%)	150 (37.5%)	221 (55.3%)	3 (0.7%)		11 (2.7%)	173 (43.3%)	204 (51%)	12 (3%)
1.7 Are you given returned dates for follow-up?	13 (3.2%)	86 (21.5%)	279 (69.8%)	22 (5.5%)		38 (9.5%)	116 (29%)	210 (52.5%)	36 (9%)
1.8 Are you satisfied with the information given when living the Health Centre?	36 (9%)	86 (21.5%)	250 (62.5%)	28 (7%)		38 (9.4%)	97 (24.3%)	229 (57.3%)	36 (9%)

Based on the findings in item 1.1, Agincourt Health Centre had more (73%) of respondents who disagree that they are informed about waiting time before consultation while Thulamahashe had 60.5%. The results show that both Health Centres do not inform patients about waiting time before consultation. Patients expressed dissatisfaction with inflexible administrators that leave them not knowing who to contact (Ericksson & Svedlund, 2007).

The results in item 1.2 shows that more than half (54.5%) of respondents from Agincourt agree that the information given by nurses is enough while only 33.5% of respondents from Thulamahashe Health Centre agree. Patient satisfaction cannot be achieved without communication and information giving. The possession of information, knowing what to expect and understanding clinic routine facilitates the retention of control by patients (Irurita, 2013).

The results on item 1.3 indicate that Agincourt had 58.5% and Thulamahashe had 33.3% of respondents who are informed about any procedures to be done. Patients need to be informed and pre-counselling before procedures as they feel anxious (McCabe & Lindwall, 2004). The results in item 1.4 indicate that Agincourt had 62.8% while Thulamahashe Health Centre had less than half (40.5%) of respondents who are not given time at the consultation to explain. Based on the results, most (62.8%) respondents from Agincourt Health Centre are not given time to explain at the consultation room as compared to Thulamahashe Health Centre.

According to the results in item 1.5, Agincourt had 71.7% while Thulamahashe Health Centre had 72.8% of respondents who agree that explanations about diagnosis and treatment were done clearly. Patients need information regarding their care and condition as they feel anxious and vulnerable during their hospitalization (Strahan & Brown, 2008). More than half (55.3%) of respondents from Agincourt Health Centre while almost half (51%) from Thulamahashe Health Centre disagree with item 1.6. The results in item 1.7 show that 69.8% respondents from Agincourt and 52.5% respondents from Thulamahashe disagree that they are given return dates for follow-up. Follow-up and return dates are important for continuity of care and patient monitoring (Schroder, Anlstrom & Larsson, 2006).

The findings in item 1.8 indicate that 62.5% of respondents from Agincourt and 57.3% from Thulamahashe Health Centre disagree that they are satisfied with the information given when living the Health Centre. Walsh and Walsh (2009) affirm that adequate information giving is a necessary condition for patient empowerment and will reduce the risk of legal action when things have gone wrong. Deficiencies within this level of Maslow's hierarchy due to neglect, nurse's attitude, shunning and ostracism can impact the individual's ability to form and maintain emotionally significant relationships in general, such as friendship (Goebel & Brown, 2009).

4.3.5 Staffing and nurses' attitudes

Table 4.3 Responses on Staffing and nurses' attitudes

	AGINCOURT HEALTH CENTRE					THULAMAHASHE HEALTH CENTRE			
ITEMS	**SA**	**A**	**D**	**SD**		**SA**	**A**	**D**	**SD**
1.1 Do you think there is insufficient nursing staff at the Health Centre?	56 (14.3%)	290 (72.2%)	38 (9.5%)	16 (4%)		50 (12.5%)	260 (65%)	35 (8.7%)	55 (13.8%)
1.2 Do nurses work under pressure?	16 (4%)	282 (70.5%)	86 (21.5%)	16 (4%)		21 (5.3%)	245 (61.2%)	122 (30.5%)	12 (3%)
1.3 Do nurses have	30 (7.5%)	91 (22.8%)	264 (66%)	15 (3.7%)		43 (10.8%)	120 (30%)	202 (50.5%)	35 (8.7%)

positive attitude towards your health?									
1.4 Does nurse's attitude affect your health positively?	42 (10.5%)	227 (56.7%)	103 (25.8%)	28 (7%)		40 (10%)	96 (24%)	218 (54.5%)	46 (11.5%)

The results of on item 1.1 in tables 4.3 show that 72.2% of respondents from Agincourt and 65% from Thulamahashe Health Centre agree that there are insufficient nursing staffs at the Health Centre. The respondents from both Health Centres believe that there is a shortage of nurses. Persistent shortage of nursing staff results in inadequate nurse to patient ratio to meet all the demands, socio-demographic characteristics and the patient's health status are all factors which affect satisfaction with nursing care (Soleimanpour, 2011).

The results in item 1.2 indicate that 70.5% of respondents from Agincourt and 61.2% of respondents from Thulamahashe Health Centre agree that nurses' work under pressure. Extended work shifts of twelve hours or longer are common and even popular with hospital staff nurses, but little is known about how such extended hours affect the care that patients receive or the well-being of nurses (Vahey, 2011). Extended shifts undermine nurses' well-being, may result in expensive job turnover, and can negatively affect patient care (Aiken, 2011). According to the results in item 1.3 it shows that 66% of respondents were from Agincourt while almost half (50.5%) were from Thulamahashe Health Centre who disagree that nurse have positive attitude towards their health. According to Hornstein et al. (2007), the relationship between the patients and the nurse is a determinant of patient satisfaction with nursing care.

The results in item 1.4 indicate that Agincourt had 56.7% while Thulamahashe Health Centre had 24% of respondents who agree that the attitude of nurses affect their health positively. Attitude of nurses to patient contribute on the overall patient satisfaction with the nursing care (Friberg, Andersson & Benghtsson, 2007). Positive attitudes to patients, increase their hopes on their condition and they gain trust to the Health facility, Health staff and treatment (Thorsteinsson, 2012). According to Maslow hierarchy of need, humans need to feel a sense of belonging and acceptance among their social groups. Many people become susceptible to loneliness, social anxiety and clinical depression in the absence of this love or belonging element (Julia, 2010).

4.3.6 Service and environmental condition

Table 4.4 Service and environmental condition

	AGINCOURT HEALTH CENTRE					**THULAMAHASHE HEALTH CENTRE**			
ITEMS	**SA**	**A**	**D**	**SD**		**SA**	**A**	**D**	**SD**
1.1 Are you satisfied with the services at Health Centre?	54 (13.5%)	245 (61.2%)	72 (18%)	29 (7.3%)		29 (7.3%)	134 (33.5%)	189 (47.2%)	48 (12%)
1.2 Is the environment safe for your health?	29 (7.3%)	251 (62.7%)	119 (29.7%)	1 (0.3%)		42 (10.5%)	122 (30.5%)	235 (58.7%)	1 (0.3%)
1.3 Are you satisfied with the environmental condition?	19 (4.8%)	86 (21.5%)	272 (68%)	23 (5.7%)		35 (8.7%)	82 (20.5%)	250 (62.5%)	33 (8.3%)

1.4 Does the environment have enough privacy?	24 (6%)	246 (61.5%)	113 (28.3%)	17 (4.2%)		30 (7.5%)	84 (21%)	247 (61.7%)	39 (9.8%)
1.5 Does the environment affect your satisfaction?	68 (17%)	252 (63%)	48 (12%)	32 (8%)		88 (22%)	112 (28%)	132 (33%)	68 (17%)

Table 4.4 shows the findings based on the service and environmental condition of the two Health Centres in Bushbuckridge. The results in item 1.1 show that 61.2% of respondents from Agincourt and 33.5% from Thulamahashe Health Centre agree that they are satisfied with the services provided. Less than half (33.5%) of respondents from Thulamahashe agree with the service as compared to Agincourt Health Centre.

According to Aiken et al. (2012), Patients' perceptions of nursing care remain the strongest predictor of behavioural intention and include the likelihood of returning to a particular clinic and to recommending it to others. Patients increasingly want to learn more about their health conditions and they want to participate in the planning, organization and decision-making of services related to their health (Merkouris, Ifantopoulos, Lanara & Lemonidou, 2008).

With regard to item 1.2, Agincourt Health Centre had 62.7% and Thulamahashe Health Centre had 20.5% of respondents who agree that the environment of the Health Centres is safe for their health. Based on the findings, Thulamahashe Health Centre has a problem with the environmental condition as compared to Agincourt Health Centre. The Facilities and Infrastructure domain covers the requirements for clean, safe and secure physical infrastructure (buildings, plant, machinery, equipment) and functional, well managed health services, and effective waste disposal. This includes proper buildings, grounds, safety and security, cleanliness and linen (NDoH, 2011).

The results in item 1.3 show that 68% of respondents from Agincourt and 62.5% from Thulamahashe Health Centre disagree that they are satisfied with the environmental condition. The results show that the two Health Centres do not comply with the Patients' Rights Charter which aimed to provide a healthy and safe environment for all South African citizens. According to Maslow's hierarchy of needs, in the absence of physical safety due to poor working environment, conducive waiting area and consultation rooms, patient may re-experience post-traumatic stress disorder or trans-generational trauma (Muller, 2009).

