



SPHMMC

**FACTORS AFFECTING THE PRACTICE OF COMPASSIONATE
RESPECTFUL CARE AMONG HEALTH CARE PROVIDERS IN SAINT
PAUL'S HOSPITAL MILLENIUM MEDICAL COLLEGE,ADDIS
ABABA, ETHIOPIA.**

BY: DR. BETHELEHEM TEBEBE (INTERN)

ADVISOR: MR.KINFE HAILE (MPH)

MRS.MEAZA GETAHUN (MPH)

**A STUDENT RESEARCH PROJECT REPORT SUBMITTED TO DEPARTMENT OF
PUBLIC HEALTH, SAINT PAUL'S HOSPITAL MILLENIUM MEDICAL COLLEGE IN
PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR
OF MEDICINE.**

JULY, 2018

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Acronyms and Abbreviations

- CRC-Compassionate respectful care
- FMOH-Federal ministry of health
- SPHMMC- St Pauls' hospital millennium medical college
- SPSS- Statistical Package for Social Science

Abstract

Background

Compassion has been defined as a deep awareness of the suffering of another which is coupled with a wish to relieve it and it is the most frequently referenced term as a hallmark of quality of care by patient, family members, health care providers, administrators and policy makers. Disrespect and abuse of patients during institutional health care service is one of the deterrents to utilization of health care services in Ethiopia as well as in those countries with low and middle income. This paper identifies factors which are associated with the poor practice of compassionate and respectful care in Saint Paul's hospital millennium medical college.

Objective

This study aimed to investigate the factors which affect health professionals working in Saint Paul's hospital millennium medical college to practice compassionate and responsible care.

Methods

A cross-sectional descriptive study using quantitative method was conducted in Saint Paul's hospital millennium medical college from May-June 2010. A total sample size of 307 was used. Summary measure frequency was used. The chi square and cross tabulation was implemented to identify possible association with the independent and dependent variable.

Results

Among 307 professionals participated in the study 264 (86%) of them had a good knowledge regarding compassionate and respectful care and most of the participants 195(63.5%) had a good attitude. With this a good practice of compassionate and respectful care was seen among 251(81.8%) of the respondents. With possible factors being gender, training, salary proportional to workload, provision with job description and scope, availability of someone to consult and good administrative support.

Conclusion and recommendation

In general though it's thought practice of compassionate and respectful care is poor in Saint Paul's hospital, this research find that there is a good knowledge, attitude and practice among the hospital staffs. The possible factors for the practice of compassionate and respectful care in Saint Paul's hospital millennium medical college were gender , training, salary proportional to workload , provision with job description and

scope ,availability of someone to consult and good administrative support. Therefore other health facilities should also take this practice as a good example and they have to address the gap by giving emphasis on the possible mentioned factors which affect the practices of compassionate and respectful care in a particular set up.

Chapter one: Introduction

1.1 Background

Compassionate care is expected by patients and is a professional obligation of clinicians.

Compassion has been defined as a deep awareness of the suffering of another which is coupled with a wish to relieve it and it is the most frequently referenced term as a hallmark of quality of care by patient family member, health care providers, administrators and policy makers (1).

According to Lowenstein compassion focuses on the recognition of the uniqueness of another individual and the willingness to enter in to a relationship in which not only the knowledge but the intuitions, strengths and emotions of both the patient and the health care professional can be fully engaged. Compassionate care has also been defined as being open, welcoming, giving comfort, reassuring and not being threatening to the patient. It's also an attitude, a manner and an approach. Care is compassionate when patients, their families and other supporters are treated with kindness and caring. Therefore compassionate care is holistic, Non-judgmental, empathetic, respectful and empowering (2).

Although the relevance of compassionate care seems self-evident, studies have repeatedly identified the presence of a gap between patients and clinicians perception of compassionate care showing that it's yet the poorly understood element of quality care.

Disrespect and abuse of patients during institutional health care service is one of the deterrents to utilization of health care services in Ethiopia and low and middle income countries.

Resent concerns about suboptimal patient care and a lack of compassion have prompted policymakers to question the preparedness of clinicians for the challenging environment in which they practice. CRC professionals have become a high priority issue in Ethiopia in the current health sector transformation agenda item (HSTP). Towards this goal manuals and curriculum have been developed and health care workers are taking training on all cadres to achieve the goal of CRC and be better professionals (4).

Key words; CRC

1.2 Statement of the problem

Patient satisfaction is becoming an emerging health policy all over the world. It is a key determinant of quality of care and an important component of pay-for-performance metrics. Furthermore, patient satisfaction is critical to ensure how well patients do. Many research clearly identified a link between patient outcomes and patient satisfaction scores (5).

