THE PERCEPTIONS OF REGISTERED NURSES ABOUT PATIENT-FRIENDLY HEALTH SERVICES RENDERED WITHIN AN AMBULATORY CARE SETTING IN KING ABDULAZIZ MEDICAL CITY, RIYADH

by

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JUNE 2013
DECLARATION

I declare that THE PERCEPTIONS OF REGISTERED NURSES ABOUT PATIENT FRIENDLY HEALTH SERVICES RENDERED WITHIN AN AMBULATORY CARE SETTING IN KING ABDULAZIZ MEDICAL CITY, RIYADH is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

04 June 2013
DATE

Beatrix Jannette Isabella Magdalena Rademeyer
ABSTRACT

The purpose of this study was to explore and describe the perceptions of registered nurses about patient-friendly health services rendered within an ambulatory care setting in the King Abdulaziz Medical City, Riyadh (KAMC-R), Kingdom of Saudi Arabia. A qualitative, explorative, descriptive and contextual design was used. Fifteen registered nurses (one male and 14 female) voluntarily participated in this study. The data collection process comprised of semi-structured individual interviews with the participants to explore what they perceived to be patient-friendly health services. The obtained data were analysed using Van Mannen’s thematic analysis method. The emerging empirical data identified four themes, three categories and nine sub-categories; a literature control was incorporated to validate the findings. The study findings revealed that the participants identified cultural differences as a quintessential obstacle in rendering patient-friendly health services in the study context. Professional yet patient-friendly communication proved to be a challenge as did ambulatory care flow. This had the potential to compromise patient-friendly health services. Meeting the patients’ needs was acknowledged. However, the needs, goals and values of patient-friendly healthcare services were perceived differently by the patients on the one hand and the registered nurses on the other and this affected the process of interaction and delivery of patient-friendly care. Despite the fact that the registered nurses daily experienced ongoing challenges which compromised patient-friendly health services, they were aware and committed to deliver patient-friendly health services. The process of scientific inquiry concluded with the limitations of the study and recommendations were made based on the findings.

KEY CONCEPTS

Patient-friendly health services; perception; ambulatory care; registered nurses; patient; culture; communication.
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Dedication

This dissertation is dedicated to my two sons, Ulrich and Mauritz Rademeyer who offered me unconditional love and support throughout the course of the study.
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CHAPTER 1

ORIENTATION TO THE STUDY

“If you talk to a man in a language he understands, that goes to his head.

If you talk to him in his language, that goes to his heart.”

(Mandela 2013).

1.1 INTRODUCTION

The worldwide development in political, social and economic conditions coupled with technology, globalisation and an increased access to information have changed the role and responsibilities of the health care industry and, without a doubt, those of health care providers forever. Of the myriad challenges that health care service delivery are faced with currently and which will have to be continuously addressed and assessed in coming years, is the rapidly changing pattern of rendering care to patients (Howard 2000:22).

In the health care industry, successful change means to improve health; improving health care on all levels is the business of fostering, leading or implementing change. Successful change is by no means an end in itself; in the health care milieu it is rather a means of improving performance, quality of service and ultimately, of improving health (What makes a good hospital 2010:2).

Swan and Haan (2011:331) remark that if ambulatory care is to achieve its highest level of quality and safe service delivery, its “golden age” as these authors refer to it, nurses who work in ambulatory care must be “prepared to lead change”.

In all parts of the world, the demand for improved, patient-centered and humane health care is rising. The modern patient does not want to be looked upon as simply the recipient of frequent injections and treatment but wants to be recognised as a vulnerable, sick human being in need of expert and humane care (Howard 2000:23).
One of the philosophies that have emerged in the universal quest to deliver ultimate quality care to the patients is **patient-friendly health services**. The fundamental principle underpinning patient-friendly health services is that all employees act accountable for creating an environment in which patients feel satisfied about the care they receive (What exactly is customer service/customer satisfaction 2010:1). Being patient-friendly means that every health care worker, whatever his or her role in the health care service delivery domain, takes responsibility for making the service more patient-friendly and the experience for the patient as good and as pleasing as possible (Patient friendly recognition 2006:1).

For many patients, specifically for first-time patient and illiterate ones, visiting a health care facility for health services is an unnerving experience and they may feel anxious and scared (Welcome patients: helpful attitude, signs and more 2012:1). Therefore, if the nurses and the rest of the health care team create a patient-friendly environment, it may help the patients to feel more at ease and experience a sense of welcome that can encourage them to participate in their own health care experience (Welcome patients: helpful attitude, signs and more 2012:1). The fact is that providing more personalised patient experiences have over the last years become an important aspect of health care services worldwide. Staff members, for example, are encouraged to be service “champions” to help reinforce the message of patient-friendly health services (Achieving patient-friendly services 2011:87).

### 1.2 BACKGROUND TO THE STUDY

The focus of this study was the King Abdulaziz Medical City, Riyadh (KAMC-R). Riyadh is the capital city of Saudi Arabia. KAMC-R is a joint commission internationally accredited (JCIA) hospital. The majority of nursing staff is not indigenous to the Saudi culture but comes from a variety of cultures for example South Africa, Philippines, Malaysia, United Kingdom, Egypt, Jordan and Lebanon. In fact, at the time the current study was conducted the workforce consisted of 42 different nationalities. These nurses may have knowledge of basic nursing science and art, basic training and commonalities, but they often graduated from different universities and nursing schools across the globe. This means that they are from contexts and educational backgrounds which differ considerably from the context where they have to render health services. The diversity of experiential backgrounds could potentially lead to different
understandings and interpretations of the concept ‘friendly behaviours’ and, hence, to a perceivably negative effect on the service being perceived as ‘patient-friendly’ despite the best efforts made by the staff of KAMC-R.

According to Andrews and Boyle (2003:18), nurses must be aware of their own attitudes, beliefs, practices and cultural values to gain insight into the way the nurse relates to individuals or groups of people with diverse cultures and backgrounds. Unfortunately, nurses from all over the world who arrive in Saudi Arabia to deliver nursing care to the patient population receive very little or no education about the patients’ culture and backgrounds. Moreover, all nurses have to work with other nursing colleagues who also come from different cultural and traditional backgrounds. The dualisms in cultures and backgrounds – between nursing staff and patients and among nursing staff themselves – could have a negative impact on rendering patient-friendly health services as the nurses might act in a manner which could be perceived as culturally inappropriate by the patients and vice versa. Another problem is that the expatriate nurses from countries other than the Middle East do not speak Arabic which is the native tongue of the patient population. Different languages express different personal and cultural realities (Arnold in Arnold & Boggs 2011:202). Patient-friendly health services in the Ambulatory Care Centre (ACC) are further challenged since most of the nurses do not understand the Arabic language while the majority of the patients do not speak English either.

In an effort to address the cultural and traditional differences which can bedevil successful quality health care delivery in the country, the KAMC-R declared the organisational focus, ‘Patients and families first’, as one of the main objectives of the organisation (Al Knawy 2009). The nursing services of Saudi Arabia National Guard Health Affairs (NGHA) are at the forefront of the organisation’s drive for quality health care. All staff members are expected to pay special attention to cultural appropriateness while providing holistic and patient-centered health care to patients.

The organisational leadership expects the employees to demonstrate desirable attitudes and behaviours when dealing with patients and their families. However, this may be perceived and implemented differently by registered nurses allocated to the clinical setting in the ACC. Clinical practices are expected to be focused on the clinical as well as non-clinical needs of patients. It is the perception that, if the nurse is
welcoming and friendly, the patients will feel valued, the staff may experience greater job satisfaction and the working place will be more appealing (Achieving patient-friendly services 2011:87). Yet, at the same time, the researcher sought to investigate how registered nurses perceive patient-friendly health services in order to improve the quality of care as desired, especially in the context of both the nurses’ and patients’ different cultures and orientations.

1.3 RESEARCH PROBLEM

Burns and Grove (2009:29) define a research problem as “an area of concern in which there is a gap in the knowledge base needed for nursing practice”. The researcher is concerned with the identified problem and would like to make a contribution so that it is empirically investigated for a better understanding of the phenomenon (Polit & Beck 2008:112).

1.3.1 Source of the research problem

According to Burns and Grove (2009:72), sources of research problems include nursing practice, researcher and peer interactions, literature review, theory and research priorities identified by funding agencies and special groups. Polit and Beck (2008:82) also indicate sources that might fuel a researcher’s curiosity are clinical experience, nursing literature, social issues, theories and suggestions from others. Brink, Van der Walt and Van Rensburg (2008:59) add that research problems may be derived from many sources such as clinical practice, literature, theory, ethical dilemmas, observed health and illness patterns, interaction with colleagues, students, individuals and communities as well as established research priorities. In the case of this study, the source of the research problem was situated in the ACC; more specifically in the experience of one person. She was a nurse known to the researcher who had been consulted as a patient in one of the ACC clinics.

Scenario

On a particular day this person visited a clinic in the ACC as a patient and not as a nurse. She was not received with friendliness or any display of good customer service by the staff members. The reception staff, which included registered nurses, did not
look up from their computers nor did they make eye contact with her. Although the walk-in visit was accepted by the clinic coordinator and the attending physician, the reception nurses seemed uninterested to assist. The patient was requested to wait in the female waiting area where there was no chair available and was only called in after 45 minutes for screening before being examined by the resident physician. A resident physician in the KAMC-R refers to a physician who is out of medical school and receiving training in a specialty in the hospital under the supervision of a consultant physician. A consultant physician in the KAMC-R refers to a senior physician who completed all his or her specialist training and is responsible for the care of the patients referred to them including supervision of resident physicians. ACC guidelines stipulate the consultant has to be present during his or her clinic session in the ACC to supervise the actions of the residents.

The resident took the patient’s medical history while waiting for the consultant to arrive at the clinic since the consultant normally has to supervise the residents in the ACC. The patient requested to have the opinion of the consultant and therefore had to wait again. The consultant arrived 30 minutes later and the patient had to repeat the medical history. The out processing of the visit was delayed as there was only one unit assistant on duty and many patients waiting to be out processed. The unit assistant did not even once speak or look at the patient, no information was relayed to the patient, but only handed her the documents for a follow-up visit, the prescription for the pharmacy and a laboratory form. This experience was shared with the researcher who was intrigued by the following question: “How do the nurses in the ACC perceive the concept of patient-friendly health services?”

The question that the researcher decided to investigate relates to everyday nursing challenges and concerns in the ACC. This scenario became the motivation that led the researcher to undertake the current study (Jolley 2010:9). Although this brief description can be perceived as a simple and even irrelevant event, the fact is that such negative experiences commonly occur and are encountered by patients on a daily basis (Jolley 2010:9).
1.3.2 Background to the research problem

The Chief Executive Officer (CEO) of the NGHA, His Excellency Dr Bandar Al Knawy released a circular to all four NGHA hospitals under his auspices, stated that the shared commitment of the organisation was to put patients and families first by focusing on the following fundamental goal:

- To establish the cornerstone of organisational values in terms of research, quality patient care, innovation, friendly service and multidisciplinary teamwork.

The rationale for this study was to make use of this opportunity to participate in the structure, process and outcome of the current initiative of organisational development by assessing the prevalent status of the registered nurses’ knowledge, views, ideas and opinions regarding patient friendliness in the context of the Saudi Arabian culture. This would provide the necessary underpinnings for future work in designing educational activities and workplace routines. With the establishment of the King Abdullah International Research Centre and the King Saud Bin Abdulaziz University for Health Sciences, the NGHA health care providers now have numerous research opportunities to make the expected contribution and to enter into partnerships to ensure safe and quality patient care in the new health care provision settings.

One of the stated organisational goals is to pursue research and innovation to enhance quality patient care and patient friendliness is a vital component of the intent to deliver quality patient care. Patient friendliness is especially important in ambulatory care settings as the time window for interaction with patients is much more limited than in inpatient settings. The study also indirectly sought to embrace the rest of the stated organisational fundamental goals which are to:

- foster academic health education
- achieve excellence in quality patient care and safety
- advance operational efficiency and effectiveness
- provide community health care
- make NGHA the best place to work at
- grow professionally and personally (Al Knawy 2009)
A study conducted by Douglas and Douglas (2004:65) revealed that a patient-friendly hospital or clinic is established by the staff; by getting the small things right, meeting the needs of the patients and involving them in decisions about their health care. As described in a study by Howard (2000:23), the health care industry as a marketplace has to “take the customer’s breath away” in order to achieve outstanding customer service. In a study conducted by Mansour and Al-Osimy (1993:165), the definition of humaneness was defined as the “respect, concern, friendliness and courtesy that health care providers show to patients”.

1.3.3 Statement of the research problem

The health care industry has been very slow to initiate customer service reformation. Nurses have to take responsibility for ensuring patient-friendly health services by means of a customer oriented approach. However, it seems as if most nurses are not formally trained to deliver care beyond the technical care that the patients in any case expect (Howard 2000:22). Although technical skills will always be the first nursing priority, a study by Geanellos (2004:38) revealed that a patient values nurses’ interpersonal skills as high as, or even higher, than their technical abilities. Howard (2000:23) concedes that patients have certain expectations of health care services; however, their requirements can by overly demanding in that they expect the “health care industry to find out what they want and to provide even more of it” or, alternatively, the health care industry must be “knowledgeable as to what the patients do not want and to avoid it”.

On the whole, productivity continues to be the main component of rendering nursing care. In Green’s (2004:283) view, this leaves nurses with little time to identify friendly behaviour and establish caring relationships with patients. Additionally, the nurses’ responsibilities continue to expand. Considering the aforementioned realities in the nursing context, it is obviously of crucial importance that nurses persist with reflecting on their roles in order to keep their patients satisfied (Green 2004:283). In fact, Green (2004:288) reminds nurses to be attentive and not to compromise inherent nursing characteristics such as friendliness and a caring attitude for more productive primary care in challenging ambulatory care settings. The fact remains that the attitudes and behaviour of nurses are as important as the professionalism of health services since
patients will choose a health care institution that is both professional and compassionate (What makes a good hospital 2010:1).

Nurses started to notice the demands for improved, quality health services (Howard 2000:22). Howard (2000:23) continues by stating that a customer service programme has to be established that offers health care leaders protected time, dedicated staff training and development, and available resources. However, reorienting a health system and developing “customer mindedness” among nurses could be a long-term process (World Health Organization [WHO] 2008:100). During the process of growth and development, a health care organisation’s focus has to be on its unique organisational culture and climate of patient care (Howard 2000:25).

Furthermore, in the study conducted by Geanellos (2004:38) patients were highly appreciative of nurses who took the time to explain medical procedures, offered a laugh or joke, and who showed interest in the personal comfort of patients. Nurses’ friendly behaviour made the patients feel cared for. Friendly attitude and behaviour are important tools in the skill set of a nurse but, unfortunately, not all nurses develop interpersonal skills; in fact, some do not even perceive such a skill to be important (Geanellos 2004:38). Another drawback for patient-friendly health services is the fact that nurses are often overloaded with work such as attending to inquiries or finding prescriptions for patients which leaves little time for practicing refinements of nursing which means so much to patients (Ensuring a patient focused service 2011:88).

Although ambulatory nursing care and patient-friendly models of care have been extensively studied in recent years (some of which are cited in this study), an investigation into the perceptions of nurses at operational level relating to the concept “patient-friendly health services” has not been conducted. In consideration, it is thus clear that there was a need to conduct a research study on nurse friendliness to enhance health care institutions as patient-friendly as well as nurse-friendly institutions.

1.4 RESEARCH OBJECTIVES

The objectives of this study were to explore and describe the perceptions of registered nurses about patient-friendly health services rendered within an ambulatory care setting in KAMC-R.
1.4.1 Research question

The following research question guided this study:

What are the perceptions of registered nurses about patient-friendly health services rendered within an ambulatory care setting in King Abdulaziz Medical City, Riyadh?

1.5 SIGNIFICANCE OF THE STUDY

The study findings will contribute to making the shared organisational commitment a reality for patients and families, health care providers and the health care facility. The findings can lead to recognition and identification of the challenges to be addressed by the hospital leadership and administration in order to design and implement patient-friendly health service processes. Current administrative policies and procedures can be modified to guide the employees, particularly the nurses.

Patient satisfaction can be improved by an ongoing process of ensuring staff readiness to provide patient-friendly health services. Other inductive inferences from the study findings may be to enable staff to be actively involved in assessing and improving patient satisfaction by creating a friendly health care environment.

The findings can furthermore lead to the generation of effective education activities aimed at staff development with the focus on unpacking the statement: ‘Patients and families first’ (Al Knawy 2009). Staff development in this respect refers to reviewing existing professional competencies to provide viable patient-friendly health services. Nurses can be empowered with skills, knowledge and guidance to address important socio cultural aspects to provide holistic and comprehensive patient-friendly health services.

1.6 CONCEPTUAL DEFINITIONS

A definition states the precise meaning of ‘a word, term or concept’ (Polit & Beck 2006:35). A conceptual definition of variables explains the meaning of a specific concept and gives a theoretical or abstract explanation of the study concepts based on
authentic sources such as dictionaries, thesauruses or discipline-related literature. An operational definition, according to Burns and Grove (2009:775), means the ‘description of how a concept or variable will be applied, manipulated or measured in a study’.

1.6.1 Ambulatory care clinic

The Oxford Thesaurus English Dictionary (2006:601) defines ‘ambulatory care’ as medical care “that includes assessment, diagnosis, observation, treatment and rehabilitation which is provided on an outpatient basis”. It is care given to persons who are ambulate and includes persons in wheelchairs. The American Academy of Ambulatory Care Nursing (2012:1) defines it as “health services provided on an outpatient basis to those who visit a hospital or any other health care facility, are treated there and depart on the same day after treatment has been administered”.

In this study ‘ambulatory care’ meant care rendered by registered nurses to patients or clients who visited the outpatient clinics for health care and did not require hospital admission. This care included assessment, diagnosis, observation, treatment and rehabilitation. After having received treatment on the day of their visit to the outpatient clinic, they had to depart either to their homes or be transferred to admission units depending on the consultant’s decision.

A ‘clinic’ is defined as a department of a hospital or an independent health centre specializing in the assessment, diagnosis, treatment and care of patients with particular health disorders and/or diseases and injuries (Chambers Concise Dictionary 2004:228).

‘Clinic’ in this study referred to a place in the ACC, where assessment, diagnosis, treatment and care of patients with particular health disorders and/or diseases and injuries occurred, or where a particular kind of medical treatment or advice was given based on the observations of both the patient and the medical personnel. In this study the ambulatory care setting referred to any clinic within the ACC building in KAMC-R.

1.6.2 Patient

According to Blackwell’s Nursing Dictionary (2005:295), a ‘patient’ is a person who is physically or mentally ill or is undergoing treatment for a health care problem and/or is
registered with a general practitioner. A ‘patient’ is a person who receives medical treatment, attention and care. The person is ill or injured and in need of treatment by a physician or other health care professionals (Concise Oxford Dictionary 2008:1040).

‘Patients’ in this study were persons scheduled for first or follow-up visits, or who visited the ambulatory care setting as walk-ins seeking medical treatment. Outpatient patients were not admitted to a hospital neither stayed there overnight, but visited a hospital, clinic or associated facility for a diagnosis or treatment and departed.

1.6.3 Patient-friendly health services

‘Patient-friendly health services’ refer to a positive image of the staff and the organisation which allows a patient to feel warm care and satisfaction and experience a welcoming attitude from the staff (Welcome patients: helpful attitude, signs and more 2012:2).

In this study ‘patient-friendly health services’ meant that patients were to feel valued, cared for, and that their health needs were met.

1.6.4 Perception


In this study, ‘perception’ meant nurses’ conscious understanding of how patient-friendly health services had to be rendered in terms of their professional and personal disposition, attitude and behaviour in a way that would promote patient satisfaction with the care provided.
1.6.5 Registered nurse

A ‘registered nurse’ is defined as ‘a health care professional who graduated from a nursing programme and passed a national licensing examination’ (South Africa 2005:33). Expatriate nurses in the NGHA must have evidence of current licensure from their country’s licensure board and have to register with the Saudi Council for Health Specialties. Freshwater and Maslin-Prothero cited in Blackwell’s Nursing Dictionary (2005:400) define a ‘nurse’ is a person who is “specially prepared and registered to provide care for both well and unwell individuals as well as their families and their communities”. Only those whose names appear on the register maintained by the nursing and midwifery council are entitled legally to be called nurses (Blackwell’s Nursing Dictionary 2005:402).

In the South African context, ‘nurse’ refers to a nurse registered with the South African Nursing Council (SANC) under section 31(1) of the Nursing Act (South Africa 2005).

A ‘registered nurse’ in this study referred to a nurse who had graduated from a nursing programme, had passed a national licensing examination from his or her own country of training and education, and who had had two years’ experience in the field of ambulatory care in his or her own country. In this study the term ‘nurse’ referred to a nurse registered as outlined above.

1.7 FOUNDATIONS OF THE STUDY

Although qualitative studies are not necessarily based on a particular theory, they contribute to theory development. The philosophical underpinnings of this qualitative study were rooted in a constructive epistemological approach to generate objective theoretical knowledge through the qualitative inquiry process (Groenewald 2004:4). Meta-theoretical and methodological assumptions were formulated for the development of logic and guidance in the research process which was followed (Parahoo 2006:136).