According to the results in item 1.4, Agincourt Health Centre had 61.5% while Thulamahashe Health Centre had only 21% of respondents agree that the environment of the Health Centres have enough privacy. Based on the findings, Thulamahashe Health Centre had the list (21%) of respondents who are happy with the environmental condition as compared to Agincourt Health Centre. According to Stover and Sayers (2013), report of patients experiences where information was given in a thoughtful way in a quiet area, which was appreciated by the concerned patients. However, in some cases, the authors reported some lack of privacy with patients complaining that were overheard by people while discussing life threatening issues.

The results in item number 1.5 in Table 4.4 show that 63% of respondents from Agincourt Health Centre and 28% from Thulamahashe Health Centre agree that the environmental condition affect their satisfaction with the nursing care. More than half (63%) of the respondents from Agincourt believe that the environmental condition affect their satisfaction with the nursing care as compared to Thulamahashe Health Centre. Dignity and privacy of patients during hospital visit can only help in achieving patient satisfaction (Liu, Mok, and Wong, 2006). Dignity and privacy have also been established as determining factors in patient satisfaction. Patients for the most part trust that the nursing staff will maintain their dignity, privacy and confidentiality of information as well as trusting that the staff knew what they were doing Erikson and Svedlund (2007).

According to Maslow's hierarchy of needs, air, water, shelter, ventilation and food are metabolic requirements for survival in all animals, including humans (Torres, 2007). The absence of safety needs due to poor working environment, conducive waiting area and consultation rooms, patient may (re-) experience post-traumatic stress disorder or trans-generational trauma (Tang, Ibrahim & West, 2008). In this study, patients are not satisfied with the environmental condition of the Health Centres and they responded that it affects their health.

4.3.7 Reporting dissatisfaction

Table 4.5 Forms of reporting dissatisfaction

	Frequency	percent
Suggestion box	581	72.6%
Operational Manager's office	102	12.8%
Department of Health	85	10.6%
Other	32	4.0%

According to the findings in table 4.5 there are different ways used by respondents to launch complains at the Health Centres. Majority of respondents (72.6%) use the suggestion box, 12.8% report to the Operational Manager's Office, 10.6% report to the Department of Health and 4.0% uses other forms to report complains. Suggestion box is the most preferred method to launch complains as compared to other methods.

4.3.8 Shortage of treatment (medication)

4.3.8.1 Treatment for your condition?

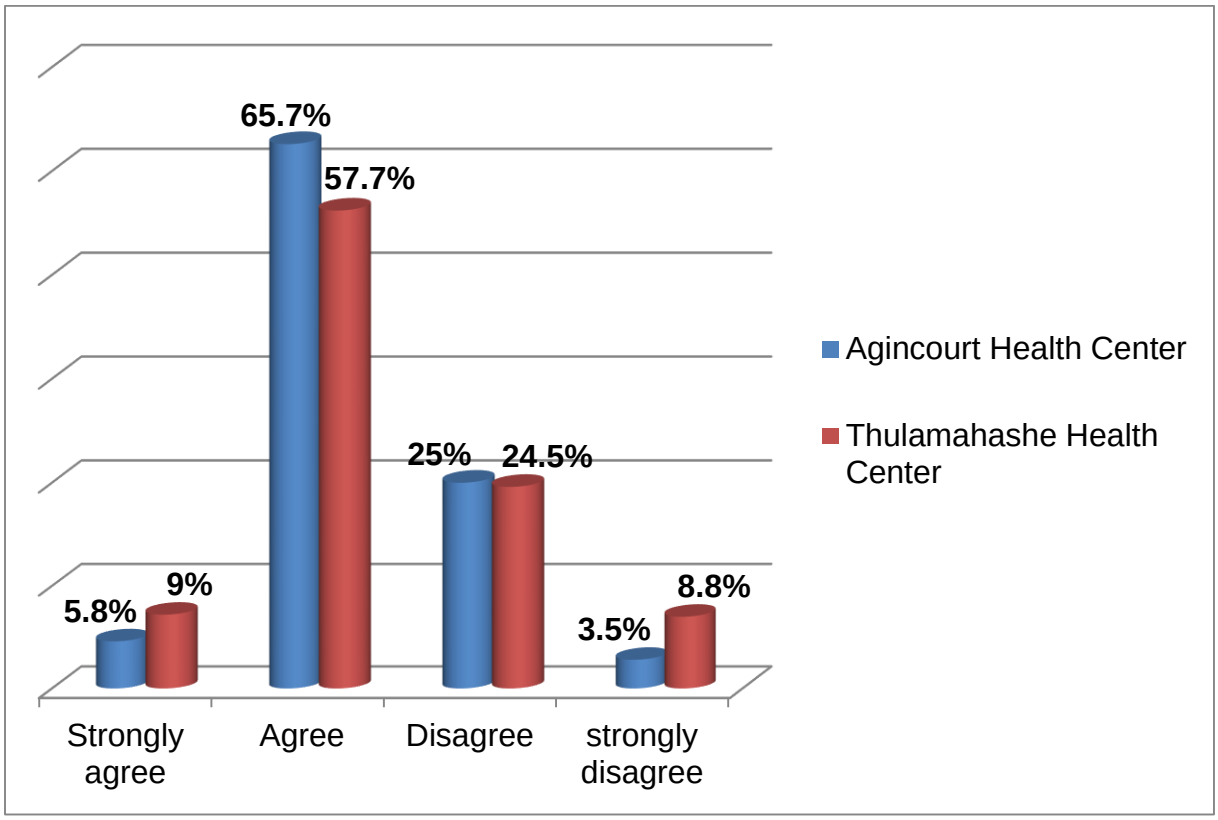

Figure 4.9: Treatment for your condition

Figure 4.9 shows the results of respondents' treatment for their condition. Agincourt Health Centre had 5.8% of respondents who strongly agree to the treatment, 65.7% agree, 25% disagree and 3.5% strongly disagree, while 9% of respondents from Thulamahashe Health Centre strongly agree, 57.7% agree, 24.5% disagree and 8.8% strongly disagree. Agincourt Health Centre had the most (65.7%) of respondents who agree to their treatment while Thulamahashe Health Centre had almost half (57.7%) of the respondents who agree. According to Maslow's hierarchy of needs, the safety need of resources, property and health was not met in the Health Centres because there are still patients who are not getting treatment for their condition. Lack of safety needs also results in patients' dissatisfaction with nursing care.

4.3.8.2 Shortage of treatment during consultation

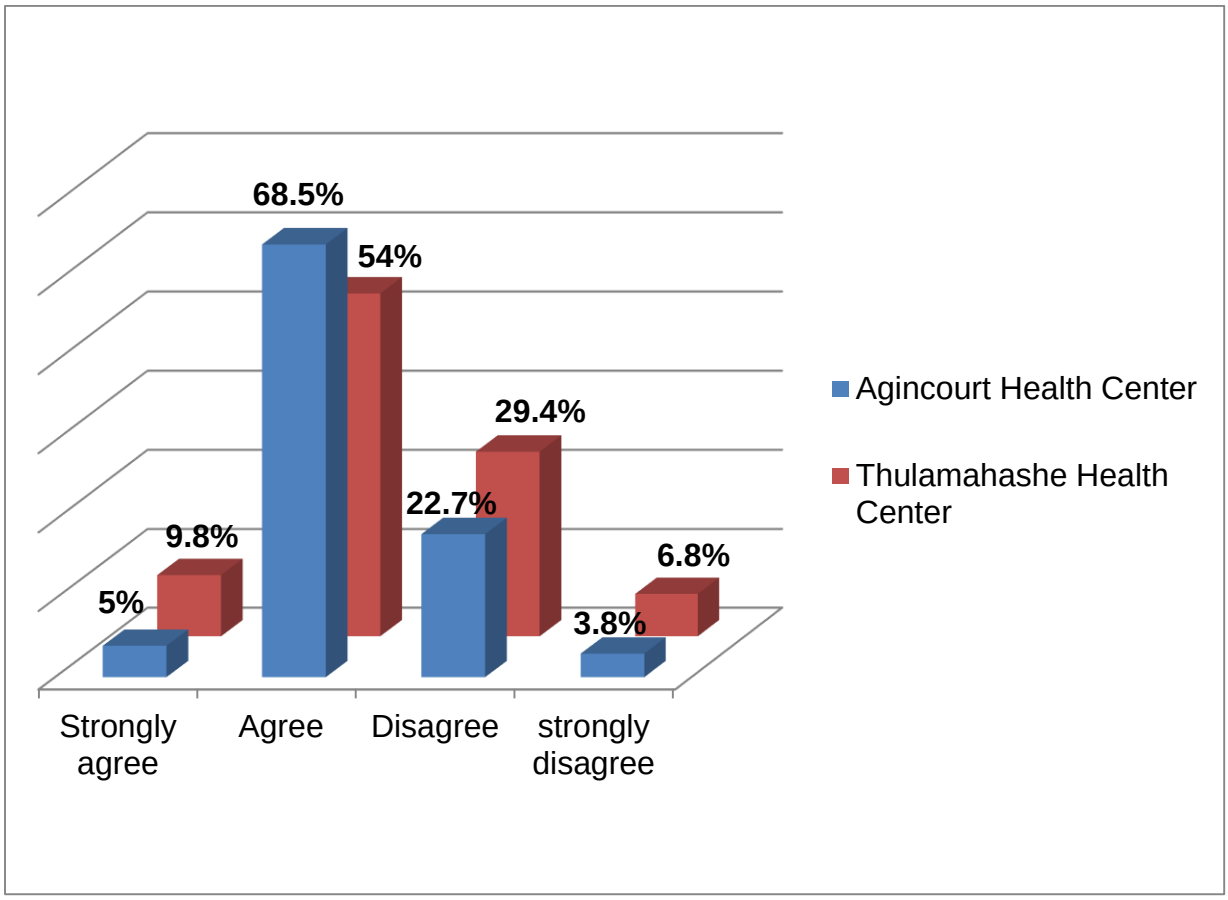

Figure 4.10: Shortage of treatment (medication)