Disrespect and abuse of patients during institutional health care service is one of the deterrents to utilization of health care services in Ethiopia and low and middle income countries. Though a lot has been done to improve the health status of the community and huge resources are being spent for the improvement of the health care service, it is still failing to achieve its core fundamental point which is the compassionate and responsible caring (4).

Patient satisfaction is multifaceted and very challenging outcome to define but regarding this, evaluation of clients satisfaction can address the reliability of services or the assurance that services are provided in a consistent and dependable manner; the responsiveness of services or the willingness of providers to meet clients need; the courtesy of providers; and the security of services and records to keep the best level of confidentiality. Therefore, evaluation of health care provision is essential to improve and keep the quality of medical services. From these it's important to look for the prevalence of practice of CRC and possible factors for its impedance (5).

There are lots of possible factors which can be contributed for the impedance of the practice of CRC in SPHMMC. As most people agree quality care particularly in the health sector should be given with compassion therefore, one has to be aware of the patients feeling and has to have a wish to resolve the problem of the patient so as to involve in the healing process of those who are ill.

Compassionate care these days is an indispensable attribute in optimum medical care and establishes a universal and enduring insight in medical ethics. Quality medical service is commonly associated with applying a mix of scientific-technical knowledge and humanism that is the caregivers' interest in and respect for patient as a person experiencing illness (4).

However, a great many patients undergo considerably dehumanizing and depersonalized treatment which creates a destructive health care systems causing crisis to the patients, families, communities as well as the systems themselves and professionals (4).

1.3 Significance of the study

Patient dissatisfaction regarding the health care service is the most common complaint which has been raised for the past unspecified years. This is also thought to be one of the reasons for the less demand of modern medicine in our society. Therefore this requires quite concerted effort to increase the professionals' compassionate and respectful care. The ministry of health is working these days by giving more emphasis on the practice of CRC.

Although providing the health service to the whole population by itself is a great challenge those who are lucky to get these opportunities are entitled be treated and provided support with love, compassion and respect. Thus, this study will contribute to fill the gap to scale up the practice of CRC while focusing on the most important impending factors which has to be avoided.

The result will be used to alert the responsible authorities about the importance of expanding the practice of CRC by solving identifiable barriers. Therefore it helps to reduce the number of dissatisfaction of the patients and gives plenty of learning opportunity for the health provider.

In general this study will provide a feedback on the service provided in the hospital. It may provide an insight into the system and may be used to improve any shortcomings of the service provided.

This study will also allow the administrators to focus on the requirements of the staffs to practice CRC and improve the service which makes the hospital competent.

Chapter two: Literature review

Despite being espoused as a hallmark of quality care, and emerging research that suggests it has a positive effect on patients' health, an evidence based framework on the nature and key domains of compassion in health care remains nascent. The study of compassion in health care tries to address the theory-practice gap and a significant conceptual issue; the lack of both patients and practitioners perspective of compassion (2).

“Compassionate care is an important and frequently overlooked component of patient-centered care. It addresses the emotional and psychosocial aspects of the patient experience and the patient's innate need for human connections and relationships. At its core, it means recognizing the concerns, distress and suffering of patients and their families and taking action to relieve them. It is based on active listening, empathy, strong communication and interpersonal skills, knowledge of the patient as a whole person including his or her life context and perspective, and the ability to work together to relieve distress.” (6).

Although humans are innately endowed with compassion, factors like living load, work environment inconvenience and low pay have deteriorated it. Besides, lack of role models in many health facilities and measuring the worth of a profession by how much it pays are attributed to lower patients' satisfaction ratios. These factors together with a number of health system related challenges have been subjected to lack of CRC service and being common source of complaints in health facilities (4).

Patient satisfaction is a topic that is important to medical (health) care providers, patients themselves and other third party stakeholders in the medical care industry. For health care providers ensuring that customers are satisfied is a continuous effort. However, deciding the right instrument and methodology to effectively satisfy patients is the major challenge for health care providers (11).

A total of 189 patients participated in a study conducted in Jimma which assesses patient satisfaction with the in patient service and the proportion of overall net patient satisfaction was 117 (61.9%). Majority of the respondents 148 (78.3%) reported that they got the kind of service they anticipated. Cleanliness of the ward 145 (76.7%) and time to get back to home 27 (14.3%) were found to have the highest and the lowest proportion of satisfied respondents, respectively. Patients with no formal education 60 (76.9%) and patients from the rural areas 75 (68.8%) were satisfied higher than those from their counterparts. Patients at medical 22 (61.1%) and ophthalmology 10 (62.5%) wards were less satisfied than patients in other departments (5).

The above study showed that the highest 85.7% rate of dissatisfaction was due to the recommended time to get back home which could be due to the fact that most patients stayed in the ward for more than 3 days while attendants are also expected to care for other members of the family at home (5).

