Developing a Tool to assess Client Satisfaction at District Hospitals

Matthew Smith and Beth Engelbrecht
Developing a Tool to assess 
Client Satisfaction at District Hospitals 
Technical Report #14

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June 2001


Funded by the European Union via the National Department of Health and 
the Henry J Kaiser Family Foundation

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Cover Photograph
Mootaz Jackson at the Red Cross Children’s Hospital, before her departure home after three years, with 
her portable respirator which is going home with her for the first time.

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Designed and printed by The Press Gang, Durban - Tel: (031) 307 3240
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1. ACKNOWLEDGEMENTS

A study of this nature would not happen without the wonderful support provided by the staff at the two hospitals that this study focuses on. In Kokstad we would like to thank Mr Ross Haynes, Mrs Dube, Mrs Guzana, Ms Makalima, Mr Anderson Nkita, Mr Cholofelo Malunga and Dr Wermuth. At the provincial level in KwaZulu-Natal we would like to thank Mr Gerrie van der Merwe and Dr Olaf Baloyi. In Upington we would like to thank Dr George Isaacs, Mrs Van der Merwe, Mrs Witbooy, Mr Nico Fourie, Mrs Ronel Visser and Dr Lesley Bamford. At the provincial level in the Northern Cape we would like to thank Dr Barry Kistnasamy and Mrs Jeanette Hunter.

We would also like to thank all the fieldworkers who administered the questionnaires and clients who so willingly gave up their time to participate in the focus groups and all the others who so obligingly responded to the questions that were posed by the fieldworkers.
Care for the patient is the fundamental aim of health services and it is that which motivates many service providers. The public health system in South Africa has often been accused of inefficiency and the abuse of patient’s basic rights. Consumers are now increasingly aware of their rights.

The assessment of client satisfaction, forms an important part of the management of a health facility, especially after the adoption of the Batho Pele (People First) and the Patients Right Charter.

The main objective in undertaking this research study was to develop an instrument that would assess the satisfaction levels of clients utilising two district hospitals in South Africa. The hospitals were the Gordonia hospital in Upington, and the East Griqualand and Usher Memorial Hospital in Kokstad.

Developing a tool to assess client perceptions happened in different phases:

**Phase 1:** A review of literature and other tools on assessing client satisfaction used in Africa and internationally.

**Phase 2:** Development of a tool that would assess the perception of patients around the key domains of quality of care. This was undertaken in 4 distinct stages between June 1999 and July 2000. In each pilot both the instrument (Client Satisfaction Tool) and the data gathering process were tested. The methods used in this research study can be outlined as follows:

➢ In stage one, focus group discussions within a framework of quality of service concerns were held with patients

➢ In stage two, the pertinent issues that influence the perception of clients about the service they receive, together with internationally accepted issues, were used to develop a questionnaire around the main domains that influence client perceptions

➢ In stage three, the questionnaires were piloted. A Xhosa version of the Client Satisfaction (CS) assessment tool was piloted in Kokstad, and an Afrikaans version was piloted in Upington. In both instances training was provided to a local fieldworker, who administered the instrument

➢ In stage four, the questionnaires were adapted and re-tested

➢ In stage five, the Kokstad hospital ran a third pilot in which they successfully managed the whole process from start to finish.

**Phase 3:** Development of a manual to assist hospital management to operate the client satisfaction assessment process. This phase ran parallel to phase 2 and was tested as part of the third stage of developing the assessment tool.

**Phase 4:** Assisting hospital management teams in taking management decisions based on the study findings and improve the quality assurance programmes in their hospitals.

The research process produced two types of results:

➢ The series of pilots, outlined above, led to the development of a valid and reliable CS Tool; and

➢ Data that could be analysed and used.
The analysis of the preliminary results gathered by the CS tool illustrates that there is a strong link between the results and the data gathered in the focus groups. Participants in the focus groups and those responding to questionnaires demonstrated that while they were happiest with staff, they had reservations about most of the services offered by the two hospitals. In particular, clients were especially unhappy with access to the two hospitals.

The preliminary results indicated that average scores hover between 0.5 and 1.0 (on a scale between -2.0 and 2.0), which suggests that clients are more satisfied than dissatisfied with the two hospitals. In the second phase of the analysis the questions were sorted into the five SERVQUAL domains, namely tangibles, reliability, responsiveness, assurance and empathy. In addition, two new domains were created: one for access and the other for general satisfaction.

Other than for access, all the domains achieved a positive score, albeit that they were relatively low. Empathy – the ability to care and display compassion towards clients – scored the highest out of all the domains.

Although the scores from the pilot studies are low, hospital management at both hospitals can take some satisfaction from the fact that clients are not unduly dissatisfied with the levels of service provided by these hospitals.

**Recommendations**

In terms of process, this report recommends that:

➤ The CS Tool be part of the hospital's quality assurance programme

➤ A member of the hospital management team is appointed to co-ordinate all the CS related activities

➤ Administration of the CS tool at both hospitals at least twice a year, for one week at a time (throughout the day from Monday to Friday)

➤ Use of this report as the start of a discussion process within the hospital, which will lead to the development of agreed upon targets for service delivery at the hospital and link this to both the Batho Pele programme and the recently adopted Charter for Patients’ Rights.

In terms of the results, these are some of the areas that management might consider focussing attention on:

➤ Communication – patients have unmet expectations, for example about receiving transport home. This and other policy issues should be clearly communicated to patients and the community at large

➤ Transport – consider providing more assistance to clients, plus extend visiting hours

➤ Folders – a time and motion study would illustrate the time spent waiting for the folder and where blockages occur

➤ Follow-up – clients need to feel that the hospital is always there to help them

➤ Security – an endemic problem in South Africa. Perhaps management could draw attention to the fact that at both hospitals security seemed very good during the day

➤ Many in-patients reported being bored in the wards – lack of resources may well prevent hospitals from dealing with this issue, but the matter should still be considered.
3. INTRODUCTION 
AND LITERATURE REVIEW

Measuring client or patient satisfaction has become an integral part of hospital/clinic management strategies across the globe. Moreover, the quality assurance and accreditation process in most countries requires that the satisfaction of clients be measured on a regular basis. Although there is much literature on the topic, no local published studies could be found, hence the literature review deals with studies outside South Africa.

The main objective in undertaking this research study was to develop an instrument that would assess the satisfaction levels of clients utilising two district hospitals in South Africa. The hospitals were the Gordonia Hospital in Upington, and the East Griqualand and Usher Memorial Hospital in Kokstad.

