ST.MARY'S UNIVERSITY

SCHOOL OF GRADUATE STUDIES

ADULT PATIENT EXPERIENCE AND SATISFACTION IN OUTPATIENT SERVICES OF ST. GABRIEL GNERAL HOSPITAL, ADDIS ABABA, ETHIOPIA.

BY

PETROS SAMSON

MAY, 2016

ADDIS ABABA, ETHIOPIA

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A THESIS SUBMITTED TO ST.MARY'S UNIVERSITY, SCHOOL OF GRADUATE STUDIES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF BUSINESS ADMINSTRATION

MAY, 2016

ADDIS ABABA, ETHIOPIA

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DECLARATION

I the undersigned, declare that this thesis is my original work, prepared under the guidance of Asst. Prof. TirunehLegesse. All sources of material used for the thesis have been duly acknowledged. I further confirm that the thesis has not been submitted either in part or in full to any other higher learning institution for the purpose of earning any degree.

PETROS SAMSON ……

Name Signature

St. Mary's University, Addis Ababa **MAY 2016**

ENDORSEMENT

This thesis has been submitted to St. Mary's University, School of Graduate Studies for examination with my approval as a university advisor.

TIRUNEH LEGESSE (Asst. Prof) ……

Advisor Signature

St. Mary's University, Addis Ababa **MAY, 2016**

ACKNOWLEDGEMENTS

First and foremost, I thank the never changing God, my Creator for illuminating my path, for guiding my steps, granting me the strength and the divine health during the period of the study, and courage to complete this thesis.

I wish to express my gratitude and sincere appreciation to:

- My academic adviser, Ass. Prof. Tiruneh Legesse, for his wise counsel, valuable guidance, constructive evaluation and sustained support and encouragement during this research.
- My brother Ass. Prof. Ashebir Getachew, who willingly, thoughtfully, and generously shared his professional advice and experiences with regard to hospital practices from the inception to the end of this work. I have learned far more from him than the data I needed to complete this thesis.

In addition, I would like to acknowledge with gratitude the contribution of the following:

- St. Gabrieal General Hospital staffs, I don't have a word to explain how much they help and cooperate with me in every aspect of my project particularly distributing and collecting the questionnaire.
- All the respondents who completed questionnaires and spent time to make valuable contributions to the completion of this study.
- Last but not least, my close family members at [Kasanchis and Gergi] for their encouragement and support.

Dedication

I dedicate this thesis to:

My late dear dad, Brigadier General Samson Haile

Who did not live to witness the completion of this thesis.

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LIST OF ACRONYMS

Dr.	Doctor
OPD	Out Patient Department
St.Gabriel	Saint Gabriel
WHO	World Health Organization

Abstract

Patient satisfaction is as important as other clinical health measures and is a primary means of measuring the effectiveness of health care delivery. This research was conducted to evaluate patient's experience and satisfaction level towards claims service of outpatient department at St. Gabriel General Hospital. The study mainly used a cross sectional descriptive research design. By using a pre structured self-administered questionnaire,a standardservice quality measures:communication, courtesy, availability, environment, accessibility and affordability was assessed. A total of 280 questionnaires were administered to clients of St. Gabriel who have claimed during the study period and 261 questionnaires were returned and usable for a comprehensive empirical analysis. After data collection, the collected data was analyzed using Microsoft Excel software package and Stata version 10 computer program. A descriptive statistics has been used to investigate the research objectives and questions. From the analysis it was found that nurse's communication and physician communication both with the mean score of (3.3) are the highest determinant factors of patient satisfaction. Regarding the overall satisfaction level measurement, 80% of the respondents are satisfied with the service provided at St. Gabriel General Hospital. The research proves that affordability, accessibility and availability service dimensions lags behind patient's expectation and St. Gabriel is not doing well in meeting patient's expectation on these service satisfaction measures. Based on the findings of the study, recommendations have been forwarded to improve the service quality of the hospital which in return enhances the level of patient satisfaction.

Key words: ***Patient, Patient satisfaction, patient experience, Outpatient Department.***

CHAPTER ONE

INTRODUCTION

This chapter presents an overview of the entire study. It includes background of the study, statement of the problem, research question, objective of the study, significance of the study, and scope of the study.

1.1 Background of the Study

Growing demand for health care, rising costs, constrained resources, and evidence of variations in clinical practice have increased interest in measuring and improving the quality of health care in many countries of the world. Quality improvement is high on the national agenda both in the UK (Roland, Holden & Campbell, 1999) and in the USA (Schuster, McGlynn & Brooks, 1998).

As per Stafford (1996) service quality becomes a primary competitive weapon. Hossian and Leo (2009) added that service quality of the service industries globally remains a critical one as businesses strive to maintain a comparative advantage in the market place. Companies need to be heavily focused on customer relationship development and management (Verhoef, 2002).

However in the health care service many symptoms experienced by individuals are not presented to formal health care systems (Rogers, Hassell & Nicholaas, 1999). We recognize that pathways to formal care are complex and multidimensional (Campbell & Roland, 1996; Rogers et al., 1999). They are dependent on factors which include the socio-demographic characteristics of the population (Ben-Shlomo, White & McKeigue, 1992; MacIntyre, McIver & Sooman, 1993), health need (Evandrou, Falkingham, Le Grand & Winter, 1992; Feinstein,1993) and factors such as lay support (Robinson & Gran®eld, 1986; Oakley, 1994), frequent attendance (Neal, Heywood, Morley, Clayden & Dowell, 1998) and health beliefs (Egan & Beaton, 1987; Murray & Corney, 1990; Van der Kar, Knottnerus, Meertens, Dubois & Kog, 1992).

Patient satisfaction is as important as other clinical health measures and is a primary means of measuring the effectiveness of health care delivery (Powell, 2001). According to Lindr-pelz

(1982) over the years there have been various definitions of patient satisfaction. Patient satisfaction is "…positive evaluations of distinct dimensions of the health care. (The care being evaluated might be a single clinic visit, treatment throughout an illness episode, a particular health care setting or plan, or the health care system in general.)" The suggestion is that satisfaction must be understood within the context in which a variety of elements may be more or less satisfying to the patient. The identified 10 elements that can be used to determine satisfaction were Accessibility/convenience, Availability of resources, Continuity of care, Efficacy/outcomes of care, Finances, Humaneness, Information gathering, Information giving, Pleasantness of surroundings, Quality/competence.

The goal of this paper is to assess patient experience and patient satisfaction in outpatient service of St. Gabriel General Hospital, identifying gaps, potentials and constraints based on the information gathered from patients who had been treated by the outpatient department. As quality service becomes a primary competitive advantage in today's health care system, patient satisfaction should be a measure of how service delivered by hospital meet or surpass patient expectation.

Therefore, the result of the study would help to awaken St.Gabriel General Hospital's management team about the hospital's current level of performance in relation to the quality of service and patient satisfaction hence, they develop their strategic plan to retain existing customers' as well as to attract potential customers.

1.2 Statement of the Problem

There is good evidence now that better patient experience leads to: higher levels of adherence to recommended prevention and treatment processes; better clinical outcomes; better patient safety within hospitals; less health care utilization. (Price, 2014). It is therefore important that health care service givers avoiding patient experience as too subjective or mood-oriented, ignoring from the factual clinical work of measuring safety and effectiveness.

According to Peabody (2006) patients have explicit desires or requests for services when they visit hospitals, However many cases of patient dissatisfaction can occur due to inadequate discovery of their needs. World Bank (2008) added that however, in both developing and

developed countries, there has been an implicit acknowledgment that many health services do not meet minimum standards for clinical effectiveness or client satisfaction.

Some patients expressed complaints about specific aspects of the service delivery at the hospital. These related to the availability and price/costs of drugs, costs for investigations, staff shortage and poor behavior of some members of staff, the quality and quantity of facilities and medical equipment, and the time patients spend waiting for services. (Muhondwa et.al. 2008).

Customer dissatisfaction can affect an organization in various ways. First, customer who experiences an unsatisfactory service encounter never revisits that particular service provider again. Second, the customer may not only want to have been rectified that incident but may request that the damage done to their interpersonal relationship with the provider be repaired (Krapfel, 1985), thereby incur costs to the organization. The key for providing superior service (benefit) is to understand and respond to expectations when judging the quality of firms' services offering (parasursaman et al. 1988). According to Richins (1983), perhaps the most damaging to the organization is the tendency for an unsatisfied customer to engage in negative word of mouth communication.

St. Gabriel General Hospital was established in September 1995 and had been the first private hospital of its kind in Ethiopia. St. Gabriel General Hospital provides a comprehensive range of general and specialist services for both local and international residents of Ethiopia. Over the past 20 years, the hospital has served over 500,000 inpatients and outpatients.

St. Gabriel General Hospital provides 24 hours of medical services every day 24/7 from Monday to Sunday for both in and out patients. The Hospital provides high quality emergency services, outpatient and specialist patient-focused care which is accessible and responsive. This care is delivered by skilled and motivated staff, in conjunction with overseas medical experts stationed within the hospitals premises precisely designed for such purpose. The hospital has 187 permanent professional and administrative staff. St. Gabriel General Hospital has taken institutional strengthening at all levels to accommodate the needs of its patients. These include: being as accessible and accommodating as possible for patients and visitors with disabilities, laying the landing area of the new helipad, extending input services & the number of inpatient beds from 30 t0 180, fulfilling all medical equipment requirements, doubling exiting operating

theatres, establishing telemedicine and cancer research centers, accommodating medical experts from abroad who provide medical assistance for special needs within the hospital premises and also accommodating the compound with garden and enough space of parking.

Despite these efforts which aim at bringing satisfaction to the patients, patient preference and expectations seem not to match up with the hospital's initiatives. There are countless compliant in relation inpatient and outpatient service delivery of the hospital. Among others, this has been reflected by the shifting of those companies who has health insurance coverage and individual customers to other competitor hospitals. This is highly affecting the performance of the hospital. Besides, to the best of my knowledge, patient satisfaction research has not been conducted for the last twenty years in St. Gabriel General Hospital.

The emergence of new entrants and the rivalry among the existing competitive hospitals call for the need to assess the level of patient satisfactions in relations to the quality of service and come up with findings of the study to recommend possible solutions for the improvement of service quality.

1.3. Research Questions

1. To what extent are St.Gabriel General Hospital's patients satisfied with the quality of service?
2. Which of the domains of patient satisfaction with regard to service quality that St. Gabriel General Hospital lacks to perform towards patient expectation?

The research questions are supplementing the specific research objectives as the answers for the questions will achieve the research objectives.

1.4. Objectives of the Study

1.4.1. General Objective

The study attempts to asses adult patients experience and satisfaction in outpatient service of St. Gabriel General Hospital.

1.4.2. Specific Objectives of the Study are to:

1. Determine **Patient experience and evaluation** in **6** patient satisfaction domains:

1.1 .To determine the patient's perceived quality of **interpersonal communication** between professional staffs connected to the patient's health care.

1.2 .To assess the degree to which patients' **information** needs are met during their hospital stay: specifically to determine whether or not patients have been given information which allows them to make informed decisions about their care? involvement/ participation in care decisions.

1.3 .To determine patients perceived quality of hospital's **physical environment**, with special regard to cleanliness.

1.4 .To determine patients perceived **affordability** of service during their care?

1.5 .To determine all the prescribed medicines **availability** in the pharmacy service.

1.6 .To assess **access** to hospital services in terms of ability to find hospitals units and identify staff.

2. To identify which of the first **4** Patient Satisfaction domains that St. Gabriel General Hospital lacks to perform towards patient expectation.

1.5. Definition of Terms

According to (Ware, Davies-Avery & Stewart, 1997):

Accessibility/convenience: The time and effort required to get to the place where care is delivered, convenience of location, hours during which care can be obtained.

Art of Care: The most frequently focus on such provider characteristics as concern, consideration, friendliness, patience, and sincerity.

Availability: Usually focused on whether medicines or type of services are given or not.

Continuity of Care: It is regularity of care from the same facility or provider in terms of availability of follow up care.

Courtesy: It is the showing of politeness in one's attitude and behavior towards others. (http://www.oxforddictionaries.com/definition/english/courtesy?q=Courtesy).

Finances: Defined as the dollar/Birr cost of treatment and flexibility of payment mechanisms. Ware, Davies-Avery & Stewart, (1997).

Outpatient:A patient who comes to the hospital, clinic, or dispensary for diagnosis or treatment but is not admitted for an overnight stay. Miller-Keane, (2003).

Patient satisfaction: Patient's opinion of care received. Farlex,(2012).

Physical Environment: According to (Ware, Davies-Avery & Stewart, 1997), Include general pleasantness of the atmosphere, attractiveness of waiting room, clarity of signs and directions, quiet, and clean, neat, and orderly facilities and equipment.

Quality: The standard of something when it is compared to other things like it, how good or bad something is. Sally Wehmeier (Ed). (2005).

Respect: polite behavior towards somebody. Sally Wehmeier (Ed). (2005).

Satisfaction: Fulfillment of one's wishes, expectations, or needs, or the pleasure derived from this. (http://www.oxforddictionaries.com/definition/english/satisfaction).

1.6. Significance of the Study

This research has a great deal of importance/significance for the managers of St. Gabriel General Hospital because it can provide information about the level of quality service the hospital is providing to its patients from the point of view of the patients. So the study could also insight about the gap between patients' perception of service performed as promised. Hence the study will help where we are doing well and to highlight where we may have opportunity to improve the care and services provided. There by help the hospital to examine its service procedures. Furthermore the study may serve as a base line data that allows the hospital to measure its performance over time as well for future researches.

