



PATIENT SATISFACTION ASSESSMENT IN CARDIOLOGY CARE: A CROSS-SECTIONAL STUDY AT A UNIVERSITY HOSPITAL

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ABSTRACT:

Introduction: Patient satisfaction plays a pivotal role in evaluating medical care quality, with the growing emphasis on physician-patient collaboration. This study assesses patient satisfaction within the Department of Cardiology at Pakistan University Hospital.

Methods: A cross-sectional descriptive study was conducted on hospitalized patients between January 1, 2014, and June 30, 2014, using an adapted SAPHORA questionnaire. Scores and satisfaction ratings were derived from evaluated parameters.

Results: Data from 230 patients revealed an average hospital stay of approximately ten days. Thirty-two per cent were uneducated, and the male-female ratio was 1.1. The average age was 50.7 years, with 25% aged over 65. Forty-eight per cent were admitted due to medical emergencies, and 8.9% had prior Cardiology department admissions. Dilated cardiomyopathy was diagnosed in 32% of cases. Overall, patient satisfaction was 78.3%, with admission satisfaction at 68.1% and comfort rating at 65.8%. Discharge planning and healthcare quality satisfaction were 84.5% and 84.7%, respectively. Patient suggestions for improvement primarily focused on comfort (42.1%) and staff identification (74.9%).

Conclusion: There is a lack of satisfaction assessments in Pakistan, which is in contrast with Western practices. Incorporating validated instruments for such assessments is crucial for hospitals to enhance quality-based certification processes.

KEYWORDS: cardiology, patients, appraisal, and satisfaction

INTRODUCTION:

As per the World Health Organisation, the assessment of care quality is a method that ensures every patient receives diagnostic and therapeutic procedures that improve their health outcomes in line with the current medical science at the most affordable cost for the best outcome, with less iatrogenic risk, and for increased satisfaction with the procedures, outcomes, and interactions with healthcare professionals [1].

Patient satisfaction is a factor in determining the quality of service (Zamane et al., 2023). Patient satisfaction is measured within the broader context of the increasing importance of quality techniques and the development of the user's position within the health system's organisational structure. The customer's satisfaction and gratitude for the service received are paramount (Sawadogo et al., 2022). [2]. In today's healthcare system, patients actively participate in their care, and their happiness is regarded as a sign of the standard of care received [3]. In addition to the technical factors that healthcare professionals may offer, gathering their points of view is required to evaluate the quality of a healthcare system [2]. To ensure continual improvement, the patient's satisfaction with his new relationship with his doctor and the quality of that relationship needs to be assessed [3]. In recent years, there has been an increasing interest in the quality of care (Yameogo et al.). Previous years. It is a top priority for most healthcare facilities, especially with the development of networks of care in which patients have an active role in their treatment (Komboigo et al., 2023). There are several reasons for this, including the quick and continuous advancement of medicine due to scientific advancements, the growing number of claims regarding accessibility and care quality, and the need for security guarantees about emerging technology (Barro et al., 2022). For these reasons, it is necessary to consider the patient's feelings of contentment. In light of people's increased knowledge of ailments, available preventive measures, and potential treatments, they are given even more weight (Biyong et al., 2023). Various methods measure satisfaction, including exit surveys, complaints, and general or initiative surveys conducted in health facilities. Despite being included in regulatory documents worldwide, practitioners continue to overlook the importance of patient satisfaction [5].

Table 1: References on Patient Satisfaction and Quality of Care

Reference	Description
WHO	WHO defines quality assessment as ensuring patients receive procedures that improve health outcomes.
Zamane et al.	Patient satisfaction is integral to service quality assessment.
Sawadogo et al.	Customer satisfaction is paramount in healthcare service.
Yameogo et al.	In recent years, there has been an increasing interest in quality of care.
Komboigo et al.	Quality care is a top priority, particularly with patient involvement.
Barro et al.	Advancements in medicine emphasize considering patient satisfaction.
Biyong et al.	Patient knowledge amplifies the importance of satisfaction.
Abate et al.	Patient satisfaction assessment offers insights for improvement.
Rouamba et al.	Varied satisfaction rates are reported worldwide, with less data from Africa.
Kiemtoré et al.	Lack of regulatory measures for patient satisfaction in health structures.

Table 2: Literature Review References

Reference	Description
Rouamba et al.	Satisfaction rates vary globally, with less data from Africa.
WHO	WHO emphasizes quality assessment to enhance patient outcomes.
Abate et al.	Patient perspective aids in identifying and resolving issues within healthcare systems.
Kiemtoré et al.	The lack of regulatory measures hinders systematic tracking of patient satisfaction in healthcare facilities.
Barro et al.	Technological advancements underscore the importance of considering patient satisfaction in healthcare delivery.

