THE PERCEPTION OF PROFESSIONAL NURSES ON PATIENT CENTERED CARE

by

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DECLARATION

I declare that **THE PERCEPTION OF PROFESSIONAL NURSES ON PATIENT CENTERED CARE** is my own work and that all 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.

……. …….

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ABSTRACT

The purpose of the study was to determine how professional nurses perceive their roles in patient centered care in various units, in three regional hospitals in Mpumalanga Province. The main objectives of this study were to determine

- whether the working environment in provincial hospitals is supportive of patient centered care
- what factors could hinder the provision of patient centered care
- the extent to which patient centered care is provided to patients in provincial hospitals
- professional nurses' perception of their role in patient-centered care

The researcher used the descriptive exploratory method. A questionnaire with closed and open-ended questions was used to collect data from professional nurses in the three hospitals. Seventy-two (72) respondents returned the completed questionnaires.

The findings indicated that the professional nurses perceived patients' and nurses' lack of knowledge as the biggest hindrance to patient centered care. Patients and relatives seemed to be less involved in their own care and the lack of information given to patients by professional nurses subsequently contributed to patients' inability to make choices for themselves.

KEY WORDS

Attitude, care, culture, nurse-patient relationship, nurse-patient partnership, patient participation, patient centered care, patient centered approach, patient's rights charter, therapeutic care, values and perceptions, nurse-patient communication.

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Dedication

I dedicate this study to

My beloved late parents,

Mmuši and Mamatlaweng

who gave me foundation of love and good life

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Chapter 1

Orientation to the study

1.1 INTRODUCTION AND BACKGROUND

Provisioning of health care in a hospital is focused on rendering quality patient care. For this, care needs to be patient centred. Patient-centred care attempts to realise contemporary demands and provide nursing care that reflects contemporary values. "The emergence of patient-centred care philosophy, under most recent developments in nursing theory, policy and practice, can be seen essentially as mirroring the respect for the individual who will be valued" (Binnie & Tichen 1999:6-7).

In South Africa and many other countries, there is growing awareness of patient-centred care that includes academic and practice dimensions. It is an essential cooperative process that requires multidisciplinary teamwork (Fulford, Ersser & Hope 1996:1-2). Patient-centred care is an attempt to bring nursing care in line with modern approaches, namely the decentralisation of decisions as well as multidisciplinary and integrated care provision.

The health care system is currently undergoing major changes, including organisational restructuring and quality improvement, for the purpose of providing patient-centred care. Although much has been written about patient-centred care, various perspectives as well as the interpretation and implementation of this concept still need to be explored.

In the literature, patient-centred care is described in two categories, namely as re-organising services around patients' needs, and as patient-perceived needs, priorities and expectations of health care.

Lutz and Bowers (2000:167) point out that in many instances the implementation is still traditional, concentrating on disease and providers, where the results of patient care are not congruent with patients' preferences. There is thus still much about the

implementation of the concept of patient-centred care that needs to be explored. This aspect was specifically being dealt with during this research.

1.2 SOUTH AFRICA'S MOVE TOWARDS PATIENT-CENTRED CARE

In South Africa legislature tries to bring patient-centred care into the provision of health care. The White Paper on the Transformation of the Public Service (Batho Pele) was introduced in 1997 and is aimed to improve the delivery of public services, including health care. *"Batho Pele,"* meaning "people first," relate conceptually directly to the concept "patient- centred care". The eight Batho Pele principles (South Africa 1997:15) cover the following areas of public service (health care) delivery:

- Consultation: Clients/patients should be consulted about the level of service they receive and be given choices of service offered.
- Service standards: People should be told what level and quality of service they will receive so that they can know what to expect.
- Access: Equal access to service for all.
- Courtesy: Patients deserve dignity, courtesy, consideration and respect.
- Information: Give full information to clients or patients regarding the service they are entitled to receive.
- Openness and transparency: All information and reports should be available for patients or clients.
- Redress: If care or service that is promised is not available, an explanation should be given and peoples' complaints should be responded to.
- Value for money: Consideration of efficiency in order to give the people the best possible value for money.

In 1999, the National Department of Health introduced the *Patient's Right Charter*. The Patients Right Charter lists the rights of patients, such as the right to "participation and decision-making. Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision–making on matters affecting one's health" (South Africa 1999). This too relates directly to the concept of "patient-centred care."

In addition, the Government strongly supports primary health care (PHC) and the education of nurses and other health care workers to change their attitudes and switch from a non-consultative approach to a more considerate, consultative information-laden patient-centred approach. Primary health care thus also gives the patients an opportunity to be closely involved in decisions that are taken by the health care workers in consultation with them.

1.3 ISSUES THAT MIGHT HAMPER GOVERNMENT'S MOVE TOWARDS PATIENT-CENTRED CARE

Overall, from the side of the Government, the stage is set for practicing patient-centred care within the health care delivery system. However, problems relating to the practice of patient-centred care might arise from different sources of which the traditional authoritative position of the nurse and the subservient dependent role of the patient might be the most important ones. Though nurse leaders may be aware of patients' needs for a more consultative approach when receiving health care and consequent empowerment of patients in patient-centred, they may also be aware of Gillies' (1997:15-16) implied warning that "a better informed public arising from a more patient-centred approach argues more strongly for their rights and attacks the professionals on their traditional unquestioned expertise". In this regard, Pill, Rees, Stott and Rollnick (1999:1493) emphasise that nurses often find it very difficult to let go of making decisions on behalf of the patient. In a study on patients' experiences of care received in health care settings, with special reference to patients' perspectives, Morrison (1997:6) found that some traditional ways of thinking about patients were depersonalising and made patients feel like objects. Morrison consequently recommended that nurses' perceptions of their care giving role needed to be explored to improve traditional ways of rendering patient care.

1.4 PROBLEM STATEMENT

Gillies' implied warning, the more open and democratic framework for practice set by the Government and the more authoritative traditional practice setting of nursing practice focus the research problem and question, namely: How do nurses perceive

their role in patient-centred care?" Little is known on the personal views of nurses regarding their role in patient-centred care and factors hindering patient-centred care.

1.5 RESEARCH QUESTION

In the light of the problem statement, the question to be answered by the study is:

- What is the role of the professional nurse in rendering patient-centred care?

1.6 STATEMENT OF PURPOSE

The purpose of the study is to describe how professional nurses perceive their role in patient-centred care in their units.

1.7 OBJECTIVES

The objectives of this study are to describe:

- whether the working environment in the provincial hospitals is supportive of patient-centred care
- the extent to which patient-centred care is provided to patients in provincial hospitals
- professional nurses' perception of their role in patient-centred care
- what factors could hinder the provision of patient-centred care

1.8 RESEARCH METHODOLOGY

The research on which this dissertation of limited scope reports was conducted within the quantitative research paradigm.

1.8.1 Research design

A quantitative, descriptive, exploratory non-experimental design was selected as there was no intervention and the phenomenon was studied as it occurred (Polit & Hungler 1995:139).

The non-experimental design was selected as to gather data from sample of subjects whose responses will be representative of the population, for the purpose of investigation and probable solution of the research problem.

1.8.1.1 Quantitative

The quantitative research approach is a formal, objective systematic process used to collect numeric data and it is appropriate to describe variables and their relationship (Burns & Grove 1999:23).

1.8.1.2 Descriptive

Babbie (2001:93) refers to a descriptive study as one where the "researcher observes and describes what was observed".

1.8.1.3 Non-experimental research

The non-experimental or descriptive approach is when the researcher does not manipulate any of the variables and instead the researcher is describing what is or what was exactly as it is (Bush 1985:68).

1.8.2 Population and sampling

When selecting samples, quantitative researchers "develop a sampling plan that will allow them to generalize the results to broader groups. Researchers decide in advance how participants will be selected, as well as how many will be included" (Polit & Beck 2004:289). In this study 25,0% of the total of 302 professional nurses was taken. An

appointment was made with the nurse manager to meet the professional nurses in all the departments/disciplines (except the professional nurses in paediatric and psychiatric wards). The allocation and duty list was used to identify all professional nurses on duty. The first available professional nurses were given questionnaires to complete.

1.8.2.1 Population

Polit and Hungler (1995:33) define a population as "the entire aggregation of the cases that meet a designated set of criteria. It is necessary to define the population in order to apply the results of the study to a specific group. In identifying a population, the researcher should be specific about the inclusion or exclusion criteria." The accessible research population for this study were the professional nurses employed in three regional hospitals, who met the inclusion criteria.

1.8.2.2 Sampling

Convenience sampling was utilised. According to Polit and Hungler (1995:638) "convenience sampling entails the use of the most conveniently available people or objects for use as subjects in the study" and it is sometimes an accidental sample.

All professional nurses who were on duty on the particular day, during the researcher's presence in that institution, were given the questionnaire to complete. All the disciplines were reached and everyone was given chance to complete the questionnaire. In smaller wards there were three professional nurses and in bigger wards like ante-natal wards, there were five professional nurses.

1.8.3 Data collection and the instrument

A structured questionnaire was developed to collect data. The questionnaire was used because it is an appropriate method in a descriptive study (Cormack 2000:301). The demographic information, perceptions of professional nurses of patient-centred care and factors enhancing and hindering patient–centred care were studied.

A questionnaire, consisting of closed and open-ended questions, was selected as data-collection instrument. “A questionnaire is a printed self-report form designed to elicit information that can be obtained through written or verbal responses of the subject” (Burns & Grove 1999:272).

A questionnaire was used because it is appropriate in descriptive studies as it is “designed to gather a broad spectrum of information from subjects, such as facts about the subject or about persons known by the subject; facts about events or situations known by the subject; or beliefs, attitudes, opinions, levels of knowledge, or intentions of the subject” (Burns & Grove 1999:272). A questionnaire was used as the study was about the perceptions of the professional nurses on patient-centred care.

The researcher personally presented the questionnaire to the respondents on various dates in the three regional hospitals. A high return rate is an advantage if personal presentation is done. The availability of the researcher helped to clarify and explain the purpose of the study (Polit & Hungler 1995:288). The researcher explained the benefit of the study for nursing professionals. The respondents completed and signed consent forms.

1.8.4 Pretesting of the questionnaire

According to Polit and Beck (2004:728), pretesting of the questionnaire is “the trial administration of a newly developed instrument to identify flaws or assess time requirements”.

After the pretest, the questionnaire was corrected and modified where it was necessary.

1.8.5 Data analysis

The researcher reduced, summarised, and described the quantitative data obtained (Polit & Hungler 1995:397). The data was coded and a statistician using the Statistical Package for the Social Sciences computer programme for data analysis and interpretation, using tables, pie charts, scatter grams, histograms and line graphs.

1.9 SIGNIFICANCE OF THE STUDY

Deficiencies in rendering patient-centred care could lead to patients' dissatisfaction, complaints and lawsuits. The study findings will be used to recommend improvements in the delivery of patient-centred care services in hospitals in Mpumalanga Province. The aim hereof is to promote more patient involvement in health and nursing care and to reduce patients' dissatisfaction with their health care and make them partners in their own health care.

1.10 DEFINITION OF TERMS

For the purposes of this study, the following terms are used as defined below:

- **Attitude**

Collins English Dictionary (1991:99) defines *attitude* as "the way a person views something or tends to behave towards it, often in an evaluative way". Attitudes are fixed ways of thinking; views or opinions about a person or objects and ideas. In patient-centred care, attitudes are "fixed ways of thinking about providing care which shows respect, mutual understanding and reflecting involvement of patients in decision making" (Burrows 1983:479).

- **Care**

Collins English Dictionary (1991:244) defines *care* as "to provide physical needs, help, or comfort (for)". To care is to be compassionate and provide for patients' needs in a physical, psychological and social way. "Care is healing the sick. Care is the nurses' way of being with, and is helping" (Leininger 1981:40).

- **Culture**

Collins English Dictionary (1991:387) defines *culture* as "the total of the inherited ideas, beliefs, values, and knowledge, which constitute the shared bases of social action; the total range of activities and ideas of a group of people with shared traditions, which are transmitted and reinforced by members of the group". "Culture refers to the complex whole, including knowledge, belief, art, morals, law, customs and any other capabilities and habits acquired by people as members of society" (Andrews & Boyle 1999:3).

- **Nurse-patient partnership**

Collins English Dictionary (1991:1138) defines *partnership* as "a contractual relationship between two or more persons".

Trnobranski (1994:734) describes the *nurse-patient partnership* as "the idea of partnership between the nurse and the patient is a key aspect to the new nursing and the nurse advocates for the sharing of decision making regarding nursing care between the nurse and the patient". Therefore the nurse/patient partnership is the association of the nurse and the patient in order to improve and/or maintain the health status of the patient in partnership.

- **Nurse-patient relationship**

Collins English Dictionary (1991:1308) defines *relationship* as "the state of being connected or related; the mutual dealings, connections, or feelings that exist between two parties or people". Ramos (1992:496) describes the *nurse-patient relationshi*p as "a mutual, professional bonding or attachment between the nurse and the patient".

- **Nurse**

Collins English Dictionary (1991:1073) defines *nurse* as "a person, usually a woman, who tends the sick, injured, or infirm".

This title is applicable to "persons who are registered under article 16 of the Nursing Act, 50 of 1978. They conform to all the requirements set out by the South African Nursing Council (SANC) for registration as professional nurses and/or midwives/ accoucheurs" (Searle & Pera 1992:47).

In this study, a nurse is someone who is registered with the SANC in this capacity.

- **Patient-centred approach**

Collins English Dictionary (1991:73) defines *approach* as "vb. to begin to deal with; n. a means adopted in tackling a problem, job of work, etc."

A patient-centred approach focuses on the patient. The patient is involved in and consulted on decisions on care plans that affect him/her.

- **Patient-centred care**

Redman (2004:11) describes *patient-centred care* as "treating the patient as a unique individual. This requires understanding specific patients' needs and preferences and based on that understanding, selection of optimal interventions to meet those needs." Patient-centred care is therefore care for patients with the patients' views incorporated into the plan of action of all interventions to be implemented for them by nurses. Patient-centred care and patient centered care is used alternatively.

- **Patient's right charter**

The *patient's rights charter* is a government policy outlining the rights and responsibilities of patients (South Africa 1999).

- **Patient participation**

Collins English Dictionary (1991:1137) defines *participate* as "to take part, be or become actively involved, or share (in); **participation** n." *Patient participation* is thus when patients take part in the process of interventions, which assist them to recovery.

- **Perceptions**

Collins English Dictionary (1991:1156) defines *perception* as "the act or the effect of perceiving; insight or intuition gained by perceiving; way of perceiving; awareness or consciousness; view". *Perceptions* are ways of seeing and understanding things. For the purpose of this study, perceptions are ways of seeing and understanding patient-centred care.

- **Therapeutic care**

Collins English Dictionary (1991:1599) defines *therapeutic* as "of or relating to the treatment of disease; curative; serving or performed to maintain health". *Therapeutic care* is a relationship of mutual trust between two people. "For a nurse it is a tool which she uses to achieve nursing objectives relating to psychological care such as alleviation of pain, giving information and aiding physical recovery" (Hyland & Donaldson 1989:11).

- **Value**

Values are the established ideals of life, objects, customs, ways of acting that members of a given society regard as desirable (*The World Book Dictionary* 1996:2311). Values are important aspects to a person. They convey a meaning about something to others, they guide or have an influence on how people take decisions (Erlen 1998:63). Values are characteristics, standards or principles that are of particular importance when a person passes judgement. They guide or influence a person's behaviour or choices.

1.11 ABBREVIATIONS

The following abbreviations are used in the study:

- SANC South African Nursing Council
- PCC Patient-centred care
- PHC Primary health care

1.12 OUTLINE OF THE STUDY

Chapter 1 introduced the study, briefly describing the problem, the purpose and objectives of the study, and the research methodology.

Chapter 2 discusses the literature review undertaken on factors that hinder or enhance patient-centred care, and the conceptual framework for the study.

Chapter 3 describes the research design and methodology.

Chapter 4 presents the data analysis and interpretation.

Chapter 5 concludes the study, discusses its limitations and makes recommendations.

1.13 CONCLUSION

This chapter discussed the research problem and aim and objectives of the study, the research design and methodology, including population, sampling and data collection, patient-centred care as a means of improving health care service, and defined terms. Chapter 2 discusses the literature review conducted for the study.

Chapter 2

Literature review

2.1 INTRODUCTION

This chapter discusses the literature review conducted by the researcher on patient-centred care, definitions and dimensions of patient-centred care, as well as various theoretical perspectives. The key words used during the on-line literature review were *patient-centred nursing care*, *caring*, *nurse-patient relationship*, *patient's rights*, and *nurse-patient communication*.