1.7 Scope of the Study

The study focuses on patient experience and patient satisfaction based on as perceived by patients towards the hospital by selecting the major departments in the outpatient services, which includes internal medicine, Surgical, Gynecology/Obstetrics.

The research was conducted in St.Gabriel General Hospital located in Addis Ababa city. Only those who had visited the hospital during the study period are considered in the study. The identified six elements that can be used to determine satisfaction was used to identify the quality of service delivery and level of patient satisfaction.

For finding out the satisfaction level of patients, the study limits itself to modified service dimensions which includes Accessibility/convenience, Finances, Humaneness, Information gathering, Information giving, Availability, Pleasantness of surroundings.

1.8 Organization of the Paper

This research work is categorized into five chapters. The first chapter is the introduction which covers the background of the study, statement of the problem, objectives, and research questions, purpose, of the study, scope and limitation and the organization of the study. Chapter two is the literature review and it covers reviews of existing literature on the subject matter. Chapter three takes the research design and methods used into account the need to achieve a representative sample of the population and accuracy of information provided by respondents. It also covers the area of study, the sampling methods and the data collection methods that were employed. Chapter four applies data analysis methods to the data gathered and presents the findings that bothers on the objectives of the study in the form of tables and charts with explanations. The last chapter, which is chapter five, presents summary of major findings, conclusions and recommendations. This chapter is followed by the reference which acknowledges all persons and institutions cited in the study and the appendices.

CHAPTER TWO

RELATED LITERATURE REVIEW

This chapter reviews works done by other theoretical and empirical evidences in relation to patient satisfaction. Theoretical review includes, theories of patient satisfaction in healthcare, the application of satisfaction in healthcare, patient experience and patient reports, instruments to measure patient satisfaction in healthcare, patient experience and satisfaction, satisfaction in the services marketing sector, patient satisfaction and perceived service quality in healthcare, consumers and healthcare quality and perceived health service quality.

The empirical review focuses on the relationship between patient satisfaction and service quality, the importance of patient satisfaction, factors that affect patient satisfaction, patient satisfaction and patient experience measurements and models. This chapter will further present theoretical framework and conceptual framework adopted in this study and explain in detail the constructs of the study.

2.1 Related Literature

2.1.1 Theories of Patient Satisfaction in Healthcare

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

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

(2) Expectancy-value theory of Linder-Pelz (1982) postulated that satisfaction was mediated by personal beliefs and values about care as well as prior expectations about care. Linder-Pelz identified the important relationship between expectations and variance in satisfaction ratings and offered an operational definition for patient satisfaction as "positive evaluations of distinct dimensions of healthcare". The Linder-Pelz model was developed by Pascoe (1983) to take into

account the influence of expectations on satisfaction and then further developed by Strasser et al. (1993) to create a six factor psychological model: cognitive and affective perception formation; multidimensional construct; dynamic process; attitudinal response; iterative; and ameliorated by individual difference.

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

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

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

2.1.2 The Application of patient Satisfaction in Healthcare

The desired need for the measurement of patient satisfaction has been largely driven by the underlying politics of "new public management" (Hood, 1995) and the concomitant rise in the health consumer movement, with patient satisfaction being one of the articulated goals of healthcare delivery. With the advent of the patient rights movement (Williams, 1994), the debate over the relationship between patient satisfaction as a valuation of the process of care versus the standard of technical care was well established. As a result, the use of patient satisfaction measures in the health sector became increasingly widespread. For example, assessing patient satisfaction has been mandatory for French hospitals since 1998, which is used to improve the hospital environment, patient amenities and facilities in a consumerist sense, but not necessarily to improve care (Boyer et al., 2006).

Whilst there are numerous specific patient satisfaction studies published in peer reviewed journals, there is a smaller body of work which critically reviews the literature and analyses the construct and its use. This work highlights agreement that patient satisfaction suffers from

inadequate conceptualization of the construct, a situation that has not changed significantly since the 1970s, and there is no agreed definition (Hawthorne, 2006). Crowe et al. (2002) identified 37 studies investigating methodological issues and 138 studies investigating the determinants of satisfaction. They indicated that there is agreement that the definitive conceptualization of satisfaction with healthcare has still not been achieved and that understanding the process by which a patient becomes satisfied or dissatisfied remains unanswered. They suggest that satisfaction is a relative concept and that it only implies adequate service. Further, both Crowe et al. (2002) and Urden (2002) separately point out that patient satisfaction is a cognitive evaluation of the service that is emotionally affected, and it is therefore an individual subjective perception. Crowe et al. (2002) also highlight that there is consistent evidence across settings that the most important determinants of satisfaction are the interpersonal relationships and their related aspects of care. What is agreed is that satisfaction has become an endpoint in outcomes research and the benchmarking of services. Patient satisfaction has come to be seen as a part of health outcome quality which also encompasses the clinical results, economic measures and health related quality of life (Heidegger et al., 2006).

2.1.3 Patient Experience and Patient Reports

Patient reports traditionally have been associated with so-called patient experience surveys instead of patient satisfaction surveys. Ware and colleagues (Davies & Ware, 1988; Ware, Snyder, Wright, & Davies, 1983) were among the first researchers to argue that ratings capture personal evaluations of attributes of providers and services; they are inherently more subjective because they reflect both personal experiences and the standards consumers apply when evaluating care (Davies & Ware, 1988). Proponents of patient reports often lump patient evaluations and satisfaction measures together, claiming that their approach is much more realistic and objective (Kennedy, 2003). Although patient evaluations are distinct from satisfaction items in that they do not ask the respondent to say how satisfied they were (Darby, Valentine, Murray, & de Silva, 2000), many proponents of patient reports still confuse the two (Cleary, 1998, 1999).

The four criteria by which to evaluate patient report and rating measures are: subjectivity, sensitivity, interpretation, and effectiveness. Several claims made by proponents of patient reports—including suggestions that patient reports (a) are more valid, less subjective, and easier

for patients to answer; (b) increase patients' willingness to report problems; or (c) facilitate quality improvement efforts compared to patient satisfaction measures are unproven. In contrast, many surveys using patient ratings have been rigorously tested and found to be reliable, valid, and effective (Carey & Seibert, 1993; Drain 2001; Kaldenberg, Mylod, & Drain, 2002; Seibert, Strohmeyer, & Carey, 1996).

2.1.4 Instruments to Measure Patient Satisfaction in Healthcare

The work of Hulka et al. (1970) began the initial steps to measure patient satisfaction in the healthcare area with the development of the "Satisfaction with Physician and Primary Care Scale". This was followed by Ware and Snyder (1975) with their "Patient Satisfaction Questionnaire", aimed at assisting with the planning, administration and evaluation of health service delivery programs. At the end of the 1970s, the "Client Satisfaction Questionnaire" was developed by Larsen et al. (1979) as an eight-item scale for assessing general patient satisfaction with healthcare services, and was superseded by their "Patient Satisfaction Scale" (1984). Since that time, numerous instruments have been developed but the question remains as to how valid and reliable those instruments really are. Further, the measurement of satisfaction varies depending on the assumptions that are made as to what satisfaction means (Gilbert et al., 2004) and a number of approaches to measurement can be identified: expectancy-disconfirmation; performance only; technical functional split; satisfaction versus service quality; and attribute importance (Gilbert and Veloutsou, 2006).

Nguyen et al. (1983) indicated that, in the absence of standardized instruments as well as satisfaction scores across studies being so high, it was almost impossible to make meaningful comparisons between different patient satisfaction scale scores. Further Ware et al. (1983) reported that between 40 and 60 percent of respondents exhibited some form of acquiescent response set bias, and Coyle and Williams (1999) argued that dependence prevented patients reporting dissatisfaction. In addition most patient satisfaction tools have been developed in the USA for "ad hoc" hospital use (Hardy et al., 1996). van Campen et al. (1995) noted that patient satisfaction had been extensively investigated, identifying over 3,000 published articles and "dozens" of measuring instruments developed in the ten years prior to their review. Interestingly, they noted that quality of care from the patient's perspective (QCPP) had often been measured as patient satisfaction. They reported that only five of 113 selected instruments were theoretically or

methodologically rigorous, and of those five, only two that had been used were actually designed to measure perceived service quality, SERVQUAL (Parasuraman et al., 1988) and the Patient Judgment of Hospital Quality instrument (Meterko et al., 1990), with the latter being the only one which offered a method for generating items that directly represented patients' views. However, it should be noted that whilst SERVQUAL has been used in healthcare, it was not designed specifically to measure perceived health service quality and it certainly does not measure satisfaction. A review by Sitzia (1999) found that 81 percent of studies used a new instrument, an additional 10 percent had modified an existing instrument and 60 percent failed to report any psychometric data. Sitzia concluded that the instruments evaluated by the meta-analysis demonstrated little evidence of reliability or validity.

2.1.5 Patient Experience and Satisfaction

Many current surveys have a combination of patient experience questions and patient satisfaction questions. This study also adopted this survey method.

Patient experience questions ask patients to give factual responses about what did or did not occur during an episode of care. Two examples of patient experience questions are (1) "Did doctors talk in front of you as if you were not there? (2) Do you think the hospital staff did whatever they could to help control your pain"? Australian Commission on Safety and Quality in Health Care (2010). Response options to these questions would be either 'yes' or 'no'.

Patient satisfaction questions ask patients to give subjective responses. Two examples of a patient satisfaction questions are (1) "How would you rate the clarity of the information you were given about how to manage your condition and/or recovery at home? (2) How would you rate the communication between staff about your care?" Pearse (2005). Response options to these questions would be in the form of a likert rating scale from 'poor' to 'excellent'.

Some patient experiences and patient satisfaction surveys will have a question that asks patients to rate their overall satisfaction with the care and services they received in the hospital. Responses to these questions are often in the form of a likert scale from 'not satisfied at all' to 'very satisfied', Productivity Commission (2011).

2.1.6 Satisfaction in the Services Marketing Sector

To demonstrate the unresolved conceptual difficulties with the satisfaction construct, in the services literature it is depicted as: both a summary psychological state and encounter specific (Oliver, 1981); the discrepancy between prior expectations and actual performance (Yi, 1990); comprised of both affective and cognitive components; an outcome state (Oliver, 1989); the fulfillment response and an experiential construct (Oliver, 1997); a response to both process and outcome (Hill, 2003). Given the range of definitions, there has been contention in the marketing literature on how to conceptualize and measure the service recipient satisfaction concept. The study of customer satisfaction has largely been driven by the desire to understand the behavioral intentions of customers (Cronin et al., 2000); however its measurement varies depending on the assumptions that are made as to what satisfaction means (Gilbert et al., 2004). A number of main approaches to measurement can be identified: expectancy-disconfirmation; performance only; technical-functional split; satisfaction versus service quality; and attribute importance (Gilbert and Veloutsou, 2006).

2.1.7 Patient Satisfaction and Perceived Service Quality in Healthcare

Healthcare sector research into patients' perceptions of the dimensions of service quality (perceived service quality) has been limited (Clemes et al., 2001), yet studies seeking to assess the components of the quality of care in health services predominately continue to measure patient satisfaction (Lee et al., 2006),. There is no consensus on how to best conceptualize the relationship between patient satisfaction and their perceptions of the quality of their healthcare. O'Connor and Shewchuk (2003) emphasized that much of the work on patient satisfaction is based on simple descriptive and correlation analyses with no theoretical framework. They concluded that, with regard to health services, the focus should be on measuring technical and functional (how care is delivered) quality and not patient satisfaction. A study by Gotlieb et al. (1994) on patient discharge, hospital perceived service quality and satisfaction offered evidence of a clear distinction between perceived service quality and patient satisfaction. They found that patient satisfaction mediated the effect of perceived service quality on behavioral intentions, which included adherence to treatment regimes and following provider advice. Cleary and Edgman-Levitan (1997) pointed out that satisfaction surveys in the health care sector did not measure quality of care as they did not include important aspects of care items such as being

treated with respect and being involved in treatment decisions. In addition, Taylor (1999) highlighted that confusion continued in the sector regarding the differentiation of service quality from satisfaction and reported that some authors, for example Kleinsorge and Koenig (1991), referred to them as synonymous terms. Nevertheless patient satisfaction continues to be measured as a proxy for the patient's assessment of service quality (Turris, 2005).

2.1.8 Consumers and Health Care Quality

The traditional concept of healthcare relationships is based on three primary assumptions: the professional is the expert; the system is the gatekeeper for socially supported services; and the ideal patient is compliant and self-reliant (Thorne et al., 2000). Historically the definition and management of healthcare quality has been the responsibility of the service provider and health services have been largely introspective in defining and assessing quality, focusing mainly on the technical provider components. As a result there is comparatively little work investigating patient perceptions of health service quality (Bell, 2004). There has, however, been some work on clinical governance which has sought to emphasize the importance of the patient perspective but, in general, this work has been based on areas defined by service providers as important rather than on what actually matters to patients (Bell, 2004). Further, Weingart et al. (2006) report that service quality deficiencies in a Boston teaching hospital are so common amongst medical in-patients that they appear to be the norm. In contrast, the literature shows significant reductions in the total cost of care when the patient's perception of the quality of the service improves, with the dynamics of poor service delivery often involving wasted effort, repetition, and misuse of skilled employees (Kenagy et al., 1999). Kenagy et al. (1999) point out that an increase in functional quality results in improved outcomes generally in medical illness and specifically in controlled studies of diabetes, hypertension, asthma and rheumatoid arthritis. Surgical outcomes show similar effects with fewer complications and shorter hospital stays. Therefore, improvements in functional quality will result in better health outcomes.