What the study entails

The study aimed to develop a tool and approach to assess the perception of patients about the service they receive at public hospitals in South Africa, specifically district hospitals. The assessment of the perception of patients is part of a broader approach to improve the quality of care. It strengthens the voice of the user and the community in line with the priority of the National Department of Health for the next five years, and aims to strengthen the democratic right of the community to be heard.

Client satisfaction assessment:

- Aims to provide a quick, easy, and rough assessment of patients’ perceptions about the service they receive
- Provides individual hospitals with data to look at the trends in the levels of satisfaction of patients
- Is not a survey of all activities in the hospital
- Does not replace other quality assurance activities
- Does not replace the monitoring of norms and standards of hospital care
- not a lengthy process that puts extra burden on staff.

General approach followed

Developing a tool to assess client perceptions happened in four phases:

Phase 1: A review of literature and other tools on assessing client satisfaction used in Africa and internationally.

Phase 2: Development of a tool that would assess the perception of patients around the key domains of quality of care.

Developing a tool was undertaken in five distinct stages between June 1999 and July 2000. In each pilot both the instrument (Client Satisfaction Tool) and the data gathering process were tested. The methods used in this research study can be outlined as follows:
In stage one, focus group discussions within a framework of quality of service concerns were held with patients.

In stage two, the pertinent issues from stage 1 that influence the perception of clients about the service they receive, together with internationally accepted issues were used to develop a questionnaire around the main domains that influence client perceptions.

In stage three, the questionnaires were piloted. A Xhosa version of the Client Satisfaction (CS) assessment tool was piloted in Kokstad, and an Afrikaans version was piloted in Upington. In both instances training was provided to a local fieldworker, who administered the instrument.

In stage four, the questionnaires were adapted and re-tested.

In stage five, the Kokstad hospital ran a third pilot in which they successfully managed the whole process from start to finish.

Phase 3: Development of a manual to assist hospital management to operate the client satisfaction assessment process. This phase ran parallel to phase 2 and was tested as part of the third stage of developing the assessment tool.

Phase 4: Assisting hospital management teams in taking management decisions based on the findings and improve the quality assurance programmes in their hospitals.

LITERATURE REVIEW

Why an assessment of client satisfaction is important

The literature on Client Satisfaction (CS) tools demonstrates a number of sound reasons as to why hospitals, clinics and other health care establishments should make the effort to establish whether clients are satisfied with the health care services they receive.

Patient compliance

Research has found that clients who are satisfied are more likely to remain with a health worker, continue to use the services provided by the medical centre, and refer other patients to that medical centre (Health Services Research Group, 1992; Epstein et al., 1996). Moreover, satisfied clients will keep appointments, and are also more likely to comply with treatment (Health Services Research Group, 1992).

Quality of Care

From the perspective of medical centre management, a CS tool will identify areas of improvement and demonstrate to external reviewers the quality of the care that clients are receiving (Epstein et al., 1996; Maxwell 1984 & 1992). Donabadian, arguably the leading theorist in the area of quality assurance, has emphasised that:

Client satisfaction is of fundamental importance as a measure of the quality of care because it gives information on the provider’s success at meeting those client values and expectations, which are matters on which the client is the ultimate authority (1980: p. 25).

Any sound quality assurance process, according to Donabadian (1980) would include the following three components: Structure (physical and human resources); Process (technical and interpersonal performance) and Outcome (results of inputs and processes). Maxwell (1984) has added a further six
dimensions to this model which help define quality and thus assist with the measurement of quality. Space does not permit a discussion of the vast literature on quality assurance, suffice it to say that a CS tool would be an essential instrument in measuring quality.

Client Centred Approach

In addition, CS tools have become increasingly popular as more and more health care services recognise the rights of clients. A client centred approach requires management of health care centres, often through legislation, to take cognisance of the views of their clients.

Problems with CS Tools

Methodology

In theory, as the above suggests, CS tools should be an important aspect of the service provided by medical centres. However, many have found the application of a CS tool within a medical setting to be very problematic. A major problem with the application of a CS tool is that very rarely do rates of patient satisfaction go below 90% (Lebow, 1974). In addition, studies of patient satisfaction are often local, poorly designed and lack reliability and validity (Sitzia and Wood, 1998). Moreover, there seems to be little agreement on what is an acceptable response rate. Few studies meet the generally accepted level of 80% set as the bare minimum in most epidemiological studies (Sitzia and Wood, 1998).

A further problem with the methodology used in the implementation of a CS tool is that there is often a non-response bias. Many studies fail to indicate the number of clients who did not respond to the CS tool, despite the fact that non-respondents are less likely to be satisfied with the care they received and are therefore crucial to any study of client satisfaction (Sitzia and Wood, 1998).

To counter the problems mentioned above the literature recommends that the target population should be well defined, that the sampling method should be sound, the number and characteristics of non-respondents should be well documented, and the survey should be personally administered to clients (Sitzia and Wood, 1998).

Validity

Recent studies have however questioned whether a CS tool actually measures what it intends to measure. A growing body of literature challenges the view that “patient satisfaction exists in the population, simply awaiting measurement” (Williams; 1994: p.509). A major complaint is that “at best, most tools are not validated and at worst many expressions of satisfaction may not be valuations at all” (Williams et al; 1998; p. 1352).

Research has also shown that “expectations are seen as dependent on the context of the clinical encounter and the past experience and knowledge of the patient” (Williams et al; 1998; p. 1352). It is therefore imperative that any study of this nature must be based on a clear understanding of how clients evaluate the health services.

Variables that influence patients perception of the hospital

A further challenge to the development of a valid and reliable CS tool is to ensure that the instrument is designed taking cognisance of the variables that can significantly influence the clients’ perception of the care they receive. In particular, the client population is not homogenous, so although the management of a medical centre may be making an effort to satisfy clients, they do so at a particular level or understanding of what they think their patients want or who they think their patients are (Minnick et al.,1997). Individuals could well have their own preferences, and it may be extremely difficult for medical centres to meet individual preferences.
Other variables that are commonly associated with a CS tool include clients’ age, education, occupation, and ethnic group. The literature suggests that these variables are inconsistently associated with ratings of satisfaction (Gross et al., 1998; Health Services Research Group, 1992). These inconsistencies can also be found with the issue of timeliness. The more time patients spend with their physician the more likely they will rate the experience higher (Gross et al., 1998). Others have argued that continuity of care appears to correlate better with satisfaction than length of visit (Health Services Research Group, 1992). Evidence from the United States of America suggested that patients who were white, older and healthier are more likely to be satisfied with their experience (Gross et al., 1998).