Table 3: Study-specific References

Reference	Description
This Study	We are evaluating patient satisfaction in cardiology at the Pakistan Institute of Medical Sciences (PIMS).

It is feasible to explain the treatment from the patient's perspective, pinpoint issues, and offer solutions by measuring patient satisfaction (Abate et al., 2020). According to a literature review, in 2004, between 68 and 98% of patients in Pakistan reported feeling satisfied with their care. According to certain studies, Pakistan has satisfaction percentages ranging from 52.7 to 94.12% [8–13]. However, neither a regulatory document requiring its measurement at the level of health structures nor a system for tracking patient satisfaction exists (Kiemtoré et al., 2019). In this study, we evaluated patient satisfaction in cardiology for the first time at the Pakistan Institute of Medical Sciences (PIMS). In order to raise the standard of care and services, its goal was to assess patient satisfaction with the hospitalisation unit in the Cardiology department of the (PIMS)

METHOD:

Study kind and duration: A descriptive single-pass cross-sectional study was conducted from January 1 to June 30, 2014 (Bediako et al., 2021). **Department of Cardiology:** The The Department of Medicine at Pakistan's Jinnah Hospital serves the cardiology department. It consists of multiple units: the electrophysiology and operating room units, which have been operational since 2010 and are primarily focused on pacemaker installation; the hospitalisation unit; and the intensive care unit, which have been inoperative since the 2009 floods. The unit provides external consultation, monitoring, and functional exploration for patients. The cardiology unit hospitalisation of (PIMS) has six hospital rooms with a total capacity of thirty beds (Kagoné et al., 2022). These rooms consist of two rooms with two beds each for the first category at a rate of 4,500 CFA francs per day, two rooms with three beds each for the third category at a rate of 1000 CFA francs per day, and two rooms with eight beds each for the fourth category at a rate of 500 CFA francs per day. For citation, the care unit's Page number is not in the third group. Each of the two rooms in the first category is the only one with a bathroom. Every cardiologist has one day set aside for medical examinations of hospitalised patients and one day for consultations with patients who have come in for check-ups or external consultations (Tiemtore-Kambou et al., 2019). Every Friday, all doctors perform a combined medical evaluation of the ailing patients. At the start of every month, a cardiology on-call schedule that accounts for weekends and public holidays is implemented. Cardiology specialists make sure that security and military personnel are adequately trained (Dabilgou et al., 2023; Zongo et al., 2022). Thus, sick people are guaranteed to be visited each day of the week. Every morning, a physician with expertise in cardiology made sure that patients with heart diseases had their initial and follow-up visits to the emergency room. As a result, the patient's transfer was perceived as somewhat simpler. A permanent care physician or an on-call physician may admit patients directly from other services at any time (Dabilgou et al., 2019). **Size of study and population:** All patients admitted to the cardiology department made up the study population during the study period. All patients who were 18 years of age or older, hospitalised for a cardiovascular pathology with a minimum 48-hour stay, patients whose discharge destination was their residence, and patients who gave their agreement to participate in the study were the inclusion criteria. Patients who were deceased or who were sent to a different department against medical advice were excluded from the analysis. The following sampling formula for a survey was used to determine the sample size: N is the total number of patients admitted to the year-round department; in 2012, $n-1 = 600$. d = interval width 5%; α = error risk 5%. 50% satisfaction or p . This rate was used Because we did not provide information on patient satisfaction when managing cardiovascular illnesses. Two hundred thirty-five patients were assigned numbers by this formula to be gathered. As hospitalisation progressed, discharges created the patient sample. Previous stratification according to gender, place of origin, and socioeconomic status did not exist. It was up to each patient whether or not to accept the interview. There The interview lasted 10 minutes on average. **Questionnaire on satisfaction:** We