2.2 MOVEMENT TOWARDS PATIENT-CENTRED CARE

In many countries there is a movement towards patient-centred care, which includes academic and practical disciplines, because it is an essential co-operative enterprise between disciplines, which leads to multidisciplinary teamwork (Fulford et al 1996:1-2). A patient-centred care model has profound implications for the way that care is planned, delivered and evaluated. Although most leaders in health care organisations today embrace the basic principles of patient-centred philosophy, they often find that moving towards the patient-centred care model requires an unanticipated level of commitment and adjustment in organisational structures. This means involving patients in planning, decision-making and improvement processes at all levels of organising their health care (Anthony & Hudson-Barr 2004:118).

2.2.1 Definition of patient-centred care

Defining the term "patient-centred care" appears to be problematic. As Mead and Bower (2000:1088) point out, the "conceptual and empirical development of patient-centredness is hampered by the lack of a universally agreed definition". However, Witzel (1981:2) defines patient-centred care as "keeping patients comfortable, maintaining a therapeutic environment for them, providing them with emotional support, personalised care, sympathy, friendliness, emotional acceptance and

emphasising the background of their medical problems as well as cultural understanding in decision-making related to their care". According to Fitzpatrick (1999:86), patient-centred care "revolves around actions that encourage patients to disclose how they see their world and to express concern, thoughts and feelings about care, which will be provided to them".

Patient-centred care is a style of practice, which demonstrates respect for the patient as a person and consciously adopts the patients' perspective by focusing on the patients' experience of their illness. Individual patients play more active roles in their own health care and in decision-making related to their care plans (Verwey & Crystal 1998:34).

These authors also state (1998:34) that health care communication plays a major role in a patient-centred approach. The focus is on patients, and nurses are to be responsive to the needs of their patients in a responsible and courteous manner. Wright (1995:599) emphasises that the patient "should be encouraged to make independent decisions; nurses should acknowledge their autonomy and act as nondirective facilitators, supporting the patient's choices. The latter is an example of empowerment of patients."

A patient-centred approach includes acknowledging "patients' own way of perceiving and experiencing what is happening to them. Its aim is to transform patients' experiences of illness, taking them, for example from pain to comfort, from fear to confidence, from distress to coping, and from loss to adjustment. This kind of care is a therapy in its own right: some call it therapeutic nursing. The role of the patient-centred care nurse is <u>to be there,</u> offering personal support and practical expertise, but letting patients follow paths of their own" (Binnie & Tichen 1999:16).

Patient-centred care "incorporates the overt physical, psychological, emotional and social needs of the patient. It is a model of caring for the whole person as an individual, not as an example of disease, medical diagnosis or medical condition" (*Mosby's Medical, Nursing and Allied Dictionary* 1998:711).

According to Lutz and Bowers (2000:171), patient-centred care is "an approach to hospital care that consciously adopts the patient's perspective and has eight dimensions". These dimensions are discussed in paragraph 2.2.2.

In summary, patient-centred care is a collaborative effort consisting of patients, patients' families, friends and health care professionals aimed at achieving the common goal of the patients' recovery. This is placing the patient at the centre of the health care system and developing good services that revolve around them and are responsive to their needs and preferences. This is depicted graphically in fig. 2.1 in which the attributes of patient-centred care, as reflected by the definitions quoted above, are represented and reorganised in a systems theory format. As depicted in figure 2.1, a systems theory approach basically involves a system (process) of input, throughput and output situated within an environment. The environment in which the proposed system of process is situated is the field of health care of any nursing encounter.

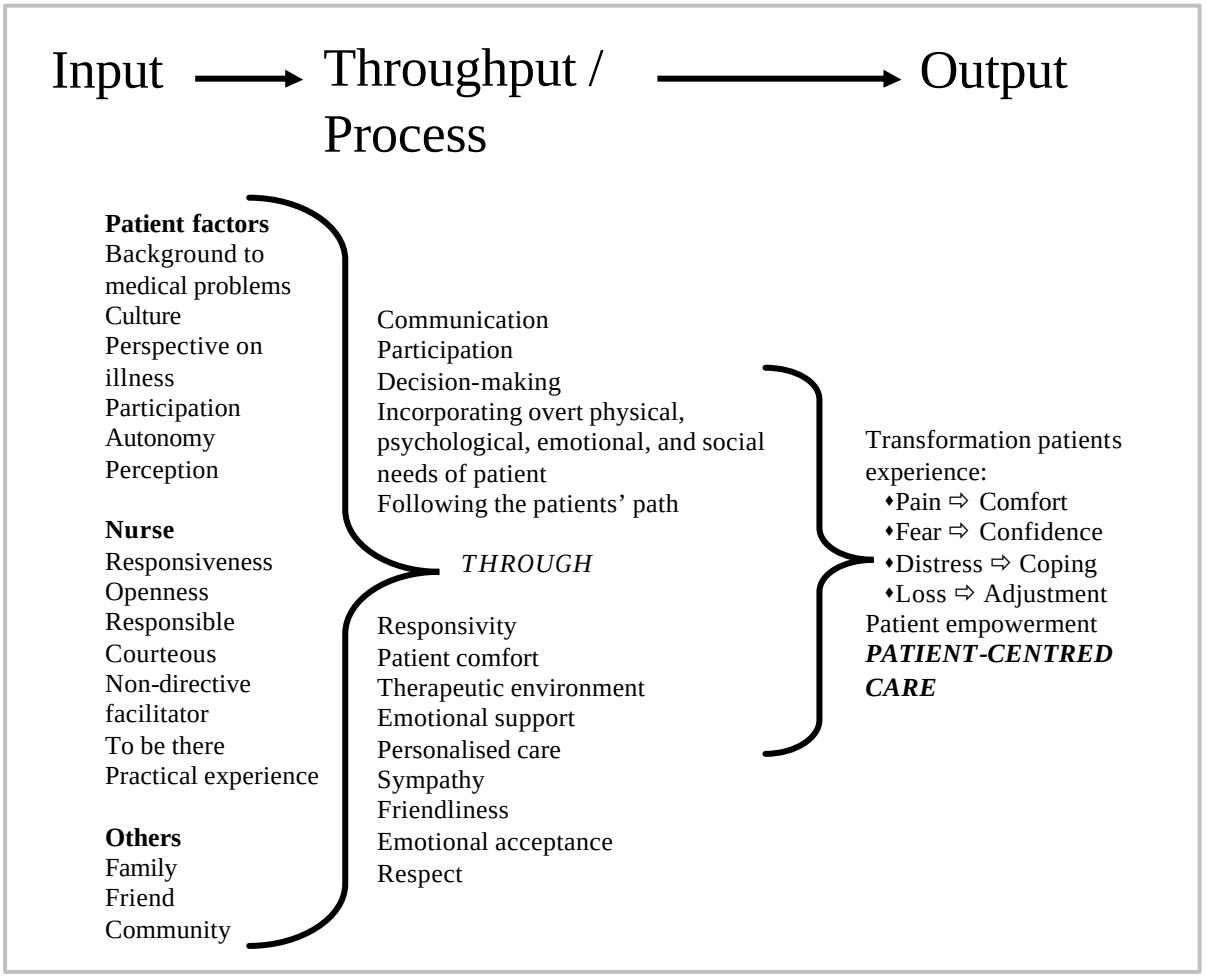

Figure 2.1 A system perspective on patient-centred care

2.2.2 Dimensions of patient-centred care

According to Verwey and Crystal (1998:34), the dimensions of patient-centred care "explicitly indicate that patients need to be empowered so that they will be equipped in the process of negotiation and shared decision-making in the nursing care plan".

Lutz and Bowers (2000:171) identify eight primary dimensions, namely:

- respect for patients' values, preference and needs
- coordination and integration of care
- information, communication and education
- physical comfort
- emotional support and alleviation of fear and anxiety
- involvement of family and friends
- transition and continuity
- access

➢ **Respect for patients' values, preference and needs**

In nursing, respect for a human being or person is the basis of all that is truly nursing. The respect of patients' values, preferences and needs is the appreciation of the self and the other, taking individuals as unique human beings in caring for them (Freshwater 2002:101).

The underlying philosophy of patient-centred care is the patterns of care that recognise the inherent value of each person as a unique and worthy individual. Patient-centred care takes the personal weaknesses and strengths of patients into consideration and provides individualised care to each patient.

Joffe, Manocchia, Weeks and Cleary (2003:104) found that patients in hospital value trust, respect and autonomy. Joffe et al emphasise that these issues be given attention in ethical models of health care. By fostering a relationship and being considerate about their needs, patients will realise that health care providers respect them.

Respect and dignity is the cornerstone of a relationship. The relationship of trust emanates from the way people are treated. Success is eminent and visible when a unit shows consideration for the needs of the people they serve, and the care provided is tailored according to their needs (Smy 2004:21).

- **Coordination and integration of care**

Service delivery that is integrated and well coordinated is conducive to patient-centred care. The nurse will advocate for the best comprehensive patient care. The multi-disciplinary approach is important so that at the end the patient receives total holistic care (Frisch, Dossey, Guzzetta & Quinn 2000:11).

Patients and families have been integrated into the care delivery model by involving them in planning, decision-making and quality improvement processes at all levels of organisation. The reason for this is to achieve full integration of the patients' perspectives and making patient-centred care alive (Ponte, Conlin, Conway, Grant, Medeiros, Nies, Shulman, Branowicki & Conley 2003:82).

- **Information, communication and education**

Information sharing between health care workers and patients promotes and facilitates achieving the goals in patient-centred care. Communication and education form an integral part in conveying information to patients. Communication is "a way of understanding others and ourselves and the receiver feels confident to ask questions and clarify doubts" (Mendes, Trevizan, Nogueira & Sawada 1999:640).

Communication is an important tool between nurse and patient. Patients need to thoroughly understand their illnesses before making decisions. Patients should be well informed about their illnesses so that they can co-operate during treatment and all interventions (Verwey & Crystal 1998:34). In patient-centred care, patients' values, preferences and needs are used to guide decision-making therefore it is vital to have discussions and information sharing. Patient education in interventions promotes

patients' compliance and cooperation with the treatment and the health care professionals.

- **Physical comfort**

Physical comfort is the care provided for patients' physical well being. Patient-centred care recognises the interconnected nature of the mind, body and spirit, therefore physical care is a component of the holistic care of patient (Ellis 1999:301).

Maintaining a comfortable environment for patients is an important caring activity, especially for patients confined to a hospital bed. The nursing activities should promote a comfortable environment (Lindberg, Hunter & Kruszewski 1994:452).

- **Emotional support and alleviation of fear and anxiety**

Patient-centred care encompasses the physical, emotional, social and spiritual needs of patients. The major aim in patient-centred care is to help patients to adjust to their present incapacity without losing their dignity and self-respect (Millers & Koop 1984:38). Giving enough information and showing sensitivity to patients' feelings alleviates anxiety and fear.

In order to alleviate fear and anxiety and provide emotional support, the nurse needs to have empathy with the patients (Baillie 1995:31). Empathy in nurse-patient relationships is a critical dimension in patient-centred care, as patients at times of helplessness perceive that help and aid is forthcoming and the nurse understands.

- **Involvement of family and friends**

The role of family in the cure and care of patients is important. In some cultures, all decisions are made in consultation with family members. Relatives and friends contribute to the process of healing and moral support of patients. In patient-centred care patients' preferences and values are considered. Health professionals should allow

family participation and accommodate cultural practices which are not detrimental to the patients' health (Leininger 1981:42).

Andrews and Boyle (1999:5) state that transcultural nursing is needed today more than ever because of the growing diversity that characterises our national and global populations. They further emphasise the important roles play by family and community of transmitting cultural values and behaviours that relate to both health and illness (Andrews & Boyle 1999:318).

- **Transition and continuity**

In patient-centred care the patients and health care workers develop a long-term relationship. It is an unbroken connected course that is continuous without any change. Continuity of relationship between health care workers and patients accrues many benefits (Stewart, Brown, Weston, McWhinney, McWilliam & Freeman 2003:122). The motion that embraces "holism and the active participation of patients in care provision links to the patients' need to be empowered and brings the idea of partnership between nurses and patients to the fore" (Trnobranski 1994:734).

- **Access**

Patients should have easy access to health care. Patient-centred care access would help patients secure appropriate, preferred, available care when and where needed. For care to be safe, effective, timely, efficient and equitable health care providers need a systematic approach and patients need to participate in the decision-making (Berry, Seiders & Wilder 2003:569). Accessibility depends to a large extent on the preparedness of professional nurses to embrace the principles of patient-centred care.

2.2.3 Role of nurses in patient-centred care: a humanistic approach

Traditionally, nurses' training emphasised humanistic matters, while modern training emphasises the use of sophisticated equipment. In a sense, patient-centred care can be

viewed as a confluence of these two traditions with emphasis on the patient as person. Positive patient-centred behaviour acceptable for nurses thus involves the following:

- The role of the nurse is to encourage active participation, offer her service so that the patient can engage in partnership with her (Trnobranski 1994:734). Patient-centred care is closely congruent with, and responsive to the patients' needs, including answering patients' questions and accepting ideas they put forward in planning the nursing care (Mead & Bower 2000:1088).
- Pill et al (1999:1493) emphasise giving patients a bigger role in the management of their own conditions thereby being patient-centred and developing more equal partnership with patients. Pill et al add that often nurses find it very difficult to let go of making decisions on behalf of the patient
- Timonen and Sihvonen (2000:543) found that poor nurse-patient communication led to non-participation by patients, which also increased patients' anxiety and insecurity. In addition, nurses frequently used too much professional language and failed to encourage patients to participate. In patient-centred care, this is not acceptable as patient-centred care essentially implies that the patient be informed throughout the therapeutic relationship.
- Fulford et al (1996:21) point out that the moral need to see things from the patient's point of view does not mean that the nurse's or doctor's views are abandoned. Rather, patient-centred care recognises that patients' evaluations are real and important and of prime consideration in the planning of their health care.
- Binnie and Tichen (1999:39) maintain that the implementation of patient-centred care needs senior practitioners to demonstrate patient-centred nursing care and develop a plan to help the nurses to learn from what they observe. A role model, coach and supervisor have a powerful impact on the way hospital patients are cared for in the wards. At present the ward sister's position as clinical leader is not recognized and is even downgraded. More emphasis is put on administration and business management skills instead of their roles as nurse-clinicians (Binnie & Tichen 1999:39).
- Organisational structure and culture as well as the constant development of nurses have a positive influence on patient-centred care (Witzel 1981:4).

- Holistic nursing as a dimension of patient-centred care emphasises individualised nursing care and the nurturing of the patient as a human being. The essence of treating the client or patient as a whole is an important aspect of the professional nurses' role (Dossey, Keegan, Guzzetta & Kolkmeier 1988:120).
- According to Hein (1998:9-10), patients view physical and technical care as important because they value a situation where their needs are catered for. However, Hein adds that the staff appeared to have different perceptions of their own caring behaviour.
- The role of the nurse is to bring congruence between the patient and the intervention of advanced care planning. Discussing the advanced care plan helps patients to understand treatment decisions and assists the nursing staff to gain insight into patients' preferences, which influence the decisions on the plans for providing nursing care. These decisions ultimately contribute to improved care (Briggs, Kirchhoff, Hammes, Song & Colvin 2004:47).

2.2.4 An honest nurse-patient relationship

Mutual understanding and collaboration are essential features of the nurse-patient relationship. This relationship brings together the nurse's compassion and knowledge and the patient's experience. They both connect in an attempt to offer help and assistance. Help offered without human connection is impoverishment. The professional role of the nurse also includes the therapeutic aspect of the relationship (Stein-Parbury 2000:20-21).

Sundeon, Stuart, Rankin and Cohen (1994:168) view an honest relationship as a learning experience in which nurse and patient interact to face an immediate health problem, to share, if possible, in resolving it and to discover ways to adapt to the situation. Moreover, this relationship is relentlessly open and honest. The ability to enter into the life of another person and accurately perceive another's feelings is important and is showing empathy. Professional nurses' level of commitment makes a major contribution to nurse-patient relationships and brings a notion of mutuality in caring (Libkin & Cohen 1986:4-5).

The ultimate honest nurse-patient relationship is the caring relationship to which Hein (1998:5) denotes the following attributes:

Honesty	Feelings	Actualising	Reciprocity
Patience	Mattering	Involvement	Engrossment
Courage	Autonomy	Relationship	Respect
Sensitivity	Trust	Dignity	Spirituality
Dedication	Assistive	Being with love	Supportive
Commitment	Facilitative	Compassion	Satisfaction
Knowledge	Tenderness	Empathy	Integrity
Skills	Growing		Closeness

In addition, Hein (1998:5-6) defines caring as "an interactive process, which requires the care to be responsive to the needs of the person cared for". This relates directly to patient-centredness.