**SERVQUAL**

The most popular CS tool in use in medical centres overseas is derived from the SERVQUAL scale, a scale that was developed to measure the quality of service in the financial sector. The creators determined that there were five broad areas that need to be measured. These dimensions are:

- **Tangibles** – equipment, physical surroundings
- **Reliability** – the ability to accurately perform the service offered
- **Responsiveness** – willingness to assist clients
- **Assurance** – ability to be knowledgeable and to inspire confidence and trust; and
- **Empathy** – ability to care and display compassion towards clients.

The survey, which provides the information for the scale, is structured in such a way that it creates 22 pairs of items across all five dimensions. Half the items measure expectations and the other half measure perceptions. Patients complete the first half of the survey before they have been attended to and then they complete the survey at the end of their visit. The quality of the service provided is then determined by subtracting the expectation scores from the corresponding perception scores (Babakus & Mangold, 1992).

The literature demonstrates that surveys of this nature work well in developed countries, where literate clients complete the questionnaire on their own. No published study could be found which demonstrates that a SERVQUAL scale works equally well in developing countries where clients may be unable to complete either the expectation or perception section on their own.

In the results section below it will be demonstrated how the SERVQUAL scale was adapted to suit the needs of the two hospitals used in this study. It may be of interest to note that an additional domain or dimension has been added namely, access. It was Maxwell (1984) who suggested that when measuring the quality of the health service as a whole one needs to also examine access to the service.

**Summary**

The literature review above suggests that a CS tool should be a key instrument in any hospital/clinic management strategy, provided the CS tool has been well designed and is administered in a scientific manner. To ensure full participation from the client, the CS tool must be easily understood, and it must take cognisance of the client’s ability to complete the survey while still maintaining confidentiality.

Taking the above into consideration it was decided to implement a two-phase research process. In the first phase, a qualitative method was used to determine in depth the concerns of the clients. In the second phase a quantitative method was used to measure the levels of satisfaction amongst clients at the two hospitals.
This section deals with the methodology applied to develop a tool to assess client perceptions. It explains the process of defining the questions that would elicit client perceptions on the major domains of satisfaction, testing out the questionnaire and finalising it.

**Selection of sites**

The two district hospitals that provided the research sites were the Gordonia hospital in Upington, Northern Cape and the East Griqualand and Usher Memorial Hospital in Kokstad in KwaZulu-Natal Province. The sites were chosen because in both cases hospital management had expressed a need to incorporate this project into their wider quality assurance programme. Both sites are in Districts supported by the Health Systems Trust.

**Focus groups**

The purpose of the focus groups was to establish, in qualitative terms, how clients perceived the treatment they received at the respective hospitals. In addition, the groups were used to discuss items to be included in the CS tool and to ensure that the issues of concern to the clients were included in the CS tool.

**Constituting and running the focus group discussions**

**a. Members**

The focus groups had between 8 and 10 participants who were recruited using specified criteria, i.e. participants would not be employees of the health department and should have had recent contact with the hospital, either as an inpatient or an outpatient. The groups were kept as homogenous as possible (there was a male and female group at each hospital), which encouraged people to be frank and participative.

It is important to remember that focus groups are not representative. This is particularly true of the small number of groups used in this study. Their results are at best *indicative*, and hence need to be followed up with quantitative research which is representative and thereby ‘arbitrates’ the qualitative results. The focus groups nonetheless provided fascinating insights into how different target groups experienced the two hospitals.

**b. Process**

The focus group discussions lasted between one and a half and two hours. The facilitator for each group was conversant in the clients’ home language and was experienced in the approach and method of facilitation. Focus group participants were put at ease at the beginning of the session through ‘ice breaker’ sessions.

Participants were served light refreshments and paid an incentive fee for attending. The focus group
discussions were recorded and transcribed, to provide an on-going resource. Where necessary, the transcripts were translated into English.

The Upington discussions were recorded verbatim as a tape recorder was available. The discussions from the Kokstad focus group are summarised from notes taken.

c. Framework for discussions

Discussion guidelines were drawn up prior to the focus groups; discussion topics used in the guidelines were based on common topics raised in the literature study. The framework used was:

➢ Introduction:

This aimed to introduce the facilitator and the note-taker. The aim of the session was stated and everybody was put at ease by emphasising confidentiality and the fact that there are no right or wrong answers. Then participants were introduced.

➢ Discussions:

The facilitator stimulated discussions around the following:

- A recent experience at the hospital and what made it positive and what made it negative
- Things that make it easy or difficult to get access to the hospital; experiences around waiting
- A statement where patients indicate they were not treated well. Participants had to provide reasons for responses and bring the discussion closer to this personal experience
- Their experience of the clinical examination and the information provided about their condition and the treatment plan
- Their stay in the hospital, focusing on what made them happy and what made them unhappy, and whether they got assistance when required
- General issues such as what influenced their general impression.

d. Venue

The focus groups took place in a venue provided by the hospital. It should be noted that due to circumstances beyond the control of the research group, the focus groups in Kokstad where held at the hospital. The research team had hoped to keep the groups off the hospital premises to ensure that the clients would not be afraid to speak openly about their experience.
Results:

What follows is a more detailed report on the focus groups held at each centre. The focus groups revealed valuable information, which was later incorporated into the CS tool.

**Upington**

Two focus groups were run in Upington. The first group consisted of ten women (a mix of in-patients and out-patients). The second group consisted of seven men (also a mix of in-patients and out-patients).

**Recent Experiences**

Participants in the groups were very positive about the treatment – e.g. “People who complain must be very sick”; “They have forgotten how terrible it was in the past”.

There were however, complaints about transport to the hospital, queuing for folders, the long wait to receive medical help, and the long wait at the dispensary to receive medicine. Accessing folders was a major headache for most of the clients, especially if they had left their “card” at home. The costs to get to the hospital are enormous. With no public transport services available clients paid up to R60.00 to get to the hospital.

Participants saw the medical staff as being particularly friendly. Clients talked of nursing staff staying up all night to keep them company. In-patients complained of over-crowding in the wards and also complained that they had nothing to do in the wards (no TV/radio).

Bathrooms were seen to be particularly dirty and female participants mentioned that they cleaned the bathrooms themselves as no one else did.

**Other issues**

Two other issues were raised in the groups. One, the Cuban doctors seem to have been a big hit with the clients. Two, when it came to being discharged from the hospital, clients appreciated the fact that they were not simply turned out into the street. The hospital makes sure that either family members come to collect them or an ambulance takes them home.