1.7.1 Assumptions

Assumptions are accepted as “the truth and represent the beliefs and values of the conceptual framework of theory” (Masters 2012:6). They are basic principles that are
assumed to be true based on logic and reason, without proof or scientific verification (Polit & Beck 2008:13). Sources of assumption include universally accepted truths such as theories, previous research, and nursing practice. In research studies, “assumptions are embedded in the philosophical base, study design and interpretation of the findings” (Burns & Grove 2009:37). The researcher’s recognition of assumptions is strengths and not weaknesses. Assumptions influence the logic of a study and their recognition leads to more rigorous study development. To this end, epistemological, ontological and methodological assumptions were posted in this study.

1.7.2 Meta-theoretical assumptions

Qualitative researchers’ share their assumptions that the truth is both dynamic and complex because people continuously change, develop and form daily interpretations to make sense of their world. Subjective reality gives meaning to the lives and experiences of people as they interact with their world. Knowledge is based on perceptions and interpretations of the external reality. People live, feel and think in terms of their background, culture and linguistic interpretations (Polit & Beck 2008:13). Meta-theoretical assumptions are based on “social constructivism”, as the “conceptual framework to guide” a research study (Holloway 2005:9). The author asserts that the approach of “social constructivism encourages the researcher to view social reality from different social perceptions” (Holloway 2005:9). The meta-theoretical assumptions underlying this study were that knowledge is generated through objective systematisation of experience and can therefore provide appropriate tools to adjust and or to and alter individual and organisational realities.

1.7.3 Ontological assumptions

According to Mouton and Marais (1994:14) and Sawatzky and Pesut (2005:22), ontological assumptions refer “to the study of being or reality”. The ontological assumptions regarding reality underlying this study were that:

- Humans are essentially intuitive beings that have their own way of perceiving things.
- Human nature has a social dimension that encompasses the need to find meaning in life and relationship with others, the self and the environment.
• All persons are valued as important human resources in the workplace regardless of their religious orientation or country of origin (Sawatzky & Pesut 2005:22).
• The meaning that patients and families come first in a health care environment seems to serve as a motivation to care.
• Rendering patient-friendly health service is inherent to best clinical practice.
• Health is a priority for most people.

1.7.4 Epistemological assumptions

Epistemological assumptions are statements that embody the ideal of science, namely “the quest for truth and knowledge” (Polit & Beck 2008:763). In this regard, the epistemological assumptions were that:

• Narrative data can elicit an understanding of the meanings that registered nurses attach to rendering patient-friendly service.
• The goal stated as 'patients and families first' as an interpretative framework can provide structure through which narrative data about patient-friendly health services can be analysed.
• Cultural and social factors show variation in how health care is provided.
• Although it is difficult to ascertain when the truth has been attained, it is, however, necessary to strive for reality as far as possible.
• Theories inductively generated from data are likely to offer insight, enhance understanding and provide meaningful guidance to action, including nursing practice.

1.7.5 Methodological assumptions

According to Polit and Beck (2008:13), this concerns what may be called the ‘how’ of research. In other words, how research should be planned, structured and executed to comply with the criteria of science. It refers to the logic of implementing scientific methods in the study of reality. Methodological assumptions regarding this study were that:
• Qualitative studies are most often associated with naturalistic inquiry into reality, which is constructed by the individuals participating in the research study conducted in a specific context (Polit, Beck & Hungler 2001:13).

• Human beings use language and words to explain the meanings of phenomena and to communicate these meanings to others.

• Open-ended questions provide participants with a large degree of freedom to tell their stories.

• Inductive reasoning in qualitative studies helps researchers to make inferences and conclusions based on the study findings.

1.8 RESEARCH DESIGN AND METHOD

A qualitative, exploratory, descriptive and contextual research design was adopted as the research design of choice for this study. It was also an exploratory and descriptive inquiry that attempted to investigate the perceptions of registered nurses in the ambulatory care setting with regard to the concept of patient-friendly health services.

Qualitative

Qualitative research is a “systematic, interactive, subjective approach used to describe the life experiences of the participants and to give those experiences meaning” (Burns & Grove 2009:22). Polit and Beck (2008:763) add that qualitative research is “the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design”.

Exploratory

According to Polit and Beck (2008:20), exploratory research begins with a phenomenon of interest and explores its full nature. De Vos, Strydom, Fouche and Delport (2005:106) state explorative research is conducted to obtain basic information about an area of interest. An exploratory approach was considered appropriate to explore the participants’ perceptions about the concept of providing patient-friendly services.
Descriptive

A descriptive design enables the researcher to describe variables in order to answer research questions with no attempt at establishing a cause-effect relationship (Brink, Van der Walt & Van Rensburg 2008:102). It was an appropriate design for this study as the researcher intended to describe the perceptions of registered nurses about patient-friendly health services rendered within an ambulatory care setting in KAMC-R.

A detailed discussion of the research design and method is provided in chapter 3.

1.8.1 Research context

A research context is defined by Burns and Grove (2009:780) as a “location for conducting research such as a natural, partially controlled or highly controlled setting”. Since this was a qualitative study, it was conducted in a real life situation in a field setting, namely in the ACC of the KAMC-R, Saudi Arabia. The context involved the different types of health conditions and services in the outpatient settings that were offered to the outpatient clients. In table 1.1 these health conditions and services are listed.

**TABLE 1.1 TYPES OF HEALTH CONDITIONS AND SERVICES PROVIDED IN THE AMBULATORY CARE SETTINGS**

<table>
<thead>
<tr>
<th>Anaesthesia</th>
<th>Nephrology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burns</td>
<td>Neurology</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Obstetrics and gynaecology</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Oncology</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Ear, nose and throat</td>
<td>Orthopaedic</td>
</tr>
<tr>
<td>Echo cardiology laboratory</td>
<td>Paediatric</td>
</tr>
<tr>
<td>Employee health and well person</td>
<td>Paediatric oncology</td>
</tr>
<tr>
<td>Family medicine</td>
<td>Plastic surgery</td>
</tr>
<tr>
<td>Gastrology</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>General and vascular surgery</td>
<td>Pulmonary</td>
</tr>
<tr>
<td>General paediatric</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>Hepatology</td>
<td>Transplant</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>Urology</td>
</tr>
</tbody>
</table>

(Researcher's working domain)
As exhibited in table 1.1 ambulatory care included the clinical, professional, organisational and technological activities engaged in by the staff, who were nurses and other health team members, to provide health care services to improve the health of all who consulted these services (American Academy of Ambulatory Care Nursing 2012:1).

The categories and numbers of nursing staff in the ACC at the time the study was conducted are indicated in table 1.2.

**TABLE 1.2 CATEGORIES AND NUMBERS OF NURSING STAFF IN THE ACC**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>NUMBERS OF NURSING STAFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of clinical nurse</td>
<td>1</td>
</tr>
<tr>
<td>Nurse managers</td>
<td>2</td>
</tr>
<tr>
<td>Clinical resource nurses</td>
<td>2</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>221</td>
</tr>
</tbody>
</table>

Other multidisciplinary health care professionals in provision of care in the ACC included patient care technicians, physicians and residents, medical imaging staff, laboratory and orthopedic technicians, patient care technicians, patient educators, diabetic educators, unit assistants (interpreters), patient escorts and runners, Saudi nursing students, patient relation, and religious services. However, nurses are normally the largest and most important cadre that is in a position to impact on the environment of patients either positively or negatively.

### 1.8.2 Population and sample

The population in this study was 221 registered nurses working in the ACC in the KAMC-R.

The accessible population was both male and female registered nurses working in the NGHA ambulatory care services who were on duty on the days when the data were collected. Polit and Beck (2008:338) are of the opinion that the criteria that specify population characteristics are referred to as eligibility criteria or inclusion criteria while Burns and Grove (2005:343) indicate that inclusion criteria are those characteristics that a subject or element must possess to be part of the target population. In chapter 2 these criteria are discussed in depth.
A non-probability sampling method known as *purposive* sampling was used to recruit suitable informants to participate in this study (Basavanthappa 2007:195). The sample consisted of one male and 14 female registered nurses who had worked in the ambulatory services for more than a year. Data saturation was achieved after interviewing 15 participants.

### 1.8.3 Data collection

Data collection is the process of gathering information related to the research question and objectives (Stommel & Wills 2004:363). According to Burns and Grove (2009:545), data collection in qualitative research is guided by the research question or central theoretical statement as well as the research method chosen to collect data. In this study the researcher conducted semi-structured individual interviews. Observation of non-verbal cues was jotted down in field notes and reflecting them in a journal completed the data collection process (Parahoo 2006:66). A thorough description of the data collection process is presented in chapter 2.

### 1.8.4 Data analysis

De Vos (in De Vos et al 2005:333) states that data analysis is the process of bringing order, structure and meaning to the mass collected data. In qualitative research the collected data are non-numerical and usually in the form of written words, field notes, and audio or video recordings, thus rendering a substantial amount of collected data that have to be analysed. Van Mannen’s method (Polit & Beck 2008:521) was used as a data analysis method. The data analysis of this study is discussed in detail in chapter 3.

### 1.9 MEASURES TO ENSURE TRUSTWORTHINESS

One of the important challenges in qualitative research is to ensure the credibility and trustworthiness of data. The following four criteria proposed by Lincoln and Guba (cited in Stommel & Wills 2004:288) was used as a method to assess the quality of the qualitative data:
credibility
- transferability
- dependability
- confirmability

Polit and Beck (2006:332) describe Lincoln and Guba’s four criteria as the “gold standard” for qualitative research. Lincoln and Guba’s (1985:290) concepts of the criteria to ensure trustworthiness are displayed in table 1.3.

**TABLE 1.3 LINCOLN AND GUBA’s CRITERIA TO ENSURE TRUSTWORTHINESS**

<table>
<thead>
<tr>
<th>QUALITATIVE APPROACH</th>
<th>CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility</td>
<td>Truth value</td>
</tr>
<tr>
<td>Transferability</td>
<td>Applicability</td>
</tr>
<tr>
<td>Dependability</td>
<td>Consistency</td>
</tr>
<tr>
<td>Confirmability</td>
<td>Neutrality</td>
</tr>
</tbody>
</table>

(Stommel & Wills 2004:288)

**Credibility**

The first criteria to evaluate qualitative data is credibility. Various techniques and steps are used to ensure the accurate description and interpretation of the study findings (Polit & Beck 2006:332). The techniques applied and steps taken in this study to ensure credibility are outlined next.

- Prolonged engagement which was employed by the vast working experience of the researcher in the ambulatory care setting with most of the participants in this study. The researcher sought to understand the situation without being unfoundedly judgemental. She strived to be open, set aside any preconceived ideas of the phenomenon under study, and to be sensitive and respectful in dealing with the participants.
- The average time per interview was 20–30 minutes and the researcher observed the non-verbal cues of the participants.
- Multiple data collection methods such as semi-structured individual interviews, observations, field notes and a reflective diary were used to obtain relevant data.
• Peer examination was done by allowing a research expert in theory, who was the study supervisor, to critique the study. Study chapters were corrected and edited (Polit & Beck 2006:332).

These described variables helped to set the necessary boundaries to enhance credibility in this study.

Transferability

A second standard in evaluating the quality of qualitative data is transferability. Transferability is a standard “which includes and refers to which degree the findings can be applied to other similar contexts, situations, settings and populations” (Stommel & Wills 2004:288). In this study, thick descriptions of the research process or steps taken to enhance transferability were provided to enable replication studies to be done. This may, however, according to De Vos (in De Vos et al 2005:346), be problematic because of the dynamism of settings and the social world that is always being constructed. Capturing of the research events was done from the perspective of the people being studied in order to provide an insider’s view (Holloway 2005:4). Purposive sampling was used “as a strategy to obtain richness and depth of the participants’ experiences”; participants were purposively recruited for participation and to provide rich information (Holloway 2005:110). The study findings can be contextualised and useful to all primary health care (PHC) settings in the organisation because of the similar populations and nature of services rendered.

Dependability

A third standard to assess the quality of qualitative data is dependability. Dependability is the alternative to reliability and refers to “the stability of data over time and conditions” (De Vos in De Vos et al 2005:346). The researcher had to follow this process in order to evaluate how stable or unstable the data were over time and in the conditions under which the study was conducted (Polit & Beck 2006:335). Stepwise replication implies that a number of researchers are divided into two groups to conduct independent final coding of the data (Polit & Beck 2006:335). The researcher had to consider the data that were likely to remain stable in comparison to the less stable data (Stommel & Wills 2004:288). Relevant supporting documents such as the audio recordings, field notes of
how the data were analysed and interpreted as well as the verbatim transcribed notes were kept for scrutiny by an inquiry audit (Polit & Beck 2006:549). The study supervisors also conducted an inquiry audit by reviewing the interview transcripts and providing feedback.

**Confirmability**

The fourth standard in evaluating the quality of qualitative data is confirmability. Confirmability refers to the “degree to which the findings are a function solely of the participants and conditions of the research and not of the researcher’s biases, motivations, opinions and perspectives” (Lincoln & Guba 1985:296). Polit and Beck (2006:315) explain that achieving neutrality means that research results are embedded in the obtained data and not in the preconceived ideas, biases, values, interests, knowledge and experience of the researcher. According to De Vos (in De Vos e al 2005:347), confirmability captures the traditional concept of objectivity. In this study, the researcher composed a detailed research report. Audit trails, as indicated earlier, served to enhance the confirmability of the study results by means of detailed documentation contained in the research report (Stommel & Wills 2004:288). Congruency was reached between the researcher and the two study supervisors about the meaning, relevance and accuracy of the data (Botma, Greeff, Mulaudzi & Wright 2010:292). Materials assembled during the inquiry such as the data collecting instruments, verbatim transcriptions and audio recordings remain available and are kept safe and locked in a cupboard in the office of the researcher where only the researcher has access to.

**1.10 ETHICAL CONSIDERATIONS**

The researcher complied with and adhered to the ethical standards established by the Democratic Nursing Organisation of South Africa (DENOSA) during the research study (DENOSA 1998:221). The standards used as reference and for guidance throughout the study are discussed in detail in chapter 2 but a brief outline thereof is given next.

- The study was conducted in such a way that the participants were not exposed to any harm.
- Permission to conduct the study was obtained from all the relevant stakeholders.
• The rights of the participants were protected by making sure that the principles of informed consent, confidentiality, anonymity, dignity and privacy, and withdrawal from the study were adhered to.

Although researchers have the right to study whatever is of scientific value, they have a responsibility to protect the rights of institutions and participants; moreover, they have to ensure scientific integrity (De Vos et al 2005:75).

1.11 STRUCTURE OF THE STUDY

This study consisted of four chapters as outlined in table 1.4.

TABLE 1.4 STRUCTURE OF THE STUDY

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>TITLE</th>
<th>BRIEF SUMMARY OF CHAPTER CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Orientation of the study</td>
<td>Overview of the research problem, purpose, research question, objectives and significance of the study, research design, research method, measures of trustworthiness and ethical considerations.</td>
</tr>
<tr>
<td>2</td>
<td>Research design and method</td>
<td>The overall plan and research procedures such as population, sample size, sampling technique, data collection and data analysis, ensuring trustworthiness including ethical considerations.</td>
</tr>
<tr>
<td>3</td>
<td>Data analysis and presentation</td>
<td>Analysis, presentation and descriptions of the study findings.</td>
</tr>
<tr>
<td>4</td>
<td>Conclusions and recommendations</td>
<td>Discussions, conclusions and recommendations based on the study findings.</td>
</tr>
</tbody>
</table>

1.12 SUMMARY

In this chapter an informative introduction and overview of the entire study was given. The background information to the research problem that existed was discussed and the purpose of the study, research question and objectives presented. The significance of the study and the definitions of key concepts were also presented. The research design and method were described to indicate how the study was conducted and included the research setting, population, sample and sampling technique, data collection methods, and analysis. An overview of measures to ensure trustworthiness and of the ethical considerations that were considered in the study was also given. In chapter 2 the research design and method are presented.
CHAPTER 2

RESEARCH DESIGN AND METHOD

“Research is to see what everybody else has seen, and to think what nobody has thought about.”

(Szent-Gyorgyi 2013)

2.1 INTRODUCTION

This chapter focuses on the research processes, procedures and techniques that were followed to make decisions concerning the research methodology applied in this study. The described research methodology comprises the research design, setting and methods such as population, sample and sampling technique, data collection and data analysis. The standards to ensure trustworthiness and adherence to ethical considerations are also detailed in this chapter.

2.2 RESEARCH DESIGN

To decide on a particular research design is the single most important phase of a research study process as the design has an effect on the overall study (Gerrish & Lacey 2006:20). The research design for this study was a qualitative, explorative, descriptive and contextual design based on the traditional qualitative methods of inquiry.

A research design is the blueprint for conducting a study that “maximises control over factors that could interfere with the internal and external validity of the findings” (Burns & Grove 2005:211). According to Stommel and Wills (2004:33), a research design is a plan that specifies on which observations the researcher needs to focus, when to make the observations, and how to measure these observations. Research designs may be described as the means to achieve the research goals as they link theoretical frameworks, research and questions together (Flick, Von Kardoff & Steinke 2004:152). A research design involves logical steps taken by the researcher to answer the research question and objectives (Brink et al 2008:92). The research design is also described as a plan that provides empirical evidence regarding the research problem, question or
hypothesis (Stommel & Wills 2004:26). The research design indicated for this study was qualitative, explorative, descriptive and contextual in nature.

In this study, the qualitative research tradition was concerned with the exploration and description of the perceptions of the participants. It was the researcher’s task to explore and describe the experiences as expressed by the participants, using the direct quotes of the participants derived from the study findings (Parahoo 2006:68).

2.2.1 Qualitative research

Qualitative research refers to the investigation of a phenomenon holistically by means of data collection and analysis using a flexible research design (Polit & Beck 2010:30). Qualitative research comprises an investigation that uses “a set of predefined procedures to answer a question, collect evidence and reveal findings beyond the borders of the study” (Mack, Woodsong, MacQueen, Guest & Namey 2005:1). According to Mack et al (2005:1), qualitative research is specifically adequate in capturing cultural information about “values, behaviours and opinions of distinct populations”.

Bassett (2004:4) states qualitative research includes elements such as grounded theory, action research, focus groups and phenomenology. Qualitative research can be defined as using interactive, inductive and flexible methods to collect and analyse data (Parahoo 2006:63). Basanvanthappa (2007:53) points out that qualitative research focuses on people’s uniqueness, perspectives and subjective lived experiences. It is a “systematic, interactive and subjective approach used to describe life experiences and to ascribe meaning to them” (Burns & Grove 2005:23).

Advantages of qualitative research

Qualitative research thoroughly describes the various dimensions of the study phenomenon (Polit & Beck 2006:20). In this study, the advantages of qualitative research included the use of open-ended questions as it afforded the participants the opportunity to respond freely and meaningfully (Mack et al 2005:4). Bassett (2004:4) observes that the focal point of qualitative research is to gain an understanding of human nature; in fact, qualitative research can provide important information about
attitudes and satisfaction that can be used to improve patient care. Thus, the fact that the researcher grew close to the participants in this study without imposing her own opinion was advantageous in the sense that it enhanced trust and open communication between her and the participants which, in turn, led to the collecting of valid, relevant and important data. According to Bassett (2004:4), qualitative research findings also have the advantage that it can be used to base future quantitative research studies on.

**Disadvantages of qualitative research**

The qualitative research design differs from quantitative research in that there is no step-by-step plan for the researcher to follow (Fouche in De Vos et al 2005:269). Qualitative research is, however, expensive and time-consuming as it is often done by means of one-to-one interviews (Bassett 2004:4).

### 2.2.2 Exploratory research

Exploratory studies are conducted to gain more information about areas of which little is known. The word “explore” means to scrutinise unknown areas for the purpose of discovering new information and fields of knowledge base (Basanvanthappa 2007:182). In this study, exploratory research assisted with the understanding of the different ways in which the phenomenon under study manifested itself as well as the underlying processes (Polit & Beck 2006:21). The researcher adopted a qualitative approach to explore the perceptions of registered nurses regarding patient-friendly health services rendered within an ambulatory care setting in KAMC-R.

### 2.2.3 Descriptive research

Descriptive research provides detailed summaries of a phenomenon in everyday language (Botma et al 2010:194). In this study, ‘descriptive’ provided meaning to the perceptions of registered nurses with regard to the patient-friendly health services that they delivered to patients in the ambulatory care setting. The descriptive method helped the researcher to obtain an overall picture of the phenomenon which was significantly useful when recommendations were made to the organisation’s leadership.
2.2.4 Contextual research

Contextual research describes the phenomenon under study for immediate and intrinsic significance as it focuses on the environment where human experiences take place (Yin 2011:8). It is Yin’s (2011) stance that contextual research reveals the influence that the environment and/or institutional conditions have on human events. According to Creswell (2007:40), it is impossible to separate what people say from the context, whether the context is their family, home or work, in which it is said. Creswell (2007:51) further states contextual research is conducted in a natural setting and with sensitivity to the people under study. This study was done in the ACC in the KAMC-R.