Regarding the service provided by the physician, 60.3% of the patients were satisfied with their knowledge, courtesy and respect to them. But it was still low when compared to a report from a study conducted in Singapore hospitals, where doctors explain thoroughly about medical conditions the patients having. But 62.4% of the patients were dissatisfied with the level of education and communication they received about their illness and 69.8% of patients had received incomplete information about their illness which is higher compared to a study conducted in South Africa. This difference could be explained by high numbers of patients expected to be seen by a physician resulting in shortage of time and also due to low level of education of the patients which might be a barrier in understanding of communication (5).

Most of the dissatisfaction scores were higher for nursing services, education and communication about the illness, privacy and confidentiality, crowdedness of rooms, restricted visiting hours, outpatient pharmacy and laboratory services. The reason for this could be that most of these services are labor intensive while some of the other services like X-ray and laboratory services are financially costly (5).

Satisfaction is one of the core outcome measures for health care. It is intuitively more appealing than measures of health care effectiveness or efficiency that are more difficult to understand. Satisfaction is the extent of an individual experience compared with his or her expectation (13).

Avis, Bond and Thomas (1995) said studies on patient satisfaction provide facts on the health care providers' success at the patients' expectation and need, as well as an important tool for research and management (13).

Studies by Lauer, Murphy and power (1982) and Oberst (1984) demonstrated a strong relationship between adequacy of information and overall patient satisfaction with care. Information given helps to empower patients to take control over health care and to comply with treatment other than making them happy and comfortable (13).

Based on the studies patient satisfaction is one area where the quality of service of a particular discipline can be assessed.

A research done on the patient perspective of status of caring, respectful and compassionate health care practice in Tgrai regional state which involves 1436 clients with response rate of 100%. The mean age of the study participants was 38.3 + 15.2. The majority 63.1 % of the participants was married and 37.4% were with No formal education. Almost all 93.4% were Tegar by ethnicity and 18.9% were housewives regarding occupation (3).

Similar proportion of males and females (53.4 versus 55.7) had a good experience towards caring, respectful and compassionate health care practice. Besides, about 70 % of the participants who were self employed had poor experience and the majority (76.3 %) were farmers and they had good experience concerning patient centered care (3).

Male and female had similar level of poor level of perception (42.3) versus (45.3) towards caring, respectful and compassionate health care practice. Similarly, those with age less than or equal to (37.8)and greater than (37.8) had similar level of good practice (57.8) verses (53.7) on the other hand those who are divorced by marital status, (63.2%)and (36.8%) had good and poor practice respectively (3).

In general the experience of patients towards caring, respectful and compassionate health care practice was found to be good in 55% of respondents and poor in the rest 45% respondents. Similarly patient's perception towards CRC was assessed and found to be good and poor in 56% and 44% of the respondents respectively (3).

With this the research suggest that much should be done to improve the practice of CRC through policy & guideline development, continuous training for all health professionals and community awareness (3).

In related literatures, studies that analyze the influence of socio-demographic characteristics on patients' satisfaction showed no consistent relationship with age, race, gender, education or income. Some previous studies, however, have found that older patients were more likely to report satisfaction compared with younger patients. In some studies, females were more likely to express satisfaction than males while in others no relationship was found between gender and satisfaction.

Overall in a study done in Jimma regarding patient satisfaction with the in patient service there was no observed association between satisfaction and basic socio-demographic variables.

Patients' perceptions of care are significantly eroded by lack of confidence in either nurses / doctors and by increase in missed nursing care. The average number of types of missed care was negatively related to six of the 8 outcomes. Ors ranged from 0.78 (95% CI 0.68-0.9) for excellent care rating to 0.86 (95% CI 0.77-

0.95) for medication completely explained positively associated with higher patient to nurse ratio equals to 0.15, 95% CI 0.10-0.19) and negatively associated with better work environments ($b=-0.26$ 95% CI (-0.48 to -0.04) (10).

On a study done in Germany on 8428 patients 10 determinants of global patient satisfaction which are the outcome of treatment followed by nursing kindness result of this study have implication for health providers aiming at improving the service quality of care. In total 6595/80% patients rated the global satisfaction with hospital stay related to all performed service with grouped median score as 5.4 and kindness of hospitals scores 5.3 (12).