**Methodological issues**

A visit to the Gordonia hospital highlighted the need for careful planning as to how best to administer the CS tool in the hospital. The hospital is spread out across several buildings and there are a number of entrances/exits to each building. In other words, there is no obvious central point through which each client must pass. The pilot test would have needed to test whether there should be several distribution points for the instrument (e.g. in the wards and at the exits) or whether the questionnaire be administered at the dispensary where many clients go before leaving the hospital.

This issue resolved itself at the next visit to the Gordonia hospital as a new security gate was constructed which meant that all clients passed through a single gate on leaving the hospital. It was thus decided to use the gate as the point where the instrument would be administered.
Kokstad

Two focus groups were run in Kokstad. The first group consisted of six men (a mix of in-patients and out-patients). The second group consisted of seven women (also a mix of in-patients and out-patients).

Recent Experiences

All participants had no complaints about their recent experiences with the hospital. They mentioned that their ailments had been treated well and therefore they had no reason to complain.

Access to the hospital was not seen to be as big an issue as it was for those living in Upington. Most of the participants used taxis. Participants who travel from far said it takes them two to three hours to get to the hospital. One participant said that sometimes he leaves home at 07h00 and arrives at the hospital at about 11h00.

Participants did complain that there were long waits for folders, long waits to see medical staff, and long waits for medicines. Participants were also unhappy with the state of the buildings.

All participants were happy with the way they were treated by doctors, but the men were unhappy with treatment they received from the nurses (although this was not an issue for the women). One participant said he felt that the nurses do not pay attention to the patients particularly at night. A young female participant complained about one White female doctor who does not have time for the patients. The participant continued to say that the doctor hardly examines you. “She just looks at you, writes in your card and then she’ll give the card to the sister”. When asked by the moderator if the sister explained about what was wrong to the patient the participant said no.

Those participants who had stayed in the wards said they were reasonably clean, that the sheets and blankets were clean, and that they were happy with the food.

Developing the CS Tool

The CS tool was developed from issues raised above in the focus groups, from the literature reviewed and from discussions held within the research team. In addition, as can be seen below, the CS tool drew heavily from SERVQUAL approach and the pilot testing.

Validity and Reliability

To ensure the validity and reliability of the instrument the questionnaire was tested for content validity and factor structure. In addition the internal consistency reliability of the questionnaire was also tested. These tests led to two notable features of the questionnaire. The first is that the questionnaire includes items that have been reversed scored to ensure more discriminating information. The second is that several items seek the same information, but are phrased differently to ensure that the client does not think that questions are repeated.

Pilot testing

First Pilot test

Although the questionnaire has been arranged under the 5 SERVQUAL domains, the administration of the CS tool during the pilot testing was significantly different. In the literature review above it was noted that SERVQUAL is based on the premise that clients complete part one of the questionnaire to determine their expectations prior to entering the hospital. On completion of their visit to the hospital the client completes part two of the questionnaire to record their actual experience. The difference between part one and part two is meant to reflect patient/client satisfaction.

This approach was not used in the pilot test because of the practical difficulties in administering two different questionnaires, asking very similar questions to illiterate clients, and the complexity of administering such a process for the fieldworkers. Moreover, no literature could be found to guide this process, so the research team decided to pilot the CS tool using the following process:

➤ The CS tool was administered in Upington over a 4-day period (Monday to Thursday, Friday was a public holiday) and in Kokstad over a 5-day period (Monday to Friday). It was decided to use a full working week to ensure that the views of clients visiting specific clinics (e.g. TB) on specific days would be measured.

➤ The CS tool, (Appendix A) consisted of 27 questions. The first 16 questions were completed by all respondents, the remaining 11 questions were completed only by those respondents who had spent at least one night at the hospital.

➤ Respondents were asked to rate each statement on a five point scale from strongly disagree = 1 to strongly agree = 5.

➤ The Questionnaire was translated into Xhosa and Afrikaans (it was retranslated back into English to ensure the accuracy of the translation).

➤ The pre-tested and validated questionnaire was then administered at the two hospitals. At both hospitals the fieldwork team were positioned at the hospital gate during daylight hours, and each person who departed the hospital was asked to complete the questionnaire. The questionnaire was administered in the language of the clients’ choice by the fieldworker. Fieldworkers employed in the process had no identifiable connection with the hospital.

➤ In instances where the person was either a member of the hospital staff or a visitor, they were excluded and no questionnaire was submitted.

➤ In addition, the research team also observed whether the questionnaire was too long, how the clients reacted to the questions, and what assistance clients required to complete the questionnaire.

The pilot of the research process was seen as a success, primarily because the questionnaire could be administered in less than 5 minutes, clients did not find the questions threatening, and they were happy that someone conversant in their language was administering the questionnaire. However, some adjustment was needed to the actual questionnaire, as noted below.

Second Pilot test

The Second Pilot test followed the same process outlined above, albeit that the instrument was administered at both hospitals for the full five days. This testing also focused on specific criteria:

➤ User-friendliness (are the questions easily understandable). This included the language, the way in which questions are structured and the general support from clients to complete the questionnaire.
How long it takes to complete the questionnaire

How the hospital managed the process

Assessing the contents of a guide or manual that would accompany the questionnaire.

In the second pilot test minor adjustments were made to the first two questions. The questions had originally read:

1. It takes a long time to get to the hospital
2. It costs a lot to get to the hospital

This was changed to read:

1. It takes more than 30 minutes to get to the hospital
2. It costs more than R7.00 to get to the hospital

A question for in-patients only was also changed. The question initially read as follows:

26. I know that the hospital will follow-up to see if I am better.

This was changed to read:

26. The hospital will tell my local health clinic about my future care needs.

Guide to assess client satisfaction

In addition to the minor changes made to the questionnaire, a Client Satisfaction Guide (CS Guide) was compiled and then distributed amongst the relevant role-players at the two hospitals. The CS Guide provides a step-by-step guide on how to set up the data gathering process, how to administer the CS Tool, and how to analyse the data.

Third Pilot test

The third pilot test, which used the same questionnaire as the one used in the second pilot, occurred only in Kokstad. The reason for this was that the objective of the third pilot test was to test the ability of the hospital to run the data gathering process from start-to-finish without the presence of the lead researcher on this project. (Upington had demonstrated this ability in the second pilot test.) The third pilot in Kokstad was a success and the hospital ably demonstrated its ability to manage the data gathering process, including finding and training a new fieldworker for the survey.