2.3 RESEARCH SETTING

The research setting refers to the place where the study is undertaken (Burns & Grove 2005:359). The qualitative researcher conducted the current study in a natural setting because she was concerned with how nurses perceived patient-friendly health services (Polit & Beck 2006:32). The phenomenon was examined in the life setting of the participants (Polit & Beck 2006:213). The setting was the workplace of the participating registered nurses. This meant that the researcher did not change the environment; the study was conducted in the uncontrolled, real life domain of the participants as ascertained by Burns and Grove (2005:359).

The research setting was the ACC in a 1 000-bed academic hospital in KAMC-R. The clinical settings offered a variety of ambulatory care services to outpatients as indicated in table 1.1, chapter 1. Table 2.1 shows the average number of patients who visited the specific out-patient clinic specialties per day, the particular out-patient clinic specialties that were utilised as well as the number of registered nurses (the participants in the study) assigned to each clinic at the time this study was conducted.
At the time the study was done, the following visits per day per specialty:

**TABLE 2.1  CLINIC SPECIALTIES**

<table>
<thead>
<tr>
<th>UNIT</th>
<th>SPECIALTY</th>
<th>AVERAGE NUMBER OF PATIENTS PER DAY</th>
<th>NUMBER OF REGISTERED NURSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic 101</td>
<td>Obstetrics/gynaecology</td>
<td>300</td>
<td>26</td>
</tr>
<tr>
<td>Clinic 104</td>
<td>Endocrinology</td>
<td>180</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Diabetes mellitus</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pre-employment</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speech therapy</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Clinic 201</td>
<td>Audiology</td>
<td>200</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Swallowing assessment</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pre-employment hearing tests</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ear, nose and throat</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>Clinic 301</td>
<td>General surgery</td>
<td>200</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Neuro/vascular surgery</td>
<td>15/15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Podiatry/wound care</td>
<td>15/120</td>
<td></td>
</tr>
<tr>
<td>Clinic 302</td>
<td>Urology</td>
<td>180</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Plastic surgery</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Clinic 303</td>
<td>Dermatology</td>
<td>200</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Neuro-modulation</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anticoagulants</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>Clinic 404</td>
<td>Liver and renal transplant</td>
<td>120</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Hepatology: adult and paediatric</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hepatobiliary</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gastrology</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

(Researcher's working domain)

The participants who worked in the ACC were assigned and rotated as needed on a daily basis according to clinic acuity to the specified clinics presented in table 2.1. The two clinical resource nurses performed nursing education activities and ensured that the nurses were updated with mandatory competencies in all the clinics.

The KAMC-R commenced its operation in May 1983 and continued to expand while providing services to a rapidly growing patient population in all its catchments areas. It
is currently recognised as a distinguished health care facility and received the Joint Commission International Accreditation three times. The third accreditation was conducted from 8 to 12 December 2012. This accreditation included all four NGHA hospitals. The ACC consists of 26 clinics with a combined average of 50 000 patients seen monthly.

2.4 RESEARCH METHOD

The research method represents the means, procedure or technique used to carry out some process in a logical, orderly and systematic way (Berndtsson, Hansson, Olsson & Lundell 2008:12). In this study a logical process was followed. The scientific methods and procedures applied to investigate the phenomenon under study included the population, sample and sampling technique, the data collection and data analysis as well as ensuring trustworthiness and ethical considerations.

2.4.1 Population

A universal population is the “entire group of individuals, items or objects that has at least one characteristic in common” (Kombo & Tromp 2006:76). In this study the population referred to all the registered nurses working in the 1 000-bed academic hospital known as the KAMC-R, Saudi Arabia.

2.4.2 Target population

According to Burns and Grove (2005:342), the target population refers to all the elements or individuals that meet the sampling criteria. The target population for this study was the registered nurses from the NGHA ambulatory care services working in the ACC.

2.4.3 Accessible population

According to Basavanthappa (2007:190), an accessible population is the “aggregate of subjects that conforms to the criteria of the designated population and who is available and accessible to the researcher as a pool for the study”. The accessible population for
this study comprised of both male and female registered nurses working in the NGHA ambulatory care services who were on duty on the days when the data were collected.

The criteria that specify population characteristics are referred to as eligibility criteria or *inclusion criteria* (Polit & Beck 2006:260). *Inclusion criteria* are those characteristics that a subject or element must possess to be part of the target population (Polit & Beck 2006:260):

The *inclusion criteria* for participation in this study were:

- Participants had to be registered nurses.
- Participants had to have worked in the ambulatory care setting for 12 months or more before the study commenced.
- Participants could be male or female.

*Exclusion criteria*, according to Polit and Beck (2008:338), relate to characteristics that people must not have. In other words, exclusion criteria refer to any characteristic that can cause a person or element to be excluded from the target population (Burns & Grove 2005:343).

*Exclusion criteria* in this study referred to the following:

- Registered nurses who had been employed for less than 12 months in the ambulatory care setting in KAMC-R at the time the study commenced.

### 2.4.4 Sample

A sample is defined as a set of elements constituting the population and refers to the most basic unit about which information is collected (LoBiondo-Wood & Haber 2006:263). In this study the sample consisted of 15 registered nurses who had worked in the ambulatory care for more than a year.
2.4.5 Sample selection technique

A sample selection technique refers to “the plan that the researcher adopts in selecting sampling elements or units from which inferences about the population are drawn” (Basavanthappa 2007:191). In this study the researcher used purposive sampling, a non-probability sampling method, to recruit participants who were thought of as rich informants. Purposive sampling afforded the researcher the opportunity to select participants who were able to provide extensive information about the study phenomenon (Brink et al 2008:134). Participants who were selected for inclusion were of various ages and with varying years of experience. Possible sampling bias was identified as a potential disadvantage of purposive sampling as the researcher knew most of the participants and was known to them (Brink et al 2008:134).

The sample size for this study was determined by the purpose of the study and the depth of information that had to be obtained to gain insight into the phenomenon (Burns & Grove 2005:358). Saturation of the data was reached after a total of 15 participants were interviewed. Burns and Grove (2005:358) explain data saturation is reached when “no new information emerges, only redundancy of previously collected data”.

2.5 DATA COLLECTION

Data is a term that refers to information that is collected by research procedures (Jolley 2010:96). Data collection in this study was means of semi-structured interviews with the purposefully selected participants (Burns & Grove 2005:545). A data collection plan is a written, formal plan that stipulates detailed procedures for data collection (Stommel & Wills 2004:364). The nurse researcher has different ways available to collect information about the research subject. In the current study the data collection process and procedures were planned to be systematic and objective (LoBiondo-Wood & Haber 2006:317). The data collection methods used varies on four dimensions, namely its structure, the researcher’s obtrusiveness, quantifiability and objectivity (Polit & Beck 2010:366).

The data collection was the most rewarding stage of the research process since the researcher could at last ask the questions that had originally ignited her curiosity and inspired her to conduct this study (Gerrish & Lacey 2006:26). The qualitative research
data collection methods used were semi-structured individual interviews, the observation of non-verbal cues that were recorded in field notes, and the reflection of the researcher's own perceptions in a reflective journal (Parahoo 2006:66). The interviews took place during December 2011 and January 2012. The individual interviews were captured by means of an audio recorder after the hospital, unit management and the participants themselves had granted permission for the use of an audio-recorder.

**Bracketing**

A qualitative researcher strives to bracket her or his own presuppositions and ideas about the phenomenon under study (Parahoo 2006:207) by purposefully setting them aside. In this study the researcher attempted to bracket her own preconceived ideas, values, presence and behaviour that could affect the interpretation and analysis of the data (Parahoo 2006:527) in order to approach the phenomenon under study with as much openness and objectivity as possible (Gerrish & Lacey 2006:225). The bracketing procedure assisted the researcher in putting her own preconceived ideas and knowledge about the experience in abeyance (Stommel & Wills 2004:183). This was achieved by writing down her own notions, feelings and views about the phenomenon in a reflective journal.

**2.5.1 Data collection instruments**

In this study the researcher was the primary data collecting instrument which gave her the opportunity to include and adjust various complex realities (Hoskins & Mariano 2004:35). The role of the researcher was to concentrate on and think about the questions during each interview. The researcher appreciated, evaluated and developed a reasonable understanding of the meanings that the participants ascribed to their lived experiences (Hoskins & Mariano 2004:35).

A biographical questionnaire (see section A, annexure F) that consisted of the participants' demographic data in terms of gender, age, professional title, nationality, highest level of education and years of nursing experience in the ambulatory care clinics to which they were assigned, was developed. An interview guide (see section B, annexure F) was used to pose the same questions to all the participants; it was then
followed up with probing questions. To get the interview going and relieve tension, the researcher started every interview with general questions which the participants found easy to answer. The researcher then progressed to ask first the open-ended question. From there she moved to more sensitive and complex probing questions that centred on the participants’ responses (Holloway 2005:45). The semi-structured open-ended questions posed to the participants are noted below:

- Tell me what is your understanding of patient-friendly health service?
- Please name the components or parts of patient-friendly health service.
- In your opinion, which components/elements/parts/aspects or portions of patient-friendly health service do you consider the most important?
- What do you consider as the most challenging component in patient-friendly health service?

The probing questions posed to the participants were as follows:

- How do you balance professionalism with friendliness?
- In this culture, how do you think gender will influence friendliness?

2.5.2 Pre-testing of the interview guide

The purpose of pre-testing the interview guide was to evaluate the duration of an interview and to test the skills of the researcher in asking interview questions and using the audio-recorder. Pre-testing of the interview guide was also needed to ensure standardisation in asking both the demographic information and the open-ended questions (Babbie 2011:283) as well as to determine the shortcomings and addressing the weaknesses, if any, of the question (Basavanthappa 2007:441).

The pre-testing process was a small-scale study conducted with two eligible registered nurses during which the semi-structured interview guide; the researcher's interviewing skills and her ability to use the audio-recorder were pre-tested. In fact, to ensure that she was adept at using the audio-recorder, the researcher practiced on how to use it a few times before the data collection began. She also tested the downloading of the recordings on two different computers. Additionally, before conducting every interview
during the data collection process, the researcher made sure the audio-recorder was in working condition and ensured that spare batteries were available at all times in case of a power failure.

The responses of the two participants during the pre-testing process provided the researcher with a fair idea about whether the participants understood the concepts and the broad question in the same way (Parahoo 2006:309). The word ‘component’ in the probing questions was not clear to the participants during the pre-testing process, and the researcher decided to define it more clearly by using simpler words such as ‘elements’, ‘parts’, ‘aspects’ and ‘portions’.

2.5.3 Data collection methods

There are specific methods of gathering semi-structured data in qualitative studies. In this study, one-to-one semi-structured individual interviews, field notes and a reflective diary were the methods used.

2.5.3.1 Interviews

Interviews are merely an extended and formalized conversation with a purpose (Greeff in Botma et al 2010:292; Holloway 2005:152; Streubert Speziale & Carpenter 2007:28). Conversations are verbal interactions between two or more individuals who ideally have an equal opportunity to express their viewpoints (Greeff in Botma et al 2010:292; Holloway 2005:152; Streubert Speziale & Carpenter 2007:28). Henning, Van Rensburg and Smit (2004:53) define interviews as “a mechanism to source data from participants by means of structured conversations”. If used methodologically and applied according to the strict principles of objectivity and neutrality, the responses of interviewees will yield information that represents reality more or less “as it is” (Henning et al 2004:53). Holloway (2005:153) points out interviews are often referred to as ‘in-depth’, implying that a considerable amount of detailed data is collected. In this study, Langford’s (2001:153) observation that interviews allow the researcher to tap into the perceptions, opinions, attitudes, and values of participants proved to be true since the researcher was able to obtain significant and relevant information from the participants concerning their perceptions and experiences regarding patient-friendly health services rendered within the ACC in Riyadh.
A semi-structured interview guide was used in the current study to conduct interviews with individual participants for data collection (Holloway 2005:151).

- **Semi-structured individual interviews**

The most commonly used types of interviews in qualitative research are semi-structured interviews and narrative in-depth interviews. The researcher sets the agenda for semi-structured interviews in terms of the topics to be addressed but the responses from the participants determine the information revealed about the topics and the importance of the topics (Green & Thorogood 2004:80). According to Mason (2002:62), no research interview can be devoid of structure, even if that structure is the use of a single open question to prompt thought or discussion.

In the current study semi-structured individual interviews were conducted with a purposively selected sample of 15 registered nurses. These interviews were relatively broad in focus and gave rise to data from which concepts could be extracted. The semi-structured interview guide comprised four open-ended questions and two probing questions to encourage participants to elaborate freely on their experiences, feelings and perceptions. In a semi-structured interview the researcher is allowed flexibility to some extent by using probing questions (Parahoo 2006:329). Semi-structured individual interviews were selected as they were regarded most appropriate to explore the perceptions and opinions of participants regarding complex and sensitive issues; they furthermore enabled the researcher to use gentle probing during the interviews to obtain relevant responses (Parahoo 2006:330), clarify ambiguous answers, or request further explanation of a comment when necessary.

Sampling and data collection focused on gathering data that would generate, delimit and saturate the emerging concepts related to patient-friendly health services.

Following, the advantages and disadvantages of using semi-structured interviews to collect data in this study are presented. The advantages are attended to first.

- **Semi-structured interviews are useful in studying sensitive topics and to increase response rates (Parahoo 2006:330).**
The response rate from interviews is higher than that from questionnaires and, during interviews, questions may be clarified if misunderstood (Burns & Grove 2005:397).

One-to-one dialogue in this study assisted the researcher in ensuring that both parties commonly understood what was being communicated, as the researcher confirmed the accuracy of the collected data with each informant (Jolley 2010:110).

The researcher and the participants shared the goal of understanding the experiences and meanings attached to them (Jolley 2010:111).

The validity of the responses in the interview was enhanced due to the presence of the researcher who could seek clarification from the participants (Parahoo 2006:331).

The disadvantages of semi-structured interviews are noted next.

- Interviews are time-consuming and expensive (Brink et al 2008:147).
- The main disadvantage of the one-to-one individual interviews in this study was that they were resource-intensive and time-consuming (Jolley 2010:111).
- Arrangements for interviews were challenging to make in this study as the researcher had to follow up on the scheduled dates and times with the nurse coordinators of the clinics to confirm if the nurse was on duty in the specific area as they can be float out to other clinics, could be off sick and not informing the researcher, could take annual leave without notifying the researcher. This happened throughout the study schedule.
- Participants provided socially acceptable answers because the researcher was one of the nurse managers in the organisation.
- Some participants seemed anxious because their answers were recorded despite the fact that anonymity and confidentiality were guaranteed. In such instances the researcher took time to set them at ease by talking to the participants about their hobbies, families and their next vacation. The researcher noticed informal discussions had a positive outcome on the interviews.

An audio-recorder was used during the semi-structured interviews after permission had been granted by all the participants that their interviews could be recorded. Recording
the interviews was useful to the researcher in various ways. It allowed her to concentrate better on what the participant was saying, thus preventing misinterpretations or simply missing important data that were shared. She also had the time and opportunity to observe non-verbal cues, body language and other points of significance or interest and wrote it down in her field notes.

### 2.5.3.2 Field notes

According to Langford (2001:155), field notes are written accounts of what the researcher sees, hears, experiences and thinks during the data collection process. In this study field notes were kept to record observations made in the field, as well as the interpretation of these observations. As suggested by Polit and Beck (2008:754), these observations included the participants’ non-verbal behaviours, gestures, facial expressions or postures as they responded to the questions as well as other non-verbal responses that were later clarified with them.

### 2.5.3.3 Reflective journal

A reflective journal was also kept to provide an account of and record the researcher’s own perspectives, thoughts, feelings and knowledge about the topic as the categories emerged. The journal and field notes enhanced credibility by creating an audit trail (Krefting 1991:220). This study therefore focused on examining the perceptions of registered nurses of the social interaction between them and their patients in the environment of care, whether the concept of friendliness was evident or not. This concurs with King’s theory of goal attainment (Masters 2012:108) that, during the nursing process, the nurse and the patient perceive each other, make judgements about each other, and take action with resulting reaction.

### 2.5.4 Process of data collection

Individual semi-structured interviews were scheduled according to the participants’ choices and by also considering the clinics’ acuity levels. The least busy day in the ACC was a Wednesday which made it easier to schedule the interviews. Verbal permission to conduct the interviews was obtained from the unit managers and clinic coordinators where the participants worked. One of the nurse managers in the ACC arranged a
meeting with the nurse coordinators from the 26 clinics specifically to introduce the study and make them aware of the activity. A PowerPoint presentation of the proposed study was presented during this meeting. The researcher explained the objectives of the study, inclusion criteria for the participants and the study process. The nurse coordinators returned to their respective clinics after the meeting and informed the nurses about the study in order to give the nurses time to think whether they wanted to participate or not. Fifteen semi-structured interviews were ultimately conducted after which data saturation occurred.

Data were audio recorded, transcribed verbatim and documented for analysis. All interviews were conducted on the work site in the ACC, in a relaxed and quiet environment designated for that purpose. A ‘Do not disturb’ sign was put outside the interview room to limit disturbances during data collection. The researcher wrote down her observations in the field notes during each interview. The participants were set at ease by assuring them that there were no incorrect answers to the questions. Subsequently, the participants described in their own words how they perceived the concept of patient-friendly health service. Interviews lasted between 20 to 30 minutes. The transcribed and typed transcripts were then subjected to the determined data analysis process.

It has to be mentioned here that the language barrier could have contributed to the limitations of the study, as English was the second language of the participants who were all from mixed nationalities. For this reason it was possible that the language barrier could have led to perceptions not being expressed clearly by the participants and interpreted not accurately by the researcher during the data analysis. Although, to a certain extent, the field notes and reflective dairy could have assisted the researcher to understand what had been said. However, the researcher omitted some non-verbal cues which could have had a notable impact on the interpretation of the perceptions of the participants. The researcher was a novice with regard to qualitative interviewing. Questions posed were at times leading and not all responses were sufficiently probed. Also, since this study was conducted in an identified facility in one hospital with a relatively small sample size, results could not be generalised to other settings (Delport & Fouche in De Vos et al 2005:352).
2.6 DATA ANALYSIS

Data analysis was a process that assisted the researcher to bring order, structure and meaning to the collected data, as data in qualitative research is non-numerical and usually in the form of written words as transcripts, audio or video recordings. Qualitative responses from participants transformed the data into findings (Strydom & Delport in De Vos et al 2005:333). Data analysis commenced during data collection in order to make sense of data that emerged while still in the field. This improved the quality of data collection and its analysis (Brink et al 2008:184).

Qualitative data analysis required the researcher to follow certain steps such as data audio recording, verbatim transcription, organising and managing of the data which included coding, finding common themes and defining categories and sub-categories that emerged consistently. The services of an independent data transcriber were secured. The researcher read the collected data several times, became familiar with the data and performed minor editing and corrections. Van Mannen’s data analysis method and procedure was used as the data analysis method of choice. The participants’ descriptions of their perceptions were analysed in accordance with the three levels of Van Mannen’s approach (Polit & Beck 2006:521) which were the following:

- A holistic approach was followed where the researcher viewed and read the text as a whole and attempted to capture the meaning.
- Themes, recurring language, ideas and patterns of belief that linked people and settings together were identified (Strydom & Delport in De Vos et al 2005:338).
- A selective or highlighting approach was followed where the researcher underlined the statements about what seemed essential to the experience under study, namely “patient-friendly health service”. It also entailed a detailed line-by-line approach where the researcher analysed every sentence (Polit & Beck 2006:409).

An example of a transcript is available as Annexure H. In this study all the approaches of the analysis method were used and four themes, four categories and nine sub-categories were finally identified. A detailed presentation of the data analysis is done in chapter 3.
2.7 MEASURES TO ENSURE TRUSTWORTHINESS

One of the important challenges in qualitative research is to ensure the quality of data. Lincoln and Guba (1985:290) propose four criteria to assess the quality of qualitative data, namely credibility, transferability, dependability and confirmability (Stommel & Wills 2004:288). The four criteria are described as the “gold standard” for qualitative research (Polit & Beck 2006:332).

Credibility was confirmed by using various research techniques and steps to ensure the accurate description and interpretation of the study data. These techniques included prolonged engagement, using multiple data collection methods, and peer examination. Transferability was enhanced through thick descriptions and purposeful sampling. Dependability was enhanced through stepwise replication and describing all aspects of the study. Confirmability strategies included an audit trail and confirmability assessment. The detailed application of these is described in chapter 1 under section 1.9.

2.8 ETHICAL CONSIDERATIONS

A vital concern in this study was the matter of ethics (Babbie 2011:26). The researcher had to follow national guidance and legislation as well as international agreements, codes and ethical review systems to ensure acceptable ethical consideration (Bowling & Ebrahim 2005:567). These authors further ascertain that every country has professional codes for each profession and members of such professions are expected to comply at all times. The researcher had to be knowledgeable about ethical principles related to the context of the study while conducting the study and also making sure that the study would not harm the participants in any way (Botma et al 2010:56). The researcher had to follow the ethical standards for research to ensure the protection of persons (Stommel & Wills 2004:392). Self-determination, privacy, confidentiality, anonymity, protecting of persons from harm or discomfort and fair treatment were human rights that required protection during this study (Burns & Grove 2005:207).