Findings about shortage of treatment are presented in figure 4.10 above, and the results show that 5% of respondents from Agincourt Health Centre strongly agree that there is shortage of treatment, 68.5% agree, 22.7% disagree and 3.8% strongly disagree, Thulamahashe Health Centre had 9.8% of respondents who strongly agree that there is shortage of treatment, 54% agree, 29.4% disagree and 6.8% strongly disagree. The T-value was t=0, therefore there is a significant difference between Agincourt and Thulamahashe Health Centre. Agincourt Health Centre had most respondents (68.5%) who experienced shortage of treatment while Thulamahashe Health Centre had 54% as shown in the figure 4.10. The Clinical Support Services domain covers specific services essential in the provision of clinical care. This includes the timely availability of medicines and efficient provision of diagnostic, therapeutic and other clinical support

services and necessary medical technology, as well as systems to monitor the efficiency of the care provided to patients (NDoH, 2011).

Based on the findings, the principle of domain number three of the National Department of Health was not met. Shortage of medicines and supplies has become more common across the country (South Africa). The problem with suppliers maybe budget related, lack of payment or failure to place order in time. The Agincourt and Thulamahashe Health Centres do not comply with the National Patients' Rights Charter which aims on equal distribution and availability of resources for all. Based Maslow's hierarchy of needs, the health need of patients in the Health Centres was not met and patients experienced shortage of treatment which affects their Health need resulting to dissatisfaction.

4.3.8.3 Discharged without treatment

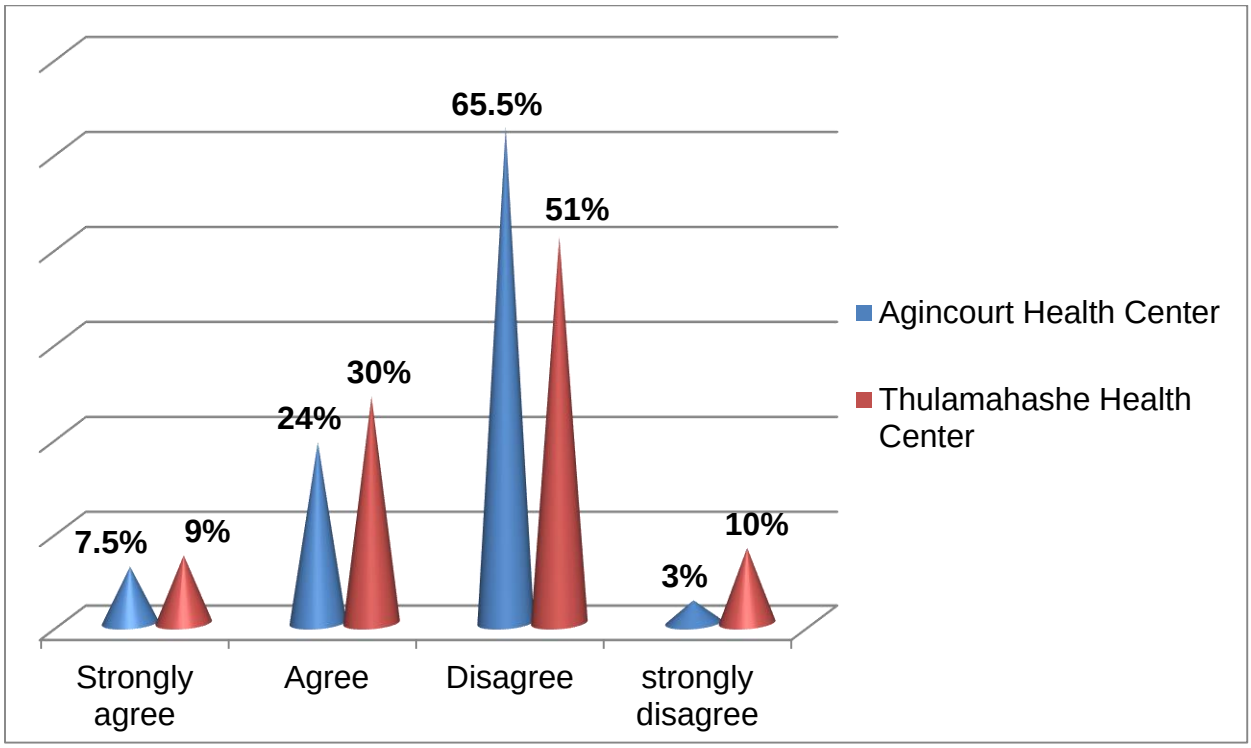

Figure 4.11: Discharging patients with no treatment (medication)

Figure 4.11 shows the results of respondents who were discharged without their treatment. Agincourt had 7.5% of respondents who strongly agree, 24% agree, 65.5% disagree and 3% strongly disagree, while Thulamahashe had 9% of respondents who strongly agree, 30% agree, 51% disagree and 10% strongly disagree that they were discharged without treatment. More than half (65.5%) of respondents from Agincourt disagree that they were once discharged without treatment, while Thulamahashe Health Centre had only 51% of respondents who disagree. As shown in figure 4.11 above, discharging patient without treatment is more common at Thulamahashe compared to Agincourt Health Centre.

The calculated t-test value was t=0, therefore there is a significant difference between Agincourt and Thulamahashe Health Centre. Thulamahashe dominated with respondents who were discharged without treatment as compared to Agincourt Health Centre. According to Maslow's hierarchy of needs, the safety need of resources, property and health was not met in the Health Centres because there are still patients who are discharged without treatment. Discharging patients without treatment lead to delay patient healing process and worsen patient condition. Patients' life style and daily routine changes due to inability of the human body to perform same of the functions. The delay in treating patients with communicable disease may result in increased rate of infecting others.