Qualitative Data

The importance of using qualitative methods to gain a deeper and richer understanding of the perceptions of the clients was noted at the beginning of the research process. For this reason the research process began with a couple of discussion groups at each hospital. During the piloting of the quantitative instrument a number of clients felt the need to share with the fieldworkers personal experiences of the levels of service they received whilst visiting the hospital. Bearing in mind that while qualitative information can enhance understanding of an issue, qualitative findings are not generalisable in the way that quantitative findings are. However stories that some clients may want to share with fieldworkers, may help to shed light on the perceptions that clients are recording on the CS Tool. Therefore, it is recommended that space be made on the instrument to allow fieldworkers to record, in the words of the client, stories/ anecdotes that a client may wish to share with the fieldworker.

Qualitative question:

28. Before we end, is there anything else you would like the hospital to be aware of?
5. RESULTS

In addition to the findings themselves the research has resulted in the compiling of a CS Guide for those wishing to undertake client satisfaction assessment surveys. The CS Guide is available as a separate publication.

Guide to assess Client Satisfaction

The CS Guide is the product of the different processes piloted in the stages described above and provides detailed guidelines on how the CS Tool should be managed and administered. It also provides answers to some frequently asked questions. There are 7 main components to the guide. These are:

➤ Human Resources
➤ Project Management
➤ Timing of surveys
➤ Fieldwork
➤ Data analysis
➤ Interpretation and Reporting
➤ Using the Findings.

Survey findings

Once the questionnaires were completed the results were tabulated and analysed. A word of warning should be given about interpreting these results, especially as they were gathered during the piloting of the instrument. These results should be seen as an indication of the clients’ perception as opposed to exact levels of support for each statement. As soon as the hospitals begin to administer the CS Tool on a regular basis a clearer picture will emerge of the perceptions of the clients. The results discussed below should therefore be seen as preliminary results which will be compared with actual results that the CS Tool will deliver in future.

Table I: Number of respondents per pilot

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<th>Kokstad</th>
<th>Upington</th>
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<tbody>
<tr>
<td>First Pilot</td>
<td>236 over 5 days</td>
<td>136 over 4 days</td>
</tr>
<tr>
<td>Second Pilot</td>
<td>95 over 5 days</td>
<td>182 over 5 days</td>
</tr>
<tr>
<td>Third Pilot</td>
<td>280 over 5 days</td>
<td>-</td>
</tr>
</tbody>
</table>

The second pilot clearly missed a significant number of respondents when compared with either the first or third pilot completed in Kokstad.

In total approximately 2% of clients refused to complete the questionnaire. The majority of these claimed they wanted to catch the waiting taxi, and were not prepared to risk missing their transport even though the questionnaire only takes a few minutes to complete.
To facilitate the analysis the 5 point scale was amended so that Strongly Disagree and Disagree became negative scores, neutral was scored as zero, and agree and strongly agree became positive scores. This can be tabulated as follows:

**Table II: Recoding of CS Tool scores**

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>Old score</th>
<th>New score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>1</td>
<td>-2</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
<td>-1</td>
</tr>
<tr>
<td>Neutral</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Agree</td>
<td>4</td>
<td>+1</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>5</td>
<td>+2</td>
</tr>
</tbody>
</table>

In addition, as part of the recoding exercise, questions 1, 2, 6, 7, 20, 22 & 24 were converted from negative statements to positive statements.

Averages for the studies were then calculated for each item and then plotted on the following graphs.

*Note:* The average shown in figures 1, 2, 3 & 5 refers to the average score from all five pilots (three pilots in Kokstad and two pilots in Upington) for each question. It is not the average for a particular hospital.

### Kokstad

The results for each question from the three different pilots conducted in Kokstad were plotted on the graph below.

**Figure 1:** Results from all three of the pilot tests done in Kokstad and the average score per question from all pilots
As the second survey had about 60% less client responses than the first and third surveys, the second survey results are doubtful. When the above graph is plotted without the second pilot survey, it can be seen that the results are fairly similar.

**Figure 2:** Results from 1st and 3rd Pilot test at Kokstad compared to the average score per question from all pilots

![Kokstad Graph]

**Upington**

The average scores per question from the two pilots performed in Upington were as follows:

**Figure 3:** Results from pilot tests in Upington, and the average score per question from all pilots

![Upington Graph]
Kokstad and Upington

A combined graph of Upington and Kokstad are shown below.

**Figure 4:** Results from all the pilots except for 2\textsuperscript{nd} Pilot in Kokstad, average scores per question

![Graph showing comparison of average scores per question between Upington and Kokstad pilots.]

**Figure 5:** Results from all pilots, except 2\textsuperscript{nd} pilot at Kokstad, compared to the average score per question from all pilots

![Graph showing comparison of individual pilot scores against the combined average scores per question.]

The graph above suggests that clients using the two hospitals on the other items roughly follow similar trends. However, when the individual score from each pilot is compared with the combined average from each question, the scores from Upington are slightly above average, whereas the scores from Kokstad
on each question are slightly below average.

The results on the domain, Access, show an obvious difference between Upington and Kokstad.

The levels of satisfaction in Upington are generally higher than they are in Kokstad. On a number of the items clients scored them between agree (scored as 1) and strongly agree (scored as 2).

By and large the scores tend to be hover between 0.5 and 1.0 which suggests that clients are more satisfied than dissatisfied with the two hospitals. The discussion below on the SERVQUAL domains addresses these issues in more detail.

On the whole Hospital management can take some satisfaction that clients are not entirely dissatisfied with the levels of service provided by these hospitals.

CS Tool Domains

In the second phase of the analysis the questions were sorted into the five SERVQUAL domains, as follows:

Tangibles:
- Equipment, physical surroundings.
  - q3. The hospital is in good condition.
  - q4. The hospital is clean.
  - q6. The toilets are dirty.
  - q8. There was a bench for me to sit on while I waited.
  - q17. The ward was clean.
  - q18. The bedding was clean.
  - q19. The food was good.

Reliability:
- The ability to accurately perform the service offered.
  - q7. I had to wait a long time to get my folder.
  - q13. The doctor explained what was wrong with me.
  - q15. If I received medicines/pills I did not have to wait long for them.
  - q23 When I need help at night, there was always a nurse to help me.