"Through identifying with patients, nurses involve themselves in a personal way in patients' experiences. This involvement, of being close to the heart of the situation, enables nurses to notice what is significant and to notice subtle changes in the patients. Rather than hampering nurses' clinical judgement involvement has the potential to enhance it" (Stein-Parbury 2000:30).

2.2.5 Benefit to patients of patient-centred care

People's dignity and worth should be respected so that they can express who they are and what they are experiencing. If patients receive warmth and respect, they open up and become receptive, their anxiety and fear are alleviated and the burden of disease is lessened. Goodwill exists and healing takes place (Stein-Parbury 2000:81-83). Patients benefit in patient-centred care because they have an input in the building of health facilities and in improving the quality of health care. Patients participate and have a responsible role in decision-making. Furthermore, communication and patient-provider relations are greatly improved (Ward 2004:89).

The global community is gradually embracing patient-centred care in health care delivery. According to Scott (2004:937), “patient empowerment”, “patient-centred approach” and “patient choices” are buzzwords and high on political agendas. Governments want patients to be empowered and to experience a sense of ownership and recognition that they are also stakeholders in their treatment and care. The benefits of patient-centred care include health promotion activities, functional status, autonomy, quality of life and continuity of care.

Patient-centred care makes patients aware of their own information and educational needs based on their values and beliefs, in the context of their lives. The approach of care that moves from the provider or disease management perspective to a patient-centred approach offers a new blueprint for improving quality of care (Anthony & Hudson-Barr 2004:133-134).

Another important benefit of patient-centred care is that the patient is able to secure appropriate and preferred health service at any time. When nurses provide care, they should be vigilant that there is continuity and patients are able to receive the care they require at any time. Equity, efficiency, effective, and safe patient care reflect patient-centredness (Berry et al 2003:569).

2.3 LACK OF CULTURAL CONSIDERATION

Nurses’ values, education, family life, health perceptions, and financial status are often very different from the people they serve which results in a lack of cultural consideration of clients/patients. Morrison (1997:136) found that patients view professionals as “well-educated people in control of their lives, distant, different and superior” while health professionals regard patients mainly as “vulnerable, poor, unemployed, elderly, physically and mentally handicapped and inferior”. Maintaining these opposites in perception can only lead to creating a divide rather than a confluence as implied by patient-centred care.

"Reciprocal cultural misunderstandings between patients and nurse, often accompanied by language difficulties, present a barrier to effective communication and permit only a superficial nurse-patient relationship to be formed" (Burrows 1983:481).

2.4 DAILY NURSE-PATIENT INTERACTION

Erlen (1998:60) examined who made the decisions relevant to patient care in the daily nurse-patient interaction ? the nurse, the physician, the patient's family, others or all the individuals mentioned, "realising the important endeavour they are all engaged in". Erlen (1998:60) found that nurses are under pressure to change and improve quality of care and make the services more responsive to patients' needs.

Feelings of isolation, loss of worthiness, uselessness and dependence sometimes overwhelm patients in health care institutions. Moreover, patients are frequently viewed as objects, making them feel inferior. Many professionals tend to assume that they know what is best for patients. There are several reasons for their lack of consultation with patients. For example, Baillie (1995:30) found nurses unwilling or reluctant to understand how patients feel because they "probably would not understand anyway" or "it interferes with care and is time consuming, we have important tasks to do". Hindcliff, Norman and Schober (1993:255) found "a wide difference between what nursing staff thought best for their clients and what the clients themselves wanted".

2.5 PATIENTS' PERSPECTIVES AND COMPLIANCE

Patients' compliance is often overestimated and its improvement lies in influencing their behaviour and habits. Patients' involvement and participation in decisions affecting their health will enhance their recovery (Grol & Lawrence 1995:129).

In a study on patients' experiences of care received in health care settings, with special reference to patients' perspectives, Morrison (1997:6) found that some traditional ways of thinking about patients were depersonalising and made patients feel like objects. Morrison consequently recommended that nurses' perceptions of their care giving role needed to be explored to improve traditional ways of rendering patient care.

2.6 CONCLUSION

This chapter discussed the literature review on patient-centred care, the nurse-patient relationship, the role of the professional nurse in patient-centred care, and dimensions of patient-centred care. How patients can be helped to make decisions regarding their health care were emphasised.

Chapter 3 deals with the research design and methodology.

Chapter 3

Research design and methodology

3.1 INTRODUCTION

This chapter describes the research design and methodology, including the population, sampling, and data-collection instrument. Reliability, validity and ethical considerations are also covered.

3.2 RESEARCH DESIGN

Polit and Hungler (1995:36) define a research design as the researchers overall plan for obtaining answers to questions. Burns and Grove (1999:185) refer to the research design "as a blueprint for conducting of the study that maximises the control over factors that could interfere with the desired outcomes from studies". In order to establish the factors which promote or those which hinder patient-centred care in the three regional hospitals in Mpumalanga Province, a quantitative non-experimental, descriptive research design was used.

This study was quantitative, descriptive, exploratory and non-experimental as there was no intervention and the phenomenon was studied as it occurred (Polit & Hungler 1995:139).

3.2.1 Quantitative

"Quantitative research is a formal, objective, systematic process in which numerical data are used to describe variables, examine relationships between them and thus obtain information about the world" (Burns & Grove 1999:16). During the present study, quantitative/numerical data were collected to determine how professional nurses perceive their role in patient-centred care.

3.2.2 Descriptive

The study was descriptive because the aim was to give an accurate account of the characteristics of a particular group, professional nurses, as well as what patient-centred care delivery entails. It thus gave new meaning, described what exists, commented on the frequency of occurrences, and categorised them (Burns & Grove 1999:24).

Polit and Hungler (1995:640) refer to descriptive research as "research studies that have as their main objective the accurate portrayal of the characteristics of individuals, situations, or groups and frequency with which certain phenomena occur".

3.2.3 Exploratory

Exploratory studies are designed "to explore the dimensions of a phenomenon or to develop or refine hypotheses about the relationships between phenomena" (Polit & Hungler 1995:702). The study explored a perceived problem, namely nurses' lack of awareness of their role in patient-centred care. The aim was to generate "new" knowledge; knowledge pertinent to the area in which the research was conducted.

3.3 POPULATION

A population is "the entire aggregation of the cases that meet a designated set of criteria" (Dempsey & Dempsey 1996:233; Polit & Hungler 1995:278). It is necessary to identify the population in order to apply the results of the study to that specific group.

In identifying a population, the researcher should be specific about the inclusion or exclusion criteria (Polit & Hungler 1995:33). The target population comprises the total number of cases about which the researcher wants to make generalisations (Polit & Hungler 1995:230).

According to Polit and Hungler (1995:635), the "accessible population is the population of subjects available for a particular study; often a non-random subset of target population". The accessible research population for this study included the professional nurses employed at the three regional hospitals and who met the following criteria:

- Respondents must be 18 to 60 years old.
- Respondents must have a minimum contact of three days (36 hours) a week with patients.
- Respondents must be involved in assessing patients' needs and in planning, implementing and evaluating or monitoring of patient care.
- Respondents must be employed in one of the three regional hospitals in Mpumalanga Province.

Both sexes were included in the sample. Professional nurses working in the psychiatric and paediatric sections were excluded, because patient-centred care requires the patient's input and involvement in the plan for treatment and the children and psychiatric patients are not in the position to make decisions about their care.

3.4 SAMPLE AND SAMPLING

Sampling is "the process of selecting a few elements from a population to represent the entire population" (Clamp & Gough 1999:88). A representative sample of professional nurses in three regional hospitals of Mpumalanga Province was selected.

3.4.1 Sampling

A non-proportional of 25% convenience sample of professional nurses from different disciplines was taken from the three hospitals. They were the professional nurses who were on duty and available on the day the researcher was doing the research. The three hospitals were visited on three different days.

Convenience sampling is the use of accessible individuals, who are readily available, and easy to identify and contact (Knapp 1998:106). The available professional nurses on duty in the various nursing care units were requested to complete the questionnaire. The first three to five professional nurses in each discipline were given the questionnaire to complete. Three in smaller wards and five in bigger wards. All disciplines were represented. As this sample was a convenient sample it cannot be generalised to other groups.

A sample of 25,0% of the professional nurses meeting the inclusion criteria was estimated to reflect the true population value (Polit & Hungler 1995:240). The sample was taken from a total of 302 professional nurses after excluding the professional nurses from the psychiatric and paediatric departments of the three hospitals. The size of the sample is largely determined by how accurate or precise these estimates are. Monsen (1992:337) points out that "the larger the sample, the more information about the population and the more precise the estimate". An unnecessarily big sample entails wastage whereas a small sample is adequate to measure the variables (Brink & Wood 1989:127). The professional nurses were selected from all the disciplines in the regional hospitals except the psychiatric and paediatric sections.

The paediatric and psychiatric patients are treated in a human and specialise manner. In patient-centred care there is direct involvement in decision-making and in this instance nurses play a more prominent role in patient advocacy and use other role players like parents and family.

3.5 DATA COLLECTION

Research data, particularly in quantitative studies, are often collected according to a structured plan that indicates what information is to be gathered and how to gather it. When data are collected in a highly structured way, the researcher must develop an instrument if an existing one is not available (Polit & Hungler 1995:310-311).

3.5.1 Data collection instrument

The questionnaire was selected as the most appropriate data collection instrument for this study. A questionnaire is "a printed self-report form designed to elicit information that can be obtained through written responses of the subjects" (Burns & Grove 1999:272).

The researcher developed a questionnaire in English that was simple, clear and brief so that the respondents would have no difficulty completing it (Cormack 2000:305). The questions covered the survey objectives as conceptualised. The supervisor and joint supervisor corrected and verified the questionnaire before pretesting it.

3.5.2 Format

The questionnaire contained both closed and open-ended questions and was divided into three sections.

- Section A (items 1-5) dealt with demographic information of the respondents.
- Section B (items 6-11) covered the qualifications and experience of the respondents.
- Section C (items 14-17) consisted out of different sub-items covering the perceptions of patient-centred care of the respondents.
- The questionnaire does not contain a question 12 and 13 as it was moved to the end of the questionnaire and the following were not amended accordingly.

A four-point Likert scale was used to rate the responses. The Likert scale is a widely used scale and consists of "... several declarative items that express a viewpoint on a topic" (Polit & Hungler 1995:339). According to Polit and Beck (2004:357) the summation feature of such scales makes it possible to make fine discriminations among people with different points of view. In this study the Likert scales assisted the researcher to collect data about the respondents' attitudes about patient-centred care. The Likert scales for this study consisted of four categories of alternatives, namely

strongly disagree, disagree, agree and strongly agree or in other questions as totally insignificant, somewhat insignificant, somewhat significant and totally significant.

A semantic differential scale was also used to collect data about the respondents' feelings on aspects of patient-centred care. "A semantic differential scale consists of two opposite adjectives with a 7-point scale between them"(Burns & Grove 1999:279).

3.5.3 Pretesting

Dempsey and Dempsey (1996:230) refer to pretesting as "the process of testing out the effectiveness of a measuring instrument in gathering appropriate data".

A pre-test was done at a similar hospital whereby a convenience sample of professional nurses who attended a sister's meeting was selected. The representatives of each discipline were given a questionnaire to complete. Twelve professional nurses completed the questionnaire and the data collected was analysed through the use of a statistician and the researcher.

The purpose of the pre-test was to

- test the data-collection instrument and identify possible problems
- give the researcher experience in administering it to the subjects
- determine whether the instrument collects the type of data required (Cormack 2000:25)

The pre-test enabled the researcher to establish face validity and judge whether the questions were appropriate for the intended purpose (Cormack 2000:31). In addition, the researcher was able to test the use of the questionnaire and to assess whether the questions were understood (Streubert & Carpenter 1995:46). This further determined the questionnaire's reliability (Abdellah & Levine 1986:239). After the pre-test, refinement was done with the assistance of the statistician, supervisor and joint supervisor to eliminate and reduce problems encountered during the pre-test (Polit & Hungler 1995:37-38).

Some of the wording of questions was changed because some of the professional nurses indicated that they did not understand it well.

Questions 12 and 13 were moved to be the last questions. The time for answering the questionnaire was made to be 20 minutes instead of being 10 minutes.

3.5.4 Administration of the questionnaire

Nursing service managers were contacted telephonically to secure appointment dates. The researcher personally presented the questionnaire to the individual participants in the three regional hospitals on the various dates. A higher return rate of questionnaires can be expected if personal presentation is done. The availability of the researcher to explain or clarify questions and answer respondents' queries helped to establish rapport and a good relationship (Polit & Hungler 1995:288). The researcher explained the purpose and benefit of the study and informed consent forms were completed and signed by the respondents. The sectional managers assisted in distributing and collecting the questionnaires. Data was collected during June and July 2004.

Twenty-five percent (25,0%) of the professional nurses meeting the inclusion criteria in each hospital were given questionnaires to complete.

The records indicated that a total of 439 professional nurses were employed in the three hospitals. Of these, 137 failed to meet the inclusion criteria and were subtracted from the total. The remaining 302 were then the population. Table 3.1 represents the professional nurses in the three regional hospitals.

Table 3.1 Professional nurses in the three regional hospitals

HOSPITALS	NURSES IN EACH HOSPITAL	EXCLUDED [PAEDIATRIC AND PSYCHIATRIC*]	TARGET POPULATION	NUMBER OF QUESTION-NAIRES HANDED OUT	NUMBER OF QUESTION-NAIRES RETURNED
HOSPITAL A	84	20	64	20	17
HOSPITAL B	128	30	98	30	22
HOSPITAL C	227	87	140	40	33
Total	**439**	**137**	**302**	**90**	**72**

**Excluded from the study.*

3.6 DATA QUALITY

A questionnaire is "not an end in itself but a means to an end. It is an instrument producing scores, which represent a measure of the phenomenon in which the researcher is interested for the purpose of the research" (Treacy & Hyde 1999:51). In quantitative research, the major criterion for assessing the quality of data is by means of establishing the validity and reliability of the data-collection instrument (Polit & Beck 2004:428).

3.6.1 Validity

Polit and Hungler (1995:418) and Monsen (1992:13) refer to validity as "the ability of the instrument to measure the phenomenon it intends to measure". Validity is concerned with the soundness and effectiveness of the measuring instruments. Validity was ensured by phrasing each question carefully to avoid leading respondents to a particular answer (Monsen 1992:71).

Before the actual data collection was done, the instrument was tested to establish its validity. Four aspects of validity of an instrument are assessed, namely "face validity, content validity, criterion-related validity and construct validity" (Polit & Hungler 1995:418).

3.6.1.1 Face validity

Face validity is the appropriateness of the instrument for collecting the desired information (Thomson 1997:77). Face validity does not refer to what an instrument actually measures, but rather what it appears to measure (De Vos & Fouche 1998:84). The questionnaire was appropriately and logically checked and re-checked by the supervisor, joint supervisor and statistician.

3.6.1.2 Content validity

Content validity is concerned with "the extent to which the instrument adequately covers the various dimensions under investigation" (Cormack 2000:31). Content validity is also how accurately the questions asked tend to elicit the information sought. In this study the questionnaire was given to the supervisor and joint supervisor for corrections and to check the appropriateness of the content and that the questionnaire was relevant to identify the factors which hinders and that enhance patient-centred care in the hospitals.

3.6.1.3 Criterion-related validity

This is the degree to which the scores on an instrument are correlated with the same external criterion believed to measure the concept under investigation (Polit & Hungler 1995:355). Criterion-related validity assesses at what level the subject performs on a given measurement tool. The factors which hinders and factors which enhance patient-centred care are coordinating with the issues in the literature.

3.6.2 Reliability

"Reliability indicates whether the results can be repeatable or be reproducible" (Monsen 1992:71). Scientific procedures were followed, likely to produce qualifying information and be able to generalize (Thomson 1997:13). In this study reliability was measured, using Cronbach's Alpha coefficient.

Cronbach Alpha is a method to evaluate the internal consistency of the instrument. The higher values reflect, a higher internal consistency (Polit & Beck 2004:420).

Santos (1999:1) refers to Nunnaly (1978) who "indicated 0,7 to be an acceptable reliability coefficient". In this case Item 14 has the lowest reliability of 0,809 which is higher than the accepted level of 0,7. Table 3.2 thus indicates a high overall reliability for the questionnaire.

Table 3.2 Cronbach's Alpha coefficient

ITEMS	CRONBACH'S ALPHA
14 The extent that patient-centred care is applied in the working environment	0,809
15 Factors hindering patient-centred care	0,963
16 Application of patient-centred care activities in the nurses' daily activities	0,931

Items 14, 15 and 16 comprised the bulk of the questionnaire and were the only items suitable for calculating Cronbach's Alpha coefficient. Table 3.2 illustrates the reliability of the questions.