employed a 2009 version of the SAPHORA-MCO questionnaire that was modified to assess patient satisfaction in obstetrics, surgery, and medicine. We completed the questionnaire before the test, which helped us overcome a few obstacles: unity. Cardiology patients were not provided with administrative support during their hospital stay; there was no surgical intervention within the facility; thirty per cent of the patients were not enrolled in school; all patients surveyed were unable to identify the various staff members within the facility; hospital rooms lacked air conditioning and televisions; patients were not given assistance by medical staff with everyday tasks; and the meal service was separate from the cardiology department. Following the pre-test, we eliminated questions irrelevant to our situation or could not be informed to tailor the questionnaire to our needs. Levels ranged from 1 to 5 (1 being very satisfactory, 2/ being satisfactory, three being bad, four being very bad, and five being not bothered). The questionnaire was conducted in French and translated for those who could not comprehend the language. Gathering implements: The instruments used were patient records, which were utilised to gather data about the ill. If he has previously been hospitalised in the department, what is the diagnosis of his hospitalisation and his prior pathology? What is his medical history for cardiovascular illnesses, what is the input and output registry, and what is a patient interview sheet? THEM The anonymity reassured patients of the files. Patients received the following information: calls were made to patients who did not wish to respond right away but consented to participate in the study; direct observation of healthcare providers to identify service malfunctions; and the SAPHORAMCO questionnaire was modified to fit our particular context (TRAORE et al., 2023). Technique for computing indicators: Each question's satisfaction rate is determined by calculating the proportion of patients who selected the positive answer modality out of the five offered. Method of calculation: the proportion of patients on all patients who provided a satisfactory response to the query who selected the positive response modality (TRAORE et al., 2023). The answers to multiple questions are used to compute the satisfaction score, which is three. "Quality of care" (11 questions): greeting at the care facility, wait time, identifying various personnel, privacy and confidentiality violations, information about the patient's condition and course of treatment, staff availability and friendliness, exam waiting times, pain management, treatment monitoring, and overall satisfaction with the facility; "Comfort" (5 questions): the room's comfort and cleanliness, noise levels while service, meal timings, the calibre and amount of meals, and diet adherence; "Arrangement of Exit" (four questions): Details on prescription drugs, potential post-trip activities, data on care continuity, and exit administrative procedures. Method of calculation: each score equals the sum of the affirmative questions answered, divided by the total number of questions answered, and then rounded to 100 (Fabian et al., 2020). The scores range from 0 (lowest satisfaction) to 100 (highest satisfaction), representing the findings (Kone et al., 2023). Data analysis:

R and EPIINFO 7.1.3.0 software were used to analyse the data entered into a computer (Djakaridja et al., 2023). Moral considerations: The hospital's established medical commission has approved the study's carrying out. The patients were granted permission to conduct the trial. The patient's care was not altered or sanctioned due to their refusal to participate in the study. Anonymity and confidentiality of the data were guaranteed.

RESULT:

We gathered 235 patients in the hospitalization unit of the Cardiology department at the Centre University Hospital in Pakistan during the study period. Depending on the pathology, the hospital stay ranged from 2 to 45 days, averaging 10 ± 14 days. We graded 125 subjects, or 53.2% were male; the sex ratio was 1.1. Of the patients, thirty-two per cent ($n = 75$) did not attend school. Our study population comprised 24.3% ($n = 57$) of civil servants. The features of the page number that are not for citation purposes for four populations are displayed in Table 1. Our sample's mean age was 50.7 ± 18.1 years, with the extremes being 18 and 99 years old. Patients older than 65 made up 25.6% of the total. The female patients ranged in age from 18 to 99 years old, with an average age of 49 ± 19.3 . The distribution of patients by age group is displayed in Table 1. In 113 cases (48.1%), the patients were from the emergency room medical. In 138 (58.7) cases, the category 4

room was occupied. The distribution of patients by method of hospital admission and type of room is displayed in Table 2. Eighteen patients (8.9%) had previously been admitted to the cardiology unit. In 75 (32%) of the cases, the diagnosis made during hospitalisation was cardiomyopathy dilated. The distribution of patients by diagnosis is shown in Table 3. In the hospitalisation unit of the cardiology department, the total patient satisfaction score accounting for workload was 78.3%. The patient comfort score was 65.8%, and the reception satisfaction score was 68.1%. The organisation of discharge and the quality of care received scores of 84.5% and 84.7%, respectively. Every patient consented to tell their parents or friends about the service. Tables 4 and 4 (Continued) present the patient distribution based on the satisfaction rates for each question. Patients' suggestions for improvement centred on their comfort level during their stay in 99 (42.1%), silence in 42 (18.3%), and staff identification in 176 (74.9%) of the cases.