4.3.8.4 Another day for treatment collection

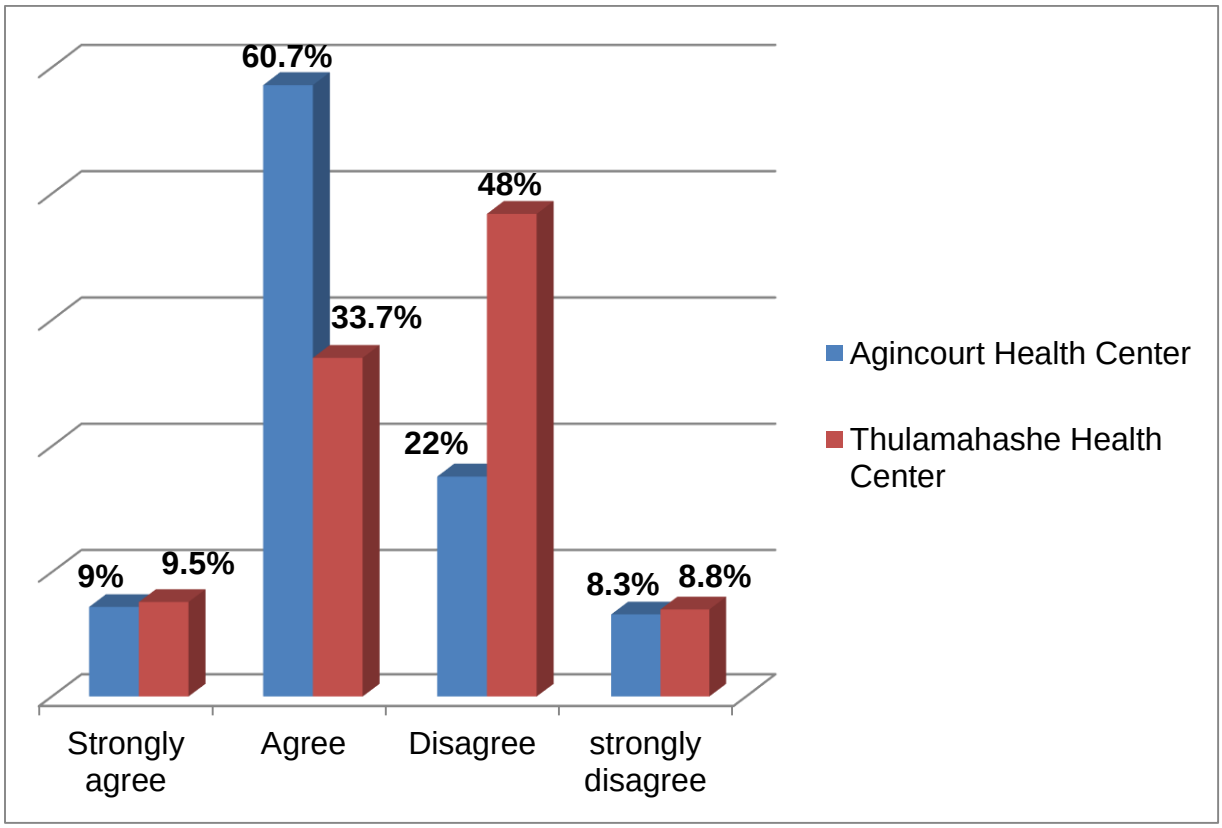

Figure 4.12: Return dates for treatment

Figure 4.12 shows the results of respondents who were given another day for treatment collection. Agincourt had 9% of respondents who strongly agree, 60.7% agree, 22% disagree and 8.3% strongly disagree, while Thulamahashe Health Centre had 9.5% of respondents who strongly agree that they were given other days for treatment collection, 33.7% agree, 48% disagree and 8.8% strongly disagree. The T-value was t=0, therefore there is a significant difference between Agincourt and Thulamahashe Health Centre. Most respondents (60.7%) from Agincourt as compared to Thulamahashe Health Centre (33.7%) agree that they were given another day for treatment collection because is not available on the day of consultation. Patients who are unable to receive their treatment they need on the day they come to collect it suffer not just the inconvenience and costs but possibly also the worsening of their condition (NDoH, 2011). According to Maslow's hierarchy of needs, the safety need of resources, property and health was not met in the Health Centres because there are still patients

who are not getting treatment for their condition. Lack of safety needs also results in patients' dissatisfaction with nursing care.

4.3.8.5 Advise to buy treatment at chemist

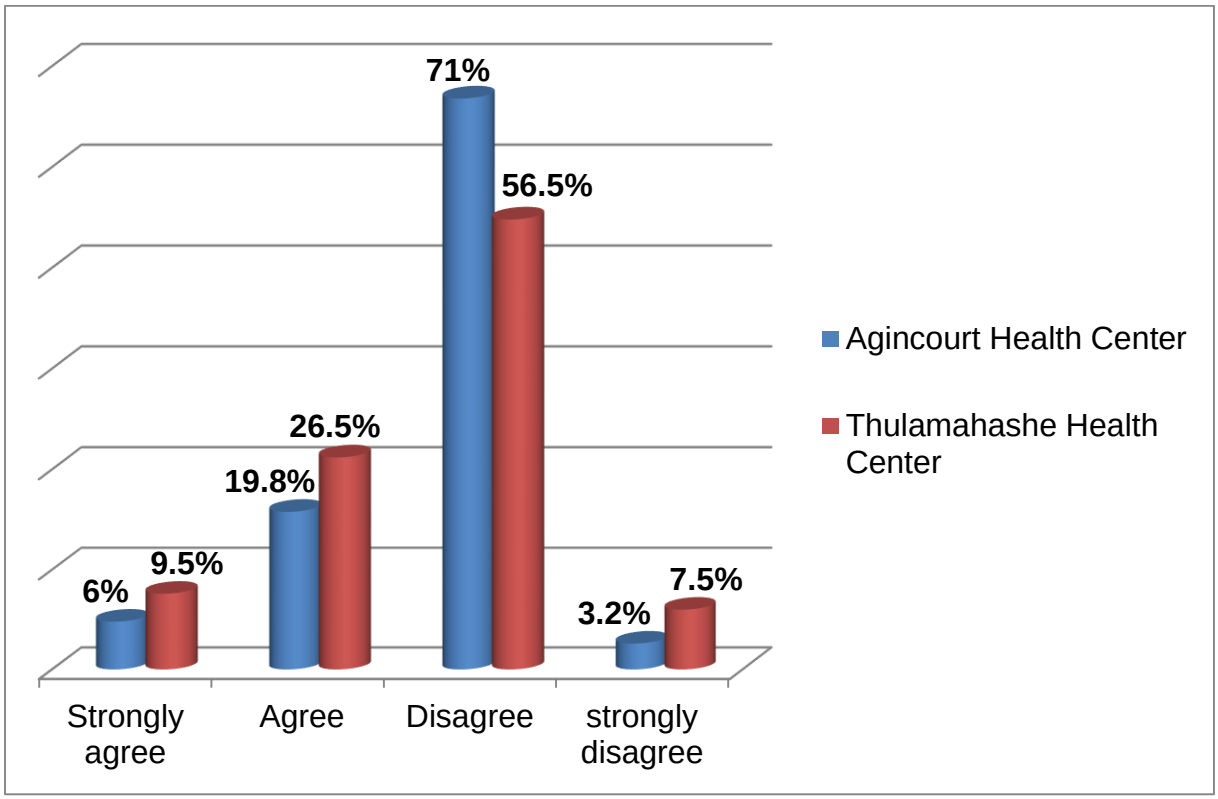

Figure 4.13: Advice to buy treatment

The results on patient advice to buy treatment are represented in figure 4.13. According to the findings shown in figure 4.13, 16, 6% of respondents from Agincourt strongly agree, 19.8% agree, 71% disagree and 3.2 strongly disagree. The responses from respondents at Thulamahashe were: 9.5% strongly agree, 26.5% agree, 56.5% disagree and 7.5% strongly disagree. Agincourt had almost three third (71%) of respondents who disagree that they were advised to buy treatment while Thulamahashe had more than half (56.5%).

According to the results shown in figure 4.13, Thulamahashe had more (26.5%) of respondents who were advised to buy treatment than Agincourt Health Centre.

The vision of the National Department of Health and social services indicates the commitment to providing quality services at all levels. The provision of quality services is a legitimate expectation in a democratic society and is an essential yardstick for ensuring that the communities are protected, respected, treated fairly and has equal access to health services. All South African residents have a constitutional right to receive services that meet their expectations (NDoH, 2011).

4.3.8.6 Referral to another Health care facility to request treatment

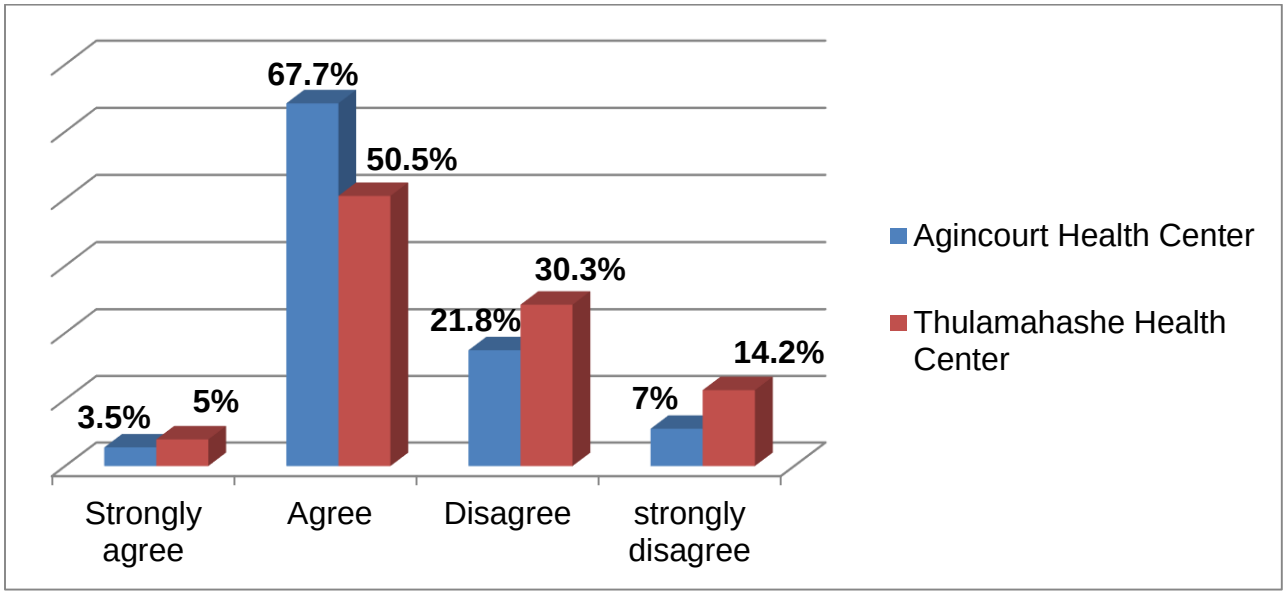

Figure 4.14: Referral to another facility to request treatment

Figure 4.14 shows that Agincourt Health Centre had 3.5% of respondents who strongly agree that they were referred to another facility to request treatment, 67.7% agree, 21.8% disagree and 7% strongly disagree, while the results from Thulamahashe Health Centre were 5% for strongly agree, 50.5% agree, 30.3% disagree and 14.2% strongly disagree. Agincourt Health Centre had the most (67.7%) respondents who were referred to another facility to request treatment. According to Maslow's hierarchy of needs, the safety need of resources and property was not met in the Health Centres because there are patients who are referred to another Health facility to request treatment and those patients are affected financial and emotional.