3.7 ETHICAL CONSIDERATIONS

Mouton (2001:240) maintains that since scientific research is a type of human conduct, it follows that the research has to correspond with general accepted norms and values. The researcher took care to ensure that the respondents' rights were protected. Furthermore, "a fair, proper, acceptable, humane and accountable approach considering the ethical responsibility to protect the rights of the research subjects" was followed (Burns & Grove 1999:368). The following principles were considered: permission, informed consent, risk-benefit ratio, right to decide to participate and right to privacy.

3.7.1 Permission

Permission to conduct the study was obtained from the Mpumalanga Provincial Ethical Committee and the superintendents of the three regional hospitals. The researcher completed the provincial ethical committee form and included the proposal as required (see annexure 4 for letter requesting permission). Permission was also sought from the professional nurses participating in the study through the informed consent form (see annexures 2 and 3).

3.7.2 Informed consent

Informed consent is a term “used by courts to uphold the ethical principle of self-determination which underlies the legal principle of informed consent to medical treatment “ (Earle 1993:629). “Complete consent, however, is impossible without information, “informed consent’ would appear redunt or self-justifying” (Earle 1993:631).

The respondents were informed of the purpose of the study in writing. Confidentiality and anonymity were assured. The respondents were asked not to write their names or any other identifying particulars on the questionnaires. They handed the questionnaires to the researcher who placed it in envelopes. Before the data was collected, each respondent signed an informed consent form (see annexure 3).

3.7.3 Risk-benefit ratio

In deciding to conduct a study, the researcher must carefully assess the risks and benefits to be incurred (Polit & Hungler 1995:135). This principle assesses the likelihood of potential relative risks, whether physical, psychological, social or legal. In this study, the risk taken by the participants did not exceed the potential of humanitarian benefits of the knowledge to be gained. The questionnaire was non-interrogative and respondents were given time to complete it. The researcher was present to explain the procedure and clarify any concerns. “This approach has the obvious advantage of maximising the number of completed questionnaires and allowing the researcher to clarify any possible misunderstanding about the instrument” (Polit & Hungler 1995:288). The anticipated benefit of the study to professional nurses was also explained.

3.7.4 Right to decide to participate

The right to self-determination also means that respondents have the right to participate in research voluntarily without risk of penalty or prejudice (Polit & Hungler 1995:436). Furthermore, they have the right to terminate their participation or refuse

to give information. The fact that the researcher was not in an authority position over the respondents avoided coercion and undue pressure. Before handing out the questionnaires, the researcher explained that their participation was voluntary (Burns & Grove 1999:168-169).

3.7.5 Right to privacy

Polit and Hungler (1995:139) stress that researchers need to ensure that their research is not more intrusive than it needs to be and that the participants' privacy is maintained throughout the study. Privacy in research can be achieved through anonymity and confidentiality.

Anonymity occurs when the research report does not include any names. Furthermore, for the sake of anonymity, the three regional hospitals were referred to as hospitals A, B and C. The questionnaires were nameless.

Knapp (1998:34) states that the "emphasis and assurance that the investigator will not identify the respondent in anyway is vital". In this study, the respondents were assured that there would be no identifying data that could link them to the information given. Confidentiality was assured by refraining from passing on the information collected for any purpose without the respondents' explicit permission. The participants were promised confidentiality because no identifying information would be entered on the questionnaire or the computer files, nor did any such information appeared on the questionnaires (Polit & Hungler 1995:124).

3.8 RESPONSE RATE

Out of 90 questionnaires distributed, 72 were returned, which represented a return rate of 80,0%. This can be regarded as a good return rate, because Burns and Grove (1999:272) state that the return rate for mailed questionnaires is usually 25,0-30,0%.

3.9 DATA ANALYSIS

A statistician (see letter of confirmation – annexure 6), using the Statistical Package for the Social Sciences (SPSS) computer program, did the data analysis.

The data was coded and analysed quantitatively, and presented tables, pie charts, scatter grams, histograms and line graphs (Cormack 2000:369) (see chapter 4). Looking at the data and the relationship between variables is important. During this step the researcher reduces, summarises and describes the quantitative data obtained (Polit & Hungler 1995:397). A factor analysis was also performed. According to Burns and Grove (1999:325) a factor analysis "examines interrelationships among large numbers of variables and disentangles those relationships to identify clusters of variables that are most closely linked."

An analysis of variance (ANOVA) was done. The ANOVA is used when data from multiple groups (such as the different hospitals) is compared to determine if they differ. If, however, a significant result is found between groups, it does not tell us between which groups the difference exists. The hospitals were compared with regard to their views on patient-centred care by means of an ANOVA test (http://www.statsoft.com/textbook/stathome.htm).

The responses of the respondents on the open-ended questions were arranged according to emerging themes.

3.10 CONCLUSION

This chapter described the research design and methodology, including population, sampling and the data-collection instrument. The validity and reliability of the questionnaire and the ethical considerations involved were also explained.

Chapter 4 discusses the data analysis and interpretation.

Chapter 4

Data analysis and interpretation

4.1 INTRODUCTION

This chapter presents the data analysis and interpretation, covering the respondents' demographic profile, a component analysis and the results of the data on patient-centred care. In an attempt to maintain the flow of discussions, tables were placed directly following discussions or headings. For this reason some longer tables continue on consecutive pages.

4.2 RESPONDENTS' DEMOGRAPHIC PROFILE

4.2.1 Item 1: The hospitals in the sample

Research was conducted in three hospitals designated for purposes of anonymity as Hospitals A, B and C. Figure 4.1 indicates the percentage of questionnaires completed in each hospital.

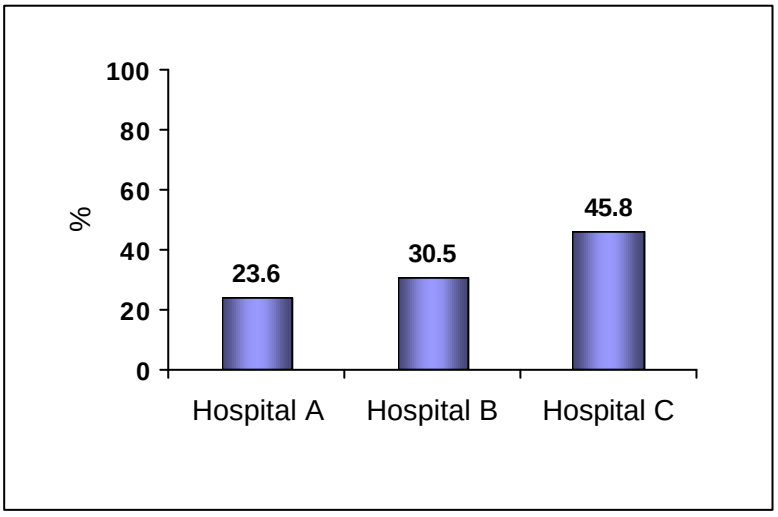

Figure 4.1 Questionnaires completed in each hospital (n = 72)

4.2.2 Item 2: Gender

Figure 4.2 presents the respondents' gender profile. All the respondents except one provided their gender, accounting for the sample size of 71. Most of the respondents (89,0%) were female. This is in line with the gender composition for the nursing profession in South Africa where 93,6% of the profession are females and 6,4% males. (www.sanc.co.za/stats/stat2003/distribution%202003xls.htm).

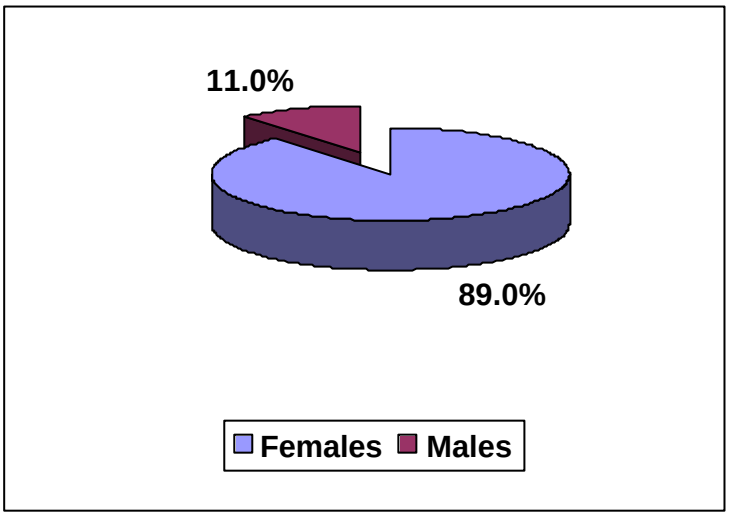

Figure 4.2 Respondents' gender profile (n = 71)

4.2.3 Item 3: Average age

Of the respondents, 67 of the 72 indicated their age.

The average age of the respondents was 38 year, with the oldest being 54 year and the youngest, 26 year, accounting for a range of 28 years.

Table 4.1 Respondents' average age

	N	Minimum	Maximum	Mean	Range	Std deviation
Age	67	26,0	54,0	38,0	28	6.0815

4.2.4 Item 4: Race distribution

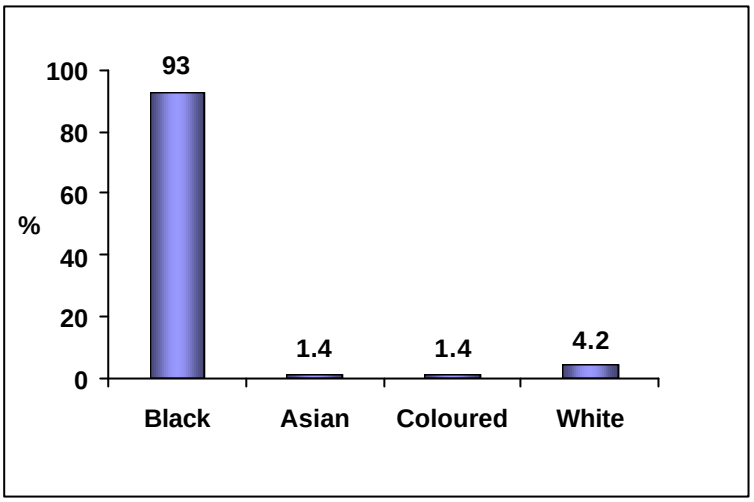

Figure 4.3 Respondents' race distribution (n = 72)

Of the respondents, 67 (93,0%) were Black, 1 (1,4%) was Asian, 1 (1,4%) was Coloured and 3 (4,2%) were White (see figure 4.3). All the respondents answered this question.

4.2.5 Item 5: Highest professional qualification

Of the respondents, one omitted to answer this question. Figure 4.4 depicts the respondents' highest qualification and education distribution.

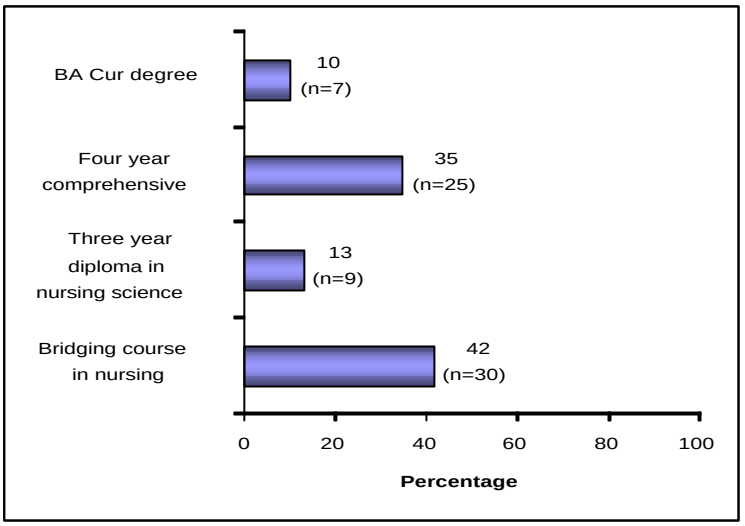

Figure 4.4 Respondents' highest qualification (n = 71)

Of the respondents, 30 (42,3%) had done a bridging course in nursing, 25 (35,2%) had a four-year diploma comprehensive qualification, 7 (9,9%) had a BA Cur degree and 9 (12,7%) had completed the three-year diploma in nursing science.

4.2.6 Item 6: Main area of practice

All respondents answered this question. They practised as registered nurses in a wide variety of areas in the hospitals. Of the respondents, 22 (30,6%) were in general nursing, 16 (22,1%) in midwifery and 17 (23,6) in surgical wards. Since the three hospitals in the research sample were situated in small towns in a rural area, only a few respondents indicated working certain areas, namely 4 (5,6%) in ICU, 1 (1,4%) in theatre, 2 (2,8%) in medicine, 5 (6,9%) in casualty and 2 (2,8%) in outpatients.

Table 4.2 Respondents' main area of practice (n = 72)

	Frequency	Percentage
General nursing	22	30,6
ICU	4	5,6
Theatre nursing	1	1,4
Midwifery	16	22,1
Surgery	17	23,6
Medicine	2	2,8
Casualty	5	6,9
Outpatients	2	2,8
Other	3	4,2
Total	**72**	**100**

4.2.7 Item 7: Respondents' experience as professional nurses

Of the respondents, 2 did not indicate the number of years' experience hence the base size for this question is 70. The respondents' average experience in nursing was 7,5 years; 1 had 31 years' experience and 1 had only four months' (0,33 year) experience.

Table 4.3 Respondents' average years' experience (n = 70)

	N	Minimum	Maximum	Mean	Range	Std deviation
Years of experience	70	0,33	31,0	7,52	32.67	6,369

4.2.8 Item 8: Time spent on patient care

Of the respondents, only 62 answered the question (see figure 4.5).

When focusing especially on the aspect of patient-centred care, 33 (53,2%) of the respondents indicated that they spent 71 to 90% of their time on direct patient care.

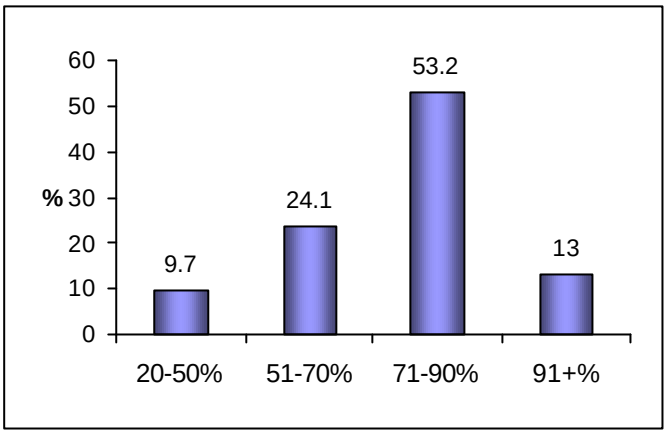

Figure 4.5 Time spent on direct patient care (n = 62)

4.2.9 Items 9 and 10: In-service training in patient-centred care

Of the respondents, 36 (51,4%) indicated that they had received in-service training in patient-centred care and 2 did not answer the question (missing values = 2) (see figure 4.6). A disturbing large percentage 34 (41,4%) of the respondents indicate that they did not receive in-service training in patient-centred care.

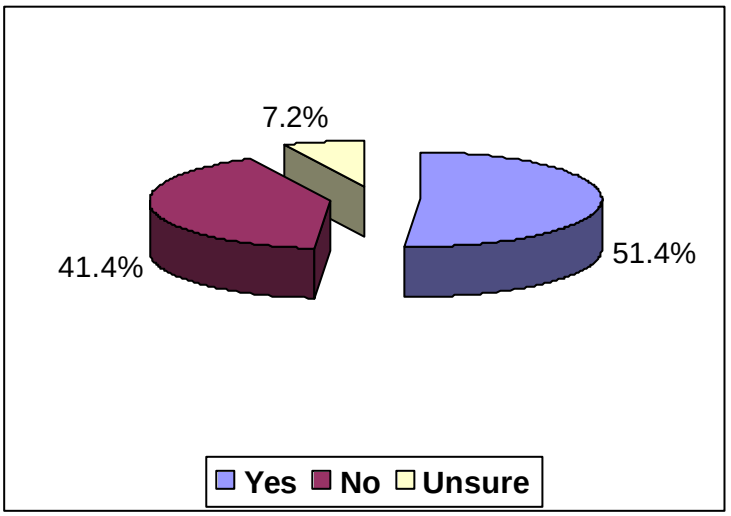

Figure 4.6 In-service training about patient-centred care (n = 70)

A cross-tabulation (see table 4.4) between the highest qualification and the attendance of in-service training (where patient-centred care was the topic) revealed that 13 (56,5%) of the 23 respondents with a four-year comprehensive qualification and 5

(71,4%) of the 7 with a BA Cur degree indicated that they had received in-service training in this aspect.