2.1.9 Perceived Health Service Quality

A healthcare service is one that requires high consumer involvement in the consumption process, and Lengnick-Hall (1995) argued that the traditional health sector views of technical quality and patient satisfaction were inadequate to manage the complex relationships between the healthcare

provider and the patient. Importantly, effective healthcare relies significantly on the co-contribution of the patient to the service delivery process. Studies have also evidenced that compliance with medical advice and treatment regimes is directly related to the perceived quality of the service and the subsequent resulting health outcome (O'Connor et al., 1994; Irving and Dickson, 2004; Sandoval et al., 2006).

Over the past few decades in the services marketing sector, much work has been undertaken to evaluate the consumer's perception of service quality, and a number of service models have been developed, with the gap model (Parasuraman et al., 1985) and its accompanying SERVQUAL (Parasuraman et al., 1988) having offered significant advances to the understanding and measurement of perceived service quality. Perceived health service quality has been studied extensively in the private healthcare sector; with SERVQUAL having been used frequently in a modified form and predominantly in the "for profit" American health sector (O'Connor and Trinh, 2000). More recently, Brady and Cronin (2001) advanced the multidimensional hierarchical conceptualization offered by Dabholkar et al. (1996) by combining that model with the three factor model of Rust and Oliver, and proposed a hierarchical multidimensional model of service quality. Based on this work, Dagger et al. (2007) have proposed service quality as a multidimensional, higher order construct, with four overarching dimensions (interpersonal quality, technical quality, environment quality and administrative quality) and nine sub-dimensions. They suggest that consumers assess service quality at a global level, a dimensional level and at a sub-dimensional level, with each level influencing perceptions. From their work with private oncology patients, Dagger et al. (2007) have shown that their model reflects the private patient's service quality perceptions, and they have developed and tested a scale for measuring perceived private healthcare service quality. Yet this work has had little impact, as the study and measurement of patient satisfaction continues to be the key target for consumer research in the health sector.

Further, only a few studies have sought to evaluate the provider understanding of the patient's perceptions of health service quality (O'Connor et al., 2000), and very few studies of perceived public healthcare service quality have been undertaken (Sanchez-Perez et al., 2007). Finally, Brown (2007) editorially highlighted that the patient is becoming an ever more silent partner in the health care system, as their views of quality have largely been sidelined by the number of

attempts to exclusively determine patient satisfaction with health care. Research that focuses on strengthening our understanding of the meaning, measurement, and management of perceived service quality from the patient's perspective in healthcare is now arguably paramount.

However World Health Organization (WHO) suggests that a health system should seek to make improvements in six areas or dimensions of quality, these dimensions require that health care be:

> ***Effective*****,** delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
>
> ***Efficient***, delivering health care in a manner which maximizes resource use and avoids waste;
>
> ***Accessible*****,** delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
>
> ***Acceptable/patient-centered***, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;
>
> ***Equitable*****,** delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;
>
> ***Safe***, delivering health care which minimizes risks and harm to service users. (World Health Organization, 2006).

2.2 Empirical Review

This part of the paper takes closer look on empirical studies on patient experience and patient satisfaction. Patients tended to be more satisfied when providers gave more information (Houston & Pasanen, 1972), when they were counseled by a physician (Linn, 1975).When payment plans were explained (Bashur, Metzern, & Worden, 1967). Other characteristics of the provider-patient relationship that have been related to satisfaction include the nature of the provider-patient communication (Korsh, Gozzil, & Francis, 1968).

Continuity of care has been linked to patient satisfaction by several investigators. Patients tend to be more satisfied when they saw the same physician or were seen for the same problem and were scheduled for a return visit (Linn, 1975). Several characteristics of facilities and service have been related to satisfaction ratings. Patients reported being more satisfied when they were in large hospital (Abdellah and Levin, 1958) and the rooms environment was more pleasant (Houston and Pasanen, 1972). Accessibility and availability of service and resources are also related to patient satisfaction.

Relationships between financial variables and satisfaction ratings have been reported in a few studies. Patients tend to be more satisfied when they had hospital insurance (Hulka, Zyzanski, Cassel, et al. 1971), where not on medicare (Enterline, Salter, McDonald, et,al. 1973). Another issue is the extent to which patient satisfaction ratings are influenced by factors outside the control of the medical care system. For example, patient satisfaction ratings are correlated with more general attitudes toward the community (Linn, 1975; Rojek, Clemente, and Summers, 1975).

If we look at the socio-demographic relationship between satisfactions, older persons were more satisfied than younger persons with medical care service in general (Rojek, Clemente, & Summers, 1975). However satisfaction with the medical profession in general correlated negatively with age for men. In another study Hulka, Kupper, Daly,et al. (1975) reported that older persons were less satisfied with access/finances. When we see the other socio-demographic variable, Linn (1975) found no relationship between sex and satisfaction .However, Hulka et al. (1975) reported that females were significantly more satisfied than males with art of care, technical quality, and access/finances. It is difficult to summarize the literature regarding demographic and socioeconomic correlates of patient satisfaction.

When the empirical literature on patient satisfaction is viewed critically and emphasis is placed on empirical studies in which measurement issues were well handled. Four kinds of evidence emerge that are relevant to the meaning of the satisfaction concept and its usefulness to health and medical care researchers. The first two relate to the measurement and meaning of the satisfaction concept, the second two to the usefulness of the concept.

First, psychometric studies (that is those that focus on measurement methods and issues) indicate that satisfaction is a multidimensional concept and that the dimensions are related, some dimensions like art and technical quality of care are highly related, Ware & Syder (1975). Studies of the importance placed on characteristics of providers and services also yield multiple satisfaction categories.(Corney & Bigman,1973).

Second, studies of relationships among questionnaire items hypothesized to measure specific satisfaction dimensions (e.g. the factor analytic studies published by Bice & Kalimo, 1971) provide empirical evidence in support of the validity of patient satisfaction variables. This evidence is particularly important because it is not based on presumptions underlying theory about the relationships between satisfaction and other concepts. The state of the art is such that patient satisfaction theory should be held as much in question as patient satisfaction measures. Hence, it is desirable to include tests of validity that are independent of theory about how satisfaction relates to other concepts.

Third, according to Ware, Avery & stewart, (1977) there is published evidence regarding the characteristics of providers and medical care services that influence patient satisfaction ratings. The weight of this evidence favors the usefulness of satisfaction as dependent variables in evaluation of health and medical care services. However, as noted earlier, there are substantial gaps in understanding how well satisfaction questionnaires work for this purpose and which dimensions are more important. Further research on the specificity of measures of each satisfaction dimensions in detecting variations in one major characteristic of providers and services (as opposed to reflecting many or all such characteristics) would contribute greatly to this understanding. For example, virtually nothing is known about the validity of patient satisfaction ratings in distinguishing art of care from technical aspects of the quality of care. Yet, if valid patient satisfaction measures could be constructed for that purpose, they could provide one cost-effective solution to the urgent but unsolved methods problems in quality of care assessment.

Fourth, the concept of patient satisfaction appears to be related to health and illness behavior. Although the magnitude of the relationships, the more important dimensions, and the nature and direction of causality remain to be clarified, even the most conservative critique of the literature would conclude that there is some evidence for the usefulness of the satisfaction concept in

predicting what people do at a very general level (e.g. total consumption of health and medical care resources) and at the specific level, for example appointment keeping (ware et. Al., 1977).

2.3 Theoretical Framework

There are two principal dimensions of quality of care for individual patients; access and effectiveness. In essence, do users get the care they need, and is the care effective when they get it? Within effectiveness, there are two key components effectiveness of clinical care and effectiveness of inter-personal care, this study focuses on effectiveness of inter-personal care. These elements are discussed in terms of the structure of the health care system, processes of care, and outcomes resulting from care.

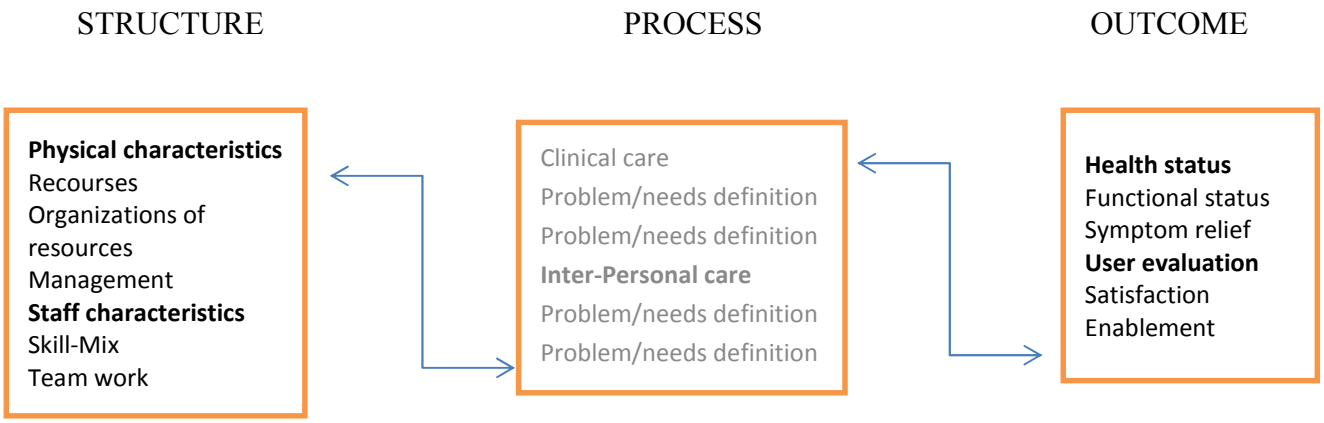

Fig 2.1 A System Based Model for Assessing Care.

Source: Adopted from Social Science & Medicine 51(2000).

2.3.1 Structure

Structure refers to the organizational factors that define the health system under which care is provided (Donabedian, 1980). Campbell, Roland & Buetow (2000) identified two domains of structure: physical characteristics and staff characteristics, and Fig. 2.1 shows the dimensions of each of these domains. Components of the dimension of resources include, for example, personnel, equipment and buildings. The ways in which those services are organized would include, for example, opening hours and the existence or otherwise of a booking system for appointments. These are both structural elements of the health care system. Structural features of health care provide the opportunity for individuals to receive care but do not guarantee it. On the

whole structures, whilst being able to increase or decrease the likelihood of receiving high quality care, are indirect and contingent influences on care. However, structural features within a systems based model of care can have a direct impact on processes and outcomes, e.g. if necessary equipment or skills are not available to undertake an effective examination or if all appointments are booked-up prohibiting a patient accessing care.

2.3.2 Process

Processes of care involve interactions between users and the health care structure; in essence, what is done to or with users. Process is the actual delivery and receipt of care. Two key processes of care have often been identified: technical interventions and inter-personal interactions between users and members of a healthcare system (Blumenthal, 1996; Donabedian, 1988, 1992; Irvine, 1990; Tarlov et al., 1989; Steffen,1988). Technical care refers to the application of clinical medicine to a personal health problem (Donabedian, 1980) and is based upon a theory of function which can be evaluated for efficacy and generally standardized. Care should be appropriate and necessary (Kahan et al., 1994; Brook, 1994). In practice, care is often overused, i.e. provided when inappropriate, and underused, i.e. not provided when necessary (Brook, McGlynn & Cleary, 1996; Schuster et al., 1998). Both necessary and appropriate care must be seen from both ends of the scale; for example, appropriateness is used as much to define what is inappropriate as appropriate.

Both `clinical care' and `technical care' have been used to describe the more bio-medically oriented aspects of health professional's behavior. Clinical care is the more appropriate term to use as there are also technical aspects to inter-personal care, e.g. specific skills in relation to giving information to patients. We therefore define the process of care in terms of clinical and interpersonal aspects of care. Interpersonal care describes the interaction of healthcare professionals and users or their care givers. This includes ``the management of the social and psychological interaction between client and practitioner'' (Donabedian, 1980). A number of skills underlie good inter-personal skills including: communication, the ability to build a relationship of trust, understanding and empathy with the patient (Blumenthal, 1996) and to show humanism, sensitivity and responsiveness (Carmel & Glick, 1996). Patients want explanation and discussion about their symptoms (Woloshynowych, Valori & Salmon, 1998), and to be involved in decisions about their management.

2.3.3 Outcome

Outcomes are consequences of care. Structure as well as processes may influence outcome, indirectly or directly. However, the relative importance of each of these components will vary in different situations and the relationships between them are not necessarily linear.

The effectiveness of structure and processes (both clinical and inter-personal) can be defined in terms of their capacity to result in two principal domains of outcome: health status and user evaluation incorporating non-health as well as health related outcomes. There may be feedback loops with, for example, an individual's user evaluation (outcome) influencing their subsequent consulting behavior, or care negotiated in one consultation affecting subsequent decisions (Rogers et al., 1999).

The framework focuses upon care for individual users so outcome in Fig. 2.1 refers to health status and user evaluation, e.g. satisfaction, enablement (Howie, Heaney & Maxwell, 1996). These must also be related to patient expectations and to the needs of that individual patient (Stott et al., 1997). User evaluation of the study mainly focuses on assessment of processes of care (e.g. communication skills of the health professional).