Participation in this social research study was voluntarily with no physical or psychological harm to the participants foreseen (Babbie 2011:28). The researcher alone could not accomplish ethical practice; it also depended on negotiations and collaboration with the participants (Pope & Mays 2006:61). Ethical awareness was
enhanced by the study supervisor’s mentorship. The supervisors offered advice during challenging issues on account of the sensitivity of the topic (Holloway 2005:22). In this study, the researcher made an effort to protect the rights of the study institution and the participants and to ensure scientific integrity.

2.8.1 Protecting the rights of the research institution

Permission to conduct the study was first obtained by means of ethical clearance from the University of South Africa (UNISA) Department of Health Studies Research Ethics Committee (see Annexure A). Before the study commenced, approval was sought from the KAMC-R hospital’s ethical committee (see annexure B) and the institutional review board (IRB) of the hospital (see annexure D). The researcher was granted approval (see annexure C) for the research study by the hospital management in written format. A memorandum with the project reference number RC 025/11, including permission from the institutional review board, was obtained (see Annexure D). It was expected of the researcher to complete the study in one year from the time permission was granted as well as to provide the hospital committees with regular updates regarding the progress, completion and the outcome of the study findings.

2.8.2 Protection of the rights of participants

The participants took part in this study voluntarily and were not exposed to any inconvenient or harmful situations. A fundamental ethical issue that was observed was not to expose the research participants to any harm (Babbie 2011:27). Ethical standards of informed consent, confidentiality and anonymity, privacy and dignity, respect for persons and the right to withdraw from the study were adhered to.

Informed consent was obtained from the participants by ensuring disclosure and openness towards them by means of an honest introduction of the investigation, a brief outlining of the research questions, and informing them of the study objectives, data collection processes, the overall purpose of the study and the benefits of participating (Pope & Mays 2006:59). The participants were given complete, accurate information (see annexure E) about the study (Polit & Beck 2010:555). They had the right to free choice which enabled them to consent voluntarily to participate in the research or decline participation without victimisation (Streubert Speziale & Carpenter 2007:63).
The researcher secured the participants’ written informed consent after they had been well informed.

**Confidentiality** means that a person can choose with whom to share information without being obliged to share everything. The researcher had the responsibility to maintain confidentiality (Botma et al 2010:17). All the research documents were kept safe. No unauthorised persons had access. The transcripts and audio-tapes were kept under lock and key.

**Anonymity**, an act of keeping individuals nameless as regards their participation in a research study, was maintained (Burns & Grove 2005:188). Although in this qualitative study anonymity to the researcher was impossible during the one-to-one interaction interviews, it was maintained during this study as the names and personal data of the participants were not recorded in any of the documents.

**Privacy and dignity** were maintained at all times. This principle refers to the freedom the individual participants had to determine the extent to and general circumstances under which private information would be shared with or withheld from others (Burns & Grove 2005:186).

The principle of **respect for persons** means that people have the right to self-determination and the freedom to choose to participate or decline participation as well as to withdraw from a study at any time (Burns & Grove 2005:180). In this study the participants were all treated fairly. Moreover, all the participants’ traditions and cultures were respected which had the potential to decrease their withdrawal from the study (Botma et al 2010:20).

It was made clear that participants could at any time, without fear of victimisation, withdraw from the investigation if they felt uncomfortable (Strydom in De Vos et al 2005:59). The researcher gave the participants an opportunity to ask questions and explained to them that withdrawal from the study would not have any adverse effects on them and their employment (Gerrish & Lacey 2006:149).
2.8.3 Scientific integrity enhancement of the study

The researcher did not manipulate the data or the design and research methods. The researcher endeavoured not to fabricate, falsify or forge information or to present work or ideas of others without acknowledging them (Brink et al 2008:40). The researcher ascertained that the final written report was accurate, clear and objective (Strydom in De Vos et al 2005:66). Plagiarism was avoided, as the researcher acknowledged all references and sources used in this study. All the findings of the study were reported, especially the direct quotes, without fabrication or falsification of the gathered information. The measures to ensure trustworthiness of the study assisted the researcher in ensuring the scientific integrity of it. The dissertation report is the original and an independent effort of the researcher. It had not been presented anywhere else. The researcher acknowledged the persons who contributed to the completion of the study such as the study supervisors, participants, editor and secretary who formatted the chapters.

2.9 SUMMARY

This chapter covered the research design and method. The entire process, the means by which the study was conducted with reference to the qualitative, exploratory and descriptive approach, was comprehensively described. Qualitative inquiry as a research tradition was described. The research setting was broadly explained. The research method included the population, sample and sample selection technique. Data collection was discussed in terms of the data collection instruments, pre-testing of the interview guide and how the semi-structured individual interviews were conducted. The data analysis was briefly described. Ethical considerations included the protection of the rights of the research institution and of the participants as well as ensuring scientific integrity.

Chapter 3 deals with the data analysis and presentation as well as with the description of the study findings.
CHAPTER 3

PRESENTATION AND DESCRIPTION OF THE STUDY FINDINGS

“If we knew what it was we were doing, it would not be called research, would it?”

3.1 INTRODUCTION

Nurses have to take responsibility for ensuring patient-friendly health services by means of a customer oriented approach. The objectives of the study were to explore and describe the perceptions of registered nurses about patient-friendly health services rendered within the ACC in KAMC-R, Saudi Arabia. The analysis, presentation and description of the study findings are discussed in this chapter.

Qualitative data analysis can be referred to as the analysis of social research with the purpose of organising and interpreting narrative data to discover important underlying themes, categories and patterns of conceptual relationships (Babbie 2011:378). In fact, Strauss (2003:3) considers that the analysis of qualitative data consists of breaking down data gathered from a “variety of specialised nonmathematical techniques such as tape recordings and transcripts of interviews”. The proposed data analysis method and procedure used for this study was Van Mannen’s method, according to which the participants’ descriptions of their perceptions of patient-friendly health services in the ACC were analysed at the three levels of approach, namely selective holistic, line-by-line, or in detailed fashion (Loiselle, Profetto-McGrath, Polit & Beck 2011:329). By using this process the researcher identified four themes, four categories and nine sub-categories from the verbatim transcriptions of the interviews as evidenced in table 3.4.

3.2 PARTICIPANTS’ PROFILES

Fifteen participants were recruited for the research study analysis. Their demographic data are presented in tables 3.1, 3.2 and 3.3.
Firstly, in Table 3.1 the participants’ demographic data by gender, age, and nationality are illustrated.

**TABLE 3.1 PARTICIPANTS’ DEMOGRAPHIC DATA BY GENDER, AGE AND NATIONALITY**

<table>
<thead>
<tr>
<th>NATIONALITY</th>
<th>20 - 29 Years</th>
<th>30 - 39 Years</th>
<th>40 - 49 Years</th>
<th>50 - 59 Years</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Saudi</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>South African</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Filipino</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Jordanian</td>
<td>1</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>15</td>
</tr>
</tbody>
</table>

In the second table, Table 3.2, the participants’ demographic data by professional title and years of experience are shown.

**TABLE 3.2 PARTICIPANTS’ DEMOGRAPHIC DATA BY PROFESSIONAL TITLE AND YEARS OF EXPERIENCE**

<table>
<thead>
<tr>
<th>PROFESSIONAL TITLE</th>
<th>2-10 Years</th>
<th>11-20 Years</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Clinical resource nurse</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nurse coordinator</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Staff nurse I</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Staff nurse II</td>
<td>4</td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15</td>
</tr>
</tbody>
</table>

Table 3.3 indicates the participants’ demographic data by gender and level of education.

**TABLE 3.3 PARTICIPANTS’ DEMOGRAPHIC DATA BY GENDER AND EDUCATIONAL LEVEL**

<table>
<thead>
<tr>
<th>EDUCATIONAL LEVEL</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma</td>
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<td></td>
<td>3</td>
</tr>
<tr>
<td>Bachelor degree</td>
<td>1</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15</td>
</tr>
</tbody>
</table>

3.2.1 Analysis of the participants’ demographic data

Of the 15 participants, 14 were females and one was male. In the ACC, due to cultural customs and traditions, the majority of the nursing workforce normally consists of
female registered nurses. Male nurses may deliver nursing care only to the male patients unlike their female counterparts who are delegated to deliver nursing care to both female and male patients. The ages of the participants ranged from 29 to 54 years. The youngest two participants were 29 years old and the oldest participant was 54. Five of the participants were between 30 and 39, three were between 40 and 49 and five participants were between 50 and 59 years old.

Three participants were employed in the positions of clinical resource nurse, four were in the positions of nurse coordinator while four were employed in the position as staff nurse I and four participants in the position of staff nurse II. The participants were all from different nationalities and cultural backgrounds, namely Saudi, South African, Filipino and Jordanian. The cultural differences seemed to have a bearing on the perception of patient-friendly health services as evidenced by the major responses on and discussions about this concept.

Three participants were diploma graduates. Eleven participants held Bachelor degrees while one participant held a Master’s degree. It was noted that none of the participants had any formal training or had done any courses related to patient-friendly health services. The length of nursing experience in the ambulatory care setting varied. The participant who held a Master’s degree had only had two years’ experience and gave less input in spite of her higher educational level. Most of the participants, a total of 12, had ambulatory care nursing experience which ranged between two and 10 years. Three participants had significant experience in the ambulatory care setting which contributed to valuable and informed responses from them. Experience in the work area empowers nurses with knowledge and insight in clinical care. This view correlates with the nurses’ observed behaviours in the clinical area. Therefore, nurse managers and nurse educators need to encourage nurses to enhance their knowledge by means of participation in and continuation of educational endeavours (Celik & Hisar 2002:186).

3.3 DISCUSSION OF THEMES, CATEGORIES AND SUB-CATEGORIES

Table 3.4 presents an overview of the themes, categories and sub-categories that were derived from the interview data. These ranged from the most general to the most specific. A discussion of the themes then follows.
### Table 3.4 A Summary of the Themes, Categories and Sub-categories Relating to the Perceptions of Registered Nurses About Patient-friendly Health Services Rendered Within an Ambulatory Care Setting in KAMC-R

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Sub-categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3.1 Theme 1: Cultural differences</td>
<td>3.3.1.1 Category 1: Cultural sensitive patient care</td>
<td>3.3.1.1.1 Sub-category 1: Influence of language on patient-friendly health services</td>
</tr>
<tr>
<td>3.3.2 Theme 2: Need for meaningful communication</td>
<td>3.3.2.1 Category 1: Professional yet patient-friendly communication</td>
<td>3.3.2.1.1 Sub-category 1: Listening to the patient’s need for meaningful communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.2.1.2 Sub-category 2: Providing the patient with information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.2.1.3 Sub-category 3: Body language of the nursing staff</td>
</tr>
<tr>
<td>3.3.3 Theme 3: Ambulatory care workflow</td>
<td>3.3.3.1 Category 1: Awareness of patient-friendly health services</td>
<td>3.3.3.1.1 Sub-category 1: Reception of the patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.3.1.2 Sub-category 2: Readiness to serve the patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.3.1.3 Sub-category 3: Patients’ waiting times in the ACC</td>
</tr>
<tr>
<td>3.3.4 Theme 4: Needs of patients</td>
<td>3.3.4.1 Category 1: Meeting the needs of patients</td>
<td>3.3.4.1.1 Sub-category 1: Understanding the needs of patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.4.1.2 Sub-category 2: Need for patient satisfaction surveys</td>
</tr>
</tbody>
</table>

#### 3.3.1 Theme 1: Cultural differences

Kozier, Erb, Berman and Snyder (2004:1451) define culture as a world view and a set of traditions and related attitudes used and transmitted from generation to generation by a particular group. The basic characteristics of a culture are that it is learned from birth by means of socialisation and language. It is shared by members of the same group and is an ever-changing dynamic process (Smeltzer & Bare 2004:114).
In the study context it was vital that nurses recognised the impact of the cultural differences if patient-friendly care were to be given. It was, for example, expected of them to use the right hand when giving an object to a patient.

In the context of this study, using the right hand was viewed as communicating respect in a non-verbal way whereas using the left hand was interpreted as an insult to the patient. Also, male nurses took care of male patients while only female nurses rendered care to female patients. Furthermore, it was observed by the participants that the patients tended to believe the physicians and rely on their explanations; it appeared as if the patients did not consider other health care workers of similar professional stature as the physicians.

Hence, the participants identified cultural differences as a quintessential obstacle in rendering patient-friendly health services in the study context. Six participants, although not from Riyadh, could speak Arabic and were of the Muslim faith but they all mentioned that the differences in culture strained the relationship between them and the patients who were from Riyadh.

Another culture related challenge was the experiences of the nurses during their interaction with the male patients. During the interviews, it was brought to the researcher’s attention that some male patients demanded immediate attention, regardless of whether the nurse was busy with another patient or not. This attitude gave the nurse the perception that male patients viewed a female nurse as a “female object” who had to do as he commanded. This notion is confirmed by the following statement:

**P4:** “The higher educated and the lower educated type of male [patient] in particular, the women is ok; least educated males will be...ah...expect immediate, sometimes they are demanding, more demanding...immediate attention...as if I am female object, I must obey the thing they say.”

Participants experienced being treated as “objects” rather than professionals with extensive experience as challenging and difficult.
It is indeed a problematic issue that cultural differences still posed a challenge where rendering patient-friendly health services were concerned despite the experience of the nurses and the many years that they have been in this service and done the work.

Moreover, male patients sometimes misinterpreted the female nurses’ friendliness as evidenced in the following quote:

**P2:** “Without…overstepping the boundaries I presume, that is why we have to understand the culture…you will have to have the understanding…in any culture. Especially if you do not understand the difference between being ah…being friendly or flirty…if you become friendly, they will think this is flirty…I experienced it.”

Other participants indicated that the male patients’ misinterpretation of the nurses’ friendly helpfulness was as a challenge in the environment:

**P7:** “If you become very friendly they…the men…they will think it is flirting…men [are] not exposed to female contact outside the family…this is my experience.”

**P11:** “Here [in Saudi Arabia] we need to approach the men different…I mean…according to their age…the men who are the same age as the nurses…the younger men…they will perceive what we do in a different way you know…”.

Some nurses shared that they rendered care to both females and males in the same professionally prescribed way:

**P14:** “In the hospital setting…sex segregation is so crucial…but…I am treating the men the same as in my country”.

**P15:** “In my personal experience…I treat both males and females the same…the same manner…even if the men ask me questions I will answer them…”. 
A participant said that “because of their culture the doctor want[s] to protect himself as well” (P3). This is supported by another participant who said the doctor would ask the nurse to leave before examining a male patient:

**P13:** “the doctor when he examines the male patient…the doctor will ask the nurse to go outside…wait outside.”

One participant showed a positive response to the cultural differences and the need for meaningful communication. She demonstrated the belief that dealing with different cultures affords one the opportunity to learn more and grow as a person. Being exposed to other norms and beliefs develops one’s own personality and, as one gains knowledge about and insight into other cultures, one becomes more open-minded and tolerant. This is evidenced by her statement below:

**P3:** “Culture makes you sometimes understand…or if you adapt to culture…makes you understand how to deal with them [patients], their mentality. You know people get more chance to learn more about …about cultures…knowledge so yes, yes I do believe about it…ok, more opportunities to learn cultures of others…”.

Although cultural differences were viewed as a barrier to building a patient-friendly atmosphere, it is interesting to note that one participant viewed it as an opportunity to learn about other people’s cultures and to thus be able to care for them as required. According to 14 participants, the culture barrier definitely hampered the building and development of creating and building a patient-friendly atmosphere. The fact that only one participant saw it as a learning experience, is quite disturbing since Yoder-Wise (2007:151) states that global cultural diversities among nursing staff members afford frequent opportunities to be broad-minded and for the nursing knowledge base to grow through the interconnectedness with colleagues in other countries.

Discussions about cultural differences continue in the identified category and sub-category.
3.3.1.1 Category 1: Cultural-sensitive patient care

Yoder-Wise (2007:153) defines culture-sensitive care as care that resembles affective behaviours in individuals’ capacity “to feel, convey and react to ideas, habits, customs or traditions unique to a group of people”. The word ‘care’ as a noun is defined as “an act of taking serious attention or caution” while as a verb it denotes “to feel concerned or interested in another person” (Concise Oxford Dictionary 1983a:139). In the context of patient-friendly care, ‘care’ would entail providing care which focuses on the whole person in an affirmative way. Subsequently, the person will be empowered and enabled to make the best use of all her or his personal and spiritual resources when facing and coping with the doubts, anxieties and questions that arise in a health care setting where patients are confronted with health deviations. It is thus required of nurses to provide care that addresses health needs based on the understanding of the patient’s culture and way of doing things (Gould, Berridge & Kelly 2007:30).

The perceptions of the participants regarding patient-friendly care were included in their referrals to the culture of the patient population throughout the interviews. Due to cultural restrictions, the nurses had to be heedful and not touch patients of the opposite sex unless it was necessary (as alluded to in sub-category 2.1.3) and expressed in the following statement:

P1: “No unnecessary touch[ing]…anticipates and do what you need to do…use body language to assist you.”

Persons of the opposite sex were not allowed to be alone in a room with a closed door. An administrative policy and procedure (APP) was implemented to secure this rule. The nurses had to keep in mind that in the Saudi Arabian culture, gender segregation is a crucial norm. Persons of the different genders do not mingle outside the family borders. If gender segregation is understood the nurses would not be offended when a patient prefers to be cared for by a nurse of the same gender. Also, female patients may refuse to open their faces for examination purposes in the presence of a male nurse. (When in public, the women wear a hijab which covers their heads and faces). Another critical issue is that the nurses need to be sensitive and aware of the different approaches to patients of different ages. It is acceptable for nurse to be friendly towards an elderly patient but being similarly friendly towards a patient in his or her twenties is frowned
upon. The responses of the participants demonstrated their understanding of the need for culture-sensitive care. The correct choice of words when speaking to the patient is also very important since it can be perceived as quite different to what the nurse intended to say or explain. One participant stated the following:

**P1:** “...like proper communication.... We have to be careful with words and communication; stay professional in approach”.

The same participant who perceived cultural differences as an opportunity for personal and professional growth viewed rendering care to patients of a different culture also as a challenge to study and learn, either formally or informally, how to be culturally competent in providing care in a different cultural context. This participant made the following comment:

**P3:** “...and very interested people because more you know open-minded...to gain more...or to know more. To learn and understand, for me I have [the] chance to deal with both [male and female patients] you know...people, everybody, all people, that's [what] make your personality more stronger...the challenge...to face, to understand”.

Delivering culture-sensitive care is crucial to creating a patient-friendly environment. Yoder-Wise (2007:164) concurs with this finding by stating that nurses need to be fully cognisant of how culture affects one's health and the delivery of health care in accordance with the patient’s culture in order to adapt the care appropriately. The participants voiced their experience in this cultural environment in the following statements:

**P6:** “…the female patients...they did not want to open their faces for the examination in ENT...this is the culture...only to the family they will open [the hijab]...".

**P9:** “…step a step backwards for the culture...should not touch or mingle with them...nursing care is the same...no unnecessary touch...respect that they are males...men...".
3.3.1.1.1 Sub-category 1: Influence of language on patient-friendly health services

Berlin, Tornkvist and Hylander (2010:1) state worldwide “multicultural interaction between nurses and patients has been problematic and challenging”. In the KAMC-R the patient population speaks Arabic. The majority of patients do not speak or understand English. The nurses either do not speak Arabic at all, or if they do, it is not fluent. Subsequently, the services of interpreters when conversing with patients are essential. However, there are not enough interpreters in the ACC and therefore all the clinics do not have interpreters at all times. Andrews and Boyle (2003:30) point out that the difference in language between patients and nurses is one of the greatest challenges in cross-cultural or transcultural communication.

Almost all the participants agreed that the language barrier was the main challenge with regard to providing patient-friendly health service. Although six participants could speak Arabic, it was not a solution because of the fact that they had to intervene daily to help the staff who could not speak Arabic. Obviously this situation affected the nurses’ time management and the timely execution of their duties. Another response from the participants as regards the language barrier was from nurses who were willing to help the patients, but without the assistance of an interpreter. The fact is that this arrangement was also not conducive to patient-friendly care because, in a participant’s words, it was “really difficult”. When asked categorically about patient-friendly health service, one participant started the conversation with:

P1: “This is my message to you and this is the thing that I sometimes struggle [with], the language barrier”.

This particular participant explained that she would use the Arabic words “kalam” ("talk"), “baden” ("later") and “dagiga” ("wait for a moment") in this specific order in an effort to convey to the patients the message that, although they could not be attended to immediately, they were still valued as human beings in need of care and would be
attended to shortly. The positive side in this scenario is that the nurse, fully aware of and wanting to render patient-friendly health service tried to communicate this to the patient. The negative side, unfortunately, is that a limited vocabulary consisting of a few words cannot convey the nurses’ commitment or what they (the nurses) really mean to the patients in an effective way. Nurses, who are not proficient in the language of their patient population, will experience it as a “fundamental barrier to effective health care delivery” (Arnold in Arnold & Boggs 2011:202).

In the specific context of the current study, a major issue was that a nurse was invariably alone with the patient(s) without the assistance of an interpreter. One of the participants echoed the feelings of most of the participants by stating that the patients did not understand what the nurses tried to explain to them:

P3: “[The] Unavailability of interpreters at the time when we need them compromises friendly-service delivery to patients and causes delay to care.”