4.4 Protocol to enhance patient satisfaction with regard to nursing care at the Health Centres in Mpumalanga Province.

In this study, a protocol with regard to nursing care at the Health Centres was developed based on the findings from the respondents. Factors leading to patient dissatisfaction with regard to nursing care were used in the development of the protocol as in figure 4.15.

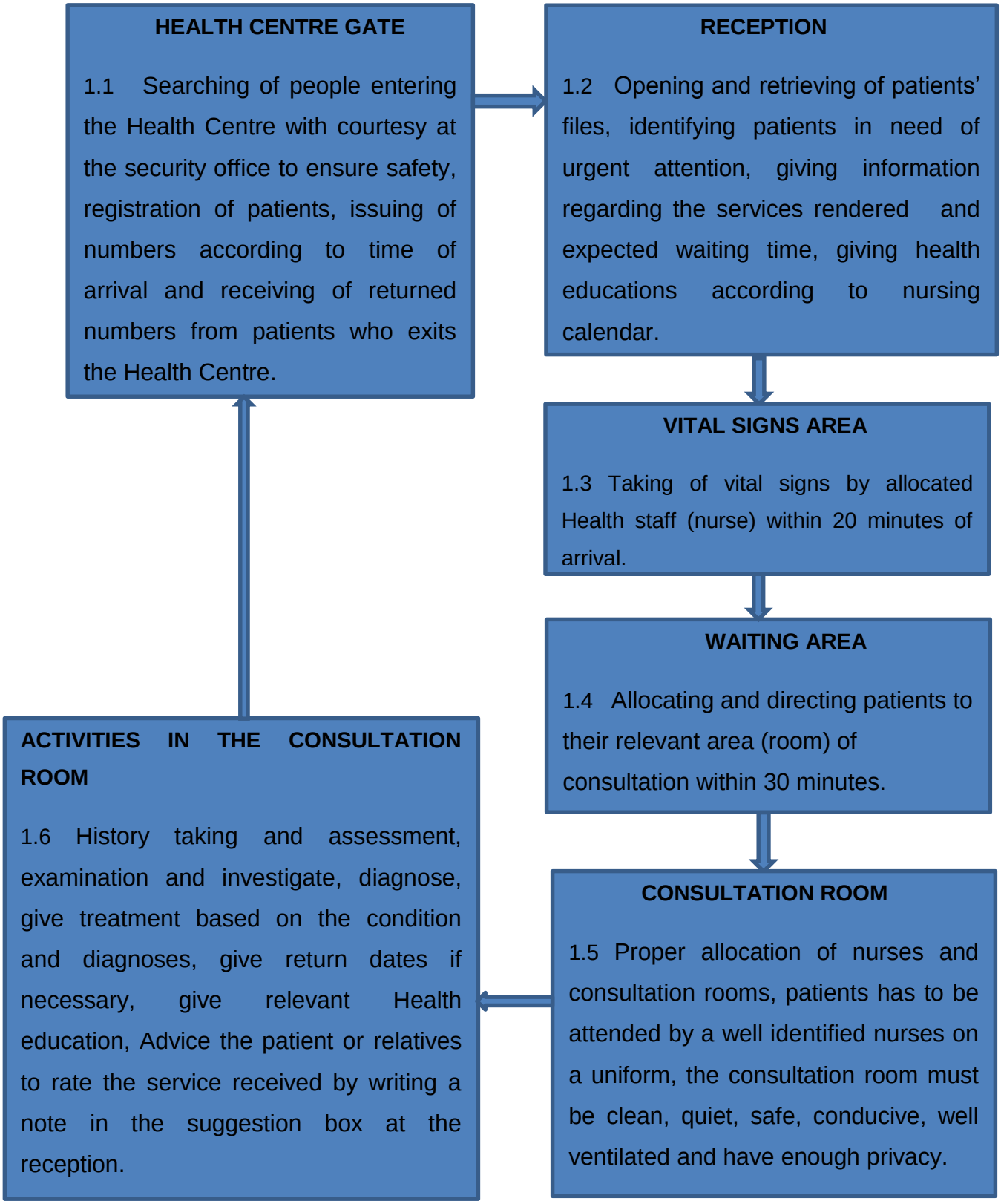

Figure 4.15: Protocol to enhance patient satisfaction

4.4.1 Health Centres' gate

The Health Centres' gate is the first point for patient entering the facility. Activities to enhance patient satisfaction start at the gate. The gate has a security office and it is occupied by security officers. Searching of people entering the Health Centres at the security office is done to maintain safety of patients and health staff. Searching patients with courtesy is important as required by Batho Pele principles. Patients have the right to healthy and safe environment. Security officers have the responsibility to ensure that the patients' rights are not violated. Registration of patients entering the Health Centres' gates is done for quality assurance. The security officers give numbers to patients according to time of arrival to avoid mix-up of the queue and for statistics purpose. All patients exiting the Health Centres' gates return the numbers to the security officers who should record the time of exit.

4.4.2 Reception

Reception is the most important area because it is where vital activities are being done. At the reception of the Health Centres, there is opening and retrieving of patients' files. Patients in need of urgent attention (serverely ill, open bleeding wound, TB patients and pregnant woman in labour) are identified at the reception and directed to the relevant consultation room. The health staff members who are responsible for the reception must give information to patients and relatives regarding the services rendered and expected waiting time for re-assurance purpose. Giving health education according to nursing calendar helps to empower patients and relatives with information and knowledge regarding health-related issues. At the reception patients should not wait for more than 20 minutes as required by the NDoH. The admin officer is responsible for calculating the time spent in the facility per patient.

4.4.3 Vital signs area

The vital signs area is where first assessment and examination of patients start. At the Health Centres, vital signs are taken and also help to identify abnormalities such as elevated blood pressure by the allocated nurse. Directing patients to their relevant area

(room) of consultation is done by the vital signs nurse at the waiting area. Directing patients also serve for continuity of care. Waiting time at the vital signs area should not be more than 20 minutes.

4.4.4 Waiting area

Waiting area at the Health Centres is a place where patients wait and queue to enter the consultation room. At the waiting area patients must be directed to the relevant consultation. The waiting area of the Health Centres must be large, free from harm, well ventilated, clean and quiet. At the Health Centres, patients should not wait more than 3 hours before consultation.

4.4.5 Consultation room

The consultation room of the Health Centres is the last stage of patient nursing care. There must be proper allocation of nurses and consultation rooms to meet patient demands or needs. Patients in the consultation room have to be attended by well identified nurses wearing uniform to ensure courtesy in terms of Batho Pele principle. Patients have the right to be treated by a named healthcare provider. The nurses in the consultation rooms must be friendly, open and have good communication skills to be able to freely communicate with patients. The consultation rooms of the Health Centres must be:

- Clean to prevent infections.
- Quiet for better concentration and to avoid interruption.
- Safe room to prevent harm.
- Conducive for quality nursing care services.
- Well to prevent inhalation of infection.
- Provided with enough privacy for patients to freely ventilate their problems. Confidentiality and privacy must be maintained as required by the patients' right charter.

The activities at the consultation room of the Health Centres are: history taking and assessment, examination and investigation, diagnose, prescribe and give treatment

based on the condition and diagnoses and give return dates if necessary. Giving relevant Health education based on the condition, diagnosis and treatment prescribed for the patient is also done at the consultation room. Nurses at the consultation rooms issue treatment because they are no pharmacists at the Health Centres. The nurse at the consultation room must also advice the patient or relatives to rate the service received by writing a note and post it in the suggestion box at the reception when leaving the facility.

4.5 Conclusion

This chapter presented research findings, interpretation of the results and supporting literature. Based on the results, majority of respondents were female and that most of the respondents experienced similar problems such as: long waiting time, poor communication and information, shortage of nurses and attitude, poor service and environmental condition, shortage of treatment (medication). Chapter 5 discusses the summary, limitations, recommendations and conclusion of the study.

CHAPTER 5

SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

Chapter 4 focused on discussion and interpretation of the results. This chapter summarises the study, present the findings, discusses the limitations of the study and makes recommendations, further the research study and the protocol.

5.2 Summary of the study

5.2.1 Aim of the study

The aim of the study was to develop a protocol to enhance patient satisfaction with regard to nursing care at the Health Centres in Mpumalanga Province.

5.2.2 Objectives of the study

The objectives of the study were as follows:

- Determine factors leading to patient dissatisfaction with regard to nursing care at Health Centres in Mpumalanga Province, South Africa.
- Develop a protocol to enhance patient satisfaction with regard to nursing care at Health Centres in Mpumalanga Province, South Africa.

The returned questionnaires were coded and then captured using the Microsoft Excel program. IBM SPSS statistics program was used for data analysis (Statistical Package of Social Sciences) version 22.

5.2.3 Findings

The findings were discussed based on the objectives of the study.

***** Determine factors leading to patient dissatisfaction with regard to nursing care at the Health Centres in Mpumalanga province, South Africa.

Responses on waiting time

- Half (50%) of the respondents visit the Health Centres once in a month.
- Almost half (48.5%) of respondents at Agincourt Health Centre waited for more than 4 hours for consultation, while 45.3% of respondents from Thulamahashe Health Centre waited 3 – 4 hours.