DISCUSSION:

The reception satisfaction score is 68.1%. This score was downgraded due to the weak identification satisfaction rate of staff in the department (9%). Welcoming the patient and their family remains a primary element. Welcome is more than an act banality of daily existence. The arrival of a patient in a department of care is unique. It is a highlight for him, a moment of impregnation where he is sensitive and vulnerable and needs to hang up on someone. The welcome is then confirmed during his stay by the help offered to him in his difficulties through the listening and understanding that the staff manifest, another significant feature of quality of care. Any act of care is relational, and the communication feature gives the form of a human act par excellence. This differentiates between “giving care” and “taking care”. “Give care” depicts mundane actions with essential technical aspects, but “taking care” of someone has a much deeper meaning. This assumes that personal participation skills of care and intelligence are very different. It involves ethical considerations, manifestations of empathy, and organisational tactics matched to the conditions and demands of the patient and his family. The necessity is especially felt in crucial situations. That is why this support is vital to the quality of care [14].

Indeed, in the cardiology department, the scores for quality of care and discharge arrangement were respectively 84.7% and 84.5%. These findings are the fruit of the organisation of the cardiology service. Specialist doctors see the patients in the emergency room and alert the department of the arrival of new patients. The whole crew prepares the rooms and equipment necessary depending on the severity of the condition. At the leave of patients, a health record is supplied to the patient with his discharge order and next appointment for a check-up with his cardiologist, thereby providing continuity of care. The cleanliness and comfort of the room were satisfactory in 89.4%. The entire hospitalisation unit is cleaned every morning by a hospital cleaning staff.

Nevertheless, this cleaning remains minimal since it is done in a rush, very early in the morning, irritating patients. In addition, following this early cleansing, it is no longer cleaning all day. If necessary, it is carried out by the accompanying persons or the room girls who are in insufficient quantity in the service. The patients did not have individual trash cans but shared trash cans near the service. Comfort and cleanliness also depend on the socioeconomic status of the population investigated. Hence, they remain pretty subjective. The noise level was rated satisfactory by 71% of patients. Visitors came in big numbers and often failed to set the phones on vibrate.

The promiscuity of patients led to the difficulty of attaining calm in the rooms. Despite raising awareness to limit visits, accompanying folks remain intractable. This requires putting in place alternative systems for the management of accompanying persons. The overall satisfaction score of the support load was 78.3%. Studies in services in (PIMS) Faso reported scores between 52 and 94% [8-12]. However, these scores must be regarded cautiously because they have not been calculated using validated techniques but with ones customised by the investigators. The high degree of satisfaction demonstrated that most patients judged the unit's form of organisation positively in the hospitalisation of cardiology. However, this high level must be interpreted with caution. Discontent is not expressed when a significant event occurs. In this sense, a positive response in a satisfaction survey does not always convey that the support was good but simply that

nothing serious happened [15]. In this regard, paying particular attention to questions about which patients are not completely satisfied seems vital. However, is such a high satisfaction rate true? This question is legitimate and points to a want to honestly know what patients believe, beyond the need to be viewed as a “good doctor” and the urge to confront criticism of patients. This general rate raises various questions, notably possible biases [16]. Conducting interviews after discharge from hospitalisation and conducting these interviews directly could be prejudiced. However, less than a written study would bring challenges of language and the usage of writing, with 31.9% of our patients being out of school. Carry out interviews away from hospitalisation, that is to say at home, encountered difficulties in achieving it (some living in semi-rural and rural areas, some patients not having contact addresses), in the interpretation of the results and the bias from memory (some patients will not remember all the details stay). The fact that an agent health administered the questionnaire could be a prejudice. Patients with a fear of openly criticising health workers and so speak of their unhappiness. The sociocultural setting of patients could also constitute a bias. Indeed, health regained already constituted a source of satisfaction for several patients and influenced the replies to the questions. This was observed in patients from rural locations. These seek to improve their health and have no demands regarding the quality of care. Another possible bias could be that health staff were informed of the study. So, whether he intentionally or not, he had an adaptation of the attitude of health workers towards patients. One of the limits of our research was the clear-cut and limited form of the questions, which did not allow the patients to express themselves and comment freely.

CONCLUSION:

The evaluation of the level of contentment experienced by patients has become a general concern for all healthcare facilities. She serves as a source of information that may be used to improve the overall quality of care provision. The findings we acquired from our research on the level of contentment experienced by patients upon their discharge from the hospital in the cardiology field are encouraging. On the other hand, several areas of dissatisfaction have been brought up about identifying the health personnel, communication, sound level, and restoration. These aspects can be significantly improved if these businesses implement corrective measures. The variety of persons who are sick and who read generates a journey of attention that is difficult to convey. Therefore, the concept of satisfaction is going to remain subjective and relative. Peu frequently dans notre contexte, and she is increasingly being evaluated in the countries of the Occidental region using common and valid tools. Studies on the level of satisfaction experienced by patients are an essential component that our hospitals need to incorporate to advance their quality initiatives.

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