The following quote is evident of the fact that the nurses tried in all way possible to explain situations, procedures and so forth to the patients but because of the language barrier the latter did not understand:

P1: “Even if we try, the patients do not understand what we explain to them, you have to take time…other ways, call the security, this [is] the problem here…”.

The negative influence that the language barrier had on patient-friendly health services was discussed by the participants who all expressed that it was a daunting and ongoing daily challenge to, in fact, also understand what the patients needed or said. The following quotes reaffirm that language was a significant barrier towards patient-friendly care:

P7: “We need interpreters at the area at all times…to ensure the patients understand what the nurses say to them…communication barrier…the patients do not believe what the nurses tell them…if the nurses explain so many many times…the patient is not yet satisfied…”.
It was noted that the participants found it extremely challenging to communicate with the patients. Nine of the participants did not speak Arabic and were dependent on interpretation services that were not readily available at all times in the clinical areas. The six participants who did speak Arabic were aware of the struggle those who were illiterate in Arabic had in dealing with the patients in the absence of interpreters.

It was clear that the CULTURAL DIFFERENCES observed in THEME 1 posed a huge challenge to the nurses. The cultural restrictions and the language barrier were experienced by most participants as a problematic issue that could impact negatively on delivering patient-friendly health services in the study setting. According to the statements of the participants, it was important on the one hand not to overstep the cultural barriers but, on the other hand, still take care of the patients in the ACC in the best professional way. Yet, it was also voiced that working in a multicultural setting should be viewed by the staff as an opportunity for professional as well as personal growth.

3.3.2 Theme 2: Need for meaningful communication

Kozier et al (2004:1449) define communication as a “two-way process involving the sending and receiving of messages”. Swansburg and Swansburg (2002:437) describe communication as a “perception; a human process that involves interpersonal relationships in nursing as well as other disciplines”.

P8: “…to handle the complaints…complaint resolution…due to language barrier…want to help…but you know we cannot understand them…don’t know what is their problem…”.

P9: “…the language barrier…you know I mean…the patient cannot understand what you tell them…they don’t want to accept instructions…how they perceive the instructions totally differs from your explanation…very difficult…yeah…difficult for everybody…”.

P11: “the communication barrier…we cannot understand the patient and the patient cannot understand us…the communication barrier…yes…difficult for us to understand…”.

It was noted that the participants found it extremely challenging to communicate with the patients. Nine of the participants did not speak Arabic and were dependent on interpretation services that were not readily available at all times in the clinical areas. The six participants who did speak Arabic were aware of the struggle those who were illiterate in Arabic had in dealing with the patients in the absence of interpreters.
In the *Scenario* described in chapter 1 (refer to section 1.2.1) the lack of verbal and non-verbal communication from the nursing staff’s side was evident. They did not look at the patient, was not friendly, and “the unit assistant did not even once speak or look at the patient, but only handed her the documents for a follow-up visit …”. This is not in line with the current global vision of providing more personalised patient care services that, for example, encourages staff members “to be service champions to help reinforce the message of patient-friendly health services” (Achieving patient-friendly services 2011:88). (Refer to chapter 1, section 1.1). After all, nurses are the key role players and consistent members of the health care team and nurses are therefore uniquely positioned to ensure quality, patient-friendly health care that can enhance patient outcomes.

In fact, as mentioned in chapter 1, section 1.1, the cultural and traditional differences which can prevent successful quality health care delivery in the country was addressed by the KAMC-R. It was declared that the patients and their families must come first. This included that they are entitled to receive friendly care. It is believed that, if the nurses are welcoming and friendly, the patients will feel valued, the staff may experience greater job satisfaction and the working place will be more appealing (Achieving patient-friendly services 2011:88). Yet, patient-friendly health services in particularly the ACC is a huge challenge since most of the nurses do not understand the Arabic language while the majority of the patients do not speak English either (refer to chapter 1, section 1.1).

### 3.3.2.1 Category 1: Professional yet patient-friendly communication

For the participants in this study communicating with their Arabic-speaking patient population in the latter’s language was a definite problem. Hence, other non-verbal ways of communication in the study context was used to provide information, patient instructions and interviews during health assessments, as well as guidance concerning treatment. Some information was provided by means of bulletin boards to arouse patients’ interest in health matters, stimulate thought and encourage them in engaging in healthy actions or better involvement in their health care. Various other ways of communication to provide health information were made available to the patients, for example, closed-circuit televisions placed in the waiting rooms. Signboards were placed at strategic points to identify or direct patients to different health services or specific health service areas such as the male pharmacy, the laboratory and the X-ray
department. However, in no way could these endeavours substitute the importance of the nurses’ personal communication with the patients. One participant mentioned that:

**P2:** “We have to be careful with words and communications...stay professional in our approach. If you got good communication skills with the patient and you can smile...and they will respond positively to you.”

A participant explained how she believed patients would experience friendly and helpful assistance from the nurses:

**P2:** “If a staff member is friendly and smiling and seems to be willing to assist me and help me then I am relax[ed] as a patient and I will feel safe and secure, that I am in good hands.”

Communication was identified as an important skill, as was effective time management. Nurses are the first point of contact for patients; patients view them as competent and knowledgeable human beings. However, if there is an acute language barrier in any professional milieu and particularly in one where people and their health are at stake – positive outcomes are seldom achieved. The fact that the nurses were professionals in the current study, were knowledgeable and competent could not be appreciated by the patients because language was a huge and persistent obstacle.

Further discussions on communication in this category will centre on discussions about sub-categories such as listening to the patient, the influence of language on patient-friendly health services and body language of the nursing staff.

### 3.3.2.1.1 Sub-category 1: Listening to the patient’s need for meaningful communication

Listening to what the patient says is crucial since it is by listening that the nurse receives and interprets information. To be able to listen with understanding to a patient’s complaint and then comprehend the answers provided to their questioning as regards the complaint is the collective way of determining what the patient’s problem or needs is. Participants in this study realised how important it was to listen to the patients. Meaningful communication does not only include oral conversations, but also the ability
of the nurse to listen to the patients. One participant interpreted meaningful communication with the patient as follows:

**P4:** "Give the patient the right to say what he wants… listen to the issues… their problems. Do not ignore what they tell you."

It was noted that participants were aware of the fact that connecting with the patient by listening would create an opportunity for them to engage in dialogue with the patients. This indicates that the nurses were indeed aware of and felt the need for meaningful communication between them and the patients. However, the participants reported some difficulties related to this aspect as evidenced in the following quote:

**P1:** "Yes there is this culture difference. I’m trying to understand you know. Sometimes I’m busy with somebody else…and then somebody else wants attention…immediate attention. If I don’t go that seems as if I am not listening…”.

The finding in the ACC that the non-Arabic speaking nurses’ communication with the Arabic-speaking patient population was a continuous and daily struggle was troublesome since it affected not only the verbal and non-verbal communication between them, but also reflected negatively on patient-friendly health service and appropriate care giving. Rendering successful and humane care to patients is, after all, augmented by nurses knowing, in other words speaking and understanding the language, culture and customs of the patients they are taking care of (Arnold cited in Marks 1994:11).

In spite of the communication barriers, the participants shared that they perceived connecting with the patient by simply listening to them during a conversation, however briefly, as providing a certain degree of patient-friendly health services. One participant made the following statement:

**P4:** “So just listening to what she [the patient] is telling you can be noted as friendly patient care.”

This quote affirmed that the nurses viewed the patients and their different illnesses in the ACC as important even though they were of a culture different to that of the nurses.
Health care crises may be humiliating and in some instances even dehumanising. The participants demonstrated understanding of such plights and, despite the lack of communication, they availed themselves to listen to patients’ frustrations, fears and questions. Even if some of the aspects shared by a patient were not directly linked to any of the patients’ health care problems, the participants believed that by just listening and showing interest in a caring way, a patient-friendly environment was still created where the patients were made to feel like important, worthy human beings. Listening to the patients’ need as part of meaningful communication is confirmed by the words of the next four participants:

P2: “You really need an ear to listen [lend an ear] to what the patient is telling you.”

P6: “Yeah…do not ignore what they tell you. Even if you cannot solve their issues, and [but] show your interest, they will appreciate your effort.”

P7: “…be attentive…be responsive…be a good listener…”.

P10: “Also…yes…communication…you should…active listening to know what is the problem…”.

Nurses are the first health care providers that both patients and families encounter when seeking health care. Even during visiting hours in the ACC the patients’ family members engaged with the nurses to discuss issues and ask questions about their loved ones’ health status. The participants realised the families’ needs were not only to be informed of the clinical health of the patient, but also needed their fears, anxieties and emotional needs to be addressed.

### Sub-category 2: Providing the patient with information

To be ‘informed’ means “having or showing knowledge” (*Concise Oxford English Dictionary* 2006:730); in other words, in this study context it meant that the patients had to have knowledge about how the procedures and processes in the ACC worked; they had to know where to go for procedures to be done, and also had to know what their health status was.
However, the general sentiment expressed by participants was that the patients were not knowledgeable or informed regarding the hospital policies and procedures. One participant specifically mentioned patients had “a lack of knowledge” about “how the system is running [works]” (P4) in the ACC. One example is that glucometers could only be obtained on prescription from the internal medicine consultants. Other specialties such as family medicine, endocrinology and cardiovascular were not authorised to give this prescription. Yet, as the following quote shows, patients came to any clinic in the ACC with requests for it:

**P2:** “Sometimes the patients come here…specifically we don’t have [a] diabetic clinic here…we have new patients coming here, ask[ing] for glucometer strips… which is not eligible [only authorised to be prescribed for a patient by an endocrinologist in the specific clinic]… [we have to] then guide them, give them guidance, [so that] they can have the things.”

As one participant explained, the problem was that patient-friendly health service was affected by uninformed patients who became “highly frustrated” because they did not know where to go for specific treatments:

**P1:** “In order to render patient-friendly health service, a patient had to receive clear guidance and instructions where to go to as this hospital is very big [as the name indicates ‘medical city’] and the patients got confused where to go, roaming around in the corridors, highly frustrated.”

The issue here is not only that the sick patients wasted time “roaming around in the corridors” but also that, because of the language barrier (refer to section 3.3.1.1.1 Sub-category 1: Influence of language on patient-friendly health services), for nurses to direct the patients to the correct person regarding specific issues that needed to be addressed was a time-consuming exercise that influenced their health care delivery to other patients. Nevertheless, the participants made an effort to take the time to guide and direct patients where to go to:

**P4:** “They [the patients] have to be properly guided…direct them to the correct persons to be effective, do not waste time.”
P13: “We have to give them [the patients] the correct information...yes we tell them if we cannot help them...then we refer the patients to where they can get help...”.

The importance of sharing adequate and correct information with the patient is well described in literature. Kozier et al (2004:431) point out that giving information to patients should be done in a direct manner; it should be specific and factual. George (2002:252) adds patients must be well-informed not only by literature but by friendly, informative nurses.

Participants voiced that in the ACC booklets, pamphlets and brochures on patients’ rights were available in the Arabic language. According to George (2002:252), patients’ rights include, amongst others, that they are kept informed about the condition of their health status and that it is their right to participate in making decisions about their own health. Yoder-Wise (2007:447) concurs that the information that patients receive influences their involvement in decisions made concerning their care, and in turn their perception of how care is provided in that specific care centre. In this study participants voiced that, as part of delivering patient-friendly care, it was important to them to keep the patients updated and informed about changing situations, for example, when a physician would not be in time to attend to the scheduled clinic session the patients needed to be told about the delay.

An example of providing information could be in instances where the requirements for referrals to home health care, including the completion of supportive documents, were not met by the nurses while the patient and his or her family already had the expectations of being served by home health care services.

Continuation of the interviews and responses to probing questions highlighted that patient-friendly health service was influenced by the patients’ lack of knowledge concerning how systems in the ACC were operating, as well as the nurses not explaining and giving information to the patients regarding this same matter. The researcher noted deviation from the policy (patients’ rights and responsibilities) with regard to providing the patient with complete, correct and adequate information as voiced by the participants: “Yes, this is what I say...for take home supplies...they want the supplies but they are not entitled...now the nurse needs to explain properly for time
in a nice and good way…” (P6). “Give the patient his rights…to answer questions…” (P15).

### 3.3.2.1.3 Sub-category 3: Body language of the nursing staff

Non-verbal communication differs across cultures; therefore, it is crucial for nurses to be aware of their own body language as well as that of their patients. Using silence, eye contact, space and distance, facial expressions and touch (Andrews & Boyle 2003:27) are all part of body language communication. In the culture of the context of this study, the nurse had to be very aware of her or his own body language. The participants discussed that their body language was an important aspect in delivering patient-friendly health service as they realised it formed an integral part of meaningful communication with their patients. One participant summarised it in the following way:

**P1**: “Always focus on the needs of the patient… [it all] all depend[s] on body language.”

Another participant stated that it was imperative for the nurses to remember that their body language contribute to creating a patient-friendly atmosphere:

**P2**: “Properly dressed [the nurse], the way I conduct myself…and the manner of speaking…eye contact with the patient. He [the patient] will approach you and then they even do this…finger clapping… [the nurse has] to stay calm regardless of the current situation.”

This participant’s statement clearly indicates that she was aware of the policy of compliance with the prescribed uniform which stipulated that the nurses’ elbows and legs had to be covered and the uniform was not to be tight fitting, but her dress code at the time of the interview contradicted her words. A note in the researcher’s reflective diary showed that the participant was not appropriately dressed: her uniform was too tight fitting, her elbows were exposed, she wore jewellery, and her long hair was not tied back or up. One of the slogans in the hospital corridors read: THE WAY YOU WEAR YOUR UNIFORM INDICATES YOUR RESPECT TO THE ORGANISATION. In any case, abiding by the dress code in any health care facility embodies the respect that the staff have for the patients. However, at the KAMC-R where diverse cultures and
peoples meet, showing respect towards the patient is especially crucial to the NGHA organisation since it supports the ideology that the health care organisation belongs to the NGHA patient population. For this reason, a nurse is “dressed properly” if dressed according to the NGHA dress code policy.

Another response to communication by body language related to the manner of speaking and making eye contact with the patient. The participants viewed these as important aspects of patient-friendly health service as evidenced in the following quote:

**P2:** “Even if you look apologetic enough...if your body language shows that you have got empathy and understanding, if you can smile then they [patients] will even smile back to [at] you...and they will respond positively to you. It all depends on your body language...you’ve got to have some proper professional body language.”

A study conducted by Geanellos (2004:38) confirms that a smile from a friendly nurse helps patients to cope and recover from illness. The participants reported that when the nurse was friendly and smiled at the patient, the patient was relaxed, felt safe and secure and perceived this attitude as the nurse’s willingness to assist. If the body language of the nurse showed empathy and understanding and included a smile, patients would return a smile and respond positively to the nurse. This finding is supported by King’s theory (Masters 2012:108) that the reaction of a returned smile from the patient is interpreted as a goal attained. This reaction creates criteria by which the effectiveness of patient-friendly health services can be measured. The importance of the nurses’ body language, including acknowledging the importance of the nurses’ gestures, was acknowledged by four participants:
P2: “Gestures and body language of the nurse is [are] very important…show the patient you are interested in him…always service with a smile…tries to show [a] positive attitude.”

P8: “Gestures and body language of the nurse is [are] very important…take time and explain to the patient…body language help[s] you…[what] you explain to them.”

P9: “…as a nurse…everything you do and act has to be patient-friendly…anticipate and do what you need to do…use body language to help you…”.

P14: “When the patients come in the hospital…we are not just there to carry out orders…we must be friendly…in this way they will feel comfortable…smile…smile…”.

THEME 2: COMMUNICATION emphasised that nurses needed to have an acute awareness of their body language; body language could assist with the healing process if applied in a caring and respectful way to meet the patient’s needs. The participants shared that, because of the cultural differences they were exposed to in the specific health care setting, they had to be attentive and not, for example, touch patients of the opposite gender unless it was as part of their professional care. They had to find other ways to show interest in their patients and display a positive attitude towards them, both verbally and non-verbally. The participants also had to interpret the body language of the patients who could not speak English. Finger clapping was, for example, perceived by the nurses as the patient communicating to them impatience and dissatisfaction with the care rendered.

3.3.3 Theme 3: Ambulatory care workflow

This theme explored and described how challenges in ambulatory care flow, as expressed by the participants, could compromise patient-friendly health service. The presentation and analysis commence with staff members’ awareness of the work flow and provision of patient-friendly health services and how patients were perceived in the ACC.
3.3.3.1 Category 1: Awareness of patient-friendly health services

Referring to the literature review, Green (2004:288) reminds nurses to be attentive and not to compromise inherent nursing characteristics, such as friendliness, for more productive primary health care in challenging ambulatory care settings. The KAMC-R, a Joint Commission accredited institution, declared the following organisational focus, ‘Patients and families first’ (Al Knawy 2009).

The participants demonstrated an awareness of patient-friendly health service in their discussions with the researcher. One participant expressed that:

**P2:** “The nurse should be flexible depending on the situation of the patient and could take responsibility to go beyond what was expected such as to act like a runner for them.”

The same participant, when this response was probed, explained that patient-friendly health services included the education of patients and proper communication to make them understand that the nurse would always be there for them. This finding was verified by the same participant’s remark that:

**P2:** “A patient-friendly service would not expect patients to wait, specifically patients who expect bad news about their illness.”

Another participant reiterated the vision of the NGHA organisation that patients and their needs come first by expressing patient-friendly service as follows:

**P1:** “The patients are the core of the organisation; therefore staffs should be available for the patients, and listening to them.”

The value and role of nurses in ambulatory care settings have increased in the last decade to the extent that various research studies mention the “positive relations between nursing services and patient health outcomes” (Mastal & Levine 2012:296). The next quote from a participant reflects that dedication means that nurses treat patients in the same way as they would like to be treated themselves:
This response is representative of the empathetic feeling demonstrated by the staff towards the patients cared for in the ACC. ‘Empathy’ is defined as “intellectual identification with or vicarious experiencing of the feelings, thoughts or attitudes of another: the ability to imagine oneself instead of another” (Concise Oxford English Dictionary 1983b:315). The importance of having empathy with patients is supported by Hurley (2006:13) who states that it should be remembered that “while we are nursing care givers today, we are the patient consumers of tomorrow”.

The empathetic feeling expressed by the participants was directed at the patients who were not personal associates of the nurses. The participants seemed to intimately connect with their patients and shared their distress; they seemed to have witnessed patients being treated as objects, or other female nurses being treated as objects by male patients. One participant discussed a challenge experienced with male patients. She revealed to the researcher that male patients demanded immediate attention regardless of whether the nurse was busy with another patient. This attitude gave the nurse the perception that men saw her as a “female object”. One participant stated that:

P3: “Well I continue to treat them as human beings even if I am seen differently because of my nationality.”

Nurses value patients as human beings worthy of respect and humane care. One participant elaborated on this finding as follows:

P3: “…and again patients, if you just take them as patients they become sort of objects and then they just like you are working and is cure[d] you just help and go, but with this is different that eh! you know uhm … approaching [to approach] a person as a person.”

Participants understood the concept of having ‘respect for patients as persons’ as rendering humane care that went beyond the physical in terms of how they approached patients or interpreted the plight of the sick. Conversely, it was found that female nurses too desire to be treated with respect and acknowledged as human beings:
It was in the context of this category that participants expressed that involving the patients in the care plan and informing them about what was going on was the simplest way to understand and incorporate nursing care empathetically and to enhance friendliness. One participant presented her view as follows:

**P4:** “When I am consulting a doctor, I want the doctor to involve me after examining me telling me what is wrong with me and how he is going to treat me. This helps me to treat the people I meet every day the same way that this person must be informed, and must know exactly what is wrong with the person.”

The perception of this participant was confirmed during other interviews which reflected that the participants put themselves in another’s position, viewing the social world of sickness and disease as the other person, thus the patient, does. Treating patients in a friendly way was understood as showing respect towards the ‘other person’; particularly to those who were sick and suffering. Turner and Stets (2005:100) posit that empathy can be communicated to patients by means of facial expressions, compassionate care giving and words of hope in order to bring a difficult situation under control.

The nurses perceived a patient’s satisfaction with the care given as emotionally very rewarding. Although none of the participants had any training in patient-friendly health services or customer-friendly awareness, the researcher gained the impression that they were attentive, aware and concerned with regard to assisting and caring for their patients to the best of their abilities.

### 3.3.3.1.1 Sub-category 1: Reception of the patient

It is evident that the participants in this study understood the needs of the patients as they all agreed on the importance of a cordial reception of the patient at the reception desk in the clinical area. Bearing in mind that the person standing in front of them should not be ignored, the nurses displayed a friendly, approachable, respectful attitude.
when receiving the patient at the reception desk of the clinic. They indicated their willingness to assist, responsiveness to the patient’s requests and courteousness as components of patient-friendly health service.