In general, process measures are better indicators of quality of care if the purpose of measurement is to influence the behavior of the health care system: processes are common, under the control of health professionals, and may more rapidly be altered. Outcomes are often rare, may follow a change in process by up to 10 years (e.g. management of hypertension), and may be dependent on factors outside the control of the individual health professional (Giuffrida, Gravelle & Roland, 1999). However, process measures suitable for measuring quality should be clearly linked to evidence of improved outcomes.

2.4 Conceptual Framework

Based on the above detailed related literature review the conceptual framework was developed, which shows the relationship between the study variables with patient satisfaction.

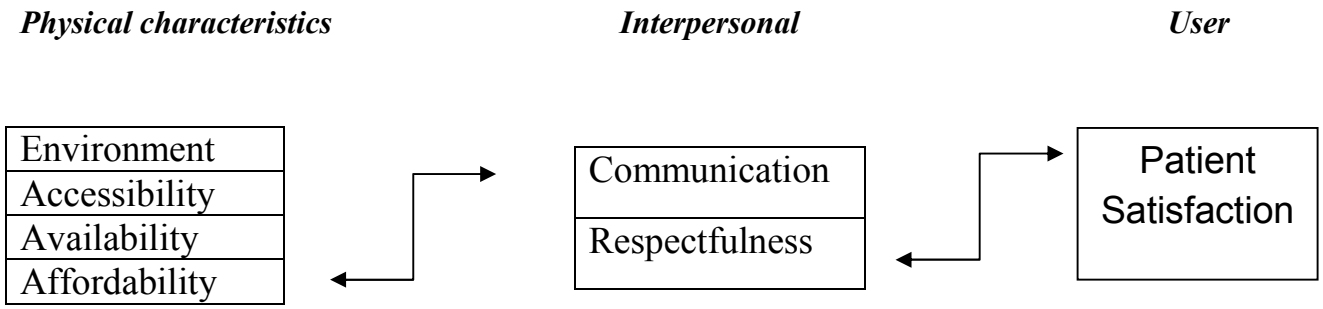

Figure 2.2 Conceptual Research Framework

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

This chapter discusses about the research design, sample size and sampling techniques, data source and data collection methods. Moreover, it will discuss about data collection method and tools. Under data collection tools data collection tool development and pilot testing for the instrument will be discussed. Finally data analysis method will be discussed.

3.1 Research Design

According to Malorta and Briks (2007), a research design is the frame work or blue print for conducting research. In other words, it is the master plan specifying the methods and procedures for collecting and analyzing the needed information. The overall design of the research is cross sectional descriptive study. Since the study is trying to find out the quality of service and level of patient satisfaction in St.Gabriel General Hospital. A study is descriptive when it intends to describe a phenomenon accurately with its specific context and when it is based on collected data in this instance the emphasis is on an in-depth description of an individual, group, situation or organization (Lauver et al 1999).

The strategy the research was used as it is mentioned is a descriptive study. Burns and Grove (2001:243) defined the purpose of a descriptive survey as providing the opinions of respondents regarding the phenomenon studies. Descriptive researches provide an accurate portrayal or account of the characteristics of a particular individual, event, determining the frequency with which something occurs and categories information. According to De Vos, Strydom, Fouche and Delport (2002), descriptive research determines what exists, the frequency with which something occurs and the categories of various aspects. With a descriptive design, the researcher plans either to assemble new information about an unstudied phenomenon or to gain more information about characteristics within a particular field of study, for the purpose of providing a picture of a situation as it naturally happens. A descriptive design was used in this study to describe the prevailing situation regarding patient experience and satisfaction in St.Gabriel General Hoaspital.

In the course of exploring the problems primary data collection procedure was conducted. The information that needed to assess patient experience and patient satisfaction in St.Gabriel Hospital was gathered based on the frame work with a slight modification. The variables that were employed in this study was the frame work components which are accessibility/convenience, availability of resources, continuity of care, finances, respectfulness, information gathering, information giving and pleasantness of surroundings.

The study mainly adapted quantitative method of data analysis using descriptive statistics. However, the study attempts to quantify results through statistical summary and hence qualitative data are in the form of descriptive. The research was employed questionnaire survey as a source of primary data, hence descriptive and simple statistical techniques were adapted for data interpretation.

3.2 Population and Sampling Design

3.2.1 Population

Polit and Hungler (1999) refer to the population as an aggregate or totality of all the objects, subjects or members that conform to a set of specifications. In this study the source of population were patients who ask the service of outpatient department in St. Gabriel General Hospital during the study period.

3.2.2 Study Population

Adult patients who ask the service of outpatient department aged greater than or equal to 18 years and those who gave consent and fulfill the inclusion criteria were included in the survey during the study period from March 2, 2016 to April 1, 2016.

3.3 Inclusion and Exclusion Criteria

3.3.1 Inclusion Criteria

The scope of the adult survey includes out-patients aged greater than or equal to 18 years, those have willing to give informed consent for participating in the study.

3.3.2 Exclusion Criteria

There are a number of patient groups who were excluded from the sample: patients who decline participation, patients coded as having a mental health problem, those patients requiring an interpreter, patients under 18 years of age, episodes involving prenatal death, patients who die in hospital, patients transferred to another hospital, admissions to the emergency department, patients in care for drug and alcohol services, patients who are admitted to the inpatient and those who could not write and read.

3.4 Sample Size Determination

Obtaining data from the population of patients as well as analyzing and interpreting vast amount of data would be impossible to accomplish with the time constraints and with the limited financial resources for conducting this research.

De Vos (1998) indicates that convenience sampling could be regarded as being a rational choice in case where it was impossible to identify all the members of population. In rough estimation per week, for the last three consecutive months 150 new clients had been visited the hospital.

The sample size will be calculated based on single sample size formula assuming

p = q = 0.5 since no research has been conducted on this topic in Ethiopian private hospital.

$$n = \frac{(Z\alpha/2)^* (Z\alpha/2) * p(1- p)}{d*d}$$

Where n = Sample size

Z=Z statistics for a level of confidence (95%)

p= expected proportion (p=0.5)

q = 1-p (q = 0.5)

d=precision or degree of error (d=0.05)

z=z statistic:

For the level of confidence of 95%, which is conventional, Z value is 1.96.

n = *((1.96)² x0 .5(1-0.5)) / (.05)²* = 385

By considering 10% non-response rate the total sample size will be n= (385+39) the final sample size was 424.

Since the total population is less than ten thousand by using correction formula, (James, Joe & Chadwick, 2001; Dessalegn.2015; Tirsit et al. 2011).

n final = n/1 + n/N,

n final = 424/1 + 424/600 = **249**

3.4.1 Sampling Technique

There are several ways in which potential participants can be selected for inclusion in a research study, and the manner in which participants are selected is determined by several factors, including the research question being investigated, the research design being used, and the availability of appropriate number and types of study participants (Geoffry, 2005). It is logically not practical to include every member of the population of interest in a research study. Time, money, and resources are three limiting factors that make this unlikely. Therefore, most researches are forced to study a representative subset-a sample-of the population of interest.

The research is conducted using simple random sampling method to ensure that every respondent had an equal chance of being chosen. Questionnaire was distributed to 280 adult outpatients at the end of their visits. They were approached by a trained nurse during the regular working hours from March 2, 2016 to April 1, 20016 in St. Gabriel General Hospital, Addis Ababa, Ethiopia. The candidates were briefed about the self-administered questionnaires. When they return the filled questioner they were encouraged to ask if there were unclear points when they fill up the questioner.

3.4.2 Type of Data to be Collected and Used

In this study a primary data was obtained by using a structured self-administered questionnaire in order to capture data relevant to the study's objective and research questions. The purpose of the study is to identify patient experience and patient satisfaction at St.Gabriel General Hospital with in the study period.

3.4.3 Method of Data Collection

The data was collected using pretested and pre-structured standard questionnaire. The questionnaire was developed in English and translated into Amharic (the local language) and retranslated back into English to ensure its consistency.

The outpatient survey questioner has 18 questions covering 4 domains. Each domain contains a mix of patient experience and patient satisfaction questions.

Patient experience questions: The majority of questions are questions with a rating scale of 'strongly disagree' to 'strongly agree'. And few questions were asked to give factual responses to questions about what did or did not occur by selecting 'yes' or 'no'. Responses are categorical and vary on the type of question, where the patient either reports on something (eg yes/no); rates some aspect of service (eg definitely no, probably no, probably yes and definitely yes); or ranks the care.

For the **patient satisfaction questions**, respondents are asked to rate their responses on a likert scale ranging from '0' to '10'.

After completing the care and immediately before discharge the participants were asked to fill self-administered questionnaires by trained nurses in the hospital. And the principal investigator was responsible for supervision and coordination of the overall data collection process.

3.4.4 Data Analysis Methods

Questions from interview guide were coded before data entry. Data entry was done using Microsoft Excel software package. Statistical analysis was done both manually as well using Stata version 10 computer program.

The descriptive statistics including means and frequency distribution was calculated and finally the findings were presented using charts, tables and text that compare with other studies and also describe overall satisfaction level as well within different study variables.

3.5 Ethical Considerations

Before the actual work started a support letter was obtained from St. Mary's university school of graduates. Then this support letter was submitted to Addis Ababa City Administration Health Bureau Ethical Reviewing Committee for ethical clearance. After analyzing the proposal the health bureau gave approval to conduct the study at St. Gabrieal General hospital. Then the approval letter was presented to St. Gabriel General Hospital and granted permission. Those patients who were given verbal informed consent were enrolled as the subjects of the study on patient experience and satisfaction in outpatient service. During the interview patients were informed not to mention their names and that of all personal information's will be kept confidential.

3.6 Validity and Reliability

Validity is defined as a measure of truth or falsity of the data obtained through using the research instrument (Burns & Grove, 2003). As mentioned on the literature review many surveys using patient ratings have been rigorously tested and found to be reliable, valid, and effective (Carey & Seibert, 1993; Drain 2001; Kaldenberg, Mylod, & Drain, 2002; Seibert, Strohmeyer, & Carey, 1996). On the other hand the questionnaire before dispatched to the target population was assessed by both internal and external advisers. Regarding its contents and clarity of questions a pilot study was conducted on twelve randomly selected clients from each department. According to their comments and suggestions some amendments were made. The five point scale anchored by standard "strongly disagree" and "strongly agree" designation was used. Since the five point Likert scale is more common in various areas of research, the general population is familiar with the format. Therefore, in addition to external validity, the use of a Likert scale could be considered a benefit as it would reduce the amount of potential confusion and increase the internal validity of the questionnaire.

Reliability is the degree of consistency with which the instrument measures an attribute (polit & hungler, 1999). It further refers to the extent to which independent administration of the same instrument yields the same results under comparable conditions (De Vos, 1998). The less variation the instrument produces in repeated measurements of an attribute the higher the reliability. The concept of internal consistency is that the items should all measures the same

thing and therefore should be highly correlated. Two diagnostic measures should be used to determine internal consistency (Hair et al., 2006).

1. Inter-item correlation (correlation >0.3); this measures the correlation among items
2. Using Cronbach's alpha is (>0.7) another method which is often used to assess the consistency of the entire scale. Table 3.1.

Table 3.1 Scale of Cronbach's alpha

Cronbach's alpha	**Internal Consistency**
$\alpha \geq 0.9$	Excellent
$0.9 > \alpha \geq 0.8$	Good
$0.8 > \alpha \geq 0.7$	Acceptable
$0.7 > \alpha \geq 0.6$	Questionable
$0.6 > \alpha \geq 0.5$	Poor
$0.5 > \alpha$	Unacceptable

Source: Kline.P. (2000). The hand book of psychological testing (2nd ed.)

The study assessed the internal consistency of all the study variables using Cronbach's alpha methods. All computed Cronbach's alpha measures clearly exceed the standard recommendation of alpha greater then or equal to 0.70. Since the results indicate good internal consistency further analysis was conducted. The reliability analysis for all 18 items of Patient Satisfaction dimensions is shown on table 3.2.

Table 3.2 Reliability Analysis

Cronbach's Alpha	**N= number of items in the scale**
0.75	18

Source: Survey Result (2016)

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION

The purpose of this study was to assess adult patient experience and satisfaction in outpatient services of St. Gabriel General Hospital. This chapter presents the data gathered from patients using a self-administered questionnaire. These data are categorized into two sections. The first part treats the characteristics (demographic character) of respondents and the second part deals with the analysis of the data obtained from patient satisfaction attributes. With regard to questionnaires 280 copies of the instrument were distributed. Among distributed questionnaires 261(93%) were analyzed. But 19(7%) were discarded. Thus, the data from filled questionnaires were organized, tabulated, transcribed and analyzed using Stata version 10 computer program to get findings.

The primary purpose of the study is to explore and determine patient satisfaction regarding the healthcare services delivered at St.Gabriel General Hospital. Individual overall satisfaction scores were computed for each of the 261 study subjects by summing scores on each of the 8 items from the Survey determined to be indicators of the construct "general satisfaction". The items regarded are: respect and caring, continuity, information, accessibility, availability, physical environment and affordability. Findings and analysis of the patient satisfaction survey data are presented in the following paragraphs. The results are arranged and presented according to the formulated research questions.

4.1 Descriptive Analysis

Descriptive statistics were applied to summarize percentages of the respondents on different background statistics.