Responses on communication and information

- Agincourt Health Centre had more (73%) of respondents who disagree that they are informed about waiting time before consultation while Thulamahashe had 60.5%.
- Agincourt had 71.7% while Thulamahashe Health Centre had 72.8% of respondents who agree that explanations about diagnosis and treatment are done clearly.
- More than half (55.3%) of respondents from Agincourt while almost half (51%) from Thulamahashe Health Centre disagree that nurses make any follow-up after diagnosis and treatment.
- The findings indicate that 62.5% of respondents from Agincourt and 57.3% from Thulamahashe Health Centre disagree that they are satisfied with the information given when living the Health Centre.

Staffing and nurses' attitude

- The results on staffing and nurses' attitudes show that 72.2% of respondents from Agincourt and 65% from Thulamahashe Health Centre agree that there are insufficient nursing staff members at the Health Centre.

- According to the results in item 1.3 show that 66% of respondents were from Agincourt while almost half (50.5%) were from Thulamahashe Health Centre who disagree that nurses have positive attitudes towards their health.
- Agincourt had 56.7% while Thulamahashe Health Centre had 24% of respondents who agree that the attitude of nurses affect their health positively.

Service and environmental condition

- The results show that 61.2% of respondents from Agincourt and 33.5% from Thulamahashe Health Centre agree that they are satisfied with the services provided.
- Agincourt had 62.7% and Thulamahashe Health Centre had 20.5% of respondents who agree that the environment of the Health Centres is safe for their health.
- Respondents (68%) from Agincourt and 62.5% from Thulamahashe Health Centre indicated that they are dissatisfied with the environmental condition.
- Agincourt had 61.5% while Thulamahashe Health Centre had only 21% of respondents who agreed that the environment of the Health Centres have enough privacy.

Forms of reporting dissatisfaction

- According to the findings on the question of ‘’ How do you report dissatisfaction/complains?’’, more than two thirds (72.6%) of the respondents report in the suggestion box, 12.8% report to the Operational Manager’s office, 10.6% report to the Department of Health. Only 4% of the respondents used other forms of reporting complains.

Shortage of treatment (medication)

- Agincourt Health Centre had 65.7% of respondents who reported that they receive treatment for their condition, while 57.7% of respondents from Thulamahashe Health Centre agreed.
- The finding about shortage of treatment shows that 68.5% of respondents from Agincourt Health Centre agree, while Thulamahashe Health Centre 54% agrees.
- Agincourt Health Centre had 65.5% of respondents who disagree that they were discharged without treatment, while Thulamahashe Health Centre had only 51%.
- Respondents who were given another day for treatment collection: Agincourt Health Centre had 60.7% of respondents who agree, while Thulamahashe Health Centre had 33.7% of respondents who agree.
- Agincourt had 67.7% of respondents who agree that they were referred to another facility to request treatment, while the results from Thulamahashe were 50.5% of respondents who agreed.

Relationship between Maslow's hierarchy of needs and the results of the study

The relationship between the theory of Maslow's hierarchy of needs and the results of the study was characterised based on the findings on factors leading to patient dissatisfaction with regard to nursing care at the Health Centres in Mpumalanga Province.

Waiting time

- At the Health Centres in Mpumalanga Province, patients are not satisfied with the time they wait before consultation. Based on Maslow's hierarchy of needs, the safety need against accidents/illness and their adverse impacts are not met in the Health Centres. Long waiting time may cause delays in referring patients that need urgent attention. Long lines and waiting times for services and care are “a waste of time” and have detrimental effects on patient’s satisfaction.

Communication and information

- The results of the study on communication and information show that nurses at the Health Centres have a gap in communicating with patients. Patients expressed dissatisfaction with inflexible nurses that leave them not knowing whom to contact. At the Health Centres, patients are not given information about services rendered, expected waiting time, enough information about their condition, procedures to be done, follow-up after treatment and return dates. Deficiencies within this level of Maslow's hierarchy of needs (love and belonging) due to neglect, nurse's attitude, shunning, ostracism communication and information will impact the individual's ability to form and maintain emotionally significant relationships in general, such as friendship which result in patient dissatisfaction.

Staffing and nurse's attitude

- Staffing and nurses' attitude are the core factors in patient satisfaction with regard to nursing care at the Health Centres in Mpumalanga Province. According to the results of the two Health Centres, patients believe there is shortage of nurses and nurses attitude affect their health. Shortage of nursing staff results in inadequate nurse to patient ratio. The relationship between the patients and the nurses is a determinant of patient satisfaction with nursing care. Positive attitude to patients' increases hopes of patients on their condition and they gain trust to the health facility, health staff and treatment. According to Maslow's hierarchy of need, humans need to feel the love of belonging and acceptance among their social groups. Many people become susceptible to loneliness, social anxiety and clinical depression in the absence of this love or belonging element.

Service and environmental condition

- The service and the environmental condition of the Health Centres have a detrimental effect on patient satisfaction with regard to nursing care. The results in this study shows that respondents are not satisfied with the services of the Health Centres, environmental condition and that the Health Centres had no enough privacy. According to Maslow's hierarchy of needs, in the absence of physical safety due to poor working environment, conducive waiting area and consultation rooms, patient may re-experience post-traumatic stress disorder or trans-generational trauma.

Shortage of treatment (medication)

- Shortage of treatment is a major challenge in the Health Centres in Mpumalanga Province. Most respondents expressed dissatisfaction with shortage of treatment for their condition during consultation, discharged without treatment, given another day for treatment collection and others were advised to buy treatment at chemists. At the Health Centres, patients who are unable to receive their treatment on the day of consultation suffer not just the inconvenience and costs but possibly also the worsening of their condition. According to Maslow's hierarchy of needs, the need of resources, property and health was not met in the Health Centres because there are still patients who are not getting treatment for their condition. Lack of safety needs also results in patients' dissatisfaction with nursing care. Discharging patients without treatment lead to delayed patient healing process and worsen patient condition.

5.3 Limitations of the study

The study was conducted at Agincourt and Thulamahashe Health Centres in the Mpumalanga Province, therefore the findings cannot be generalised to other Health Centres and Clinics of the Mpumalanga Province.

5.4 Recommendations

Department of Health

- Renovations/ building of the Health Centre's structures to accommodate large number of patients, especially in the reception, waiting area, consultation rooms, pharmacy, storage rooms.
- Shortage of nurses should be addressed and availability of posts for all categories in nursing should be filled by suitable appointment.
- Workshops regarding nursing care should be planned and implemented to nurses.

Health Centres managers' and staff

- Waiting time should be reduced to less than three hours as required by the South African National Core Standard.
- Relevant information should be given to patients for better knowledge and understanding.
- Good communication skills must be rendered by nurses to build nurse-patient relationship.
- In-services training should be implemented regarding nursing.
- Treatment (medicine) supply should be monitored closely. Treatment stock intake and out-take should be recorded. Ordering of treatment should be done frequently.

5.5 Conclusion

Findings, limitations, recommendations were discussed in this chapter. The study found that patients from the two Health Centres have same problems. The Mpumalanga Department of Health, Operational Managers, Health staff and programme co-ordinators should tackle the challenges.

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ANNEXURE 1: INFORMED CONSENT (English)

UNIVERSITY OF LIMPOPO (Turfloop Campus) ENGLISH CONSENT FORM

Statement concerning participation in a research study.

Name of Study: Development of a protocol to enhance patient satisfaction with regard to nursing care at the Health Centres in Mpumalanga Province.

I have been provided with the aims and objectives of the study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurised to participate in any way.

I know that the results of this study will appear in scientific publications that will be electronically available throughout the world. I consent to this, provided that my name is not revealed. I understand that participation in this study is completely voluntary and that I may withdraw from it at any time without supplying reasons.

I know that this study has been approved by Turfloop Research Ethics Committee (MREC), Mpumalanga Department of Health and the Operational managers of Agincourt and Thulamahashe Health Centres. I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided that my privacy is guaranteed.

I hereby give consent to participate in this study.

…….. …….

Name of respondent Signature of respondent/ guardian

…….. …….. ……

Witness Place Date

Statement by the Researcher

I provided verbal and written information regarding this study.

I agree to answer any future questions concerning the study as best as I am able.

I will adhere to the approved protocol.

…….. …… ……..…

Name of Researcher Signature Date

ANNEXURE 2: PAPILA RA MPFUMELELO

UNIVERSITY OF LIMPOPO (Turfloop Campus) XITSONGA CONSENT FORM

Xiletelo mayelana na ku nghenelela eka ndzavisiso wa xitadi.

Vito ra xitadi: Ndlela yo antswisa ku eneriseka ka vavabyi mayelana na ku nakekeriwa hi swa vuongori ekati Health Centres, xifundzha-nkulu xa Mpumalanga, Afrika Dzonga.

Ndzi nyikiwile swikongomelo na maendlelo ya ndzavisiso, ndzi thlela ndzi nyikiwa nkarhi wo vutisa swivutiso na ku nyikiwa nkarhi lowu eneleke ku ehleketisisa hi mhaka leyi. Xikongomelo na maendlelo ya xitadi (ndzavisiso) swi basisiwile eka mina. Andzi sindzisiwanga ku nghenelela hi ndlela yihi kumbe yihi. Ndza swi twisisa leswaku ku nghenale eka xitadi (ndzavisiso) lexi I Ku tsakela ka mina naswona ndzi nga tihumesa eka swona nkarhi wun'wana na wun'wana handle ko hlamusela ku hikwalaho ka yini.