Table 4.4 Cross-tabulation between qualification and in-service training in PCC (n = 69)

Nursing qualifications	Training in patient-centred care			Total in nursing courses
	Yes	No	Unsure	
	Frequency and %	Frequency and %	Frequency and %	
Bridging course in nursing	14 (46,7%)	15 (50,0%)	1 (3,3%)	30
Three-year diploma in nursing science	4 (44,4%)	5 (55,6%)	0 (0,0%)	9
Four-year comprehensive	13 (56,5%)	9 (39,1%)	1 (4,4%)	23
BA Cur degree	5 (71,4%)	1 (14,3%)	1 (14,3%)	7
Total	**36 (52,2%)**	**30 (43,5%)**	**3 (4,3%)**	**69**

The respondents' percentage exposure to patient-centred care training dropped as their education level dropped, with only 14 (46,7%) of the 30 bridging course respondents having been exposed to this topic. The inclusion of the patient-centred care approach in any curriculum will shape the students to provide better patient care and the less comprehensive courses do not seem to contain information on this subject.

4.2.10 Item 11: Extent of involvement in direct patient care and treatment

The respondents were asked to indicate the extent to which patients, professional nurses, doctors and family members were involved in direct patient care and treatment. Table 4.5 indicates the involvement of different groups in direct patient care and treatment.

Table 4.5 Extent of involvement of different groups in direct patient care and treatment

	Patient		Professional Nurse		Doctor		Family member	
	n = 64		n = 69		n = 65		n = 64	
	%	n	%	n	%	n	%	n
No involvement	6,2	4	0	0	0	0	20,3	13
Little involvement	34,4	22	5,8	4	26,2	17	39,1	25
Much involvement	39,1	25	15,9	11	44,6	29	35,9	23
Highest involvement	20,3	13	78,3	54	29,2	19	4,7	3
Total	**100,0**	**64**	**100,0**	**69**	**100,0**	**65**	**100,0**	**64**

From table 4.5 it is clear that patients themselves and family members were the least involved with 13 (20,3%) respondents indicating that family members had no involvement at all and 22 (34,4%) indicating that the patient was only slightly involved in patient care.

Family involvement in planning care for patients is important as the family will be needed at some stage to plan a proper discharge plan and further home care. Illness also has major disruptions and may alter family relationships, expectations and responsibilities. Family support during the difficult times of their ailment is of vital importance to patients (Stewart et al 2003:64).

Of the respondents, 54 (78,3%) indicated professional nurses as the role player with the highest direct involvement with the patient; 29 (44,6%) indicated that doctors were more likely to have “much involvement” as opposed to highest involvement, and 19 (29,2%) indicated that doctors had the “highest involvement”.

It would seem that the respondents still regarded patients as passive recipients rather than partners in care since 26 (40,6%) indicated that the patients had little or no involvement in their care.

4.3 DESCRIPTIVE RESULTS

The results from patient-centred care section are discussed below. The results for items 14 and 15 are given on a sub-item basis. Only the results of the four major factors created for item 16 are discussed while the sub-item results are given in Table 4.10.

4.3.1 Item 14: The extent that patient-centred care is applied in the working environment

Item 14 consisted of 23 sub-items, asking the respondents to indicate agreement on a four-point Likert scale with the extent that the patient-centred care approach is applied in their environments. A factor analysis was conducted, however, it did not indicate a sensible structure. The responses to this sub-items included in this item are indicated in Table 4.6 according to each sub-item.

Patient-centred care, also called therapeutic nursing, is important as it includes respect for the patient as a person. Its goal is to take patients from a state of pain to comfort, from fear to confidence, from distress to coping and from loss to adjustment (Binnie & Tichen 1999:16). Patients benefit from patient-centred care because they have some input in the quality of care and its improvements. The outcome of care enables patients to use the available resources effectively, efficiently and the compliance rate is higher (Ward 2004:89).

Table 4.6 Item 14: Mean scores on patient-centred care aspects (69=n=72)

Sub-item no	Item description	Mean	Std deviation
	Overall mean	**2,97**	**0,661**
14.1	Staff is knowledgeable about patient-centred care	3,07	0,743
14.2	Staff is involved in the full range of problems the patient is experiencing	3,26	0,628
14.3	Nursing staff is displaying a positive attitude in implementing patient-centred care	3,27	0,632
14.4	The clinic charge nurses is seen as a role model with regard to patient-centred care	3,14	0,756
14.5	Greater involvement of patient in own care is encouraged	3,38	0,592

Sub-item no	Item description	Mean	Std deviation
	Overall mean	**2,97**	**0,661**
14.6	There is mutual participation between patient and health professionals	3,11	0,618
14.7	Adequate nursing staff to deliver quality nursing care is present	1,76	0,911
14.8	Patients are provided with enough information to make informed decisions	3,04	0,659
14.9	Nurses have positive interpersonal relations	3,25	0,645
14.10	A nurse-patient relationship for common understanding of the goals of treatment is developed	3,34	0,506
14.11	Nurses encourage patients to voice ideas, listen to them and reflect collaboration	3,11	0,571
14.12	Delegation of authority to the lower levels is taking place	3,15	0,730
14.13	Nurses experience job satisfaction	1,82	0,811
14.14	Open two-way communication between nurses and patients exists	3,11	0,545
14.15	Nurses consider the culture of patients in planning nursing care	3,06	0,695
14.16	Patient empowerment is promoted	3,12	0,557
14.17	Holistic patient care is provided	2,99	0,606
14.18	Patients and their families display assertive behaviour	2,49	0,531
14.19	There is co-ordination between health professionals	3,00	0,707
14.20	Supplies and equipment is available	2,34	0,877
14.21	Staff understand the uniqueness of every patient	3,23	0,622
14.22	There is a personal bond between nurses and patients	2,89	0,649
14.23	Patients are assisted from a state of dependency to one of independency	3,34	0,631

From table 4.6 it is clear that sub-items 14.5 (Greater involvement of patient in own care is encouraged), 14.10 (A nurse-patient relationship for common understanding of the goals of treatment is developed) and 14.23 (Patients are assisted from a state of dependency to one of independency) had the highest scores. It is evident that the respondents have a positive attitude towards aspects that promote independence and encourage patients to be involved in their own care and involve them in developing treatment goals. Verwey and Crystal (1998:34) emphasise that as patients become more involved, participate, are assisted and encouraged, they become active, knowledgeable and informed.

Sub-items 14.20 (Supplies and equipment is available), 14.13 (Nurses experience job satisfaction) and 14.7 (Adequate nursing staff to deliver quality nursing care is present) had the lowest score. Sub-items 14.17 (Holistic patient care is provided), 14.22 (There is a personal bond between nurses and patients) and 14.18 (Patients and their families display assertive behaviour) also scored lower than the average mean of 2,97.

Based on the scores, it is evident that the lack of human and material resources, and nurses' lack on job satisfaction are a great hindrance in providing patient-centred care in the working environment. An environment lacking human and material resources contributes to low job satisfaction. In Khowaja et al (2005:35) the nurses "felt that because of shortage of staff, absenteeism and performing non-nursing tasks such as providing water, tea and removing linen from washrooms, increased their workload". A lack of adequate nursing staff can also prevent the provision of holistic patient care and the development of a personal bond between nurses and patients.

At the same time, patients and their families might observe the shortage of nurses and the nurses' dissatisfaction with their working environment. This, in turn, might influence them not to display assertiveness.

Table 4.7 Item 14: Mean scores on patient-centred care in different hospitals

Sub-item no	Item description	A		B		C	
		Mean	Std	Mean	Std	Mean	Std
	Overall mean	**2,78**	**0,610**	**2,88**	**0,598**	**2,83**	**0,650**
14.1	Staff is knowledgeable about patient-centred care	2,65	0,702	3,05	0,740	3,30	0,684
14.2	Staff is involved in the full range of problems the patient is experiencing	3,12	0,781	3,23	0,612	3,36	0,549
14.3	Nursing staff display a positive attitude in implementing patient-centred care	3,06	0,748	3,23	0,528	3,41	0,615
14.4	The clinic charge nurse is seen as a role model with regard to patient-centred care	3,00	0,935	3,18	0,795	3,18	0,635
14.5	Greater involvement of patients in their own care is encouraged	3,47	0,514	3,27	0,456	3,39	0,704

Item no	Item description	A		B		C	
		Mean	Std	Mean	Std	Mean	Std
	Overall mean	**2,78**	**0,610**	**2,88**	**0,598**	**2,83**	**0,650**
14.6	There is mutual participation between patient and health professionals	3,06	0,429	3,14	0,640	3,12	0,696
14.7	Adequate nursing staff to deliver quality nursing care is present	1,71	1,105	1,59	0,734	1,91	0,914
14.8	Patients are provided with enough information to make informed decisions	3,12	0,600	3,23	0,612	2,88	0,696
14.9	Nurses have positive interpersonal relations	3,12	0,600	3,27	0,767	3,30	0,585
14.10	A nurse-patient relationship for common understanding of the goals of treatment is developed	3,24	0,437	3,33	0,483	3,39	0,556
14.11	Nurses encourage patients to voice ideas, listen to them and reflect collaboration	2,88	0,600	3,09	0,426	3,24	0,614
14.12	Delegation of authority to the lower levels is taking place	2,94	0,772	3,32	0,568	3,15	0,795
14.13	Nurses experience job satisfaction	1,41	0,795	2,09	0,811	1,85	0,755
14.14	Open two-way communication between nurses and patients exists	3,24	0,437	3,14	0,560	3,03	0,585
14.15	Nurses consider the culture of patients in planning nursing care	3,12	0,600	3,10	0,700	3,00	0,750
14.16	Patient empowerment is promoted	3,06	0,556	3,05	0,498	3,19	0,601
14.17	Holistic patient care is provided	3,00	0,354	3,05	0,524	2,94	0,747
14.18	Patients and their families display assertive behaviour	2,59	0,507	2,48	0,602	2,44	0,504
14.19	There is co-ordination between health professionals	3,00	0,516	3,24	0,539	2,84	0,847
14.20	Supplies and equipment is available	2,53	0,874	2,57	0,870	2,09	0,843
14.21	Staff understand the uniqueness of every patient	3,07	0,704	3,36	0,581	3,22	0,608
14.22	There is a personal bond between nurses and patients	3,00	0,707	3,00	0,649	2,76	0,614
14.23	Patients are assisted from a state of dependency to one of independency	3,29	0,470	3,36	0,581	3,34	0,745

According to table 4.7, hospital B had the highest average score for the sub-items on patient-centred care contained in item 14 and hospital A, the lowest average score. This could be explained by the fact that Hospital A is a small hospital grossly affected by shortage of staff. The researcher even had difficulty getting staff released from their work to complete the questionnaire. The hospital was in the process of developing into a regional hospital and the staff faced many challenges and changes at the time of data collection.

All three hospitals had low scores on sub-items 14.7 (Adequate nursing staff to deliver quality patient care) and 14.13 (Nurses experience job satisfaction). Because the three hospitals are in the same geographical area and same province, they might have similar problems in human and material resource provisioning. However, hospital C appeared to be more affected by a lack of supplies and equipment (sub-item 14.20) than the other two hospitals.

It is not clear why hospital C where the respondents reported a higher adequacy of nursing staff to deliver nursing care (sub-item 14.7) was the one where the respondents had the lowest scores for sub-items 14.17 (Provision of holistic care) and 14.22 (Personal bond between nurses and patients).

4.3.2 Item 15: Factors hindering patient-centred care

Table 4.8 provides the mean scores on each of the hindrances and highlights the scores that were above average. As indicated in table 4.8, on average, the factors that could hinder patient-centred care is 2,8 (on a 4-point rating scale where 4 indicated the most hindrance/totally significant hindrance). The factors with the highest score therefore are indicative of the major hindrances of patient-centred care.

Patients' and nurses' lack of knowledge (sub-items 15.1 and 15.2) was seen as the biggest hindrance to patient-centred care with mean scores of 3,01 and 3,00, respectively. Tying in to the lack of knowledge were sub-items 15.4 (the lack of information given to patients by health professionals) and 15.6 (inability of patients to make choices for themselves) with a mean score of 2,91 and 2,88 respectively.

Sub-items 15.19 (Language barrier between patients and nursing staff/health services) and 15.14 (Unmotivated nurses in the work situation) were indicated as other hindrances that could affect the respondents' information giving function. The research done by Timonen and Sihvonen (2000:543) supports the finding on the language barrier between patients and nursing staff, as they found that nurses used too much professional language and terminology and "medical jargon that is very difficult for patients to understand".

Lack of motivation of employees (sub-item 15.14) holds serious implications for their work performance. Recognition and appreciation of good performance is an important aspect that raises job satisfaction and morale and affects the motivation of not only the individual staff, but also the entire nursing unit (Khowaja, Merchant & Hirani 2005:35).

Sub-item 15.7 (A poor nurse-patient relationship) was also one of the hindrances that received an above-average score of 2,96.

Sub-item 15.5 (The seriousness of the patient's illness) appeared to be less of an obstacle to patient-centred care with a mean score of 2,62.

Table 4.8 Item 15: Mean scores for factors hindering patient-centred care

Sub-item no	Item description	Mean	Std deviation
	Overall mean	**2,82**	**1,08**
15.1	Patient's lack of knowledge	3,01	1,06
15.2	Nurse's lack of knowledge	3,00	1,11
15.3	Unprofessional behaviour of nursing staff	2,66	1,18
15.4	Lack of information given to patients by health professionals	2,91	1,12
15.5	Seriousness of patient's illness	2,62	1,10
15.6	Patients' inability to make choices for themselves	2,88	0,95
15.7	Poor nurse-patient relationship	2,96	1,06
15.8	Lack of patient's involvement in decision making	2,90	1,07
15.9	Non-consultation with patient	2,83	1,17
15.10	Lack of role models for implementing patient-centred care	2,79	1,03
15.11	Dehumanising of patient by nurse	2,70	1,17
15.12	Centralised decision making by supervisors	2,68	1,11
15.13	Lack of emotional support given by nurses to patients	2,70	1,08
15.14	Unmotivated nurses in the work situation	2,97	1,21
15.15	High anxiety levels of nurses	2,84	1,07
15.16	No co-operation and integration of care activities	2,78	1,00
15.17	Failure of nursing staff to encourage patients to ask questions about their care	2,83	1,03
15.18	Patient's disempowerment	2,72	1,07
15.19	Language barrier between patients and nursing staff/health services	2,91	1,06
15.20	Poor communication between nurses and patients	2,84	1,10
15.21	No respect shown by nurses for patients' values, preferences and	2,82	1,13

Sub-item no	Item description	Mean	Std deviation
	Overall mean	**2,82**	**1,08**
	expressed needs		
15.22	Lack of collaboration between patients and health care professionals	2,87	1,05
15.23	Nurse's lack of sensitivity to the patient's feelings	2,74	1,02

Table 4.9 displays the scores of the different hospitals. By comparing each hospital's scores with its own average, some issues appeared to be consistently perceived as hindering patient-centred care. However, there was also some variability between the three hospitals.

Sub-item 15.7 (poor nurse-patient relationship) was perceived as a problem at all three hospitals. A lack of information and knowledge appeared to be a consistent problem area with either the "lack of knowledge of patients" (sub-item 15.1) or the "Lack of information given to patients by health care professionals" (sub-item 15.4) emerging as the biggest hindrances. Sub-item 15.8 (Patients not being involved in the decision-making process) was indicated by two of the three hospitals as a hindrance to patient-centred care.

The respondents at Hospital A seemed to experience more hindrances in providing patient-centred care with an average of 3. This fits in well with the results indicated in table 4.7 where hospital A obtained the lowest average of the three hospitals. The respondents in hospital A were working under pressure of upgrading the institution to a secondary specialising hospital and experiencing high workloads because of a shortage of staff as indicated on the duty list.

The respondents employed at Hospital B seemed to focus slightly more on organisational issues, such as centralised decision-making (sub-item 15.12), unmotivated staff (sub-item 15.14) and a lack of collaboration between patients and health care professionals (sub-item 15.22).

The respondents in hospital C implicated additional hindrances such as high anxiety levels of nurses (sub-item 15.15) and a lack of role models for implementing patient-centred care (sub-item 15.10) in their hospital.