4.1.1 Personal Profile of Respondents

Table 4.1: Gender and Age Characteristics of Respondents

Variables	Characteristics	frequency	Percent
Gender	Male	133	51.15
	Female	128	48.85
Total		261	100
Age	18-35	90	34.4
	36-65	168	64.5
	>65	3	1.1
Total		261	100

Source: Survey Result (2016)

Table 4.1 presents' gender and age characteristics of 261 respondents. There was comparable gender distribution with slight male predominance of 51.15% and 48.85% respectively. The median age of the respondents was 31 years with a range of 18-68. Among these respondents the large majority 64.5% was found to belong to the age group of 36-65, next 34.4% was 18-35 and the remaining 1.1% belongs to above 65 years of age.

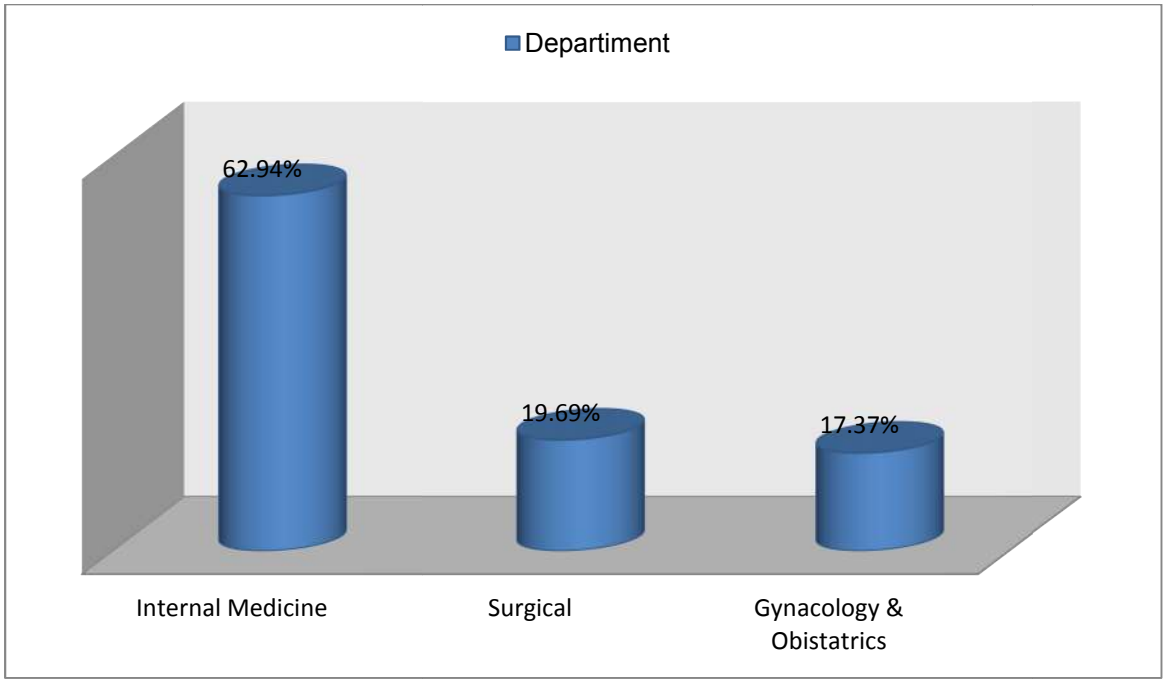

Figure 4.1: Departments Visited by Respondents

Figure 4.1 above shows the three departments that the clients have visited. The greatest number of the respondents has visited the Internal medicine department 62.94%, followed by Surgical then Gynecology and Obstetrics 19.69% and 17.37% consecutively.

Table 4.2: Educational Background of Respondents

Variables	Characteristics	Frequency	Percent
Educational Background	Primary Education (1-8)	6	2.30
	Secondary Education (9-12)	147	56.32
	Degree and Above	108	41.38
Total		261	100

Source: Survey Result (2016)

Regarding the educational background of respondents as indicated on Table 4.2 the least number of the clients 2.3% were completed primary education while more than half of the respondents 56.32% were attended secondary education and the rest 41.38% were having degree and above. This implies that they can easily understand and fill the questionnaires without the help of an assistant and can better explain about their experience and satisfaction of the service.

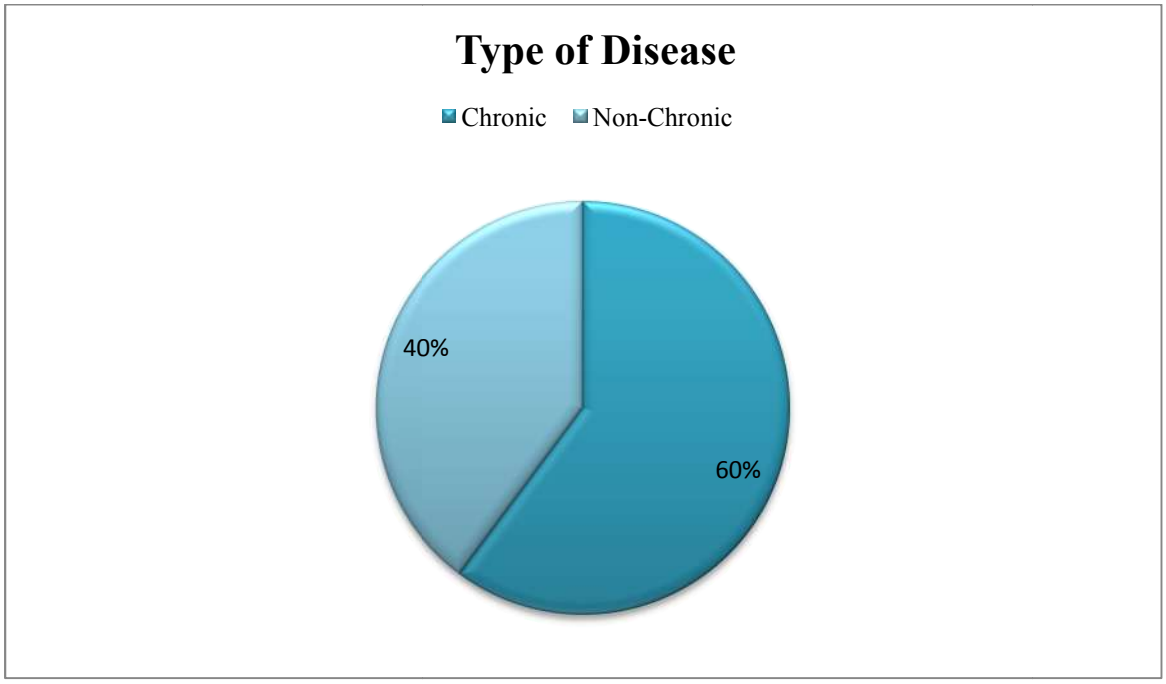

Figure 4.2: Respondents Type of Disease

As we can observe on figure 4.2, 39.85% of the clients have claimed that they have non-chronic disease while the great majority of the clients 60.15% were chronic patients. This indicates that the great majority of the respondents have a multiple visit to the hospital, so that they have a better experience about the service quality of the hospital.

Table 4.3 Respondents Time of Visit

Variables	**Characteristics**	**Frequency**	**Percent**
Time of visit	A.M	201	77.31
	P.M	60	22.69
Total		261	100

Source: Survey Result (2016)

Concerning the time of visit of the participants more than two third of the client 77.31% has come to the hospital in the morning (A.M) time while less than one third of the client 22.69% has visited the hospital in the afternoon. Since the majority of the clients have a great deal of experience about the hospital, this helps the researchers to get full cooperation and clear answer before the clients get tired (Table 4.3)

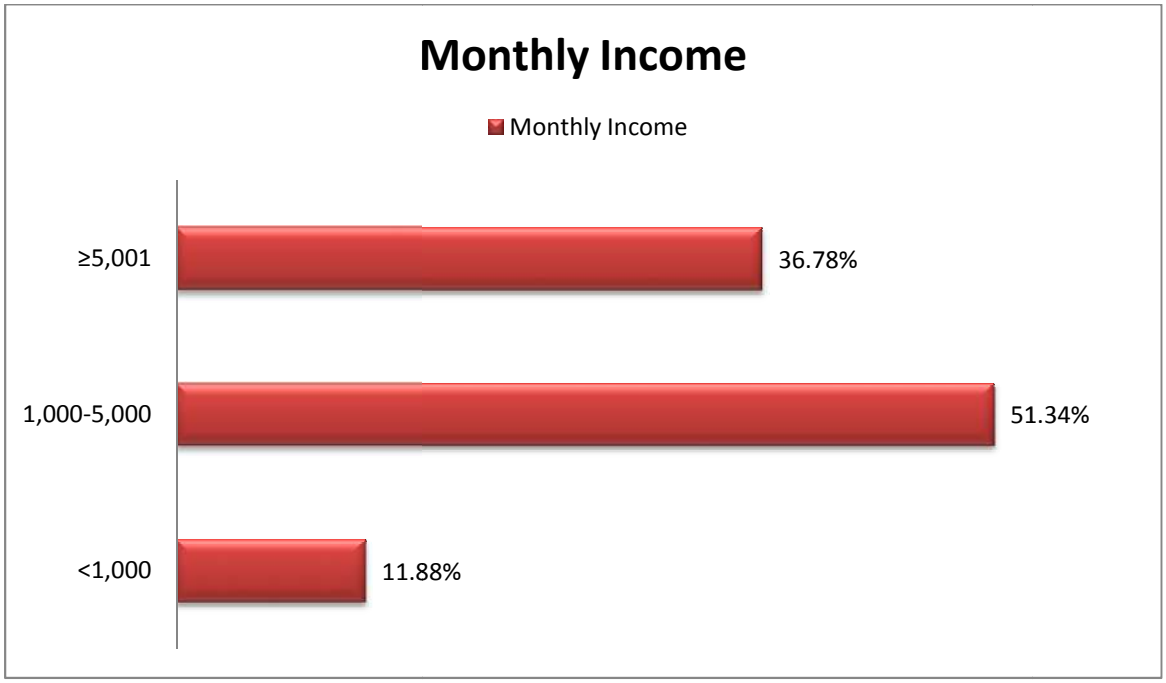

Figure 4.3 Respondents Monthly Income

As indicated on the above figure 4.3, about half of the participants 51.34% have claimed that they have a monthly income of 1,000-5,000, and second to that 36.78% ≥ 5,001 while a small number of clients 11.8% were < 1,000 Ethiopian Birr per month.

4.2 Patient Satisfaction and Experience

To understand patient experience's, respondents were asked a set of questions that were answered based on a 5 point likert scales. Where the likert-scale was 1-strongly disagree, 2-disagree, 3-neutral, 4-agree and 5-strongly agree.

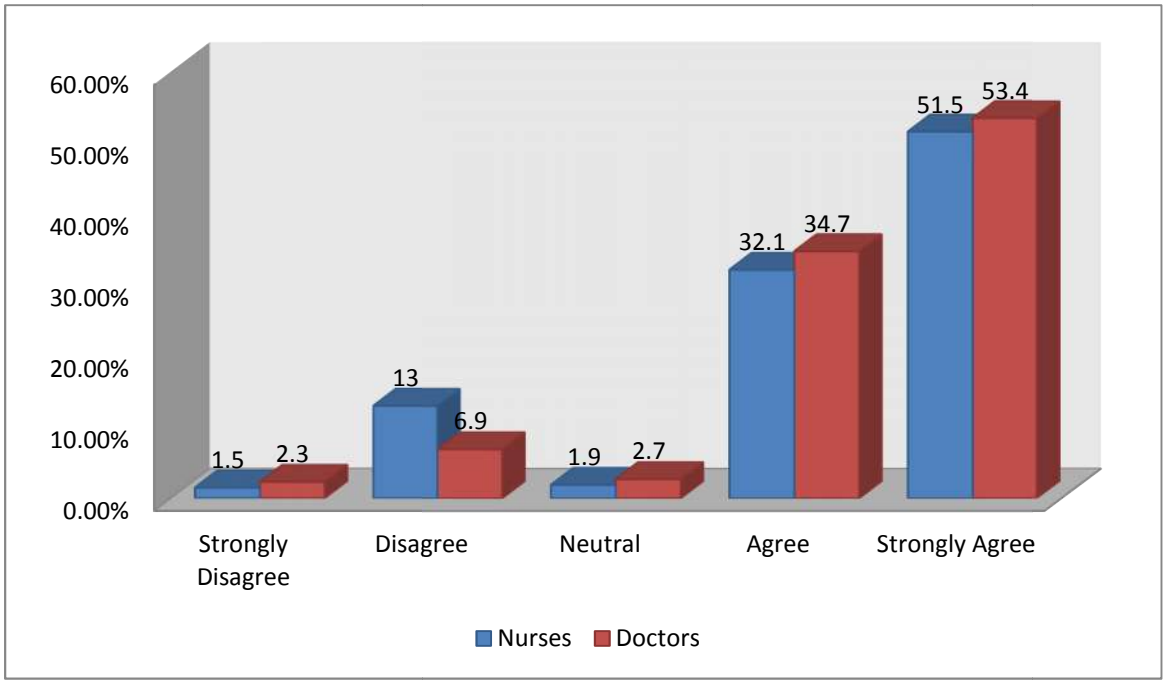

Figure 4.4: Respectfulness of Staff

Regarding respectfulness of nurses, clients were asked that nurses treated them with courtesy and respect, majority of the respondents 83.6% cumulatively answered agree and strongly agree, 14.5% strongly disagree and disagree while 1.9% choose neutral. They were also asked doctor's courtesy and respectfulness, 9.2% strongly disagree and disagree, 88.10% answered agree and strongly agree the rest 2.7% of the clients were neutral. The mean for both nurses and doctors respectfulness were 3.3, which implies that it is above the average mean score, so that respondents are satisfied with regard to respectfulness (Figure 4.4).