Ndza swi tiva leswaku xitadi lexi xi pfumeleriwile hi komiti ya swa vulavisisi leyi vuriwa Turfloop Research Ethics Committee (MREC) na ndzawulo yari Hanyo xifundzha-nkulu xa Mpumalanga na vha rangeri vha Kliliniki. Ndza swi tiva hi Ku hetiseka leswaku mbuyelo wa xitadi wu ta tirhisiwa eka swikongomelo swa tisayense nakona swi nga hangalasiwa. Ndza pfumela eka leswi, ntsena loko ndzi tiyisisiwa leswaku ndzi nga ka ndzi nga humelerisiwi kumbe Ku tivisiwa eka van'wana.

Ndzi nika mpfumelelo wo nghenela eka xitadi lexi.

…….. ….……..……

Vito ra Mungheneleri. Nsayino wa mungheneleri/ muhlayisi

……. …….. ……...

Mbhoni. Ndhawu. Siku

Xiletelo hi mulavisisi

Ndzi nyikile vuxokoxoko hi ku vulavula na hi leswi tsariweke mayelana na xitadi lexi.

Ndza pfumela Ku hlamula swivutiso hi vuswikoti bya mina eka nkarhi lowu taka mayelana na xitadi

Ndzi ta landzelerisa eka maendlelo lawa ya pfumeleriweke.

…….. …… ……

Vito ra mulavisisi. Nsayino. Siku

ANNEXURE 3: QUESTIONNAIRE (English)

10 December 2015

Dear respondent

I Maluka E.T currently am studying Master's Degree of the nursing science at University of Limpopo. The research is about development of a protocol to enhance patient satisfaction with regard to nursing care at the Health Centres, and it for the Master's Degree purposes. Your respond will help in developing strategies that could assist nurses in providing quality patient's care. You are kindly requested to complete this questionnaire and it will take about 20 minutes of your time to complete.

Please remember that no names or contact details are needed on the questionnaire. It is strictly anonymous and confidential.

Kindly return this questionnaire after completion.

Yours sincerely

Maluka E.T

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CROSSING (*x*) THE RELEVANT BLOCK

You are reassured that your response will be kept confidential and your respond is highly appreciated.

1. Name of Health Centre

Agincourt Health Centre	1
Thulamahashe health Centre	2

SECTION A: Demographic data

2. Gender

Male	1
Female	2

3. Age (in years)

18-30	1
31-40	2
41-50	3
>50	4

4. Marital status

Married	1
Single	2
Divorced	3

5. Place of residence

Agincourt	1
Croquetlawn	2
Dark city	3
Dumphries A	4
Dumphries B	5
Ireagh	6
Khaya lami	7
Kumani	8
Landela	9
Mambumbu	10
Mp stream	11
New forest	12
Newington	13
Rolle A	14
Other	15

6. Level of education

Literate	1
Illiterate	2

7. Level of employment

Employed	1
Self-employed	2
Unemployed	3

SECTION B: Factors leading to patient dissatisfaction.

Waiting time

8. How many times do you visit the facility per month?

Once	1
Twice	2
Threes	3
Other	4

9. How long do you wait before entering the consultation room?

1 hour	1
1-2 hours	2
2-3 hours	3
3-4 hours	4
> 4 hours	5

10. Are you satisfied with the waiting time?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

Communication and information

11. Are you informed about the waiting time before consultation?

Strongly agree	1

Agree	2
Disagree	3
Strongly disagree	4

12. Do nurses give you enough information?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

13. Do nurses inform you about any procedures to be done on you?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

14. Are you given time to explain at the consultation?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

15. Are explanations about diagnosis and treatment done clearly?

Strongly agree	1
Agree	2
Disagree	3

Strongly disagree	4

16. Do nurses make any follow-up after diagnosis and treatment?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

17. Are you given return dates for follow-up?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

18. Are you satisfied with the information given when living the Health Centre?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

Staffing and nurse's attitude

19. Do you think there is sufficient nursing staff at Health Centre?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

20. Do nurses work under pressure?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

21. Do nurses have positive attitude towards your health?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

22. Do nurse’s attitude affect your health positively?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

Services and environmental condition

23. Are you satisfied with the services at Health Centre?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

24. Is the environment safe for your health?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

25. Are you satisfied with the environmental condition?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

26. Does the environment have enough privacy?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

27. Does the environmental condition affect your satisfaction with the nursing care?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

28. How do you report dissatisfaction/complains?

Through suggestion box	1

To the Operation manager's office	2
To the department of health	3
Others	4

Shortage of treatment (medication)

29. Does the Health Centre give you treatment for your condition?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

30. Have you ever been told that there is no treatment during your consultation in the Health Centre?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

31. Have you ever been discharged without treatment because it is not available?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

32. Have you been given another day for treatment collection because it is not available?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

33. Have you been told or advised to buy treatment at chemist?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

34. Have you ever been referred to another health care facility?

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

THANK YOU FOR YOUR PARTICIPATION

ANNEXURE 4: QUESTIONNAIRE (Xitsonga)

10 December 2015

Eka mungheneleri

Hi mina **E.T Maluka,** ndzi yisa tidyondzo ta mina emahlweni ta degree ya le henhla leyi vuriwaka masters eka swa vuongori. Ndzi yisa tidyondzo ta mina emahlweni eyunivhesithi ya n'walungu, leyi tivekaka swinene tanihi yunivhesithi ya Turfloop.Ndzavisiso lowu wu mayelana na ku antswisa ku enerisaka ka vavabyi/muvabyi hi vuongori byo nakekela ekati Health Centres. Nakambe ndzavisiso lowu wu fambelana na degree ya masters. Ku hlamula/nghenelela ka wena ku ta pfuneta vaongori ku nika vuongori bya xiyimo xa le henhla. Wa komberiwa hi ku titsongahata leswaku u hlamula swivutiso leswi naswona swi ta teka kwalomu ka timinete ta khume-mbiri (20) ta nkarhi wa wena.

Wa tsundzuxiwa leswaku mavito na vuxoko-xoko bya wena byo ti hlanganisa na wena a swi laveki loko u hlamula swivutiso leswi.

Vuxoko-xoko kumbe tinhlamulo hinkwato leti u nga ta ti nika I xihundla naswona a swi nge humeseriwi ehandle.

Wa komberiwa hi ku titsongahata ku thlerisela papilla ra swivutiso loko u ta va u hetile ku hlamula.

Wa n'wina hi ku titsongahata

Maluka E.T

U KOMBERIWA KU HLAMULA SWIVUTISO LESWI LANDZELAKA HI KU TIRHISA XIHAMBANO (X) EKA BOKISI LERI FANELEKE

Wa tsundzuxiwa nakambe leswaku tinhlamulo ta wena ti ta va ta xihundla naswona tinhlamulo ta wena ta amukeleka swinene.

1. Vito ra kliliniki

Agincourt Health Centre	1
Thulamahashe Health Centre	2

XIYENGE XA A: Vuxoko-xoko bya wena n'wini

2. Rimbewu

Waxinuna	1
Waxisati	2

3. Malembe ya wena

18-30	1
31-40	2
41-50	3
>50	4

4. Xiyimo xa swa vukati

Ndzi tekiwile/tekile	1
A ndzi se teka/ tekiwa	2
Vukati	3

5. Ndhawu laha u tshamaka kona

Agincourt	1
Croquetlawn	2
Dark city	3
Dumphries A	4
Dumphries B	5
Ireagh	6
Khaya lami	7
Kumani	8
Landela	9
Mambumbu	10
Mp stream	11
New forest	12
Newington	13
Rolle A	14
Ku n’wani	15

6. Xiyimo xa tidyondzo ta wena.

Ndzi dyondzile	1
Andzi dyondzanga	2

7. Xiyimo xa ntirho wa wena

Ndza tirha	1
Ndza ti tirha	2
A ndzi tirhi	3

XIYENGE XA B. Swilo leswi endlaka leswaku vavabyi va nga eneriseki.

Nkarhi wo rindzela ku pfuniwa

8. Xana u endzela ndhawu/kliliniki leyi kangani hi n'hweti yin'wana na yin'wana?

Kan'we	1
Kambirhi	2
Kanharhu	3
Swin'wana	4

9. Xana u rindza nkarhi wo fika kwihi u nga se nghena ekamareni ro pfuniwa eka rona.

Awara yin'we	1
Awara yin'we ku ya ka timbirhi	2
Tiawara timbirhi ku ya ka tinharhu	3
Tiawara tinharhu ku ya ka mune.	4
Tiawara ta mune	5

10. Xana wa eneriseka hi nkarhi lowu u wu rindzaka/tshamaka loko u nga se kuma ku pfuniwa?

Ndza pfumelaSwinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

Mavulavulelo na vuxokoxoko

11. Xana u tivisiwile mayelana na nkarhi lowu u faneleke u wu rindza/tshama u nga se nghena ekamareni ro pfuneka eka rona?