Table 4.9 Item 15: Mean scores for the different hospitals (factors hindering patient-centred care)

Sub-item no	Item description	A		B		C	
		Mean	Std dev	Mean	Std dev	Mean	Std dev
	Overall mean	**3**	**0,978**	**2,8**	**1.096**	**2,76**	**1,130**
15.1	Patient's lack of knowledge	2,71	1,05	3,05	1,07	3,16	1,07
15.2	Nurse's lack of knowledge	2,71	1,21	3,05	1,05	3,13	1,10
15.3	Unprofessional behaviour of nursing staff	2,53	1,18	2,74	1,19	2,69	1,20
15.4	Lack of information given to patients by health professionals	3,24	0,90	2,71	1,10	2,87	1,23
15.5	Seriousness of patient's illness	2,71	1,05	2,71	1,06	2,52	1,18
15.6	Patients' inability to make choices for themselves	3,18	0,73	2,60	0,99	2,91	1,00
15.7	Poor nurse-patient relationship	3,35	0,79	2,90	1,17	2,79	1,08
15.8	Lack of patient's involvement in decision making	3,29	0,77	2,70	1,03	2,82	1,18
15.9	Non-consultation with patient	3,12	1,11	2,70	1,22	2,76	1,17
15.10	Lack of role models for implementing patient-centred care	2,76	1,09	2,80	0,95	2,79	1,08
15.11	Dehumanising of patient by nurse	3,06	1,14	2,65	1,27	2,53	1,11
15.12	Centralised decision making by supervisors	2,94	0,97	2,84	1,07	2,43	1,19
15.13	Lack of emotional support given by nurses to patients	2,94	1,03	2,70	1,17	2,58	1,06
15.14	Unmotivated nurses in the work situation	3,38	1,09	3,11	1,15	2,69	1,26
15.15	High anxiety levels of nurses	2,71	1,05	2,75	1,02	2,97	1,13
15.16	No co-operation and integration of care activities	2,88	0,99	2,79	0,92	2,73	1,07
15.17	Failure of nursing staff to encourage patients to ask questions about their care	3,12	0,70	2,70	1,13	2,75	1,11
15.18	Patient's disempowerment	2,76	0,97	2,74	1,19	2,68	1,08
15.19	Language barrier between patients and nursing staff/health services	3,24	0,97	2,80	0,95	2,82	1,16
15.20	Poor communication between nurses and patients	3,29	0,92	2,60	1,19	2,76	1,09
15.21	No respect shown by nurses for patients' values, preferences and expressed needs	3,00	1,00	3,00	1,17	2,61	1,17
15.22	Lack of collaboration between patients and health care professionals	3,18	0,81	2,95	1,05	2,67	1,14
15.23	Nurse's lack of sensitivity to the patient's feelings	3,00	0,87	2,74	1,15	2,59	1,01

4.3.3 Item 16: Aspects of patient-centred care that nurses do during their normal day at work

The respondents were asked to what extent they complied with providing care in certain aspects of patient-centred care. Table 4.10 portrays the results of how the respondents applied patient-centred care during their daily activities.

Table 4.10 Item 16: Application of patient-centred care activities in the nurses' daily activities

Sub-item no	Item description	N	Mean	Std deviation
16.1	Utilising momentary incidents for rendering physical care	64	3,03	0,642
16.2	Utilising momentary incidents for rendering psychological care	66	3,06	0,677
16.3	Utilising momentary incidents for rendering social care	66	2,86	0,677
16.4	Taking time to talk to patients	70	3,30	0,729
16.5	Familiarising yourself with patients' condition	69	3,23	0,667
16.6	Making a good first impression	68	3,43	0,555
16.7	Encouraging patients to take responsibility for their health	70	3,50	0,654
16.8	Encouraging patients' involvement in decision-making	69	3,35	0,660
16.9	Involving patients in planning care interventions	70	3,09	0,737
16.10	Providing counselling to patients	68	3,38	0,670
16.11	Teaching patients about their illnesses and care	70	3,57	0,579
16.12	Providing committed, creative sensitive nursing care	70	3,26	0,557
16.13	Creating a therapeutic environment for the patient	68	3,47	0,532
16.14	Encouraging patients to confide in you	68	3,29	0,600
16.15	Comforting patients	70	3,39	0,572
16.16	Being empathetic to patients	68	3,31	0,553
16.17	Allowing patients their autonomy	68	3,07	0,676
16.18	Allowing patients to take informed decisions	69	3,38	0,621
16.19	Providing a clear explanation of their illness and treatment to patients	69	3,51	0,559
16.20	Seeing patients as participants in their health care	70	3,29	0,640
16.21	Soliciting the patient's opinion when formulating a nursing care plan	69	2,97	0,641
16.22	Using standardised guidelines or protocols provided for patient care	68	3,25	0,741
16.23	Evaluating care provided on a continuous base	68	3,25	0,632
16.24	Providing holistic patient care	66	3,30	0,723

The factors which scored the highest are sub-item 16.11 “teaching of patients about illness and care” with a score of 3,57, sub-item 16.19 “providing a clear explanation of their illness and treatment to patients” with a score of 3,51 and sub-item 16.7 “encouraging patients to take responsibility for their health” with a score of 3,50. The factors which scored the lowest in this aspect are sub-item 16.3 “utilising momentary incidents rendering social care” (2,86) and sub-item 16.21 “soliciting the patient’s opinion when formulating a nursing care plan” (2,97).

Nurses perceive patients as participants in patient-centred care and they must be encouraged their involvement in their own care and nurses should also apply their knowledge of patient-centred care in their daily activities.

An attempt was made to reduce the number of items through the creation of factors. While factor analysis or component analysis is a useful data-reduction method, the limited size of the sample size prohibited its use. Therefore the statements were grouped into similar factors using the logic and theory used to formulate the questions. To ensure that these created factors were indeed reliable, an item analysis was performed on each factor.

Factors were created by calculating the mean scores of all the items in a particular factor. For example:

Factor “Education of Patient” = (sub-items 16.11 + 16.18 + 16.19) divided by 3.

This was done for each respondent, providing each respondent with a score for each factor.

The creation of the four factors, reducing the 24 sub-items in item 16, allowed for a visual comparison of the mean scores and a statistical comparison between hospitals.

An item analysis involves obtaining the internal reliability consistency value (Cronbach’s Alpha coefficient) for the entire factor and the Cronbach’s Alpha coefficient if a particular sub-item is to be excluded from that factor. If in the researcher’s discretion

the internal reliability increases sufficiently by excluding the sub-item, the sub-item should be excluded from that particular factor. A general rule of thumb for determining what constitutes a good internal reliability is given at 0,75 score of the Cronbach Alpha (Terre Blanch & Durrheim 1999:90).

It was found that item 16 could be reduced to four reliable and theoretically sound factors, namely

- encouraging patient involvement
- human touch, empathy and counselling
- education of patients
- best practices in the workplace

The tables below indicate the sub-items in each factor, the contribution made by each sub-item to the overall reliability (Cronbach's Alpha coefficient) and the overall reliability of the factor.

The item analysis for the factor "Encouraging patient involvement" is presented in table 4.11.

Table 4.11 Item analysis for "Encouraging patient involvement"

Sub-item no	Item description	Alpha if item deleted
16.7	Encouraging patients to take responsibility for their health	0,760
16.8	Encouraging patient's involvement in decision-making	0,754
16.9	Involving patients in planning care interventions	0,741
16.17	Allowing patients their autonomy	0,737
16.20	Seeing patients as participants in their health care	0,795
16.21	Soliciting the patient's opinion when formulating a nursing care plan	0,741
Cronbach's Alpha coefficient for the scale = 0,79		

The encouraging patient involvement factor as exhibited in table 4.11 shows a high internal reliability with a Cronbach's Alpha coefficient of 0,79, which was above the cut-off rate of 0,7 as suggested by Terre Blanch and Durrheim (1999:40). All the sub-items

contributed to this factor as leaving any one out would not result in a significant improvement in reliability. Sub-tem 16.17 (Allowing patients their autonomy) was the strongest item in this factor because leaving this item out would result in the highest drop in reliability. Sub-item 16.20 (Seeing patients as participants in their health care) showed the worst fit with this factor item yet the reliability could only improve by 0,005 if this item were left out and it was therefore still included.

Table 4.12 presents the item analysis for the factor "Human touch, empathy and counselling".

Table 4.12 Item analysis for "Human touch, empathy and counselling"

Sub-item no	Item description	Alpha if item deleted
16.4	Taking time to talk to patients	0,835
16.5	Familiarising yourself with patients' condition	0,812
16.6	Making a good first impression	0,799
16.10	Providing counselling to patients	0,797
16.12	Providing committed, creative sensitive nursing care	0,790
16.13	Creating a therapeutic environment for the patient	0,804
16.14	Encouraging patients to confide in you	0,810
16.15	Comforting patients	0,767
16.16	Being empathetic to patients	0,774
Cronbach's Alpha coefficient for the scale with all items = 0,818		

The sub-items relating to empathy and "human touch", such as comforting and counselling patients, showed a high internal correlation with a Cronbach's Alpha coefficient of 0,818 against the minimum cut-off value of 0,7. Leaving out sub-item 16.16 (Being empathetic to patients) would lower the reliability of the factor to 0,774. Sub-item 16.4 (Taking time to talk to patients) did not fit as well as other sub-items in this scale as the alpha coefficient would increase to 0,835 if it were left out of this factor. However, this was the most appropriate factor to include this sub-item in and the increase in reliability was considered marginal.

Factors relating to the education of the patient were grouped and showed an acceptably Cronbach's Alpha coefficient of 0,74. All sub-items contributed to the

reliability of this factor, especially sub-item 16.18, where the exclusion of this sub-item would lower the reliability to 0,573, well below the acceptable cut-off rate of 0,7.

Table 4.13 Item analysis for "Education of patient"

Sub-item no	Item description	Alpha if item deleted
16.11	Teaching patients about their illnesses	0,732
16.19	Providing a clear explanation of their illness and treatment to patients	0,656
16.18	Allowing patients to take informed decisions	0,573
Cronbach's Alpha coefficient for the scale with all items = 0,743		

Sub-items 16.24 (Providing holistic patient care), 16.23 (Evaluating care provided on a continuous base) and 16.22 (Using the standardised guidelines or protocols provided for patient care) dealt with best practices in the workplace. These three sub-items also combined to create a very reliable scale with a Cronbach's Alpha coefficient of 0,859.

Table 4.14 Item analysis for "Best practices in the workplace"

Sub-item n0	Item description	Alpha if item deleted
16.24	Providing holistic patient care	0,756
16.23	Evaluating care provided on a continuous base	0,816
16.22	Using standardised guidelines or protocols provided for patient care	0,834
Cronbach's Alpha coefficient for the scale with all items = 0,859		

All sub-items contributed well to reliability, particularly item 16.24 (Providing holistic patient care).

The mean scores of the four factors are compared in Figure 4.7.

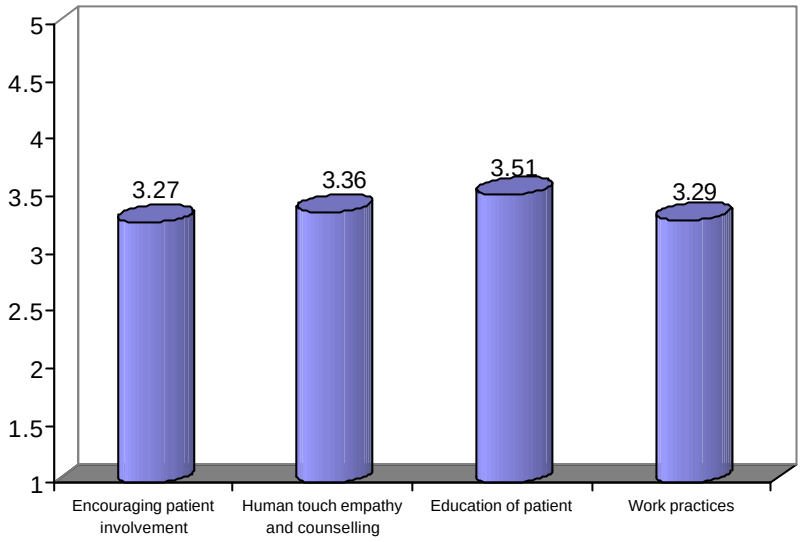

Figure 4.7: Mean scores of the four patient-centred care factors that nurses do during their normal day at work

The "Education of the patient" factor scored the highest with an average of 3,51, indicating that respondents felt this was the aspect of patient-centred care that they were most involved in. It might be that the information is not relevant or responsive to the needs of the patient, which would mean that the problem of information to the patients would still score high (see 4.3.2).

It is important to educate the clients about information that will enable them to change their knowledge, feelings, attitudes and values. The communication method or how the professional nurses communicate the information gives patients an opportunity to ventilate their feelings and ask questions. Active listening, empathy, helping responses and assertiveness are factors influencing the education of patients (Lindberg et al 1994:343).

"Encouraging patient involvement" was the dimension that the respondents felt they were the least involved in (3,27).

If the professional nurses are the least involved in encouraging patients to be involved in their care, the patient will not be part of the decision-making process and this indicate the possibility of professional nurses imposing decision on patients.

Lutz and Bowers (2000:166) state that patients require encouragement to become more involved in decisions regarding their care. Professional nurses should give them this encouragement to improve the involvement of patients in decision-making.

The mean scores of the three different hospitals are portrayed in Figure 4.8.

The three hospitals scored very similarly on the four different factors. Hospital B scored slightly higher than the other hospitals on the work practices dimension, which was consistent with their perception of the factors that hindered patient-centred care.

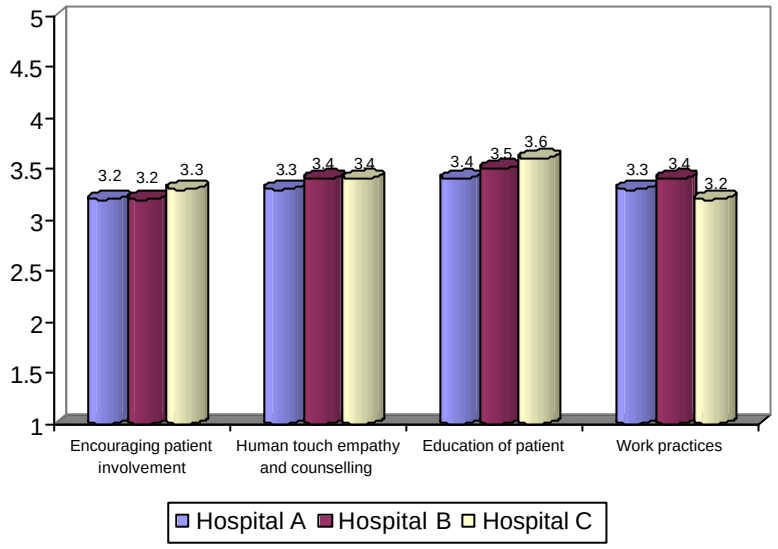

Figure 4.8: Mean scores of the four patient-centred care factors for the three different hospitals

An ANOVA was done to decide if there is a difference between the three hospitals. An ANOVA is "a statistical procedure for testing mean differences among three or more groups by comparing variability between groups to variability within groups" (Polit & Beck 2004:711).

The three hospitals did not differ **significantly** with regard to the different factors as is evident from the p-values that are all above 0,05 in table 4.15.

The three hospitals are influenced by the same policy framework and are situated in the same province and they will not differ much in certain factors.

Table 4.15 Comparison of the different hospitals with regard to the patient-centred care factors: ANOVA

		Sum of squares	df	Mean square	F	Sig
Encouraging patient involvement	Between groups	0,26	2,00	0,13	0,57	0,57
	Within groups	15,53	68,00	0,23		
Human touch, empathy and counselling	Between groups	0,13	2,00	0,06	0,40	0,67
	Within groups	10,92	68,00	0,16		
Education of patients	Between groups	0,22	2,00	0,11	0,45	0,64
	Within groups	16,83	68,00	0,25		
Best practices in the workplace	Between groups	0,44	2,00	0,22	0,54	0,59
	Within groups	27,13	66,00	0,41		

The three hospitals are all situated in a rural environment and the patients are not so exposed to the influences of sophisticated patient care like patients looking for treatment in city hospitals.

4.3.4 Item 17: Respondents' personal views on patient-centred care situations

To gain an understanding of the behaviour of the respondents in certain situations, they were asked to indicate on a ten-point scale, with two extremes of a situation at opposite ends, where they would place themselves. This kind of scale is called a semantic differential scale. This is "a technique used to measure *mostly* (I inserted) attitudes that asks respondents to rate a concept of interest on a series of bipolar rating scales" (Polit & Beck 2004:732). In this research a score of 1 indicates less patient-centredness, while a score of 10 indicates higher patient-centredness.