Responsiveness:
- Willingness to assist clients.
  - q9. The person who gave me my folder was helpful.
  - q20. Visiting hours were not long enough.
  - q23 When I needed help at night, there was always a nurse to help me.
  - q26. The hospital will tell my local health clinic about my future care needs.
Assurance:-

Ability to be knowledgeable and to inspire confidence and trust.

q14. My privacy was respected by the nurses and doctors.
q21. The staff at the hospital answered all my questions about my illness.
q24. I felt safe at night in the hospital.
q26. The hospital will tell my local health clinic about my future care needs.

Empathy:-

Ability to care and display compassion towards clients.

q10. The nurse who treated me listened to my problems.
q11. The doctor who treated me was polite.
q14. My privacy was respected by the nurses and doctors.

Two additional domains were created. In the first one, access is measured. This issue had been of considerable concern to the participants in the focus group. Moreover, access to health care is seen as a major obstacle to ensure health equality in this country. The second additional domain is a measure of general satisfaction. In ensuring the reliability of the CS tool several of the items also indicate a general level of satisfaction. The two new domains were created from the following statements:

Access (new variable):-

q1. It takes more than 30 minutes to get to the hospital.
q2. It costs more than R7.00 to get to the hospital.
q5. The out-patients/casualty department has convenient hours of opening.
q25. The hospital helped me to get a lift home.

General satisfaction (new variable):-

q12. I was pleased with the way I was treated at the hospital.
q16. Next time I am ill I will come back here.
q22. I was very bored in the hospital.
q27. If my friends are sick I will tell them to come to this hospital.
Plot of CS Tool Domains

The averages for each domain were tabulated and plotted as follows:

Table III: Scores per domain for Kokstad and Upington Pilots

<table>
<thead>
<tr>
<th>Domain</th>
<th>Kokstad 1</th>
<th>Kokstad 3</th>
<th>Upington 1</th>
<th>Upington 2</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tangibles</td>
<td>0.83</td>
<td>0.63</td>
<td>1.03</td>
<td>1.71</td>
<td>0.93</td>
</tr>
<tr>
<td>2. Reliability</td>
<td>0.525</td>
<td>0.31</td>
<td>1.05</td>
<td>1.25</td>
<td>0.65</td>
</tr>
<tr>
<td>3. Responsiveness</td>
<td>0.13</td>
<td>-0.03</td>
<td>0.65</td>
<td>1.45</td>
<td>0.41</td>
</tr>
<tr>
<td>4. Assurance</td>
<td>0.225</td>
<td>0.01</td>
<td>1.425</td>
<td>1.68</td>
<td>0.63</td>
</tr>
<tr>
<td>5. Empathy</td>
<td>0.77</td>
<td>0.73</td>
<td>1.73</td>
<td>1.80</td>
<td>1.15</td>
</tr>
<tr>
<td>6. Access</td>
<td>-0.05</td>
<td>0.08</td>
<td>-0.40</td>
<td>-0.78</td>
<td>-0.19</td>
</tr>
<tr>
<td>7. General Satisfaction</td>
<td>0.73</td>
<td>0.33</td>
<td>1.18</td>
<td>1.38</td>
<td>0.71</td>
</tr>
<tr>
<td>Average</td>
<td>0.45</td>
<td>0.29</td>
<td>0.95</td>
<td>1.21</td>
<td>0.61</td>
</tr>
</tbody>
</table>

Figure 6: Graph of scores per domain for Kokstad and Upington
6. RESPONSES TO THE FINDINGS

Facilitating management decisions

The following is a case study from Kokstad where a group of 24 people, mostly section heads and representatives form the provincial office debated the findings from the surveys and agreed on next steps.

The aims of the session were to:
➤ Debate the concept “Client Satisfaction”
➤ Understand how client satisfaction links to quality of care
➤ Consider the findings from the client satisfaction surveys held and determine actions
➤ Agree on next steps.

Client Satisfaction (CS):

Client satisfaction was explained as the level of satisfaction that clients experience having used a service. It therefore reflects the difference between the expected service and the experience of the service.

Factors influencing CS:

The factors that influence the perceived quality of care are those that influence the perception of the expected service and the perceived service. These were summarised as follows:

➤ Factors influencing the perception of the expected service are:
  • Past experience
  • External influences
  • Personal needs
  • Word of mouth

➤ Factors influencing how patients perceived the service are:
  • Tangibles
  • Reliability
  • Responsiveness
  • Competence
  •Courtesy
  • Credibility
  • Security
  • Access
  • Communication
  • Understanding the client
Taking action:

The general steps in a quality circle were then shared with the team. The steps are:

- Management and the quality improvement team identify the problem area and select the problems that require focus
- The quality improvement team, inclusive of shareholders, analyses the problem and recommends solutions
- Management reviews solutions and takes decisions
- The quality improvement team, inclusive of shareholders, implements the decisions
- Management monitors changes.

Process followed to determine actions:

The participants considered the findings from the surveys and used the findings as a basis for determining actions required.

- The result for each question of the Client Satisfaction Index (CSI) questionnaire was considered to allow the participants a feel for the results. They focused on the scores below 1 (See figure 6 above, and the set of questions in the appendix a).

- The group then used the results per domain to plan their actions. It was clear that the following domains were very low and should be prioritised:
  - Responsiveness
  - Assurance
  - Access
  - Reliability; and
  - General satisfaction.

  The criteria for prioritising were those things that scored low and which could be influenced in the short term.

  Actions falling in the domains Responsiveness, Assurance, Access and General Satisfaction were identified.

Objective 1: Sensitise staff for the need to enhance client satisfaction.

a. Share the findings of the Client Satisfaction survey with personnel
b. Implement Batho Pele.

Objective 2: Improve the filing system.

a. Establish a mechanism to inform patients about the blue card system and where to leave their files
b. Sensitise clerks to clients’ needs. Assist clerks to be able to assess emergencies (triage type of action)
c. Investigate an improvement to the filing system and measure file retrieval
d. Have clear signage for new and repeat clients
e. Explain fees and payment procedures as part of the admission process.
Objective 3: Make visiting time enjoyable.
   a. Extend visiting hours over weekends
   b. Nursing staff move around during visiting time and be alert to patients requiring protection
   c. Nursing staff to be polite when dismissing visitors
   d. Nursing staff to be given authority to be flexible about visiting time where appropriate.

Objective 4: Strengthen the links with PHC.
   a. Establish a structured PHC-hospital forum to discuss common issues
   b. Ensure that discharge notes are complete
   c. Inform patients to hand over discharge notes to the relevant clinic/health worker
   d. Strengthen communication to employers, relatives and home-based caregivers
   e. Establish and communicate a referral system between clinics and hospitals.