Ndza pfumela swinene	1

Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

12. Xana vaongori va ku nika vuxoko-xoko lebyi heleleke?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo.	4

13. Xana vaongori va ku tivisa kumbe ku byela hi leswi va nga ta swi endla eka wena?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

14. Xana wa nyikiwa nkarhi wo hlamusela leswi u ti twisaka xiswona loko u ri ekamareni ro pfuniwa eka rona?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

15. Xana wa basiseriwa hi tinhlamuselo ta leswi kumiwaka endzhaku ka ku hlahluviwa na vutshunguri bya kona ke?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

16. Xana vaongori va salerisa endzhaku kumbe ku yisa emahlweni endzaku ka ku hlahluviwa na vutshunguri bya kona?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

17. Xana wa nikiwa masiku yo vuyela ku ta endla ku yisa emahlweni kun'wana (ku salerisa endzhaku)?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

18. Xana wa eneriseka minkarhi hinkwayo hi vuxoko-xoko lebyi u nikiwaka byona loko u huma laha klililiniki?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

Matikhomelo ya vatirhi na vaongori

19. Xana u hleketa leswaku ku na ku kayivela ka vaongori laha kliliniki?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

20. Xana vaongori va tirha ehansi ka ntshikelelo?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

21. Xana vaongori van na matikhomele ya kahle eka wena?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

22. Xana matikhomele ya vaongori ma kavanyeta eka rihanyu ra wena?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

Xiyimo xa vukorhokeri na mbangu

23. Xana u enerisekile hi vukorhokeri bya kliliniki?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

24. Xana ndhawu leyi yi hlayisekile eka rihanyu ra wena?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

25. Xana wa eneriseka hi xiyimo xa mbangu/ndhawu leyi?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

26. Xana ndhawu leyi yi na xihundla hi ku hetiseka?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

27. Xana xiyimo xa mbangu/ndhawu leyi xa kavanyeta ku eneriseka ka wena eka ku kuma ku nakekeriwa hi swa vuongori?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

28. Xana mi vika/endla nhjani loko mi ri na swivilelo na ku ka mi nga eneriseki?

Eka bokisi ra swibumabumelo na swivilelo	1
Eka hofisi ya murhangeri wa kliliniki	2
Eka ndzawulo ya swa rihanyu	3
Swin'wana	4

Nkayivelo wa vutshunguri

29. Xana kliliniki i minika vutshunguri va ma vabyi ya n'wina?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

30. Xana u nga va u tshame u byeriwa leswaku ku hava vutshunguri loko u te ku pfunekeni ekliniki?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

31. Xana u nga va u tshame u muka u ri hava vutshunguri hikwalaho ka ku pfumaleka vutshunguri?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

32. Xana u nga va u tshame u nikiwa siku rin'wana ro landza vutshunguri hikuva byi nga ri kona ekliniki hi siku leri u nga lava ku pfuniwa?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

33. Xana u nga va u tshame u byeriwa leswaku u ya xava vutshunguri ekhemisi?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

34. Xana u nga va u tshame u byeriwa leswaku u ya ka kliniki yin'wana ku ya kombela vutshunguri?

Ndza pfumela swinene	1
Ndza pfumela	2
A ndzi pfumeli	3
A ndzi pfumeli nakatsongo	4

NDZA KHENSA KU VA MI NGENELE SWI VUTISO LESWI

ANNEXURE 5: PERMISSION CERTIFICATE FROM TREC

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 2212, Fax: (015) 268 2306, Email:noko.monene@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

MEETING:	**05 November 2015**
PROJECT NUMBER:	**TREC/174/2015: PG**
PROJECT:	
Title:	Development of a protocol to enhance patient satisfaction with regard to nursing care at Health Centers in Mpumalanga Province
Researcher:	Ms ET Maluka
Supervisor:	Prof JC Kgole
Co-Supervisor:	Prof ME Lekhuleni
Department:	Nursing Science
School:	Health Care Science
Degree:	Masters in Nursing

PROF TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:
i) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.**
ii) **The budget for the research will be considered separately from the protocol.**
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa

ANNEXURE 6: PERMISSION LETTER FROM MPUMALANGA DEPARTMENT OF HEALTH.

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

R563 Kruger Hazyview, Kruger National Park Road, Hoxane Multi-purpose Centre,
Mkhuhlu 1246, Mpumalanga Province
Private Bag X3009, Mkhuhlu, 1246, Mpumalanga Province
Tell: (013) 708 0104, int: +27 (13) 708 0104/46/56/184/94
Fax: (013) 708 0000, int: +27 (13) 752 7498

Litiko Letemphilo Departement van Gesondheid UmNyangoWezeMaphilo

ENQ: MS KHOZA V.L

TO : MS MATHEBULA H.R
H.R MANAGER
BUSHBUCKRIDGE SUB-DISTRICT

FROM : V.L KHOZA
SPP: HRD PERSONNEL OFFICER

DATE : 04 DECEMBER 2015

SUBJECT : APPROVAL TO DO A RESEARCH: DEVELOPMENT OF A PROTOCOL TO ENHANCE PATIENT SATISFACTION WITH REGARD TO NURSING CARE, AT THULAMAHASHE AND AGINCOURT LOCAL AREA.

This letter seeks to request approval for Mr Eddy Trevor Maluka to do a research project at Thulamahashe and Agincourt local areas under Bushbuckridge sub district Mpumalanga.

The applicant is a part time student at University Limpopo (Turfloop campus), who will be pursuing her Masters Degree in Nursing science. The study will be conducted on (2) two the above namely facilities; the research will last for up to five (05) weeks.

V.L KHOZA
SPP: HRD PERSONNEL OFFICER
BBR SUB-DISTRICT

04/12/2015
DATE

APPROVED /~~NOT APPROVED~~

MR MATHEBULA H.R
H.R MANAGER
BUSHBUCKRIDGE SUB-DISTRICT

04/12/2015
DATE

MPUMALANGA
THE PLACE OF THE RISING SUN

ANNEXURE 7: APPROVAL LETTER FROM THE OPERATIONAL MANENGERS

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

R563 Hazyview, Kruger National Park Road, Hoxane Multi-purpose Centre,
Mkhuhlu 1246, Mpumalanga Province
Private Bag X3009, Mkhuhlu, 1246, Mpumalanga Province
Tell: (013) 708 0104, int: +27 (13) 708 0104/46/56/184/94
Fax: (013) 708 0000, int: +27 (13) 708 0000

Litiko Letemphilo | Departement van Gesondheid | UmNyangoWezeMaphilo

Enquiries: Sister M.N Sibuyi
Ref: Research study

DEVELOPMENT OF A PROTOCOL TO ENHANCE PATIENT SATISFACTION WITH REGARD TO NURSING CARE AT THE HEALTH CENTERS IN MPUMALANGA PROVINCE.

Dear Mr E.T Maluka

1. Permission is hereby granted to Mr Eddy Trevor Maluka to conduct the study as mentioned above at Agincourt Health Center.

2. The Agincourt Health Center would like to have a complete copy of your research after completion of the study.

3. The researcher should be prepared to assist in interpretation and implementation of the recommendations where possible.

Department of Health
Bushbuckridge Sub-District Office
Private Bag X3009, Mkhuhlu 1246
2015 -12- 06
AGINCOURT HEALTH CENTRE
MPUMALANGA PROVINCE

.....
NURSING OPERATIONAL MANAGER
AGINCOURT HEALTH CENTER
MPUMALANGA PROVINCE

MPUMALANGA
THE PLACE OF THE RISING SUN

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

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Litiko Letemphilo | Departement van Gesondheid | UmNyangoWezeMaphilo

Enquiries: Sister R.M Nyathi
Ref: Research study

DEVELOPMENT OF A PROTOCOL TO ENHANCE PATIENT SATISFACTION WITH REGARD TO NURSING CARE AT THE HEALTH CENTERS IN MPUMALANGA PROVINCE.

Dear Mr E.T Maluka

1. Permission is hereby granted to Mr Eddy Trevor Maluka to conduct the study as mentioned above at Thulamahashe Health Center.

2. The Thulamahashe Health Center would like to have a complete copy of your research after completion of the study.

3. The researcher should be prepared to assist in interpretation and implementation of the recommendations where possible.

.....R.M.....
NURSING OPERATIONAL MANAGER
THULAMAHASHE HEALTH CENTER
MPUMALANGA PROVINCE

MPUMALANGA
THE PLACE OF THE RISING SUN

APPENDIX 8: CONFIRMATION LETTER FROM LANGUAGE EDITOR

Telefax: 0152683174
Cell: 0822198060
Rammalaj@ul.ac.za

Dr J R Rammala
440B Mankweng
Box 4019
Sovenga
0727

To whom it may concern

19 August 2016

Dear Sir/Madam

This serves to confirm that I have edited a dissertation for Maluka ET entitled:
Development of a protocol to enhance patient satisfaction with regard to nursing care at health Centres in Mpumalanga Province.

The document was edited for both language and technical appearance. The latter was done in accordance with recommendations of the UL Research Development and Administration Manual for Postgraduate Research.

Generally, there few language errors except those on number, tense and concordial agreement. There were therefore not major changes made to the body of the document. There were however challenges with table and figures as such shifted when typesetting pages. As a result of these movements the final product may have empty spaces before after such table and figures.

I confirm that the document is well edited and ready for assessment.

Signed :.....
Dr J R Rammala