The participants were dispersed across the ACC in their respective clinical areas and each of the 26 clinics had its own reception area. One participant addressed the need for an Arabic-speaking person being present at the reception desk to prioritise care to patients who needed care more due to acute illnesses than the other scheduled patients. This finding is evidenced as follows:

\[ \boxed{P3: \text{“In ACC they come to the desk, to us first. We need [an] Arabic speaker at reception to tell the patient what is going on. Need to prioritise the sick patient.”}} \]

Another participant voiced the importance of welcoming the patients on entering the clinic in order to show interest in them as follows:

\[ \boxed{P2: \text{“Show your interest in patients … asks why here [the reason they have come to the clinic]…showing concern for a patient at the first entry into the system.”}} \]

‘Concern’ is defined as an action of being involved and interested in; to be worried or trouble oneself or be anxious about something or someone (Welcome patients: helpful attitudes, signs and more 2012:2). Showing concern for patients empowers them to connect with themselves, with others and to have hope and strength to cope with the challenging situation of their health journey (Welcome patients: helpful attitude, signs and more 2012:3).

Two participants made the statements that first impressions count; it was important for these participants that the patient should have a good impression of the nursing care rendered as well as of the ambulatory care services:
Further communication with the participants revealed that they all believed that the way patients were welcomed and received at the reception desk played a pivotal role in enhancing patient-friendly health services. In brief, the participants shared that, starting at the reception desk, all staff should go beyond the call of duty to provide exemplary health services in an atmosphere where patients feel really cared for and respected:

P6: “You should entertain the patient and show interest in him. I mean…welcome the patient, know what is the feeling…why the patient comes here. You see…show your interest…they will appreciate you…”.

P12: “Receiving of the patient…reception of the patient is very, very important…”.

P13: “I must make them feel welcome…as a professional nurse even if I am busy…the patients must feel welcome…”.

Creating and sustaining an environment that is positive and welcoming in the reception area plays a pivotal role in patient-friendly health services. The demeanour of the first person a patient met in the centre was considered very important by all participants as this for set the tone for whether the subsequent services would be perceived as friendly or not. Creating a friendly environment may help; especially new patients feel welcome and positively received. This will encourage the patients’ meaningful participation in their health experience (Welcome patients: helpful attitude, signs and more 2012:3).

3.3.3.1.2 Sub-category 2: Readiness to serve the patient

Staff needed to ensure that the environment was clean, tidy and safe to deliver positive care. Properties and equipment had to be in working condition.
In all the clinical areas in the KAMC-R a six-monthly preventative maintenance of electrical appliances, outlets and medical equipment, with dated labels on each item, was performed as a quality and safety initiative and international joint commission-required standard. The nurses were responsible to ensure and maintain sufficient quantities of supplies and materials in the clinics. Daily environmental checks had to be done and documented before the patients arrived for their appointments. The files of the patients had to be screened thoroughly and timely prior to the onset of the clinics’ sessions. This concurs with literature that nurses have to take responsibility to ensure patient-friendly health services by means of a customer-oriented approach; however, most nurses seemed not to be formally trained to deliver care to the satisfaction of patients in terms of resources, attitude and information (Howard 2000:23). One of the participants expressed the meaning of readiness to serve the patients, including having strategies and resources in place to educate the patients, as cited below:

**P1:** “It’s like you know as for any customer…any client would come to your area …they have to be properly guided. Like, I mean, being friendly is to educate the patient as well…patient should be properly informed [so] that they understand.”

A note in the researcher’s reflective diary shows that a nurse interviewed in this particular clinic in the ACC could not find an example of an educational booklet or a location map. These had to be provided to the patients during their visits to the ACC for the purposes of education and directions of locations such the rights and responsibilities of the patients and the location of the department of materials and supplies.

According to another participant, teamwork and a team approach were needed to serve the patients:

**P3:** “We are all part of this chain, the team to render this quality patient care services. Direct them to the correct persons to be effective…do not waste time. Sometimes there is no interpreter or they are on break…. We tell them that they may complain about things we don’t have control [over]…also show them where to address it.”

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The above statement is supported by the following words of another participant:

**P1:** “The whole team should be able to provide and perform patient service without delays [in the] clinic. You know the whole environment is difficult and challenging … [including] insufficient waiting areas.”

One of the most important aspects of being ready to serve the needs of the patients is to know the patient population and to be pertinently aware of their expectations (Ashurst 2013:733).

The participants in this study were also concerned about staff being ready to receive the patients, direct them to the appropriate staff and not to waste the patients’ time. According to the participants, readiness to serve the patient was challenged if the nurse was unable to understand the patient’s home language. These multifactor experiences were concluded with the concern for effective and efficient time management by the staff with regard to delivering services to the patient and were expressed as follows:

**P4:** “…it needs to be timing…there is a time for everything…don’t waste time. How to deal with them? Actually you need to be in order…it needs to be timing…you could say your organisation includes everything.”

**P5:** “We as nurses should know how to deal with the patients…well-educated staffs who understand their job, the role…we prioritise the sick patients and ask the doctors to see them first.”

**P12:** “The patients do not understand what we explain to them...we do not have enough Arabic speaking staff…patients more irritated…they don’t understand us.”

**P15:** “The unit assistants [interpreters]…they need to attend more courses in communication skills…they do not have patience to deal with the patients…they are hardly helping the patient…they need to learn more…they need to go to courses to help them so they can help the patients.”

In the KAMC-R the ACC seemed to be facing challenges in delivering patient-friendly health services with regard to issues in the ambulatory care flow. It was evident that by
addressing these challenges, especially the language issue, patient-friendly health services could be improved in the ambulatory care settings. However, this may not be easy for nurses, as the findings revealed this as an organisational matter due to the NGHA organisation recruiting multinational staff members.

3.3.3.1.3 **Sub-category 3: Patients’ waiting times in the ACC**

The literature revealed that nursing responsibilities in health care continue to expand; therefore, it is of vital importance that nurses continue to reflect on their roles in order to keep their patients satisfied (Green 2004:283). The participants in this study showed concern about the fact that when the physicians did not see the patients on time and according to their scheduled appointments, patient-friendliness was compromised as the waiting period was extended. The major challenge was to keep the patients satisfied by keeping them updated with information when they had to wait to see physicians who were busy in operating rooms, the emergency department, ward rounds or board examinations of medical students. The participants expressed their empathy with the patients and explained that they would try to reschedule appointments and solve and refer related issues to the best of their abilities. This included using the patient relations department to support the nurses in their communication with the patients. One participant explained:

**P3:** “You are into [in] a hot position wherein you are trying to solve an issue related to patients waiting too long to be attended to.”

This expression shows that the participant made an effort to give attention in situations where the patients needed to wait to see a physician. In such instances, where the physicians would arrive late for the clinic sessions and patients had to wait for unspecified periods of time, patient-friendly health service was affected. Also, in the many instances where patients were late for their appointments and the physicians would subsequently refuse to see them resulted in diminishing the efforts from the staff to maintain positive patient care.
P5: “You know...so many patients and not enough doctors and then...the patients they will be upset when we let them wait for some time...for more than two hours. That is [the] cause...the reason...doctors are late...they do rounds, work in [the] OR [operating room] and ER [emergency room]...my example...the liver transplant clinic has increased patients but not so many doctors.”

P8: “Sometimes the doctor says the patient could come anytime to see him...but then the doctor will say no when the patient comes...”

The study findings as regards THEME 3: AMBULATORY CARE WORKFLOW showed that the participants intervened as advocates on behalf of the patients, trying to convince the physicians to see the patients. Another participant discussed the issue of the patients' appointment times which were, in most cases, five minutes apart. Obviously this did not leave enough time for the patients to discuss their condition with their physicians. Due to the large volumes of ambulatory care visits, there is a limit as to what the physicians can accomplish in the time allowed per patient per visit. For this reason, ambulatory care nurses thus act as advocates for their patients to ensure quality consultation sessions (Lucarelli 2008:272). It must be reported that the participants seemed to do all they could to assist their patients in dealing with challenges concerning the waiting times. This, however, seemed difficult to handle as in most cases patients waited for physicians who were legitimately held up somewhere else.

3.3.4 Theme 4: Needs of patients

The organisational leadership expects the employees to demonstrate desirable attitudes in dealing with the patients. Nurses are regarded as the front-line service providers and need to be flexible in adjusting health care practices, considering the patient’s condition and circumstances (Darby & Daniel 1999:272). A nurse needs a friendly attitude and behaviour as necessary skills to meet patients’ needs. It is an unfortunate state of affairs that not all nurses develops interpersonal skills and that some of them do not even perceive such a skill to be important (Geanellos 2004:38). As noted in the next category and sub-categories, the participants in the current study shared their experiences of the influence of being diligent in understanding and meeting patients’ presented needs.
3.3.4.1 Category 1: Meeting the needs of patients

The concept ‘patient’ is defined as a person who “receives medical treatment, attention and care” (Blackwell’s Nursing Dictionary 2005:295). Outpatient patients are not admitted to ambulatory care settings and thus do not stay overnight in the hospital. They visit a hospital, clinic or associated facility for a diagnosis or treatment (Blackwell’s Nursing Dictionary 2005:295). The participants reported the importance of them understanding, giving attention to and meeting the needs of patients as represented in the following quote:

P1: “Accommodating in the sense that we have to attend to their needs…they [patients] should feel important as well. This is the culture, I am the nurse, I am here to care for them, to see to their needs; now this is very, very important.”

It was the general opinion of the participants that for them to address the needs of patients they first had to understand what those needs were. Kozier et al (2004:197) confirm that all people have the same basic needs and the ways in which they react to these needs are influenced by the culture with which they identify. Nurses therefore need to be aware of how to meet the health needs of patients in the context of multicultural diversity. The nurse has to understand the expectations of the patient and how to provide for and fulfil those expectations as voiced by a participant:

P4: “To provide and perform what the patient expects from you…always remember what is the need of the patient.”

The nurse has to display a flexible attitude and assist even if the need is not the responsibility of the nurse or that of the physicians. The nurse furthermore needs to be familiar with the supporting services available in order to refer the patient to appropriate social services. The patient is the centre of focus and is entitled to being cared for in a holistic manner by meeting her or his physical, social, emotional, spiritual and mental health care needs. Meeting these needs should be done in such a way that the patient will recognise it as patient-friendly as reflected in the words of a participant who said “It is like being there for the patients spot on …being there” (P2).
According to another participant, meeting the needs of the patient is considered as the most important aspect of patient-friendly health services and therefore teamwork is crucial in meeting these needs:

**P8:** “Then the teamwork…it should be organised and structured…this is what it [teamwork] means…for me…the teamwork is the most important…all [must] work together.”

The importance of teamwork in meeting the needs of the patients was confirmed by other participants:

**P10:** “…it is the doctor and the nurse who provide the care…teamwork…put the patient first…the patient is very important…”

**P11:** “The most important…very important to take care of the needs…is the teamwork…teamwork…yes…”

The WHO report indicates that primary health care is of vital importance to improve health equity and to meet the basic needs and expectations of people (WHO 2008:36). Because nursing responsibilities in health care continue to expand it is essential that nurses continue to reflect on their roles and their commitment to caring for patients’ needs in order to keep their patients’ needs met and satisfied (Green 2004:283). Nurses, as the front-line service providers, have to be flexible in adjusting health care practices to the patients’ condition, circumstances and expectations (Darby & Daniel 1999:272).

### 3.3.4.1.1 Sub-category 1: Understanding the needs of the patients

The differences in needs, goals and values between the patient and the nurse affect the process of interaction and how those needs are met (George 2002:252). Nurses seem to be aware of the demands for improved quality services. Health care organisations realise the value of a patient-friendly customer service programme that serves firstly to meet the demands of a diverse patient population and, secondly, is beneficial to the image of organisations (Howard 2000:23). According to one of the participants, the role of the nurse was not only to attend to the patients’ needs but to accommodate them:
It was noted that the patients should feel important. One participant, with regard to this sub-category, stated that the nurse should be available for the patients, “don’t walk away.” She continued by advising that a nurse should “just say…‘Hold on…I’ll come to you’” (P2).

The needs of patients who call for attention by telephone should not be ignored. Telephones must be answered. Good telephone etiquette was cited as part of patient-friendliness. The same participant as above declared that “patients come first” and that the nurse had to be approachable in attending to patients’ needs, even if the nurse was busy with a patient at a given time and another patient requested attention.

In cases where patients could not be helped in a specific area due to the fact that the various specialties were attended to in different clinics, the nurse still needed to assist by guiding the patient in order for him or her to be provided with the specific services needed. Glucometer strips, as mentioned before, were only prescribed by endocrinology consultants in the endocrinology specific clinic and nurses had to direct the patients who required them to that clinic. The perception of one participant was that such good nursing practice was closely related to keeping in mind the different patients presented with different specific needs the nurse must attend to the particular identified needs:

P3: “It will also be good to keep in mind…always remember, what is the need of the patient and just attend to that need…. Even if the patient is upset, he has a problem, let’s cool him down…how could you help him feel that he is important and you really care about him. Whatever they need; because we are dealing here with different people. If he didn’t understand, you have to take time…call in the patient relation service.”
Moreover, the participants had to be familiar in dealing with patients who were upset, handling conflict situations and making patients feel important. In cases where the patient did not understand, time was taken to address the patients’ needs. Fortunately, they could obtain assistance from the patient relations department if and when needed. Discussions about this concept were concluded with one participant stating that the nurse should show “patience and understanding” in providing for and perform to the patient’s expectations; she further said the nurses had to “keep in mind that the patients must feel [they are] attended to” (P4).

The focus should be on the need of the patient and on attending to the identified need as best as possible, which imply that the needs of nurses should be put on hold. It seems that the perception of patients with regard to how they are attended to is of paramount importance. It is also notable that although nurses kept on responding that patients’ needs be attended to, they could not clearly identify what the needs were. Nurses might be working under pressure to keep patients’, managers’ and doctors’ needs satisfied at the expense of their own needs. According to Yoder-Wise (2007:160), nurses who come from other cultures have a responsibility to keep their jobs. However, demanding work environments, clouded with other influences, may lead to nurses leaving their positions due to work stress and dissatisfaction.

**P9:** “It is a big effort on the nursing side…give the patients what they need…the nurse has to anticipate everything…anticipate the pain the patient is suffering…prioritise as needed…”.

Furthermore to the discussions about understanding the needs of the patients, one participant stated:

**P10:** “The patient should feel comfortable…be kind to them…provide good care…be kind and professional to deal with the patients…”.

The expression about understanding the needs of the patients was voiced by one other participant:

**P11:** “…give them all they need…they come here for help…we try to provide for them…make it easy for them…”.
One documented response with regard to understanding the needs of the patients was noted in the following phrase:

**P13:** “The nurse needs to be observant of the needs of the patients…what they want…”.

and confirmed as follows:

**P14:** “The nurse needs to plead for the patient…nurse has to be the advocate for the patient…the nurse has to explain to the patient and to the doctor…the patient has only 5 minutes with the doctor…sometimes they need more time…the doctor is too busy…many patients waiting to see him. The patient liaison nurse is in the middle…in the middle between the patient and the doctor…hmm…it is for me an opportunity…as a professional nurse I take time…spend time…sometimes there is a problem…the patient needs the treatment but refuse it…then I go back to the doctor…I take time and explain to the patient…”.

### 3.3.4.1.2 Sub-category 2: Need for patient satisfaction surveys

Patient-satisfaction surveys are a valuable tool for patients to evaluate the health care services and for primary health care providers to obtain information about the needs of the patient population to identify and address issues of concern. According to a research study conducted by Ali and Mahmoud (1993:49), patient satisfaction is of value to primary health care providers; a patient-satisfaction survey is an indicator of the efficient and effective use of health services. One participant responded that it was important to conduct patient-satisfaction surveys in order to evaluate the nursing care provided, as patients were perceived as the core focus of the nursing profession. The participant stated that:
Nurses need to ensure patient satisfaction. This can be done by knowing how good or bad the care was according to the patients’ evaluation of the care given. Patients’ feedback could be used to become aware of shortcomings and effect improvements. It is also a way for nurses to know what the patients thought of their nursing care. A participant stated that it was rewarding when patients were satisfied with the nursing care they received and that patients had the right to express what they wanted or needed. One participant strongly felt that patients should be encouraged to evaluate nursing care, as conveyed in the following words:

P1: *Now this is very, very important... we can do a survey... let the patients evaluate our nursing care.*

The participants agreed that it was important for them to receive feedback from the patients regarding the care they received from the nurses: what were the impression, if any, that the patients had about the nurse’s attitude and care giving, the service they received and whether they felt comfortable in the environment and with the nursing care or not.

The jobs of nurses, especially the jobs of those who came from foreign countries such as South Africa, seemed to be very much dependent on the patients’ perceptions and their interpretations of the services rendered. A patient’s positive experience in the ambulatory care will lead to a positive evaluation of the nurse, the care as well as the environment. In fact, it was established by the next participant that it was a “very rewarding” experience “if the patients are satisfied”:

P2: “The patients are our core... because I want to give the patient that satisfaction... patients come first. We want to know how good is our care we give... evaluation... surveying, like in the patients you know, give us some feedback, that we can up [upgrade] our standards or whatever, we know where the faults are [and] how to go about those... survey to evaluate... so we can have some feedback at least... if we want [to know] what the patients think of us.”

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In conclusion, delivering professional and patient-friendly care in an environment where there is a considerable difference in cultural norms and traditions which is aggravated by not understanding each other’s language, is not easy to accomplish. In this study the participants confirmed this was a demanding and strenuous circumstance. They had to be aware of their own attitudes, acts and behaviours whilst attending to patients with a vastly different cultural background. It was imperative that the participants had to be careful not to impose their own norms and values on the patients.

Additionally, the participants’ responses indicated their understanding of the concept of patient-friendly health services and their willingness to assist the patients in all aspects of nursing care. It was evident that the participants, as part of the nursing workforce of the KAMC-R hospital, would go to great lengths to assist their patients. They also displayed a positive attitude towards the patients and the NGHA organisation.

3.4 SUMMARY

The analysis, presentation and description of the research findings were discussed in this chapter. The chapter included themes, categories and sub-categories that were presented and discussed based on direct quotes. These provided a general sense of how participants viewed patient-friendly health services in an ambulatory care centre. A literature control was done to support or refute the findings.

Chapter 4 will offer a discussion, the conclusions and recommendations based on the study findings.
CHAPTER 4

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

“The problem with research is that it tells you what people were thinking about yesterday, not tomorrow. It’s like driving a car using a rear-view mirror”.
(National hospice … cited in Loomis 2013).

4.1 INTRODUCTION

This chapter offers a discussion, conclusions, recommendations, and the scope and limitations of the study. Recommendations are presented based on the study findings. A qualitative, explorative, descriptive and contextual design based on the traditional qualitative methods of inquiry was used. The researcher was interested in exploring and describing the perceptions of registered nurses about patient-friendly health services rendered within an ambulatory care setting in KAMC-R. Data were collected by conducting semi-structured individual interviews with 15 participants who met the inclusive criteria. Data were analysed according to Van Mannen’s method.

4.2 SUMMARY AND INTERPRETATION OF THE STUDY FINDINGS

The key study findings were based on the objectives of the study; the discussion is focused on the following aspects:

- cultural differences
  - influence of language on patient-friendly health services
- need for meaningful communication
  - body language of the nursing staff
- ambulatory care workflow
  - reception of the patient
  - factors affecting the patients’ waiting times in ACC
- needs of patients
  - understanding and meeting the patients’ needs
  - need for patient satisfaction surveys
The data collected from the participants were qualitatively analysed. It was noted with concern that none of the participants had formal training or had attended courses related to patient-friendly health services. It was also noted during the interviews that the participants were showing positive attitudes and a willingness to incorporate patient-friendly health service aspects in their professional performance. However, the participants' responses revealed significant factors that hampered the rendering of such services. A study conducted by Mastal (2010:267) referred to ambulatory nursing care as a unique domain in which ambulatory care nurses practice in settings “quite distinctive from other nurses”.

According to the findings of the study, all the participants demonstrated awareness of patient-friendly health services. The participants at the same time disclosed that a patient-friendly health service was not always achievable due to certain hindrances. They indicated to the researcher that they would be supportive in addressing the identified hindrances, but that the nursing administration services' support would be needed. A study by Futch and Phillips (2003:140,141) describes urgent issues in ambulatory care nursing that need to be addressed, including approaches such as creating an environment in which nurses will do the “right thing, the right way, the first time”. This would strengthen awareness of patient-friendly health services, and it is reasonable to assume that ACCs will gain popularity and value with regard to good patient care (Futch & Phillips 2003:141).

4.2.1 Cultural differences

The multinational culture of the KAMC-R with a workforce of approximately 42 different countries creates a unique health care environment (Luna 1998:10). The study findings highlighted the cultural diversity between the patients and the participants. Understanding cultural differences and developing skills to resolve conflict situations are current needs and will continue to be in rendering nursing care due to changing environments and culturally diverse patient populations (Andrews & Boyle 2003:309). The researcher became aware that the Islamic religion was so intertwined in the Saudi patient population that it was challenging at times to decipher whether the practice was part of the culture or a result of the religion. The participants agreed that in order to render patient-friendly health services, they had to adapt to the local customs, traditions
and culture of the patients. The researcher noted the participants’ willingness and openness to learn more about the culture of the Saudi patient population in order to understand and respect each other. The findings of the study ultimately demonstrated that the participants, who were working as registered nurses in the ACC, were not properly prepared to render nursing care according to the culture of the Saudi patient population.