Table 4.4: Patient Experience on Communication of Information (n=261)

		Frequency (Percent)				Mean Score (n)	Standard Deviation
Domains	Strongly Disagree N (%)	Disagree N (%)	Neutral N (%)	Agree N (%)	Strongly Agree N (%)		
Communication of information							
- Nursing care explained	43 (16.4)		14 (5.3)		204(78.2)	3.1	0.0146
- Nurses listen carefully	31 (11.8)		12 (4.6)		218(83.6)	3.2	1.0647
- Dr care explained	26 (10.1)		9 (3.4)		226(86.7)	3.3	1.0645
- Dr listen carefully	26 (9.9)		13 (5)		222(85.1)	3.4	0.9472
- Medication info explained	120(86.3)		10 (7.2)		10 (6.5)		
- Medication side effect explained	98 (70.5)		9 (6.5)		33 (23.0)		

Source: Survey Result (2016)

The information dimension analysis asked related to communications with nurses, doctors and as well drug information, the result is shown on table 4.4. Regarding nurses explained things in a way they could understand, about 78.2% either agreed or strongly agreed, 16.4% disagreed or strongly disagreed. They were also asked about whether nurses listened carefully. As many as 83.6% either agreed or strongly agreed that nurses listened carefully.

Like the nurses communication they were also asked about whether physicians explained things the way they could understand and 86.7% of them either strongly agreed or agreed that doctors explained, whereas a very small number of respondents 10.1% disagreed or strongly disagreed. A very small number 9.9% disagreed or strongly disagreed that Dr. listen carefully.

On the other hand the respondents were also inquired whether the staff told them what the medications for and 86.3% answered yes, 6.5% no and 70.5% of the clients said that they were told about the medication side effect whereas 23.0% said no they did not.

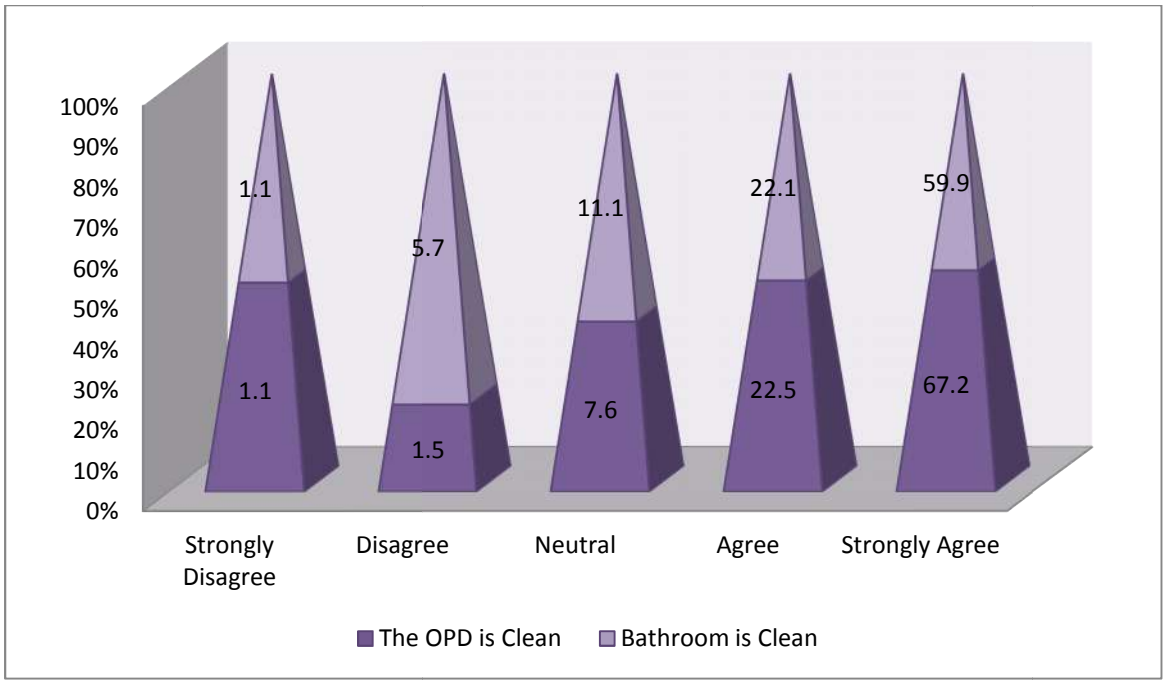

Figure 4.5 Cleanliness of the OPD

When analyzing the indicators from the physical environment dimension participants were asked about the cleanliness of care area 89.7% and 82.0% of the participants either agreed or strongly agreed respectively that the OPD and the bathroom was clean (Figure 4.5).

Figure 4.6 Easy to Find Ways Around

When patients were inquired to rate the accessibility of the healthcare more than half of the client 60.3% was having difficulty of finding the way around and 36.3% said that they were not having difficulties (Figure 4.6). Whereas when they were inquired whether they distinguish between medical staffs, 12.2% said that they couldn't distinguish between physicians from nurse though 82.4% said that they could distinguish.

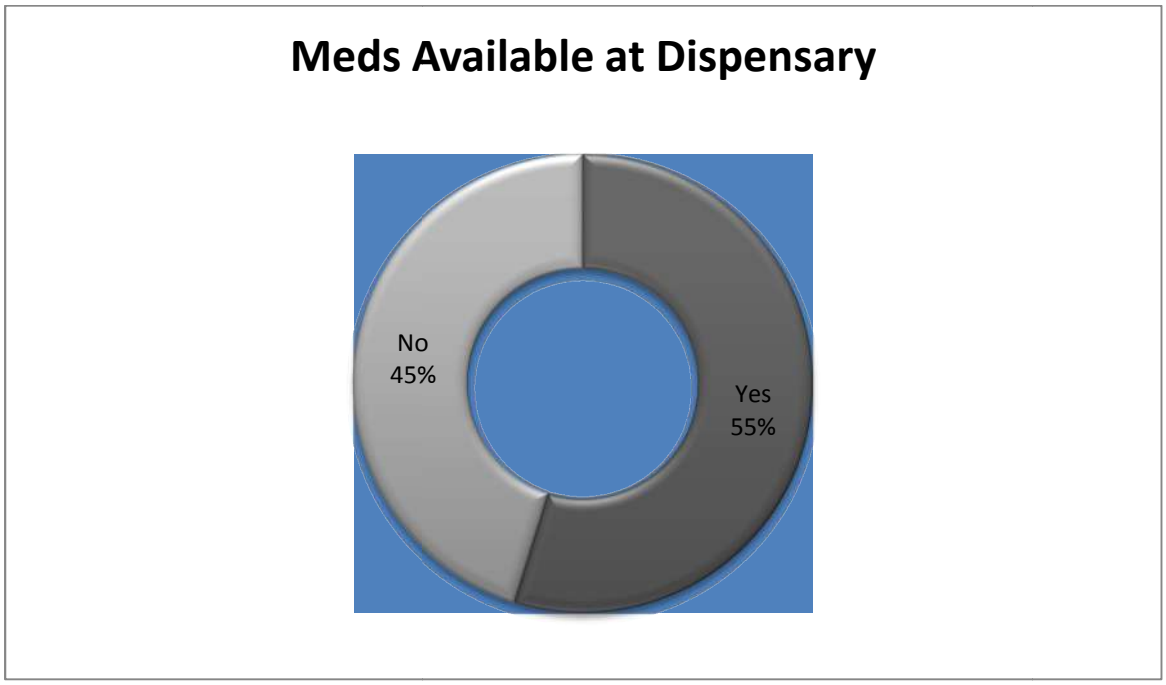

Figure 4.7 Medicines Available at Dispensary

Regarding the availability of medicines, respondents were asked about the availability of all the prescribed medicines in the pharmacy, even though 53.2% of the client said that it was available, a great deal of the respondents 43.9% said that some of the prescribed medicines were not available (Figure 4.7)

Table 4.5: Sign and Symptom to Look For

	Frequency (percent)		
Domain	Yes	No	Neutral
Follow-Up			
- Sign and symptom to look for	149(56.9)	84(32.1)	29(11.1)

Source: Survey Result (2016)

Table 4.5 shows that patients were asked whether someone ever discussed with them what symptoms to look out for after they left the hospital. 32.1% answered no but 56.9% said yes they were discussed.

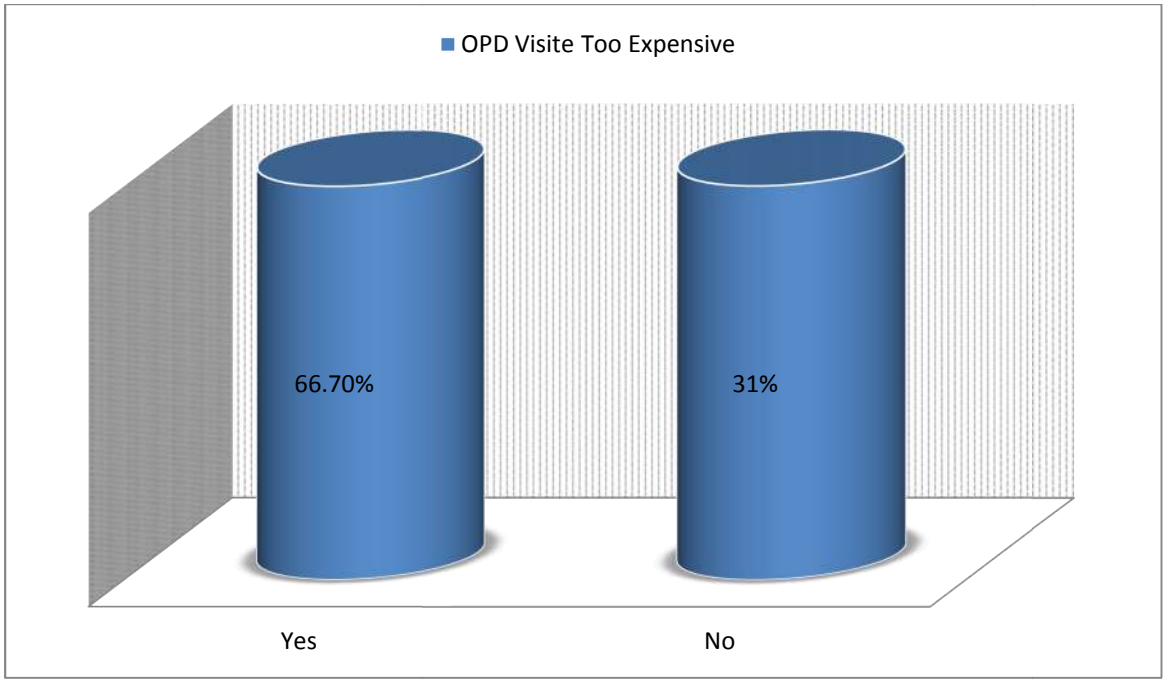

Figure 4.8 OPD Visit Too Expensive

Patients were asked about affordability of the hospitals visit. 31.0% of the client reported that it was not too expensive. Besides a great majority of the respondents 66.7% answered that it was too expensive (Figure 4.8)

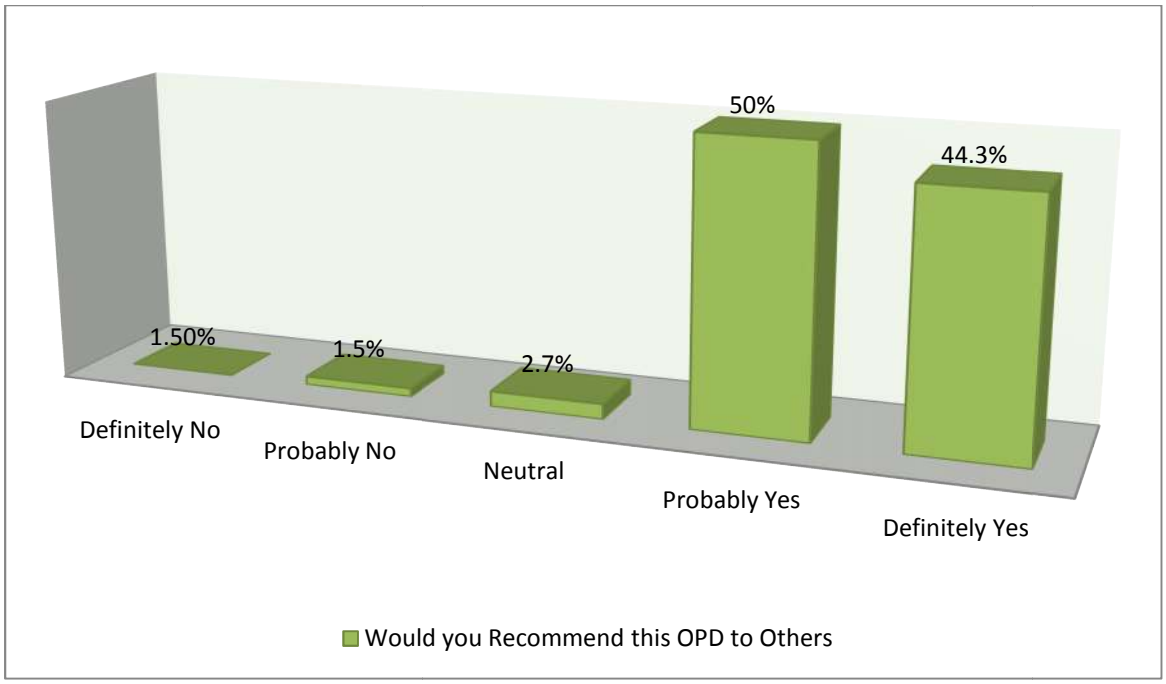

Figure 4.9 Recommending the OPD to Others

When clients were asked their opinion on recommending the hospital to others, 3% of the participants replied together definitely no and probably no while 94.3% of the patients said that probably yes and definitely yes together (Figure 4.9).