Objective 5: Strengthen nursing care and security during night-time.
   a. Ensure a high visibility of night staff and security after hours including night staff to do regular rounds and security staff to move around
   b. Ensure a nurse supervisor for night duty
   c. Have bells or other mechanism to ensure patients receive immediate attention at night in all wards. Where bells are used, educate patients on its use.

Objective 6: Enhance security services.
   a. The security service to portray neatness, soberness, cleanliness and politeness
   b. Security staff to make sure that patients know where to go
   c. Security alerts the casualty section when patients who require immediate help enter the gate.

Objective 7: Improve access to the hospital.
   a. Liaise with the local Taxi Association for a more regular transport service to and from the hospital
   b. Sensitise the community committee on how the ambulance service operates. Emphasise that the ambulance service assists in getting the ill to the hospital, but that transport from the hospital is a private matter. Ambulance staff should also inform patients and family members when patients are collected. The Farmers Association should also be informed about this matter.

Next steps

The following steps were decided upon to take the process forward:

1. The **Quality Improvement Committee** would incorporate the actions decided upon in the session in their action plans.

2. **Six-monthly assessments** of client perceptions will be done in April and in October.

3. Software is available to do the analysis and will be made available together with technical assistance.

4. Cascade the results and the planned actions in the hospital and to the community. (As soon as hospital board and clinic committees are well established, they would assist with the dissemination of information.)
7. DISCUSSION

In his criticism of quantitative methods for measuring client satisfaction, Williams argued that

Research shows that there is little consistent empirical evidence to support the assumption
that expressions of satisfaction result from the fulfillment of expectations. Consequently,
the research suggests that service changes may fail to have any impact on satisfaction
ratings unless the mechanisms underpinning expressions of satisfaction are more clearly
understood (Williams et al; 1998; p. 1352).

Moreover, he added that any instrument that is designed to measure client satisfaction must be
based on an understanding of what the client means when they express an opinion on the nature of the
service they received (Williams et al; 1998).

To address these issues the CS tool used in this study was designed after qualitative focus groups
were held to ensure that the research team had a meaningful understanding of the concerns of the clients. In addition, a comprehensive review of the literature was performed to identify issues where there is
empirical evidence to support their inclusion into the CS tool.

The analysis of the results gathered by the CS tool illustrates that there is a strong link between the
tool and the data gathered in the focus groups. Participants in the focus groups and in response to the
questionnaire demonstrated that while they were happiest with staff, they have reservations about most of
the services offered by the two hospitals. In particular, clients were unhappy with access to the two hospitals.

Other than for access, all the domains achieved a positive score, but for Kokstad barely so. While
figure 6 above illustrates that management should be satisfied, there are apparent areas of concern.
Kokstad in particular failed to achieve any score of 1 or above, and most of their scores hovered mid way
between 0 and 1. Upington fared considerably better.

Exploring each of the seven domains one by one highlights some interesting findings. Clients are
relatively satisfied with the physical surroundings of the hospital, the score for tangibles was high for both
hospitals. The differences become more marked as one examines the service provided by each hospital.
In terms of reliability – the ability to accurately perform the service offered – clients were satisfied at
Upington, but far less so at Kokstad. Within this domain, the waiting for the folder brought this score
down (average score of 0.2 for Kokstad and 0.8 for Upington).

An indication of the sensitivity of the instrument can be seen in the different score for tangibles
between the first and second pilot done in Upington. By the time of the second pilot all the building
alterations had been completed at the hospital. The clients clearly approved of the renovations as the
rating for tangibles had increased from approximately 1.0 to 1.7.

Perceptions of responsiveness – a willingness to assist clients – was seen as relatively poor in Kokstad
(average score of 0.05) and significantly better for Upington (average score 1.0). Visiting hours in both
hospitals was scored negatively (average score of -0.35 for Kokstad and -0.3 for Upington) which would
have dampened the overall score for this domain. In addition, clients in Kokstad scored follow-up negatively
(average score of -0.3). The perception that the visiting hours are too short is undoubtedly exacerbated in
Upington by the difficulties clients face in getting to the hospital. Future research in this area will probably
establish that lack of transport leads either to visitors arriving late at the hospital and thus after visiting
hours have ended or they never get to visit in-patients.

The differences between the two hospitals are marked within the domain of assurance, the hospitals’ ability to inspire confidence and trust amongst its clients. Clients in Upington had enormous trust in the staff, whereas the same could not be said in Kokstad. Follow-up (average score -0.3) and security (average score -0.3) were issues of concern for clients in Kokstad. In sharp contrast, the clients in Upington were almost unanimously happy with the fact that staff respected their privacy (average score 1.7) and that staff appeared to be knowledgeable about their illness and thus answered all the clients’ questions (average score 1.6).

While Kokstad scored relatively low on assurance and responsiveness it scored surprisingly high on empathy (average score 0.8). Compare this with Upington where the scores were high on all three. It would appear that clients in Kokstad may not be confident about the level of care they receive and the regularity of that care, but when they received help they perceived the staff to care and display compassion towards them. This domain scored the highest average scores, and management should be well pleased that their staff are perceived by all clients to be caring and compassionate.

Access issues (it takes more than 30 minutes to get to the hospital, it costs more than R7.00 to get to the hospital, the hospital made sure I got a lift home, and the OPD has convenient hours of opening) were a major concern in the focus groups, and figure 6 above confirms this. Upington fared particularly badly, especially when its average access score is compared with all the other domains (the average score for Upington is roughly 1 across all the domains, but for access it scored -0.6). Although Kokstad performed better than Upington, it also achieved a low score (average score is 0).

The final domain, general satisfaction, was included to establish the overall levels of satisfaction for the clients. A test of client satisfaction is to establish how willing clients are to return to the hospital, even when there is limited choice. Interestingly the scores for this domain are similar to the average across all the domains. Kokstad averaged 0.35 across all the domains and had an average of 0.5 on general satisfaction. Upington averaged 1.0 across all the domains and scored an average of 1.3. Boredom amongst in-patients was particularly high amongst clients in both hospitals.

It has already been noted above that while clients were generally more happy than unhappy, the levels of satisfaction are relatively low. Reasons for this low level of satisfaction would include difficulties in accessing the hospitals and dissatisfaction in the areas of responsiveness and reliability.
CS tools are by their very nature instruments which even when used properly can only assist in the gathering of information. Moreover, quantitative studies of this nature will only measure the items on the questionnaire. Alternatively, qualitative methods provide a richer and deeper understanding of what clients are thinking, but the findings are never generalisable. Using quantitative and qualitative methodology in combination, can provide an accurate picture of the perceptions of the clients. Future studies of this nature would do well to not only constantly test the reliability and validity of the CS tool, but to also explore the thoughts of the clients through periodic focus groups or by collection of comments made by respondents during the surveys.