This section dealt with the perceptions of registered nurses with regard to the need for culture-sensitive care as part of patient-friendly health services. Although none of the participants had any training or education in culture-sensitive nursing care of the patients in the Saudi culture patient population, the findings of the study revealed that the participants used their experience in the ambulatory care setting to deliver culture-sensitive care to the best of their abilities. It was encouraging for the researcher to note that the participants requested training programmes to equip them with skills in order to be effective and efficient in rendering culture-sensitive care. Literature supports the need for culture-sensitive care. Andrews and Boyle (2003:392) describe the importance of the health care organisation in meeting the culture-sensitive needs of the patients. Therefore, although the participants used their past experiences to render culture-sensitive nursing care, the importance of meeting the needs of the patients was reflected in the above-mentioned study findings.

4.2.1.1 Influence of language on patient-friendly health services

Ali and Mahmoud (1993:51) describe the language barrier as a well-known difficulty. According to Yeo (2004:60), language differences between patients and health care workers increasingly impose barriers to health care. This is highlighted by the study finding where the language barrier was pointed out as a hindrance to meaningful communication with patients, resulting in negative effects on patient-friendly health services. Although the participants who did not speak Arabic all learned words and phrases in the Arabic language to assist them in their communication with the patients, they felt that their efforts were not sufficient to meaningfully communicate with their patients.

Such experiences brought about feelings of frustration and helplessness, especially when interpreters were not available to assist staff members. The finding is supported
by a study conducted by Andrews and Boyle (2003:30) that revealed that the difference in language between patients and nurses is one of the greatest challenges in cross-cultural communication. Nurses may find themselves in one of two situations: either struggling to communicate effectively through an interpreter or trying to communicate effectively in the absence of an interpreter (Andrews & Boyle 2003:30). The consequences of poor communication due to a language barrier, as experienced by the participants in this study, is supported by Gerrish, Chau, Sabowale & Birks (2004:407) who maintain that language barriers have long been identified as a major challenge in ambulatory care services where nurses acted as gatekeepers to interpreting services. These findings suggest that the nursing staff needed support by having enough interpreters available in the clinical areas in ACC during operational hours in order for them to meaningfully communicate with their patients.

4.2.2 Need for meaningful communication

Arnold (in Arnold & Boggs 2011:176) defines listening as a “dynamic process in which the nurse hears the patient’s message, attaches meaning to the message, asks the patient questions for the purpose of clarification and provides feedback to the patient”. The findings of this study showed that the participants were aware of the importance of listening to a patient when the patient talks in order to achieve meaningful communication. Nurses are often the closest members of the multidisciplinary team to listen to the patients. Literature emphasises that active listening to the patient fulfils the key purpose of patient-care delivery (Sullivan & Garland 2010:103). The concept of listening, considered the most ancient health care skill, is identified as a critical component in all aspects of nursing care for effective and meaningful communication with patients (Shipley 2010:125). This affirmed the fact that the participants played an active role in meaningful communication with patients when they listened to the patients, even though they were not able to fully understand the conversation due to language difficulties.

Arnold (in Arnold & Boggs 2011:175) describes communication as an “important cornerstone in nurse-patient interactions and relationships”. Arnold (in Arnold & Boggs 2011:341) states that nursing goals are to enable the patients to communicate effectively with the multidisciplinary team members; therefore, the identification of communication challenges is one aspect of the nurse’s role that has to be assessed.
The patient and the nurse start their relationship with their own style of communication for the purpose of better health outcomes, better patient satisfaction and patient understanding (Boggs in Arnold & Boggs 2011:163).

The findings of the current study highlighted the issues regarding aspects of communication. It should be noted that the participants strongly agreed about the importance of communication, as supported by literature. Nine of the 15 participants did not speak the Arabic language, while very few patients could speak or understand English.

The two official languages of the organisation are Arabic and English. Difficulty in speaking the local language was noted as a significant finding. The finding revealed language difficulty as a factor that hampered communication, thus affecting the patient-friendly environment, as most of the nurses were from foreign countries.

A study by Webster, King, Toomey, Salisbury, Powell, Craft, Baker and Salas (2008:1) describes the ambulatory care setting as an area prone to problems and points out ineffective communication and flow of information as one of the top four identified problems. Yeo (2004:60) explains communication between nurses and patients as the heart of nursing. Consistent communication between health care professionals involved in patient care is supported by a study finding of Webster et al (2008:5) which indicates that the whole team in an ambulatory care clinic has to focus on meaningful communication. Andrews and Boyle (2003:21) state communication is inherent in any nurse-patient interaction since communication is a skill needed for all nursing interactions with patients.

The findings reflect that the participants would like to have more effective and efficient communication with their patients as this will not only improve nursing care delivery and language, but will certainly lead to patient-friendly health services. The findings related to body language and provision of information, as discussed in the paragraphs that follow, were indicated by the participants as having an influence on communication and, consequently, on the patient-friendliness of the service.
4.2.2.1 Body language of the nursing staff

Arnold (in Arnold & Boggs 2011:167) defines body language as the conscious or unconscious body actions or positions of a communicator and includes posture, facial expression, eye contact, gestures and touches. In this study, the finding revealed that the participants were aware of body language as a meaningful means of communication with patients. The use of touch was not welcomed by the patient population, especially by the male patients. Willingness to comply with the preferences of the patients by refraining from touching them as a means to show respect to the cultural differences, was important. This caused nursing staff members to pay special attention to and to be consciously aware of their actions at all times in order to accomplish success in this matter, as some nurses were used to touching their patients while communicating with them. The finding is supported by Andrews and Boyle (2003:27) who explain that a nurse must make an effort to understand the non-verbal communication of the patient in the use of facial expressions, space and distance, touch, eye contact and silence.

4.2.3 Ambulatory care workflow

The participants in this study identified challenges in ambulatory care workflow which could compromise patient-friendly health services as noted in the following findings.

4.2.3.1 Reception of the patient

This section dealt with the perceptions of the participants with regard to how ready the nurses were to serve their patients in the ambulatory care settings and related to the environment, equipment and supplies, patient education, and staff preparedness. The participants voiced different perceptions of how they perceived the environment, systems and themselves in being ready to render patient-friendly health services. It was evident in the study finding that the participants did not receive any formal training and/or education or attended any courses on how to deal with patients in a friendly manner in any aspect of nursing care. The memorandum distribution by hospital management stated clearly that the health care managers had a unique opportunity to change the fabric of the health care services by strengthening the skills and knowledge of the health care workers (Al Knawy 2009). The finding was supported by a study done by Mansour and Al-Osimy (1993:170) that revealed the need for regular education.
programmes for nurses to prepare them for their responsibilities in ACCs, especially with regard to crucial aspects such as creating a patient-friendly environment.

First impressions count and last long. How patients were received at the reception desk in the ambulatory care settings was deemed to make lasting impressions. The researcher noted the participants’ willingness to welcome the patients and to show interest in them; however, some perceptions revealed that not all nurses received the patients at the reception desk in a respectful and welcoming manner. The findings revealed that although the participants expressed the importance of the way in which a patient should be received at the front desk and entrance of the clinical area, staff had to make conscious efforts to ensure a warm and friendly welcome, attending to words that would achieve patient-friendly health services (Welcome patients: helpful attitude, signs and more 2012:3). Reception staff was often overloaded with work, answering telephones, finding prescriptions, and answering queries. In these circumstances, prioritising patient-friendly health services thus seemed not be regarded as a main concern.

4.2.3.2 Factors affecting the patients’ waiting times in ACC

The findings of this study reflected the participants’ concerns that patient-friendly health services in the ACC were compromised due to factors that influenced the patients’ waiting times. The attitude of the nurse when he or she needed to repeat the same explanations to the patients, for example, why the doctor was late and the patient had to wait, was another study finding that could either cause conflict between the patient and the nurse or put the patient at ease, depending on how the nurse handled the situation. In Saudi culture, repetition is a positive feature, but for the nurses to repeat the same information over and over could have negative implications, which the patients could notice in the nurses’ attitudes. It was, however, important for nurses to preserve a professional attitude at all times when dealing with the patients in order to develop and maintain adequate relationships with them.

It was also found that there was not enough time for physicians to address the concerns of the patients and, more importantly, this occurred after the patient had already been waiting for a significant period to see the physician. These responses correlated with a study conducted by Mansour and Al-Osimy (1993:168), namely that primary health care
services in Saudi Arabia are not up to the patients’ expectations. Empathy on the part of the participants was evident as they continued to discuss contributing factors affecting the waiting times of patients and how these factors compromised patient-friendly health services. This finding, which seems to remain challenging although it has been addressed in studies and articles over many years, was similar to that of Albada and Triemstra (2009:92) who consequently recommended that “the time in the waiting room should be less than 15 minutes”. A study conducted by Anderson, Camacho and Balkrishnan (2007:1) found that longer waiting times were associated with lower patient satisfaction. The combination of long waiting times to see the doctor and having a short visit with the doctor is associated with very low overall patient satisfaction.

This current study highlighted the need for nurses, as well as the rest of the multidisciplinary team members, to make a collaborative effort to address factors that affected the waiting times of patients since it had a negative impact on patient-friendly health services. One of the major findings revealed that the situation was beyond what the nurses could do. Discussions could be held with physicians and managers about this matter, as one of the contributing factors was that patients waited too long to be attended to.

4.2.4 Needs of patients

The participants shared their related perceptions on attending to identified needs of patients in the following discussions.

4.2.4.1 Understanding and meeting the patients’ needs

It was noted from the perceptions of the participants that the attitude of the nurses when dealing with patients had a significant impact on patient-friendly health services. When the nurse dealt with an aggressive patient in a friendly, calm manner, the participants indicated this occurred frequently in the ACC, the patient would calm down and conflict could be resolved or lessened. In the study findings, the participants recognised the importance of providing the patients with adequate information as well as the negative effects that providing inadequate information could have on patient-friendly health services.
Part of the professional responsibilities of a nurse is to provide patients with information about their diseases, prognosis and treatment. The participants confirmed that the patients in the ACC were not given information as indicated by the Joint Commission International organisation as part of the rights and responsibilities of the patients. In their study, Mansour and Al-Osimy (1993:173) found there was a indeed a significant need to develop programmes to orient employees to the various aspects of ambulatory care services; however, this could only be achieved with the full participation of patients.

The findings of a study conducted by Ali and Mahmoud (1993:49) in Riyadh indicated that patients were dissatisfied and complained that they were not provided with sufficient information about their health problems and treatment. Considering this finding it may be seen as a turning point in the often difficult relationship between nurses and patients of different cultures. But, once the nurse understands that patients experience frustrations and stress because they are not fully aware of what their condition and treatment plan are, if they receive scant information and are left to ‘guess’ what is wrong with them, it can evoke feelings of anger, resentment and anxiety in them. For this reason, the nurse who understands the patients’ reactions will be driven to actively advocate for the patients’ right to be fully informed of his or her condition, treatment plan and prognosis. Empowering the patients with knowledge about their illnesses and treatment regimen in a simple and understandable way will help them to understand that the nurse is on their side and is doing everything in her or his power to help them on their road to recovery.

The participants, who had all worked in the ACC for a significant period, strongly supported the importance of understanding the patients’ needs. The finding is confirmed by a study conducted by Green (2004:283) which states that nursing responsibilities in health care continue to expand, including the way in which they are expected to meet the patients’ needs. This confirms the importance of the fact that nurses need to continue reflecting on their operative roles to keep their patients’ needs satisfied. The finding of the study was furthermore confirmed by Darby and Daniel (1999:272) whose stance is that nurses, being the front-line health service providers, undoubtedly have to understand the needs of their patients. They therefore have to be flexible in adjusting health care and considering the conditions, circumstances and health needs of their patients.
Although challenges in communication with patients were experienced due to the fact that some nurses were not Arabic-speaking and from different cultural backgrounds, the nurses in this study showed determination to understand the needs of their patients in order to meet them satisfactorily. It was clearly identified that nurses in the ACC were trying to attend to the identified needs of their patients. This finding reinforced the nature of the nurse’s calling, namely to take care of human beings in need. The finding to attend to patients’ needs was strongly perceived as important to patients as it provided the latter with feelings of safety and security. The nurses used their abilities, skills and empathy to identify patients’ health needs and to take appropriate action. In attending to and fulfilling the patients’ needs, the nurses in return experienced job satisfaction. A study conducted by Wagner and Bear (2009:695) reveals that a determining factor in attending to the needs of patients is the degree to which nurses fit their care to meet the unique needs of patients. They may feel rewarded by noticeable patient satisfaction.

4.2.4.2 Need for patient satisfaction surveys

The participants strongly recommended that patient-satisfaction surveys be conducted as part of nursing care evaluation in the ACC. These could also be used to address patients’ concerns and to improve the quality of patient-friendly health services. In fact, the participants suggested that regular patient-satisfaction surveys be conducted to continually improve delivering patient-friendly health services. The findings concur with findings by Wagner and Bear (2009:699) who conclude that nurses firstly have to continue to find ways in which to improve patient satisfaction and, secondly, have to demonstrate the impact they have on patient satisfaction.

4.3 CONCLUSIONS

This study sought to answer the question, “What are the perceptions of registered nurses about patient-friendly health services rendered within an ambulatory care setting in Riyadh?” The question was answered and the study objective was met.

The findings revealed that despite ongoing challenges that compromised patient-friendly health services, the nurses were aware of and expressed their commitment to patient-friendly health services. Language difficulties and cultural differences between nurses and patients and among nurses themselves dominated the findings. Although the
registered nurses had some positive perceptions of patient-friendly health services in the ACC in the KAMC-R, gaps, such as long patient waiting times, non-availability of interpreters and gender issues, were identified and appropriate recommendations made. Implications for nursing practice, management, education and research were indicated.

4.4 RECOMMENDATIONS OF THE STUDY

The findings of this study would be disseminated to the nursing administration and the nursing education department. It is recommended that future nursing research is undertaken on topics derived from the findings of this study. The findings provided valuable information about the perceptions of nurses regarding patient-friendly health services rendered within an ambulatory care setting in Riyadh. Based on the findings, the following recommendations were made:

- Enhance and nurture a culture of patient-friendly health services not only among nurses, but among all health care providers.
- Appoint sufficient interpreters in all clinical areas as it will contribute to improving safe and quality patient care.
- Patient participation and involvement are essential to address issues identified by means of the patient satisfaction surveys will lead to better patient satisfaction rates.
- Afford expatriate nurses working in the ACC with opportunities to learn the Arabic language as this will enable them to improve communication with the patient population.
- The expatriate nurse should, in future, come prepared to the KAMC-R to deliver cultural-sensitive nursing care to the ACC patient population; thus cultural self-assessment tools and culture-related orientation guidelines must be made available by the various recruitment agencies.
- The nurse managers must supervise educational workshops with regard to patient-friendly health services and the patients’ rights and responsibilities.
- Researchers should be motivated to continue with additional research in order to obtain a broader perspective on patient-friendly health services in other ambulatory care centers and clinics in Saudi Arabia.
4.5 IMPLICATIONS OF THE FINDINGS

The implications of the findings of this study for nursing practice, nursing management, nursing education and nursing research on the improvement of patient-friendly health services and the attainment of the ‘Patients come first’ goal in the ambulatory care clinics in the KAMC-R are presented next.

4.5.1 Nursing practice

Orientation guidelines about patient-friendly health services should be integrated into the general nursing orientation programmes for nurses allocated to inpatient and outpatient clinical areas. A self-assessment tool, focussing on patient-friendliness, should be developed for nurses to complete during the general nursing orientation period for the purpose of creating patient-friendly health services awareness. The nurse managers can use this tool when completing the probation evaluation of the newly hired nurse and to identify gaps for training and education of permanent staff on the concept of patient-friendly health services.

4.5.2 Nursing management

Nurse Managers need to monitor and ensure the availability of interpreters in the clinical areas at all times to assist the nurses in their communication with their patients. Administrative and management policies and procedures should be modified to evidence a focus on patient-friendly health services.

Physicians’ attendance to their clinic sessions should be monitored and feedback given to the medical services’ management. Medical services management should take appropriate action to address issues such as long patient waiting times and physicians being late for sessions or refusing to see patients.

Furthermore, strategies should be outlined to ensure that the patients receive complete and correct information about their health status, treatment plans and options, health education, referrals and follow-up visits. It should also include addressing the patients’ questions in a proper and satisfactory manner. Annual patient-satisfaction surveys
should be conducted in the ACC to address the concerns of the patients and feedback should be given to the patients as well as the staff.

Arabic language courses presented to the nurses in the ACC on a Wednesday afternoon, when there are minimal patient bookings in the ACC, would be ideal.

Orientation guidelines for the recruitment agencies on the culture-sensitive needs of the Saudi patient population must be provided to nurses who choose to work in the ACC in the KAMC-R.

4.5.3 Nursing education

The education and training of nurses in patient-friendly health service should include a well-developed mandatory competency framework for nurses assigned to ACC in the KAMC-R. This should include a self-study module related to the competency with accredited continuous education hours that each nurse has to pass during the probation period.

In addition to the role of the ACC clinical resource nurses, each newly hired nurse should be evaluated with regard to his or her knowledge about patient-friendly health services, including the rights and responsibilities of the patients as outlined in chapter 2.

Courses and workshops on culture-sensitive care, with the focus on the Saudi patient population, should be conducted regularly and it should be mandatory for nurses to attend.

Nurses should be able to conduct cultural self-assessments to create and enhance their awareness of comprehensive patient care.

Rigorous reviews of the current in-service education programmes for nurses on transcultural nursing care should be employed to enable them to collaborate effectively and efficiently in a multinational nursing workforce.
4.5.4 Nursing research

A comparative study could be initiated on perceptions of nurses regarding patient-friendly health services in other ACCs throughout Saudi Arabia to obtain a broader perspective of the phenomenon.

Additional research on a much larger sample and different modes of enquiry is needed to fully comprehend the perceptions of nurses regarding patient-friendly health services in ambulatory care settings. Further research should consider the cultural diversity of the nursing workforce of all health care workers.

4.6 SCOPE AND LIMITATIONS OF THE STUDY

The study was conducted in the ambulatory care setting in KAMC-R, Kingdom of Saudi Arabia. Therefore, the findings cannot be generalised to other ambulatory care centres and clinics in Saudi Arabia. Some of the non-verbal cues were omitted, which could have had a notable impact on the interpretation of the perceptions of the participants.

4.7 SUMMARY

This chapter provided a discussion on the conclusions, recommendations, scope and limitations of the study. Recommendations are presented based on the study findings. The implications of the findings were discussed for nursing practice, nursing management, nursing education and nursing research in order to promote patient-friendly health services in an ambulatory care setting in KAMC-R, Saudi Arabia.
LIST OF REFERENCES


WHO see World Health Organization.


Yin, RK. 2011. *Qualitative research from start to finish*. New York: Guilford Press.

Annexure A

Ethical certificate from the Department of Health Studies, Research and Ethics Committee
UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
(HSHDC)
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

Date of meeting: 10 February 2011  Project No: 568-535-4

Project Title: The perception of registered nurses about patient friendly services within an ambulatory care setting in the Kingdom of Saudi Arabia

Researcher: Beatrix Jannette Isabella Magdalena Rademeyer

Degree: Master of Public Health  Code: MPCHS94

Supervisor: Dr LV Monareng
Qualification: D Litt et Phil
Joint Supervisor: -

DECISION OF COMMITTEE

Approved  √  Conditionally Approved  -

Prof E Potgieter
RESEARCH COORDINATOR

Prof MC Bezuidenhout
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES
Annexure B

Permission requested to conduct the study
Date: (G) 9 March 2011  
(H) 04-04-1432

To: Dr. Majed Al Jeraisy  
Head Clinical Research  
King Abdulaziz International Medical Research Center

Thru: Ms. Joan Murray  
Associate Executive Director, Nursing Services

Mr. Mustafa Bodrick  
Director Clinical Nursing, Medical & Protocol Nursing Care  
(Outgoing Interim Director Nursing Education)

From: Beatrix J.I.M. Rademeyer, BN # 42498  
ANM, MPD & Royal Clinics

Subject: Request for approval to conduct MA Health Studies research project at KAMC-R

I am a student at University of South Africa (UNISA) pursuing MA in Health studies.

Attached is the research proposal, letter from UNISA and documentation as per research committee for your review. The proposal has been submitted and approved by Dr. Lydia V. Monareng, my supervisor.

The title of the study is: "The perception of registered nurses about patient friendly health services within an ambulatory care setting in the Kingdom of Saudi Arabia".

I am looking forward to your positive response.

Thank you very much.

Cc: chrono file
Annexure C

Permission obtained from the research center
MEMORANDUM

Ref. #: RO/340/2011

Date: (G) 07 SEPTEMBER 2011
       (H) 09 Shawwal 1432

To: MS BEATRIX J.I.M. RADEMEYER
   Principal Investigator RC11/025
   Asst. Nurse Manager
   MPD Clinic
   King Abdulaziz Medical City
   National Guard Health Affairs

From: DR. MAJED AL JERAISY
      Chairman, Research Committee
      King Abdullah International Medical Research Center
      National Guard Health Affairs

Subject: RC11/025 "The Perception of Registered Nurses about Patient Friendly Services Rendered within an Ambulatory Care Setting in King Abdulaziz Medical City, Riyadh"

Thank you for submitting the above-mentioned subject, after careful review by the Research Committee Chairman, we have decided to award scientific approval for your Master Thesis project.