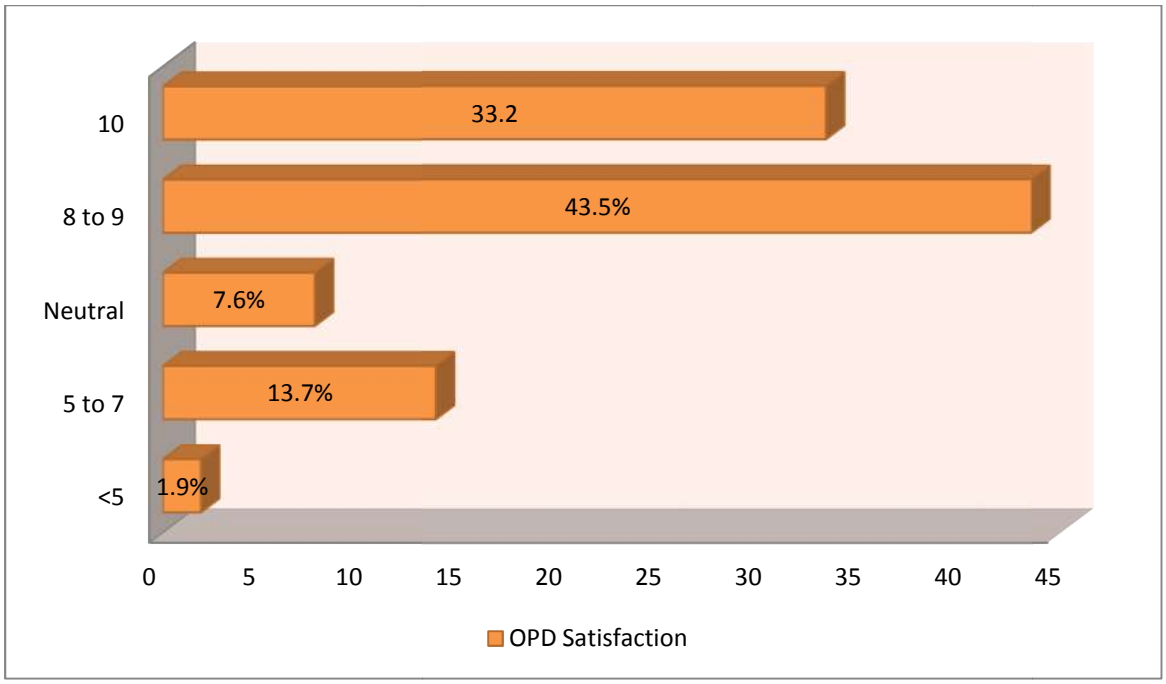

Figure 4.10 Overall Patient Experience Rating

Patients were also inquired to rate their overall satisfaction. The question was prepared as a continuous variable with a mark 0 to 10 with higher marks indicating greater satisfaction. For the overall satisfaction rating only 1.9% of the client ranked <5 but the great majority of the respondents ranked 8-10 which was 76.7%. This leads to 80% overall satisfaction (Figure 4.10).

4.3 Discussion

For the purpose of this study, as it is mentioned in the literature review it is important to differentiate between Patient satisfaction with outcome and patient satisfaction with care. Patient satisfaction with outcome refers to the actual treatment received, whereas patient satisfaction with care refers to the services the patient received during the healthcare experience (Beattie, et al., 2002). This study was conducted to assess patient satisfaction with care at St. Gabriel General Hospital.

It has been well documented that patient-centered approach to patient care results in a better outcome in both clinical and emotional health and minimizes the need for expensive diagnostic

tests. (Stewart et al., 2000). Patient satisfaction is also known to be positively influenced by friendliness and the provision of information on the part of the physician (Comstock, 1982).

This study has shown important findings in relation to client satisfaction in different aspects: health service, health workers communication and attitude, and hospital environment. The result of the study indicates that most of the client's overall satisfaction rate was 80%.This finding is higher than the study in public facilities where satisfaction with different aspects of care were as low as 41% in West Indies.(Singh 1999).57.1% In Ethiopia at Jimma University specialized hospital (Oljira & Gebre-Selase, 2001) and that of Tigray zonal hospital (Girmay 2006) 43.6% while lower than a Satisfaction studies conducted in Nottingham County 92.4% and in Indian hospital OPD 90–95% (Jawahar, 2007). Since it is a privet hospital the suggested reasons for this difference could be, due to the better attention given by the concerned board and management members of St. Gabriel Hospital.

Measuring patient satisfaction has many purposes, but there are three prominent reasons to do so (Sitza & Wood, 1997). Such studies help to evaluate health care services from the patient's point of view, facilitate the identification of problem areas, and help generate ideas towards resolving these problems. For St.Gabriel General Hospital, which is a privet hospital that has a tough competition with other private hospitals, the findings of this survey describe the health services provided by the hospital from the patient's point of view. Despite the overall high level of patient satisfaction a significant proportion of patients 66.7% expressed dissatisfaction regarding the expenses for the various medical needs. This finding is very high from a study conducted in Tanzania 10.9%. (Muhondwa et al., 2008). Information should be provided about treatment cost, alternative payment arrangements, and comprehensiveness of insurance coverage (Ware, et al., 1983). The fact that some patients expressed dissatisfaction with the expensiveness of the service; this indicates that the hospital needs to do more in the drive towards improving services.

The study has shown that lack of drugs in the hospital pharmacies was the other major problem. About 43.9% of those clients with prescription paper for drugs did not get the ordered drugs from the hospital pharmacies. This finding was lower than that of the study conducted in two different Ethiopian public hospitals, at Jimma government hospital where 63.7% of the clients lacked drugs from the hospital pharmacies (OliJera, 2001), and 64.9% in Tigray zonal hospital (Girmay, 2006).But this is a higher finding than that of the study conducted in the Amhara region

of Ethiopian hospital where about 23% of the clients did not get the prescribed drugs (Mitike, 2002).

The drug availability problem for St. Gabriel hospital could be multi factorial. This could be the current hard currency shortage, improper stock quantification, poor financial management that leads to poor medical supplies and medicine suppliers' relationship etc. The inability to get the prescribed drugs from the hospitals is in line with the report from a study conducted in South Africa were also revealed that access to drugs was one of the most suggested priorities for improvement of public health services (Gary Morris).

Dissatisfaction and distrust in the current healthcare system is impending the effectiveness of treatment and thus poses an additional obstacle to healthcare delivery. In fact, numerous studies have shown that dissatisfaction in healthcare service lead to poor treatment adherence and reluctance to use these services. (Fan et al., 2005 ; Freed et al., 1998)

The other crucial factor that got lower satisfaction score despite a higher number of literate clients was accessibility. A large number 60.3% of the client replied that it is not easy to find ways around. But in similar study conducted in Bahirdar Felege Hiwot Referral Hospital, North West Ethiopia was as low as 25 %.(Yeshambel et al.,2014). This indicates that the presence or modification of sign and direction indicators to ease the way around the hospital should be considered.

Regarding to respect and courtesy shown by the nurses and physicians the study reviles that 83.6% & 88.1% respectively reported that the behavior of the care providers was respectful "agree & strongly agree". This rating is better than the Indian study 56% (Jawahar, 2007). almost similar to that of Zimbabwe 87% (Chingarande, et al, 2013), and lowers than that of Krakow Gmina 91% (Ann, Lawthers & Harvard, 1998).

Satisfaction with this dimension can be established when the following occurs. The patient who is treated for his condition should be treated with a degree of respect, which is the positive response of the doctor from a certain perspective in an appropriate way (Dillon, 1992). The doctor should take enough time to listen to the patient carefully (Cohen, 1996). Also, the doctor should treat the patient in a pleasant, helpful, and sympathetic manner (Gerris, et al., 1998).

The other major patient satisfaction variable is cleanliness of the service environment. The various rooms and the sanitary facilities should always be clean and hygienic. The healthcare provider should strive for a pleasant ambience in the healthcare facility, which is the general positive impression that the patient has about the appearance of the healthcare facility (Ware, et. Al.,1983). In our study we have found that cleanliness of the OPD area 89.7% and the bathroom 82.0% of the participants either agreed or strongly agreed that the outpatient department and the bathroom were clean.

To answer the research question, which aspects of a patient's experience (interactions with a hospital's facilities and staff) are the most important determinants of their overall satisfaction? The study result revealed that certain attributes are more influential than others in influencing patients to give higher rating. The most influential attribute is nursing care and physician care. However the contradicting result of a high rating score on an OPD visit too expensive and as well on overall satisfaction could be due to the overall patient satisfaction rating score question appears first on the questionnaire followed by the OPD visit too expensive, that might lead to the respondents to score high on the overall patient satisfaction before answering the expansiveness of the OPD visit. This finding is generally consistent with previous studies (Otani et al. 2003), nursing care and physician care have a greater influence on a patient's decision to give an "excellent" rating than the other attributes.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

This chapter includes conclusions and recommendations of the study, limitation and implications for further research.

5.1 Conclusion

According to literature effective managing of service quality is evident to gain competitive advantage. To implement quality systems with success in the hospital, three main stakeholders are important: the nursery, the patients and the medical specialists. At St. Gabriel General Hospital, the role of patients is not considered as an active part of implementing quality systems and this research can be a tool to take this into account. In general, the role of patients with regard to customer's focus can be measured through research on their experiences or through measuring their satisfaction.

The uniqueness about health care service includes: long-term duration of interaction, heightened emotional levels such as anxiety, fear and pain; wide and increasing gap between professional technical competence and patient understanding, public and private values, ambiguous outcomes for patients and professionals, extraordinary experience such as intense emotions. The aims of the health care service are to meet people's health care needs. Patients pay an important role in the health care quality measure. Different demographical and other characteristics such as age, occupation and payment form and different treatment experience would have different effect on patient satisfaction.

The study result provides that there is a gap that influences client's satisfaction towards the service quality in the hospital. Since the key objective of the study is to answer the three research questions:

1. To what extent are St.Gabriel General Hospital's patients satisfied with the quality of service?

2. Which of the domains of patient satisfaction with regard to service quality that St. Gabriel General Hospital lacks to perform towards patient expectation?

Hence, the following conclusion is drawn from the findings of the study.

There is a high level of consistency among the 19 items of patient satisfaction and experience constructs. Which was measured using Cronbach's alpha and > 0.7 result was obtained. This articulates the existence of high reliability among items of patient satisfaction and experience; this indicates that a better service quality can be rendered at claims service by synchronizing all dimensions.

The study findings showed that patient experience and satisfaction towards the hospital service, despite the overall high level of patient satisfaction rate a significant proportion of patients 66.7% expressed dissatisfaction regarding the expenses for the various medical needs. This showed that affordability has the widest gap of the other patient satisfaction measuring items. This perceived expensiveness could be due to lack of adequate information provision about treatment cost and alternative payment arrangements. This dissatisfaction rate is followed by availability of sign and direction indicators to ease the way in the hospital. There is a gap between what the providers think that is enough indicators and what the clients expect. This is an indication that the hospital needs to understand what is very important to client's satisfaction and what is really very critical in influencing patients to be a loyal client to the hospital, So that St. Gabrieal should address the gap towards patients' expectation.

In addition to that the study findings also indicate that availability of medicines at dispensary is also another variable that has not meet patient's expectation. Since the outcome of the service is to get cured with medicines, the hospital should work hard on availing medicines in the pharmacy; the research indicates that St. Gabrieal General Hospital lacks to perform towards patient expectation on the above three patient satisfaction domains. Dissatisfaction and distrust in the current service reflects on the effectiveness of treatment and thus poses an additional obstacle to healthcare delivery. This shows that the hospital needs to do more in the drive towards improving this service area.

On the contrary the research finding also showed that interpersonal communication and information communication both with the mean score of 3.3and physical environment dimension

of the service has got the highest rate. Even though this indicates that interpersonal and information communication domain has meet patients expectation, to keep benefiting from this, health managers in St. Gabrieal should design in-service training to enable their health care providers to demonstrate better relational empathy, technical competency and non-verbal behaviors during consultations.

The overall patient experience and satisfaction with the service rendered at St. Gabriel General Hospital showed that percentage of respondents who are highly satisfied are 80% with their experience of the service while 1.9% of the respondents expressed their level of satisfaction as not being satisfied (rate their satisfaction level<5) during the time of claiming the service. There for the study indicates that among patient satisfaction measuring variables nursing care and physicians care are the most influential variables to boost overall patient satisfaction. This can lead us to conclude that the appropriateness of involving nurses and physicians participation in process design and implementation.