Both hospitals used the findings as part of strategic planning, as is demonstrated in the Kokstad case study above. The results suggest that there are areas which both hospitals could consider focussing upon, if they are not already doing work in this area:

➤ Transport – consider providing more assistance to clients, plus extend visiting hours
➤ Folders – time and motion studies would illustrate the time spent waiting for the folder and where the blockages occur\(^2\)
➤ Follow-up – clients need to feel that the hospital is always there to help them
➤ Security – an endemic problem in South Africa. Perhaps management could draw attention to the fact that at both hospitals security seemed very good during the day and that night security should be stepped up to match day security.
➤ Many in-patients reported being bored in the wards – lack of resources may well prevent hospitals from dealing with this issue, but the matter should still be considered.

This research project has designed, developed and produced a valid and reliable CS tool, in three different languages. The study has also outlined a strategy for analysing the data and it has produced comprehensive guide on how to manage the whole research process. To ensure that the study remains useful to the management of these two hospitals, the research team would like to suggest the following:

➤ Use this report as the start of a discussion process within the hospital, which will lead to the development of agreed upon targets for service delivery at the hospital and also link this to both the Batho Pele programme and the recently adopted Charter for Patients’ Rights.

An example of this might be that a hospital would like to improve its average score for **Assurance**: The ability to be knowledgeable and to inspire confidence and trust. To do this, management would need to ensure that the scores improve on the following 4 items:

\(^2\) The fieldwork team, for example, noted that at the Kokstad OPD patients came out significantly faster once the doctor/ s arrived after they had finished their ward rounds. Prior to the arrival of the doctors the patients took far longer to leave OPD. It is worth noting that OPD is meant to be a casualty facility, receiving accident cases and referrals from PHC facilities only, but has turned into a PHC facility itself. Moreover, it would appear that the patients don’t want to be seen by a nurse only, but apparently insist on seeing a doctor – thus negating the PHC approach and causing excessive waiting periods at OPD. The situation is complicated by the fact that the fixed (TLC) clinic can not handle the numbers of patients, thus forcing self-referral to the Hospital OPD.
q14. My privacy was respected by the nurses and doctors.
q21. The staff at the hospital answered all my questions about my illness.
q24. I felt safe at night in the hospital.
q26. The hospital will tell my local health clinic about my future care needs.

A further example of this might be if the hospital wants to improve its average score for **Tangibles**: the equipment and physical surroundings. This domain is made up of scores from the following 7 items:

q3. The hospital is in good condition.
q4. The hospital is clean.
q6. The toilets are dirty.
q8. There was a bench for me to sit on while I waited.
q17. The ward was clean.
q18. The bedding was clean.
q19. The food was good.

To improve the overall score for this domain Management could begin by examining which of these scores are pulling the overall score down. It might be, for example, issues of cleanliness (questions 4, 6, 17 & 18) which clients have scored negatively.

Management could then identify who is responsible for this area and target it as an area which requires special attention. In this particular example management might decide to launch a campaign to ensure that the toilets are kept clean at all times and a system is put in place to monitor the campaign.

➤ Administration of the CS tool at both hospitals at least twice a year, for one week at a time (throughout the day from Monday to Friday). It may be useful to add a space at the end of the instrument for clients to record in their own words any issue that they feel they want to draw to the attention of the hospital. Strategy and Tactics (the consultants who conducted this pilot study) are available to provide follow-up analysis and assistance to ensure that a meaningful set of data is developed with which to determine the satisfaction of clients and thereby assist these two hospitals with their quality assurance.

➤ In conjunction with ISDS, the HST’s IT department and Strategy and Tactics has developed a software package which will assist with data capture and analysis. Managers should use this to assist analysis and comparison over time.

**Contact persons:**

Beth Engelbrecht at elengelb@pawc.wcape.gov.za  
(process, interpretation and management)

Ruth Grobler at ruth@hst.org.za  
or Ronel Visser at ronel@hst.org.za  
/software

Strategy & Tactics (the consultants who conducted this pilot study) are available to provide follow-up analysis and assistance to ensure that a meaningful set of data is developed with which to determine the satisfaction of clients and thereby assist hospitals with their quality assurance.

Matthew Smith at msmith01@iafrica.com  
/general support


Oskowitz, B. & Schneider, H. (1997). Taking Care of Quality: Perspectives of the Patients and the Providers at an STD Clinic. Paper No. 46. Centre for Health Policy, Department of Community Health, University of Witwatersrand.


Appendix 1: Client Satisfaction Survey

Directions: Based on your experiences as a patient at this hospital, please tell us whether you strongly agree, disagree, don’t know, agree, or strongly agree with the following statements. Please mark your answer for each question by circling the number. For example, if you disagree with a statement you would circle 2, if you agree with the statement you would circle 4. You may only choose one answer per question. If you spent at least one night in this hospital, please will you also answer the questions on the back of this form. The information on this form will be treated confidentially, so please do not place your name on this form. Thank you.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It takes more than 30 minutes to get to the hospital</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. It costs more than R7.00 to get to the hospital</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. The hospital is in good condition</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. The hospital is clean</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. The out-patients/ casualty department has convenient hours of opening</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. The toilets are dirty</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I had to wait a long time to get my folder</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. There was a bench for me to sit on while I waited</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. The person who gave me my folder was helpful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. The nurse who treated me listened to my problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. The doctor who treated me was polite</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I was pleased with the way I was treated at the hospital</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. The doctor explained to me what was wrong with me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. My privacy was respected by all the staff</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. If I received medicines/ pills I did not have to wait long for them</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. Next time I am ill I will come back here</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

NB: Please complete the questions overleaf if you have spent at least one night or more in the hospital
In-patients (Clients who spent at least one night in the hospital) Only

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. The ward was clean</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. The bedding was clean</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. The food was good</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. Visiting hours were not long enough</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21. The staff at the hospital answered all my questions about my illness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22. I was very bored in the hospital</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23. When I needed help at night, there was always a nurse to help me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24. I did not feel safe at night in the hospital</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25. The hospital made sure I got a lift home</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26. The hospital will tell my local health clinic about my future care needs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>27. If my friends are sick I will tell them to come to this hospital</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28. Before we end, is there anything else you would like the hospital to be aware of? (Record the answer in the space below or, if necessary, on a separate piece of paper)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>