Table 4.16 Descriptive summary results of respondents' personal views (n = 66)

		Mean	Std deviation
Patient is too critically ill to make decisions: My decisions are based on scientific knowledge/standardized protocols	(1)		
versus			
My decisions are based on what I think the patient would want	(10)	4,03	2,212
Daily medication is given as: Prescribed	(1)		
versus			
as patient's condition warrants	(10)	4,21	3,188
Mobilisation of patients is determined by Policy	(1)		
versus			
patients' physical strength	(10)	6,82	2,742
Visiting hours are determined by the rules and regulations of the organisation	(1)		
versus			
by the needs of the patient and relatives	(10)	4,72	2,838
My understanding of patients experience is based on the clinical knowledge of the patient's condition	(1)		
versus			
the understanding of patients as fellow human beings	(10)	5,06	2,642
My empathy is based on consideration of factual clinical data	(1)		
versus			
personal meaning attributes	(10)	5,04	2,346
Patients are encouraged to participate by telling them what the best nursing plan is	(1)		
versus			
sharing information with the patient	(10)	6,75	2,966

Table 4.16 depicts the results and the means and standard deviations. Of the respondents, only 66 respondents completed this section and the low response rate to this question might be due to the fact that the question was placed at the end of the questionnaire and the respondents could have been growing tired.

The mean scores of all the sub-items ranged between 4,03 and 6,82 out of a possible 10.

The results indicated that the respondents still regarded the policies and protocols as important (for instance handing out medication, visiting hours and standardised nursing care plans). In other aspects (like mobilisation of patients and encouraging patients' participation) the respondents tend to patient-centred care.

In patient-centred care, people are respected, treated with sympathy and regarded as unique and different. “From this perspective, individualising interventions is seen as a central element in clinical judgement and a core process in clinical decision-making” (Redman 2004:12).

4.3.5 Item 18: How patient-centred care can be implemented in the working situation

Table 4.17 presents the responses, grouped into themes, for the open-ended item on patient-centred care implementation. More than one response from respondents was coded and percentages would thus not compute to 100. Only 53 respondents answered this item and 54 responses resulted in 8 themes.

Table 4.17 Responses to “How could patient-centred care be better implemented in your work situation?”

Themes	Frequency	Percentage based on the number of responses (n=54)	Percentage (based on a base size of 53)
Training programmes – general	21	38,89	40,0%
Training – on site/at the hospital	5	9,26	9,0%
More nurses	7	12,96	13,0%
Community education/teaching families	9	16,67	17,0%
Management support of patient-centred care	6	11,11	11,0%
Better salaries for nurses	3	5,56	6,0%
More beds/equipment	2	3,70	4,0%
Relaxation of strict rules to accommodate African culture	1	1,85	2,0%

The statistical data on table 4.17 indicate that:

- Twenty-six (49,0%) of the respondents suggested that better implementation strategies revolved around increased training of nursing staff in the hospital.

Most nurses realise that training plays an important part in increasing awareness of the concept of patient-centred care.

- Nine (17,0%) respondents suggested that the community should also be educated to share the same understanding of patient-centred care.
- Seven (13,0%) respondents suggested that more nursing staff was needed to provide patient-centred care.
- Six (11,0%) respondents suggested that they needed management support to implement patient-centred care.
- Other suggestions from six (12,0%) respondents were: provision of more beds and equipment, better salaries for nursing staff and relaxation of strict rules to accommodate African culture.

Some of the respondents commented that the community did not always understand the processes and procedures of a hospital and this could account for their not getting involved with the patients or for their negative feelings towards the hospitals and nurses.

4.3.6 Item 19: Respondents' definitions of patient-centred care

The response rate to the question of a definition of patient-centred care was even lower than to the previous open-ended questions as only 24 of the 72 respondents answered this question.

While 8 respondents provided definitions close to textbook definitions, indicating that they were familiar with the concept, the other definitions were too diverse to group into themes. The 8 respondents who did answer this question had received some training in patient-centred care.

Of the 24 respondents, 8 (33,3%) had done a bridging course, 5 (20,8%) had done the three-year diploma and 9 (37,5%) had done the four-year comprehensive course.

Of the 24 respondents, 7 were from hospital A, 8 from hospital B and 9 from hospital C.

All the 24 respondents indicated that they had undergone in-service training on patient-centred care. After reading the definitions, it could be concluded that most dealt with holistic care and that the respondents appeared to have a good basic understanding of the concept.

The respondents mentioned the following ideas in defining the patient-centred care:

- people first
- patient should be a priority
- patients should be the central construct
- nursing care which is focusing at patients
- the nursing care which evolve around the patient and family
- patient has a right and need to participate in the decision of their care

The low response rate to this item could be attributed to respondent fatigue as it was the last item on the questionnaire or a lack of understanding by some of the respondents. Nurses are often very busy and open-ended questions take time to complete.

4.4 CONCLUSION

This chapter discussed the data analysis, including the respondents' demographic profiles, factors hindering and facilitating patient-centred care. The respondents' personal views on patient care situations and implementation of patient-centred care were also considered.

Chapter 5 concludes the study, makes interpretations, discusses its limitations and makes recommendations.

Chapter 5

Findings, conclusions, recommendations and limitations

5.1 INTRODUCTION

This chapter discusses the findings, conclusions, recommendations and the limitations of this study.

5.2 PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of the study was to determine how professional nurses perceive their roles in patient-centred care in three regional hospitals in the Mpumalanga Province.

The objectives of this study were to determine

- whether the working environment in the provincial hospitals is supportive of patient-centred care
- the extent to which patient-centred care is provided to patients in provincial hospitals
- professional nurses' perception of their role in patient-centred care
- what factors could hinder the provision of patient-centred care

5.3 FINDINGS

A summary of the research findings will be presented in the sequence of the questionnaire and the factors as grouped.

5.3.1 Respondents' profile

Of the respondents, 89,0% were females and 11,0% were males and the majority were middle aged. The majority were Blacks (93,0%) with only 1,4% Asian, 1,4% Coloured and 4,2% White respondents.

With regard to highest qualifications, of the respondents, 42,3% had completed the bridging course, 12,7% the three-year diploma programme, 35,2% the four-year comprehensive course and 9,9% the BA Cur degree.

According to 53,2% of the respondents, they spent 71% to 90% of their time on direct patient care.

A cross-tabulation between the respondents' qualifications and in-service training in patient-centred care revealed that of the 30 respondents who indicated that they had not received in-service education on patient-centred care, 50,0% had completed the bridging course, 55,6% had completed the three-year diploma programme, 39,1% had done the four-year comprehensive course and 14,3% held BA Cur nursing degrees.

The average number of years experience in nursing was 7,5 years. The shortest period that a respondent had worked as a professional nurse after completion of study was 0,3 year and the longest was 31 years.

Of the respondents, 22 (30,6%) were working in general nursing, followed by 17 (23,6%) in surgery and 16 (22,2%) in midwifery. The rest of the respondents were distributed between intensive care, theatre, casualty and outpatients.

5.3.2 Patient-centred care

Patient-centred care was explored using the following six questions.

5.3.2.1 The application of patient-centred care in the working environment

According to table 4.6, the following aspects of patient-centred care were well applied:

- Greater involvement of patient in own care is encouraged (3,38).
- A nurse-patient relationship for common understanding of the goals of treatment is developed (3,34).
- Patients are assisted from a state of dependency to one of independency (3,34).

The following aspects of patient-centred care received less attention from the respondents:

- Supplies and equipment is available (2,34)
- Nurses experience job satisfaction (1,82)
- Adequate nursing staff to deliver quality-nursing care is present (1,76)
- Holistic patient care is provided (2,99)
- There is a personal bond between nurses and patients (2,89)
- Patients and their families display assertive behaviour (2,49)

While all three hospitals scored low on “adequate nursing staff to deliver quality patient care” and “nurses experience job satisfaction”, hospital C in particular was more affected by “a lack of supplies and equipment”.

5.3.2.2 Factors hindering patient-centred care

According to table 4.8, the factors hindering patient-centred care had a overall mean score of 2,8 and scores higher than the average was considered most significant. “Nurses’ and patients’ lack of knowledge” was seen as the greatest hindrance to patient-centred care with mean scores of 3,01 and 3,00 respectively. Tying in to the lack of knowledge is the “lack of information given to patients by health professionals” (2,91) and the subsequent “inability of patients to make choices for themselves” (2,88) either due to a lack of knowledge or lack of information. The “language barrier between patients and nursing staff” (2,91) perhaps also contributed to the respondents not providing the patients with enough information on their illnesses.

With a score of 2,97, “unmotivated nurses in the working situation” was a further hindrance to providing patient-centred care. These results indicated that staff who was not motivated could not impart information to patients to make decisions. At the time of the study, most of the hospitals were experiencing gross shortages of nursing staff and managers who could motivate the staff.

Table 4.9 compares the factors hindering patient-centred care from the three hospitals. By comparing each hospital's scores with its own average, it would appear that there were some issues that were consistently perceived to hinder patient-centred care, while there was also some variability in the different hospitals.

A lack of information and knowledge appeared to be a consistent problem area, with either the "patient's lack of knowledge" or the "lack of information given to patients by heath professionals" emerging as the biggest hindrances. Patients not being involved in the decision-making process were also an area of hinderance mentioned by two of the three hospitals. This indicated that patient education was done, but that the patient-centred care approach was not used and the need for information about patient-centred care is necessary.

Another area that hindered patient-centred care consistently perceived across the hospitals was "poor nurse-patient relationship".

The respondents employed by hospital B seemed to focus slightly more on organisational issues, such as centralised decision making, unmotivated staff and a lack of collaboration between patients and health care professionals.

The respondents in hospital C indicated additional hindrances such as nurses' anxiety levels and a lack of role models for implementing patient-centred care in their hospital.

5.3.2.3 Aspects of patient-centred care which nurses practise in their normal working time

Tables 4.11, 4.12, 4.13 and 4.14 display factors which were created and the item analysis on the degree to which the respondents practise patient-centred care.

The following four factors were created:

- encouraging patient involvement
- human touch, empathy and counselling

- education of patient
- best practices in the workplace

The creation of the four factors, reducing the 24 sub-items in item 16, allowed for a visual comparison of the mean scores and a statistical comparison between hospitals.

Figure 4.7 portrays the mean scores of the four patient-centred care factors that the respondents did during their normal day at work. The “education of the patient” factor scored the highest with an average of 3,51, indicating that the respondents considered this the aspect of patient-centred care that they were most involved in their daily activities.

“Encouraging patient involvement” was the dimension the respondents felt they were the least involved in (3,27).

Figure 4.8 illustrates the mean scores of the four patient-centred care factors for the three different hospitals. Hospital B scored slightly higher than the other two hospitals on the work practices dimension, which was consistent with their perception of the factors that hindered patient-centred care.

Hospital A scored low on the “human touch, empathy and counselling” and “education of patients” factors.

The three hospitals did not differ significantly with regard to the different factors as can be seen from the p-values that are all above 0,05 in table 4.15. The three hospitals were influenced by the same policy framework and situated in the same province hence they would not differ significantly in certain factors.

Table 4.15 presents a comparison of the different hospitals’ perceptions of the four patient-centred care factors. The ANOVA indicated no difference in the way that the respondents in the different hospitals perceived patient-centred care and how they applied it in their daily work.

5.3.2.4 Respondents' personal views on patient care situations

To gain an insight into the respondents' behaviour in certain situations, they were asked to indicate on a ten-point scale, with two extremes of a situation at opposite ends, where they would place themselves.

The results generally indicate that the respondents were policy-abiding people and the decisions they made when dealing with patients' situations were based on the balance between the patients' needs and preferences and the policies. The results indicated that decisions based on scientific knowledge (4,03) and the tendency to follow prescriptions (for example, medicines) (4,21) and adherence to visiting hours (4,72) were to be followed as prescribed by guidelines and policies of the institutions. On the aspect of patients' involvement or participation the respondents scored high (6,75), indicating that they involved patients when they made decision about their care and each individual was unique.

5.3.2.5 How patient-centred care can be implemented in the working situation

Table 4.17 indicates the responses, grouped into themes, for the open-ended question on patient-centred care implementation suggestions.

- Respondents (49,0%) suggested increased training programmes for nursing staff on patient-centred care in general or at the hospital.
- Another suggestion by 17,0% of the respondents was that the community should also be educated to share the same understanding of patient-centred care.
- Some respondents (13,0%) suggested that more nursing staff was needed to provide patient-centred care.
- An additional proposal by 11,0% of the respondents was that management should give the nursing staff more support to implement patient-centred care.
- Other suggestions from 6 respondents (12,0%) included more beds and equipment, better salaries for nursing staff and relaxation of strict rules to accommodate African culture.

Some of the respondents commented that the community lack knowledge of the processes and procedures of a hospital and this could be the reason for their lack of involvement with the patients or for their negative feelings towards hospitals and nurses.

5.3.2.6 Respondents' definitions of patient-centred care

Only 24 of the 72 respondents gave a definition of patient-centred care. This could be due to a lack of knowledge of the concept and should be explored further.

Eight respondents provided definitions close to the textbook, indicating that they were familiar with the concept. All eight of these respondents indicated that they had received some training in patient-centred care. From the definitions, it could be concluded that most dealt with holistic care and the respondents appeared to have a good basic understanding of the concept.

The definitions of the other 16 respondents were too diverse to group into themes.

- people first
- patient should be a priority
- patients should be the central construct
- nursing care which is focusing at patients
- the nursing care which evolve around the patient and family
- patient has a right and need to participate in the decision of their care

This indicates that patients are important and needs to take part in the decision-making in their care.

This indicates that the definition is evolving around people or patients as a central person and when providing nursing care they need to be encouraged to participate.

The low response rate to this question could be attributed to respondent fatigue as it was the last question in the questionnaire or to respondents' lack of understanding. Nurses are often very busy and open-ended questions take time to complete.

5.4 LIMITATIONS

The study had several limitations, namely

- It was conducted in only one of the nine South African provinces. To gain a more comprehensive picture of patient-centred care in South Africa, a nationally representative study should be undertaken.
- A sample size of 72 is adequate to obtain information from the three regional hospitals in total, but to compare certain demographic sub-groups it is too small, and it is also too small to generalise to larger groups. Future research could focus on increasing the sample size to ensure larger representation in the three hospitals to be compared.
- The study included 89,0% females and although representative of the nursing population in South Africa, this does not allow for a comparison between males and females with regard to patient-centred care. A future research study could be designed around the creation of two equally sized groups to investigate the male nurses' perceptions of patient-centred care.
- The last section of the questionnaire was poorly answered with only 24 of the 72 respondents completing this section. This could be attributed to respondent fatigue, or the fact that nurses have time constraints in completing surveys due to pressure of work. Future studies need to carefully consider the length of and the placement of important information in questionnaires.
- Items 14 and 15 could not be reduced to reliable factors, which resulted in the interpretation of individual items. This limited the statistical information that could be extracted from the data, such as correlations and comparisons with demographic data.

5.5 CONCLUSIONS EMANATING FROM THE STUDY

The following conclusions were derived from the study and formulated in terms of the factors.

5.5.1 Respondents' profile

The respondents were predominately Black in all the hospitals and most were females (89,0%). This is in line with the gender composition for the nursing profession in South Africa where 93,6% of the profession are females and 6,4% males. The respondents' average age was 38, with the oldest being 54 and the youngest 26 years. The respondents practised in a variety of areas in the hospitals; the highest qualification was BA Cur and most of the respondents with a four-year comprehensive qualification or BA Cur degree had been exposed to the topic of patient-centred care through training.

5.5.2 Extent of involvement of different role players in direct patient care and treatment

The respondents were asked to indicate the extent to which patients, professional nurses, doctors and family members were involved in direct patient care and treatment. The result indicated that professional nurses were seen as the role player with the highest direct involvement with the patient (78,3%) while doctors were more likely to have "much involvement" (44,6%) as opposed to high involvement. Furthermore, patients and their family were less involved in their own care. The professional nurses are therefore main role players in patient care.

5.5.3 Application of patient-centred care in the working environment

Findings of this research indicated that involvement of patients in their own care is encouraged and that a relationship between the nurse and patient is developed for the common understanding of goals. Patients are also assisted to progress from a state of dependency to one of independency.

Unfortunately factors like the lack of supplies and equipment, lack of job satisfaction of the nurses, insufficient nursing staff to deliver quality nursing care, holistic patient care not always being provided, lack of personal bond between nurses and patients and failure of patients and their families to display assertive behaviour are not supportive of patient-centred care. These factors are detrimental to patient-centred care and need to be eradicated through in-service training programme targeting these issues. Patient education plan should also be considered.

5.5.4 Factors hindering patient-centred care

"Patients' and nurses' lack of knowledge" and "lack of information given to patients by health professionals" emerged as the biggest hindrances in providing patient-centred care. Respondents from two of the three hospitals also indicated "patient not being involved in the decision-making process" as a hindrance. This indicated that patient education was done, but that the patient-centred care approach was not used and the need for giving information to patients by health care professionals is necessary. Another area consistently perceived across all three hospitals as a hindrance to patient-centred care was a "poor nurse-patient relationship".