5.2 Limitation of the Study

This study has resource limitation like time and money, so that portion of the total population was taken and the sample size restricted to 261 (Two hundred sixty one) clients. The study also limited only at St. Gabrieal General Hospital, which means that the study lacks generalizability.

This study covers only the outpatient services. However the other sections of the hospital the inpatient, reception, laboratory and imaging services were not included in the study.

Because this is a descriptive cross-sectional study, it presents an association between attribute reactions and overall satisfaction but not a cause-and-effect relationship. But, an experimental study in which attributes are manipulated would demonstrate a clear cause-and-effect relationship between attribute reaction and overall patient satisfaction. And the tool used to collect data is only structured questionnaire.

5.3 Recommendations

Based on the findings of the study and conclusions made, the following possible recommendations are forwarded.

To the Hospital Administrators:

- St. Gabrieal General Hospital should work hard towards perceived expensiveness of the OPD services. The hospital should give adequate information to the patient about treatment cost and develop alternative paying mechanisms arranging with different companies.

- St. Gabrieal General Hospital requires strengthen efforts to deliver integrated quality service to improve overall patient satisfaction and some hard work may needed to improve areas, like posting enough sign and direction indicators to ease the way around the hospital.

- Availability of medicines is also the most important predictor of service quality and patient satisfaction, Therefore St,Gabriel should improve its stock out problems by implementing a consistent medical supply mechanisms to avail enough medicines in the pharmacy.

- Patients in addition to providers, is a key player in the processes of defining and measuring quality and their opinion provides an important component to the process. Therefor St. Gabriel should conduct periodic surveys on patient satisfaction at the outpatient and inpatient departments in order to identify gaps related to provision of services.

- St. Gabriel General hospital should work hard towards providing consistent and quality services than competitors in the industry. In order to further develop trust in the minds of its client the hospital should make use of a feedback mechanism through suggestion boxes regarding the service quality to better understand patient's expectation.

- The hospital should design in-service training to enable their health care providers to demonstrate better relational empathy, technical competency and non-verbal behaviors during consultations, so that patients are well treated and respected at any point in time.

- Cleanliness of OPD and bathroom area is also the other dimension having significant impact on patient satisfaction, patient judges a hospital, the moment they lay eyes on it. Before a service experience even begins, the patient usually has already decided whether

they will be returning to the hospital again. Therefore, to improve its client satisfaction further St. Gabriel should design a regular inspection and correction mechanisms.

To the Nurses and physicians:

To increase the patient satisfaction level furthermore the following simple methods of improving interpersonal communication and information giving skills are needed:

- Treat your patient with courtesy and respect: It is important to remember that if there were no patients, there would be no health care providers. Patients keep us in business. Considering your patients as your customer will answer the satisfaction compliant from every angle of point.

- Listen and answer all your patients' question: The first step in making your patients happy and comfortable is simply to listen. Always explain things carefully and then ask if your patient has questions. It is a solution for the communication gap between you and your clients.

To the Researchers:

This survey on private hospital's patient satisfaction and patient experience may be the pioneer in our country in its kind which will be reinforce other researchers to do further studies in this area.

- As we know the assessment of patient satisfaction and the patient experience is key performance measure for the quality of care in hospital services, so that similar studies with large sample size which includes all other departments will help notice the gap behind patient satisfaction, especially on factors associated with dissatisfaction.

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APPENDICES

APPENDIX - I - DATA COLLECTION INSTRUMENT IN ENGLISH

[Outpatient Assessment of Health Care (O-PAHC)]

ST MARY'S UNIVERSITY

SCHOOL OF GRADUATE STUDIES

Dear respondents; I am post graduate student at St Mary's University School of Graduate Studies. Currently I am conducting a research entitled "Adult Patient Experience and Satisfaction in Outpatient Services of St. Gabriel Hospital, Addis Ababa, Ethiopia". The purpose of the study is to fulfill a thesis requirement for the master of Art in Business Administration. Your highly esteemed responses for the questions are extremely important for successful completion of my thesis. The information that you provide will be used only for the purpose of the study and will be kept strictly confidential. Finally, I would like to thank you very much in advance for your cooperation and spending your valuable time for my request.

***Note:**

- Please put a **(√)** marks with the option that reflects your response with the given statement.
- No need of mentioning your **NAME.**

Part 1: Respondents profile

Study Number	**Date (D/M/Y)**	**Morning☐ Afternoon ☐**
Department		
Type of Diseases	**Chronic -** ☐	**Non chronic -** ☐
Sex- Male☐ Female☐	**Age** ☐ **18-35** ☐ **36-64** ☐ **≥65**	
Educational Status ☐ **1-8** ☐ **9-12** ☐ **Degree and Above**		
Monthly Income: **<1000** ☐ **1000-5000** ☐ **≥5001** ☐		

Part 2: Patient Satisfaction and Experience

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	**During this visit, nurses treated me with courtesy and respect.**					
2	**During this visit, nurses listened carefully to me.**					
3	**During this visit, nurses explained things in a way I could understand.**					
4	**During this visit, doctors/health officers treated me with courtesy and respect.**					
5	**During this visit, doctors/health officers listened carefully to me.**					
6	**During this visit, doctors/health officers explained things in a way I could understand.**					
7	**I could distinguish between doctors/health officers and nurses**					
8	**The outpatient department was clean.**					
9	**The bathrooms/latrines were clean.**					
10	**I was prescribed new medications at this visit.**	**Yes** ☐		**No** ☐	**jump question 11 & 12**	
11	**The staff told me what the medication was for.**	**Yes** ☐		**No** ☐		
12	**The staff described the medications possible side effects in a way I could understand.**	**Yes** ☐		**No** ☐		
13	**All the medications I need were available at the drug dispensary here.**	**Yes** ☐		**No** ☐		
14	**Someone discussed with me what symptoms to look out for after I left the health facility.**	**Yes** ☐		**No** ☐		
15	**It was easy for me to find my way around the facility.**	**Yes** ☐		**No** ☐		
16	**On a scale of 0-10 (0 being the worst facility, 10 being the best facility), how would you rate this health facility?**	0 ☐	1 ☐ 2 ☐ 3 ☐	4 ☐ 5 ☐ 6 ☐ 7 ☐	8 ☐ 9 ☐	10 ☐
17	**I would recommend this outpatient department/clinic to my friends and family.**	**Definitely no** ☐	**Probably no** ☐	**Probably yes** ☐	**Definitely yes** ☐	
18	**I consider this outpatient visit too expensive.**	**Yes** ☐		**No** ☐		

APPENDIX - II- DATA COLLECTION INSTRUMENT IN AMHARIC

<u>በቅድስት ማርያም ዩንቨርስቲ የድህረ ምረቃ ፕሮግራም</u>
<u>ለታካሚዎች የተዘጋጀ መጠይቅ</u>

ውድ ደንበኞች፡-

እኔ በአሁኑ ሰአት በቅድስት ማርያም ዩንቨርስቲ የድህረ ምረቃ**(Master of business adminstration –GMBA)** ተማሪ ስሆን የመመረቂያ ጥናቴንም ‘‘የቅዱስ ገብርኤል አጠቃላይ ሆስፒታል አዋቂ ተመላላሽ ታካሚዎች በሚሰጠው ግልጋሎት ላይ ያላቸውን የእርካታ መጠንና ልምድ ’’በሚል ርዕስ ጥናቴን እየሰራሁ እገኛለሁ፡፡ የዚህ መጠይቅ አላማም ከሆስፒታሉ ታካሚዎች ስለ ሆስፒታሉ ያላቸውን ልምድ ና እርካታ በቂ መረጃ በመሰብሰብ ጥናቱን ውጤታማ ና ተአማኒነት ያለው ማድረግ ነው፡፡ይህንንም አሳካ ዘንድ የእርሶ ትብብር በጣም ያስፈልገኛል ::ስለዚህ ለመጠይቁ መልስዎን ይሠጡኝ ዘንድ በአክብሮት እጠይቃለሁ :: ለመጠይቁ የሚሰጡት ምላሽ ለጥናቴ ብቻ የሚውል ሲሆን መልስዎትም በሚስጥር ይያዛል፡፡ለትብብርዎ በቅድሚያ በጣም አመሰግናለሁ!

ማስታወሻ፡- ስም መጥቀስ አያስፈልግም፡፡ በትክክለኛው አማራጭ ፊትለፊት የራይት (√) ምልክት ያድርጉ

በቅዱስ ገብርኤል አጠቃላይ ሆስፒታል ተመላላሽ አዋቂ ታካሚዎች የሚሞላ መጠይቅ

1. ክፍል አንድ የግል ሁኔታ

የጥናት ቁጥር	ቀን (ቀ/ወ/ዓም)	ጠዋት ☐ ከሰአት ☐
ዲፓርትመንት		
የበሽታው አይነት፤	ለከትትል **(Chronic) -** ☐	መጀመሪያ **(Non chronic) -** ☐
ጾታ፡- ወንድ ☐ ሴት ☐	እድሜ፡ **18-35** ☐ **36-64** ☐ **≥65** ☐	
የትምህርት ደረጃ፡ 1-8 ☐	**9-12** ☐	**ዲግሪና ከዛ በላይ** ☐
ወርሃዊ ገቢ <1000 ☐	**1000-5000** ☐	**≥5001** ☐

2.ክፍል ሁለት የእርካታ መጠን

		መቼም ግዜ	አንድ አንዴ	ገለልተኛ	አብዛኛውን ግዜ	ሁሉ ግዜ
1	በዚህ የጤና ተቋም በነበርዎት ቆይታ ነርሶቹ በትህትና እና በአክብሮት ሕክምና ለእርስዎ የሰጡት ምን ያህል ግዜ ነው					
2	በዚህ የጤና ተቋም ቆይታዎ ምን ያህል ግዜ ነው ነርሶች በጥሞና ያዳመጥዎት					
3	በዚህ የጤና ተቋም ቆይታዎ ምን ያህል ግዜ ነርሶች ነገሮችን እርስዎ በሚገባዎት መልኩ ያብራሩልዎታል					
4	በጤና ድርጅቱ ቆይታ ግዜዎ በሀኪሞች የሚሰጥ አገልግሎት ምን ያህል ትህትናና አክብሮት የተላበሰ ነበር					
5	በዚህ የጤና ተቋም ቆይታዎ ምን ያህል ግዜ ነው ዶክተሮች በጥሞና ያዳመጥዎት					
6	በዚህ የጤና ተቋም ቆይታዎ ምን ያህል ግዜ ነው ዶክተሮች ነገሮችን እርስዎ በሚገባዎት መልኩ ያብራሩልዎት፡፡					
7	ዶክተሮችን፣ የጤና መኮንኖችን እና ነርሶችን በትክክል ለይቶ ማወቅ ይቻላል					
8	የተመላላሽ ክፍል ምን ያህል በንፅህና ተጠብቆ ነበር					
9	የመፀዳጃ ክፍል ምን ያህል በንፅህና ተጠብቆ ነበር					
10	በዚህ የጤና ተቋም ቆይታዎ ከዚህ በፊት ወስደው የማያውቁት መድሀኒት ታዘሎታል	**አዎ** ☐		**አልታዘዘም** ☐	ጥያቄ ቁጥር 11 እና 12 ይለፏቸው	
11	አዲስ መድሀኒት ከመሰጠቱ በፊት ሰራተኞች መድሀኒቱን ለምን እንደሚጠቅም አብራርተውልዎታል	**አዎ** ☐		**አይ** ☐		
12	ምንም አይነት መድሀኒት ከመስጠታቸው በፊት የሆስፒታሉ ሰራተኞች እርስዎ በሚገባዎት መልኩ በመድሀኒቱ ምክንያት ሊከሰቱ የሚችሉ ችግሮችን ገልፀውሎታል	**አዎ** ☐		**አይ** ☐		
13	በሆስፒታሉ መድሀኒት ቤት ውስጥ ሁሉም የታዘዙሎት መድሀኒቶች ነበሩ	**አዎ** ☐		**አይ** ☐		
14	የሆስፒታሉ ሰራተኞች ህክምና ጨርሰው ሲወጡ ሊያጋጥሙ ስለሚችሉ የጤና መታወክ ምልክቶች ና እርምጃዎቻቸው አስረድቶዎታል	**አዎ** ☐		**አይ** ☐		
15	በዚህ የጤና ተቋም ውስጥ የሚፈልጉትን ቦታ ለማግኘት ቀላል ነበር	**አዎ** ☐		**አይ** ☐		
16	ከ **0 - 10** ባሉት ደረጃዎች ለዚህ የጤና ተቋም የምሰጠው ውጤት	0 1 2 3		4 5 6 7	8 9 10	

	እንደሚከተለው ነው (**0** አነስተኛ ደረጃ ሲሆን **10** ደግሞ ከሁሉ የተሻለውን ተቋም የሚወክል ነው)											
17	ጓደኞችዎንና ቤተሰቦችዎን ወደዚህ የጤና ተቋም እንዲሄዱ ይመክሩዋቸዋል	በፍፁም አላደርገውም ☐			አላደርገውም ☐			አደርገዋለሁ ☐			በእርግጠኝነት አደርገዋልሁ ☐	
18	የአሁኑ ወጪዎ በዚህ የጤና ተቋም ውድ ነው ብለው ያሰባሉ	**አዎ** ☐						**አይደለም** ☐				