Your proposal will be forwarded to the Institutional Review Board (IRB) for review on the ethical point of view and final approval. You should not start your project until this approval from IRB has been granted.

Please do not hesitate to call our office at Ext. 16592/16591, if you have any questions.

Thank you.

MJ/MA
Annexure D

Permission obtained from the Institutional Review Board
MEMORANDUM
Ref. #: IRBC/212/11

Date: (G) 28 NOVEMBER 2011
       (H) 03 Muharram 1433

To:  MS. BEATRIX J.I.M. RADEMEYER
     Principal Investigator
     Assistant Nurse Manager, MPD & Royal Clinics (1407)
     National Guard Health Affairs – Riyadh

Subject: PROTOCOL RC11/025 “The Perceptions of Registered Nurses about Patient Friendly Services Rendered within an Ambulatory Care Setting in King Abdulaziz Medical City, Riyadh”

This is in reference to your subject proposal, which has been reviewed by the IRB Office on the 26th of November 2011 through the expedited review process. Upon recommendation of the Research Committee, and following the review of the IRB on the ethical aspects of the proposal, you are granted permission to conduct your study.

Your research proposal is approved for one year commencing from the above date with the following conditions:

TERMS OF APPROVAL:

1. Annual Reports: Continued approval of this project is dependent on the submission of an Annual Report. Please provide KAIMRC with an Annual Report determined by the date of your letter of approval.

2. Amendments to the approved project: Changes to any aspect of the project require the submission of a Request for Amendment to KAIMRC and must not begin without an approval from KAIMRC. Substantial variations may require a new application.

3. Future correspondence: Please quote the project number and project title above in any further correspondence.

4. Monitoring: Projects may be subject to an audit or any other form of monitoring by KAIMRC at any time.

5. Retention and storage of data: The PI is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

Prof. Amin Kasheer
Chairman, Institutional Review Board (IRB)
National Guard Health Affairs

Dr. Mohammed Al Jumah
Executive Director, KAIMRC
National Guard Health Affairs

Dr. Bandar Al Knawy
Chief Executive Officer
National Guard Health Affairs

AK/55/jue

P. O. Box 22490, Riyadh 11426
Tel. 2520888
Telex: 403450 NGRMEN SJ
KFH-MATERIALS 1457 (05/96) (ORACLE 297955)
Annexure E

Participant informed consent

Participant information letter
Informed Consent

Study Title: The perception of registered nurses about patient friendly health services rendered within an ambulatory care setting in KAMC-R

Investigator: 5685354

Contact Details: Tel: 10212; pager 9042; mobile: 0507296542
E-mail: beatrixrademeyer@hotmail.com

MPD Clinic; mail code 1407

I have read the information sheet regarding this study; I understand what will be required of me and what will happen to me if I take part in the study. My participation will be anonymous and will include written and recorded individual interviews, focus group sessions and questionnaires.

My questions concerning the study have been answered by Ms. Beatrix J.I.M. Rademeyer.

I understand that no identifying information will be included with transcription of the interviews.

I realize that my participation is entirely voluntary; I may withdraw from the study at any time I wish without giving a reason. Should I decide to discontinue my participation in this study, I will continue to be treated in the usual and customary fashion.

I furthermore understand that all study data will be kept within the research context.

I realize that the results of this study may be used for designing educational programs, developing policies, training newly hired employees, nursing publications and presentations.

There are no risks identified to this study.

I agree to take part in the study and I understand that I will receive a copy of this signed form.

______________________________________________  _________________________
Signature of the Participant                     Date:

______________________________________________  _________________________
Signature of the Witness                         Date:

______________________________________________  _________________________
Signature of the Investigator                    Date:
INFORMATION LETTER

Dear Participant

You have been selected to participate in the research study: “The perceptions of registered nurses about patient friendly services rendered within an ambulatory care setting”.

What is the purpose of this study?

The aim and purpose of the study is to generate knowledge of existing cognitive constructs of experienced health care workers and find out commonalities of themes among them. Defining common themes is important for us as health care providers as well as for the organization for educational and training purposes.

What is required from the participant?

You will be interviewed individually and participate in a two hour group discussion. The interviews and group discussions will be recorded and the researcher will keep notes. The interview will be anonymous in the sense that the participant will not be identified on the written or recorded interviews.

The group will consist of 6 – 8 participants. Group discussions will be guided by the researcher who will consider the preferences of the participants for a particular group in which you will be most comfortable to discuss your viewpoints and experiences.

After the group interview the researcher may contact you for a follow up one to one interview in order to clarify the information and or to verify interpretation for the purpose of accuracy.

It is unlikely that there will be any inconvenience or discomfort due to your participation in the study. There will be the option for debriefing at the end of the focus group interview.

The participant will not incur any financial expenses related to this study.

Why have you been chosen as participant?

You have been selected for this study because of your clinical experience provider-patient in the ambulatory care setting. Selection criteria that have resulted in your selection are:

- You are a registered nurse employed at King Abdulaziz Medical City in Riyadh (KAMC-R)
- You are assigned in Ambulatory Care Clinics
- Your experience of working in the setting is more than twelve months.

Do you have to take part in this study?

Your participation in this study is entirely voluntary. It is confirmed by written informed consent. Should you prefer to withdraw from the study at any time you may do so without stating reasons. There will be no consequences what so ever if you decide to end your participation.
How are confidentiality and anonymity ensured in this study?

It is the responsibility of the researcher to ensure confidentiality of the information and protection of anonymity of participants.

The following conditions have been adopted to ensure anonymity:
- There will be no individual information on the written material, the recorded interviews or group discussions.
- Fictitious names for clinical care settings will be used.
- Quotations of each participant will be reported under different pseudonyms in order to avoid recognition of participants.

Confidentiality of data will be ensured by only obtaining identifying information of participants when needed. Data will be kept in a locked file. As soon as the research process allows, data will be destroyed.

Participants will be assigned with an identification number that is only known by the researcher. Only the researcher will have access to the locked transcriptions, recordings and notes.

The researcher and participants will sign confidentiality statements. Participants, who object to sign confidentiality statement, will be excluded from this study.

What will be done with the results of this study?

The research study serves as a partial fulfillment of a MA Public Health Degree of the University of South Africa. The results will be reported to the University of South Africa. The results may be published in a journal. The results may also be shared with other professional health care providers in the hospital. The results may be used to design educational and training programs and management policies.

What study supervision and approval arrangements have been done?

A research supervisor of the University of South Africa has been assigned to the researcher to supervise all aspects of the study.

The Medical and Health Sciences Research Center of the hospital has approved the research study and has permitted in writing (research protocol number RC 11/025) the research to be carried out in the ambulatory care setting.

How can the researcher be contacted for more information?

If you have any queries and need more information about the participation in this study, please do not hesitate to contact the researcher and or research supervisor.

Beatrix J.I.M. Rademeyer
Nurse researcher
University of South Africa
Telephone ext: 10212; pager: 9042
E-mail: rademeyerb@ngha.med.za
Mail code: 1407

Dr. Lydia Monareng
Research Supervisor
University of South Africa
E-mail: monarlv@unisa.ac.za
Annexure F

Questionnaire with interview guide
QUESTIONNAIRE ON THE PERCEPTIONS OF REGISTERED NURSES ABOUT PATIENT FRIENDLY HEALTH SERVICES RENDERED WITHIN AN AMBULATORY CARE (ACC) SETTING IN KAMC-R.

SECTION A: PERSONAL DATA

<table>
<thead>
<tr>
<th>DATE:</th>
<th>DAY</th>
<th>MONTH</th>
<th>YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Participant’s gender</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>1. Male</td>
<td>2. Female</td>
<td></td>
</tr>
<tr>
<td>2.</td>
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</tr>
<tr>
<td></td>
<td>Age</td>
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</tr>
<tr>
<td></td>
<td>1 Less than 24</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>2 24-33</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 34-43</td>
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<td></td>
</tr>
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<td></td>
<td>4 44-53</td>
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<tr>
<td></td>
<td>5 54-63</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>6 64 years or older</td>
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</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What is your professional title?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 Nurse Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 Clinical Resource Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 Staff Nurse I</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 Staff Nurse II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Please specify your nationality</td>
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</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>What is the highest level of education you have completed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 Bachelor Degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 Honors Degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 Masters Degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 Doctoral Degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Years of Ambulatory Nursing Care experience.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 2 – 10 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 11 – 20 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 21 – 30 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 31 years or more</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In which ambulatory care clinic (ACC) are you assigned?

1. Internal Medicine
2. OB / GYNE
3. Pediatrics
4. Cardiology
5. Surgical
6. ENT
7. Psychiatry
8. Orthopedic
9. Ophthalmology
10. Health Promotion
11. Others, specify

Date of Hire

<table>
<thead>
<tr>
<th>DAY</th>
<th>MONTH</th>
<th>YEAR</th>
</tr>
</thead>
</table>

SECTION B: RESEARCH QUESTIONS

1. Tell me what is your understanding of Patient friendly health service?
2. Please name the components/parts of Patient friendly health service?
3. In your opinion, which components/part(s) of Patient friendly health service you consider the most important?
4. What do you consider as the most challenging component in Patient friendly health service?

PROBING QUESTION

1. How do you balance professionalism with friendliness?
2. In this culture, how do you think gender will influence friendliness?
Annexure G

Editor's letter
Suzette M. Swart

FULL MEMBER: Professional Editors’ Group

29 APRIL 2013

TO WHOM IT MAY CONCERN

I, Suzette Marié Swart (ID 5211190101087), confirm that I have edited the following dissertation. However, the accuracy of the final work is still the student’s own responsibility.

Student:

Beatrix Jannette Isabella Magdalena Rademeyer (student number: 568 5354).

Title:

The perceptions of registered nurses about patient-friendly health services rendered within an ambulatory care setting in King Abdulaziz Medical City, Riyadh.

The edit included the following:

- Spelling
- UK vs USA English
- Vocabulary
- Punctuation
- Grammar (tenses; pronoun matches; word choice etc.)
- Language tips
- Correct acronyms (please supply list)
- Consistency in terminology, italisation etc.
- Sentence construction
- Suggestions for text with unclear meaning
- Basic layout, font, numbering etc.
- Logic, relevance, clarity, consistency

The edit excluded:

- Correctness of crediting another’s work – PLAGIARISM.
- Content
- Correctness or truth of information (unless obvious)
• Correctness/spelling of specific technical terms and words (unless obvious)
• Correctness/spelling of unfamiliar names and proper nouns (unless obvious)
• Correctness of specific formulae or symbols, or illustrations
• Style
• Professional formatting
• Re-checking reference list against in-text sources.

Thank you

Suzette M Swart
0825533302
smswart@vodamail.co.za

LANGUAGE PRACTITIONER/EDITOR/FACILITATOR:
The Consortium for Language and Dimensional Dynamics (CLDD)
University of Pretoria (UP)
Tshwane University of Technology (TUT)
University of Johannesburg (UJ)
University of South Africa (UNISA)
Milpark Business School
South African National Defense Force (SANDF)
South African Civil Aviation Authority (SACAA)
Annexure H

Verbatim transcript
<table>
<thead>
<tr>
<th>Speaker</th>
<th>Dialogue</th>
<th>Non-verbal cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Researcher</td>
<td>Thank you for your willingness to participate in the study. Our discussions are confidential and will stay between us. There are no correct or incorrect answers, we are going to discuss your perceptions about patient-friendly health services. Please feel free to stop the conversation at any time if you need to ask questions for clarification. Good?</td>
<td>Seems to be a bit nervous but at the same time seems to be eager to participate.</td>
</tr>
<tr>
<td>Participant</td>
<td>Okay.</td>
<td>Smile and nod.</td>
</tr>
<tr>
<td>Researcher</td>
<td>So Ms. A, I want to ask you, if you hear the concept of patient-friendly health service, what do you understand about it?</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>I think it is, it is actually a very broad spectrum you know...patient-friendly health service...um...patient-friendly service...is...um...what the patient expects from you, if you are able to provide a stat service and perform that expectation. It is like being there for the patients spot on ... being there.</td>
<td>20 second silence.</td>
</tr>
<tr>
<td>Researcher</td>
<td>To perform the expectation...do you think this is only applicable for a nurse or do you see this also applicable to the multi-disciplinary team?</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>This is for the team not only for the nurse.</td>
<td>Smile and seems to be more relaxed.</td>
</tr>
<tr>
<td>Researcher</td>
<td>Thank you. Can you please name the components or parts of patient-friendly health service?</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>So you want...actually want to know...how do I experience it? What components? What patient-friendly health service is consisting of?</td>
<td></td>
</tr>
<tr>
<td>Researcher</td>
<td>Yes...yes, the different components of patient-friendly health service please.</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>It comes in a...um...consist of the environment, consist of the attitude, it consists of willingness, and also the</td>
<td>Nod, cross legs.</td>
</tr>
<tr>
<td><strong>Participant</strong></td>
<td>tools and resources available. The nurse should be flexible depending on the situation of the patient and could take responsibility to go beyond what was expected such as to act like a runner for them.</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Researcher</strong></td>
<td>Good. So environment, attitude and willingness, tools and resources available for patient care are components of patient-friendly health service?</td>
<td></td>
</tr>
<tr>
<td><strong>Participant</strong></td>
<td>Yes...these are components, part of patient-friendly health service. Also to add, a patient-friendly service would not expect patients to wait, specifically patients who expect bad news about their illness.</td>
<td></td>
</tr>
<tr>
<td><strong>Researcher</strong></td>
<td>Anything else in this regard that you would like to add? Any other ideas that you could share?</td>
<td></td>
</tr>
<tr>
<td><strong>Participant</strong></td>
<td>Sometimes the patients come here ... hmm ... you know ... specifically we don't have diabetic clinic here ... we have new patients coming here, ask for glucometer strips ... which is not eligible ... then guide them, give them guidance, they can have the things...</td>
<td></td>
</tr>
<tr>
<td><strong>Researcher</strong></td>
<td>So even if the patients come to your clinic and ask for materials and equipment which you do not have here, you will assist them in getting it from the areas where the equipment is available. Ms. A, in your opinion, which components of patient-friendly health service do you consider as the most important?</td>
<td></td>
</tr>
<tr>
<td><strong>Participant</strong></td>
<td>Hmm...attitude...attitude of...yeah...from the patient's point of view...because the attitude could actually make or break anything...it's stressing, cause if it is the staff member having a negative attitude, then immediately the patient is going to feel unwelcome. If a staff member is friendly and smiling and seems to be willing to assist me (meaning the patient) and help me (referring to the patient) then I am relaxed as a patient and I will feel safe and secure, that I am in good...</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>hands...and in the clinic we are the first line of contact. Even if you cannot help the patient but you have a nice attitude. We have to be careful with words and communication ... stay professional in approach. If you got good communication skills with the patient and you um ... you can smile ... and they will respond positively to you. Show your interest in patients ... ask why here ... showing concern for a patient at the first entry into the system.</td>
<td>Relaxed, noticeable confidence with discussion.</td>
</tr>
<tr>
<td>Researcher</td>
<td>The patients will indeed respond positively to you when you treat them in a friendly manner. From these components, what do you consider as the most challenging in patient-friendly health service?</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>Patience...patience and understanding. To stay calm regarding in, regardless of any situation that you are in...regardless the situation. He (patient) will approach you and then they even do this...finger clapping...</td>
<td>Frowning. Demonstrating the finger clapping. Seems to be annoyed.</td>
</tr>
<tr>
<td>Researcher</td>
<td>Ms. A, can I ask you, how do you balance professionalism with friendliness?</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>I think that professionalism includes a smile. I think professionalism means understanding the customs that we are working in and the environment...and ah you can still provide a good service with a really good attitude and with a smile...without over stepping the boundaries I presume, that is why we have to understand the culture.</td>
<td>That is really very important.</td>
</tr>
<tr>
<td>Researcher</td>
<td>That is really very important.</td>
<td>Seems to be eager to continue the discussion.</td>
</tr>
<tr>
<td>Participant</td>
<td>I can actually tell you about experience, the things I experienced...if you show...if your body language shows that you have got empathy and understanding, if you have good communication skills with the patient. Even if you look apologetic enough. If</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>your body language shows that you have got empathy and understanding, if you can smile then they (patients) will even smile back to you ... and they will respond positively to you. It all depends on your body language ... you've got to have some proper professional body language. Gestures and body language of the nurse is very important ... show the patient you are interested in him ... always service with a smile ... try to show positive attitude. Properly dressed (nurse), the way I conduct myself ... and the manner of speaking ... eye contact with the patient.</td>
<td>Smile.</td>
</tr>
<tr>
<td>Researcher</td>
<td>Thank you Ms. A. Can you please tell me, in this culture, how do you think gender will influence friendliness?</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>I think of it...ah...it can actually...in a very insecure position...you will have to have the understanding ... in any culture. Especially if you do not understand the difference between being ah ... being friendly or flirty ... if you become friendly, they will think this is flirty ... I experienced it...</td>
<td>Seems to be uncomfortable.</td>
</tr>
<tr>
<td>Researcher</td>
<td>Yes?</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>You need to keep in mind, always remember what is the need of the patient and just attend to that need...and to ignore any other...um...atentions that...that might be...um...unwelcome...ignore ...and it all depends on your body language. You really need an ear to listen to what the patient is telling you.</td>
<td>Touch hair, sigh.</td>
</tr>
<tr>
<td>Researcher</td>
<td>Ms. A, is there anything else that you would like to add?</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>I think in summary, if I think about the attitude...if I'm a patient in this area and there is a person that is looking at me with a friendly face and smile and attend to me immediately...or if he or she cannot attend to me immediately...just acknowledge my presence and say that I will be with you now...and...then...I will</td>
<td>Increase tone of voice.</td>
</tr>
</tbody>
</table>
| Participant | feel attended to. Don't walk away. Be approachable ... patients come first... just say, hold on ... I'll come to you. Then clear instructions as well. Also ask the patient, would you like to change your appointment, give information...that is the main thing...information to the patient. The environment is not friendly...its not customer friendly...insufficient waiting areas and the overcrowding...you know the whole environment is a...is a very difficult and challenging...overcrowding of environment. The patients are our core ... because I want to give the patient that satisfaction ... patients come first.  

We want to know how good is our care we give ... evaluation ... surveying, like in the patients you know, give us some feedback, that we can up our standards or whatever, we know where the faults are how to go about those ... survey to evaluate ... so we can have some feedback at least ... if we want what the patients think of us. |

| Researcher | Ms. A, thank you very much for your time and for sharing with me your views of patient-friendly health services. |
Annexure I

Memorandum “Patients and Families First”
Through the collective efforts of an extraordinary and dedicated group of individuals, the National Guard Health Affairs has emerged as the foremost healthcare system in the Kingdom, and I am extremely honored to serve as the Chief Executive Officer of this esteemed organization.

Our primary goal is to become nothing less than the leading healthcare facility in the region, as well as a globally recognized healthcare system with outstanding clinical services, high quality education/training and cutting-edge research. These aspirations will be built around the simple premise that the needs of the patients come first; hence we will endeavor to keep safe, quality patient care at the forefront of our ambitions. We pledge to address the health concerns of the community and promote good health through patient education and community outreach programs.

With the establishment of the King Saud bin Abdulaziz University for Health Sciences and the King Abdullah International Medical Research Center, the National Guard Health Affairs assumed a leading role in healthcare education in the Kingdom. This has given us a unique opportunity to change the fabric of our healthcare services by strengthening the skills and knowledge of the healthcare providers. Our academic institutions and research programs will continue to foster innovative learning and translational research, and will build partnerships to augment the continued development of healthcare.

Moving forward, our strategy will revolve around seven fundamental goals, which form the cornerstone of our values in terms of quality, innovation, teamwork and service. In the coming years, NGHA resolves to:

- Put patients and their families first in all that we do
- Foster academic health education
- Pursue research and innovation to enhance patient care
- Achieve excellence in safety, quality and operations
- Advance operational efficiency and effectiveness
- Provide community health
• Make NGHA the best place to work and grow

In keeping with our commitment to provide quality patient care, safety will remain a priority at NGHA. Reducing risk and ensuring safety requires that we focus our attention on developing and employing systems that prevent and mitigate errors. The NGHA Patient Safety Program focuses on continuous enhancement of safety by calling upon every employee to play a critical role in ensuring patient, visitor and employee safety. Putting the needs and safety of our patients first is not just a slogan - it is our shared commitment!

On behalf of all of the National Guard Health Affairs staff, I wish my predecessor, His Excellency, Dr. Abdullah Al Rabeelah, great success in his new role as Minister of Health, and in meeting the challenges ahead as he continues the pursuit of excellence in healthcare for the Kingdom of Saudi Arabia. I would also like to take this opportunity to express our thanks to His Excellency for bringing the organization this far. His appointment is a source of pride for all of the members of the National Guard Health Affairs.

The National Guard Health Affairs has reached a level of prominence that we can all be proud of, however, there is still much progress to be made, and therefore, I rely on each member of the organization to work with me in maintaining our main purpose of Patients and Families First.

My appreciation for the countless well wishes that I have received since my appointment to Chief Executive Officer. We remain committed to clinical and academic excellence!

I thank you all for your valued support.