Other hindrances that hamper patient-centred care perceived especially by respondents in Hospital A, were "patients' inability to make choices for themselves", "non-consultation with patient", "unmotivated nurses in the work situation", "language barrier between patients and nursing staff/health services", "poor communication between nurses and patients" and "lack of collaboration between patients and health care professionals".

The respondents employed at hospital B seemed to focus slightly more on organisational issues, such as centralised decision making by supervisors, unmotivated staff and a lack of collaboration between patients and health care professionals. Another area of hindrance for respondents in Hospital B was that nurses seemed to lack of respect for the patients' values, preferences and expressed needs.

The respondents in hospital C listed additional hindrances, such as nurses' high anxiety levels of nurses and a lack of role models for implementing patient-centred care in their hospital.

The results indicate that in all three hospitals the nurses do not give patients enough information for making informed decisions. This is a hindrance which need to be looked into.

The nurse-patient relationship is affected as well. Language barrier is also a hindrance, which affects communication between nurses and patients. The hindrance of lack of respect for the patients' values, preferences and expressed needs is affecting patients negatively and results in patients' dissatisfaction.

5.5.5 The extent to which patient-centred care is provided to patients in provincial hospitals

Table 4.10 indicates that the nurses are teaching patients about their illnesses and care, patients are encouraged to take responsibility for their health and they are providing patients with a clear explanation of their illness and treatment. The patient-centred care dimensions are practices and nurses perceive partners in care delivery.

5.5.6 Respondents' personal views on patient care situations

To gain an insight into the respondents' behaviour in certain situations, they were asked to indicate on a ten-point scale, with two extremes of a situation at opposite ends, where they would place themselves.

The respondents indicated that they are more on the opposite of patient-centred care, that is more towards one (1) than towards ten (10).

This indicated that patient-centred care was a challenge for health care professionals. They should be aware of the factors that affect patient-centred care as indicated in this

study because these factors affect the relationship between nurses and patients as well as the interaction between them.

This concludes that professional nurses are more inclined to follow procedures, policies and rules than considering any patients' condition.

5.5.7 How patient-centred care can be implemented

The respondents suggested the following as the best strategies to implement patient centred care:

- training of nursing staff
- educating the community so that they can participate fully
- increasing human and material resources to implement patient-centred care appropriately in the working situation
- management support to facilitate the process of implementing patient-centred care. This support will be valued by professional nurses when they are implementing patient-centred care.

5.5.8 Respondents' definitions of patient-centred care

As mentioned earlier (see section 5.3.2.6), only 24 of the 72 respondents gave a definition on patient-centred care. This could indicate a lack of knowledge of the concept and should be explored further.

The respondents who gave accurate definitions had received some training in patient-centred care, which indicated that in-service training is important when new care-related aspects are introduced. The low response rate could be attributed to respondent fatigue, as it was the last question in the questionnaire or to respondents' lack of understanding. Moreover, the researcher observed signs of burnout among some of the respondents. The identified themes are the perceptions of the professional nurses as they see the patient-centred care. The nurses have a broad idea as to what patient-centred care encompasses.

5.6 RECOMMENDATIONS

➢ Nursing practice

- There should be adequate time for nurses to identify patients' needs, educate them on issues related to their illness so that they can make informed decisions, as well as adequate support from the nurses to communicate effectively with patients.
- Nurses should be motivated to realise that patients and their relatives should be involved and participate in their own treatment and care. It is also recommended that there be constant monitoring and evaluation of the health care services, especially regarding patients' satisfaction and professional nurses' job satisfaction.
- Awareness campaign should be held for patients, informing them on Patient Right Charter.
- Emphasis should be placed on giving education to patients (health education).
- Patients and the community should be educated and constantly given information on matters related to the care they receive.
- Patients and their relatives to participate in decision-making.
- Barriers to effective communications between nursing staff and patients should be removed.
- Lack of information giving to patients should be improved.
- Providing sufficient staff and material resources should receive attention from authorities.
- The nursing staff needs management support for appropriate implementation of patient-centred care.
- Restructuring and re-organising patient care to accommodate patient-centred care.
- Patients need to be encouraged to participate in aspects regarding their own care.
- Motivation of professional nurses to improve their job satisfaction.

- **Nursing education**

- From this study it is clear that the highly qualified respondents had been exposed to patient-centred care during their training. The literature review emphasised patient-centred care as the best approach to provide patient-centred care because the patient is regarded as a role player. This approach should be included in the curriculum in nursing training.
- Improving the language by having a programme of teaching languages.
- Improving in-service training programmes to include topics on patient-centred care.
- Improving communication skills of the nurses.

- **Nursing research**

- It is recommended that ongoing research be conducted on patient-centred care, especially on perceptions of patients, senior management and other health care professionals in other hospitals and in all the nine provinces.
- Patient satisfaction survey to identify whether their needs are met.
- Further research should be undertaken on professional nurses' knowledge and understanding of patient-centred care.

5.7 CONCLUSION

This chapter discussed the findings and conclusions of the study and made recommendations for practice, nursing education and further research. The findings emphasise the need to acknowledge that patients are stakeholders in the care they receive.

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Q U E S T I O N N A I R E :

CARE CODE | | | |

TOPIC: PERCEPTIONS OF PROFESSIONAL NURSES ON PATIENT CENTRED-CARE: GENERAL INFORMATION ABOUT THE PROFESSIONAL NURSES

WITH REGARD TO ITEMS 1-10, PLEASE INDICATE WITH A CROSS (X) IN THE APPLICABLE BOX AS THESE ITEMS APPLY TO YOU.

1. THE NAME OF HOSPITAL:

Rob Ferreira	1
Ermelo	2
Philadelphia	3
Themba	4

2. GENDER:

Male	1
Female	2

3. AGE IN YEARS (Indicate in full years): | |

4. RACE:

Asian	1
Black	2
Coloured	3
White	4

5. HIGHEST PROFESSIONAL QUALIFICATION:

Bridging course in nursing	1
3 year Diploma in Nursing Science	2
4 year Comprehensive Diploma in Nursing	3
BA Cur Degree	4
Honours Honours Degree	5
MA Cur Degree	6
Any other Degree	7

6. MAIN AREA OF PRACTICE:

General Nursing	1
ICU	2
Theatre Nursing	3
Midwifery	4
Surgery	5
Medicine	6
Casualty	7
Outpatients Department	8
Other (Specify): ……..	9

7. PERCENTAGE (%) OF TIME YOU SPEND ON DIRECT PATIENT CARE

Please write in the % ☐

8. YEARS OF EXPERIENCE AS A PROFESSIONAL NURSE:

Please write in the number of years ☐

9. DID YOU ATTEND ANY INSERVICE TRAINING WHERE PATIENT-CENTRED CARE WAS A TOPIC?

Yes	1
No	2
Unsure	3

10. HOW MANY LECTURES / TRAINING SESSIONS DID YOU ATTEND ON PATIENT-CENTRED CARE?

Once	1
Twice	2
Three times	3
More than three	4
None	5

11. TO WHAT EXTENT ARE THE FOLLOWING PEOPLE INVOLVED IN DIRECT PATIENT CARE AND TREATMENT IN THE HOSPITAL YOU ARE WORKING IN?

KEY: 1. Indicate no involvement 2 Indicate little involvement
3. Indicate much involvement 4. Indicate the highest involvement

	1	2	3	4
Patient				
Professional Nurse				
Doctor				
Family members				

ITEMS 14.1-14.24

With regard to patient-centred care, indicate the extent to which the following apply to your working environment

		Strongly disagree	Disagree	Agree	Strongly agree
14. 1	Staff are knowledgeable about patient-centred care	1	2	3	4
14. 2	Staff is involve in the full range of problems the patient is experiencing.	1	2	3	4
14. 3	Nursing staff is displaying a positive attitude in implementing patient – centred care.	1	2	3	4
14. 4	The clinical charge nurse is seen as a role model with regard to patient-centred care.	1	2	3	4
14. 5	Greater involvement of patient in own care is encouraged.	1	2	3	4
14. 6	There is mutual participation of patient and health professionals in care.	1	2	3	4
14. 7	Adequate nursing staff to deliver quality nursing care is present.	1	2	3	4
14. 8	Patients are provided with enough information to make informed decisions	1	2	3	4
14. 9	Nurses have positive interpersonal relations.	1	2	3	4
14.10	A nurse/patient relationship for common understanding of the goals of treatment is developed.	1	2	3	4

		Strongly disagree	Disagree	Agree	Strongly agree
14.11	Nurses encourage patients to voice ideas, listen to them and reflect for collaboration.	1	2	3	4
14.12	Delegation of authority to the lower levels is taking place.	1	2	3	4
14.13	Nurses are experiencing job satisfaction	1	2	3	4
14.14	Open two-way communication between nurse and patient exist.	1	2	3	4
14.15	Nurses consider the culture of patient in planning nursing care	1	2	3	4
14.16	Patient empowerment is promoted	1	2	3	4
14.17	Holistic patient care is provided.	1	2	3	4
14.18	Patients and their families display assertive behaviour	1	2	3	4
14.19	There is co-ordination between health professionals.	1	2	3	4
14.20	Supplies and equipment is available	1	2	3	4
14.21	Staff understand the uniqueness of every patient	1	2	3	4
14.22	There is a personal bond between nurses and patients.	1	2	3	4
14.23	Patients are assisted from a state of dependency towards one of independence	1	2	3	4

ITEMS 15.1-15.25

15. Indicate with a cross (x) to what degree you feel the following could hinder patient centred care, in general.

		Totally Insignificant	Somewhat insignificant	Somewhat Significant	Totally Significant
15. 1	Lack of knowledge of the patient	1	2	3	4
15.2	Lack of knowledge of the nurse	1	2	3	4
15.3	Unprofessional behaviour of nursing staff.	1	2	3	4
15.4	Lack of information given to patients by health professionals.	1	2	3	4
15.5	Seriousness of patients' illness.	1	2	3	4
15.6	Patients' inability to make choices for themselves.	1	2	3	4

		Totally Insignificant	Somewhat insignificant	Somewhat Significant	Totally Significant
15.7	Poor nurse-patient relationship.	1	2	3	4
15.8	Lack of patients' involvement in decision- making.	1	2	3	4
15.9	Non consultation with patients	1	2	3	4
15.11	Lack of role models for implementing patient-centred care	1	2	3	4
15.12	Dehumanising of patients by nurses.	1	2	3	4
15.13	Centralised decision making by supervisors	1	2	3	4
15.14	Lack of emotional support given by nurses to patient.	1	2	3	4
15.15	Unmotivated nurses in the work situation	1	2	3	4
15.16	High anxiety levels of nurses.	1	2	3	4
15.17	No co-ordination and integration of care activities.	1	2	3	4
15.18	Failure of nursing staff to encourage patients to ask questions about their care	1	2	3	4
15.19	Patient's disempowerment.	1	2	3	4
15.20	Language barriers between patients and nursing staff / health services staff	1	2	3	4
15.21	Poor communication between nurse and patients	1	2	3	4
15.22	No respect shown by nurse for patients values, preferences and expressed needs.	1	2	3	4
15.23	Lack of collaboration between patients and health care professionals.	1	2	3	4
15.24	Lack of sensitivity for the feelings of the patient on the part of the nurse.	1	2	3	4
15.25	Other (specify)	1	2	3	4

ITEMS 16.1-16.26

16. Indicate the degree to which you comply to the following items during your daily provision of patient-centred care:

		Strongly Disagree	Disagree	Agree	Strongly agree
16. 1	Utilising momentary incidents for rendering physical care.	1	2	3	4
16. 2	Utilising momentary incidents for rendering psychological care.	1	2	3	4
16. 3	Utilising momentary incidents for rendering social care.	1	2	3	4
16. 4	Taking time to talk to patients.	1	2	3	4

		Strongly Disagree	Disagree	Agree	Strongly agree
16. 5	Familiarising yourself with patients condition.	1	2	3	4
16. 6	Making a good first impression	1	2	3	4
16.7	Encouraging patients to take responsibility for their health	1	2	3	4
16.8	Encouraging patients' involvement in decision - making.	1	2	3	4
16. 9	Involving patients in planning care interventions	1	2	3	4
16.10	Providing counselling to patients.	1	2	3	4
16.11	Teaching patients about their illnesses and care	1	2	3	4
16.12	Providing committed, creative sensitive nursing care	1	2	3	4
16.13	Creating a therapeutic environment for the patient	1	2	3	4
16.14	Encouraging patients to confide in you.	1	2	3	4
16.15	Comforting patients	1	2	3	4
16.16	Being empathic towards patients	1	2	3	4
16.17	Allowing patients their autonomy.	1	2	3	4
16.18	Allowing patients to take informed decisions.	1	2	3	4
16.19	Providing a clear explanation to patients about their illness and treatment	1	2	3	4
16.20	Seeing patients as participants in their health care	1	2	3	4
16.21	Soliciting the patient's opinion when formulatin g a nursing care plan	1	2	3	4
16.22	Using standardised guidelines or protocols provided for patient care.	1	2	3	4
16.23	Evaluating care provided on a continuous base	1	2	3	4
16.24	Providing holistic patient care.	1	2	3	4
16.25	Other (specify)	1	2	3	4

USING A SCALE OF WHERE 1 IS THE ONE EXTREME AND 10 ARE THE OTHER EXTREME, WHERE DOES YOUR PERSONAL FEELINGS LIE?

FOR EXAMPLE

YOUR IDEAL HOLIDAY IS….

		1	2	3	4	5	6	7	8	9	10	
	A nature reserve, far removed from civilisation. Living off the land.				X							A hotel in the middle of the town life, were all your meals are served in a restaurant

I chose 4, because although I like nature holidays more than those in hotels, I am not totally committed to living without take-away food or some comforts.

APPLY THE SAME CONCEPT TO THE SITUATIONS BELOW:

Patient is too critically ill to make decisions

17.1	My decisions are based on scientific knowledge/ standardised protocols	1	2	3	4	5	6	7	8	9	10	My decisions are based on what I think the patient would want.

Daily medication is given as

17.2	Prescribed	1	2	3	4	5	6	7	8	9	10	As patient's condition warrants

Mobilisation of patients are determined by

17.3	Policy	1	2	3	4	5	6	7	8	9	10	Patients' physical strength

Visiting hours is determined by

17.4	The rules and regulations of the organisation	1	2	3	4	5	6	7	8	9	10	By the needs of the patient and relatives.

My understanding of patients' experience is based on the

17.5	Clinical knowledge of the patient's condition	1	2	3	4	5	6	7	8	9	10	Understanding from patients as fellow human beings.

My empathy is based on

17.6	Consideration of factual clinical data	1	2	3	4	5	6	7	8	9	10	Personal meaning attribution.

Patients are encourage to participate by

17.7	Telling them what the best nursing plan is.	1	2	3	4	5	6	7	8	9	10	Sharing information with the patient.

18 HOW COULD PATIENT-CENTRED CARE BE BETTER IMPLEMENTED IN YOU WORK SITUATION? GIVE YOUR OWN SUGGESTIONS:

19 DEFINE THE TERM "PATIENT CENTRED CARE" IN YOUR OWN WORDS

THANK YOU FOR THE INFORMATION.

ANNEXURE 2

TO: COLLEAGUES

TOPIC: STUDY ON PERCEPTIONS OF PROFESSIONAL NURSES ON PATIENT–CENTERED CARE

I am a student in MA Cur, as part of my studies at UNISA, a research is undertaken regarding the above-mentioned topic.

Your co-operation is needed to complete the questionnaire.

It will take approximately 15-20 minutes of your time. All information is confidential and you can be frank in giving your honest, best opinions. This information will not make you suffer.

After the study, summary of findings will be available at senior management.

Yours faithfully

Ms M M Madigage

Witbank Hospital

ANNEXURE 3

INFORMED CONSENT BY RESEARCH PARTICIPANT

I _____ confirm that I was fully informed of the research project. I am aware that my privacy will be safeguarded. That all the information I share with the researcher will be confidential. I also reserve the right to have access to the report or published findings. I know that I do not have to suffer any injury of harm during research process. The information that I will give to the researcher should not be used against me in future.

NAME : _____

SIGNATURE: _____

DATE: _____

PLACE: _____

ANNEXURE 7

7 Henri Slegtkamp Street
Extention 10
Witbank
1034

01 January 2005

Tel: 0824505883

The Deputy Director
Nursing Services
Nelspruit Hospital
MPUMALANGA

TOPIC: APPRECIATION AND ACKNOWLEDGEMENT

Thank you for your assistance and cooperation in conducting the research in your institution. Could you kindly extend my gratitude to all who participated and made the study a success, especially the professional nurses and their supervisors.

With great appreciation.

Thank you

MM MADIGAGE