Conceptual frame work

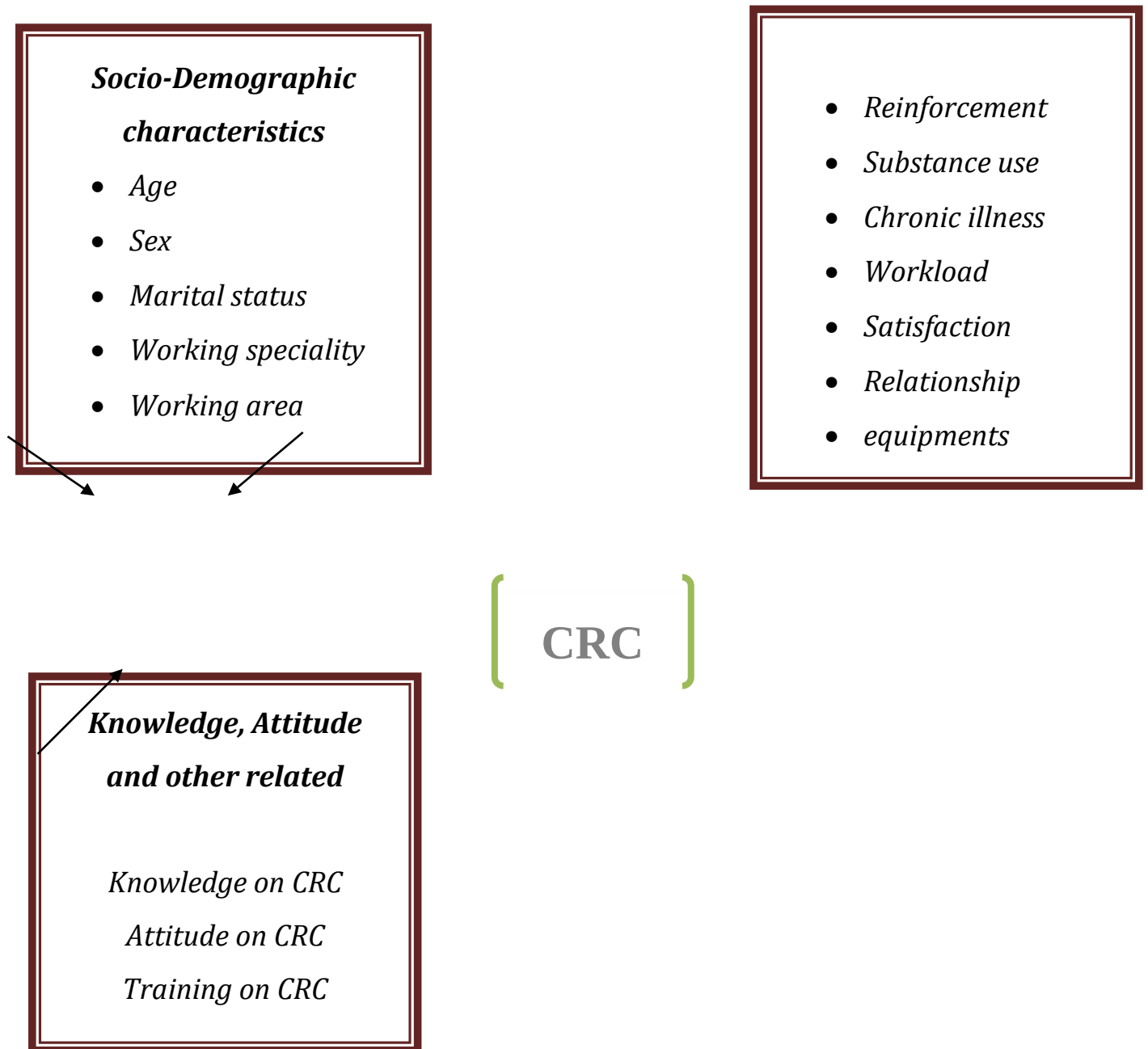


Figure 1: Conceptual framework, lists of possible factors with possible association with CRC in SPHMMC, 2010

Chapter three: Objective

3.1 General objective

- To assess factors affecting the practice of CRC in SPHMMC.

3.2 Specific objective

- To determine the effect of knowledge and attitude pattern of health care providers on CRC affect its practice in SPHMMC.
- To identify existing factors which are impeding the practice of CRC among health care providers working in SPHMMC

Chapter four: Methods

4.1 Study area

This study was conducted in SPHMMC. St Paul's hospital millennium medical college is a referral hospital in A.A under federal ministry of health. It is the second largest hospital in Ethiopia which is located in Gulele sub city. The hospital was built by emperor Haileselassie in 1969 E.C with the help of evangelical church to help economically under privilege population, providing service free of charge to about 75% of its patients.

Currently growing its capacity it has a catchment population of more than 5 million and it see annual average of 300,000 patients. There are 13 departments in the hospital.

The hospital opened its medical school by the year 2007 G.C to commemorate the millennium era of Ethiopian calendar with the core service include the provision of medical care, teaching and research. It uses the new integrated curriculum. It has currently more than 1800 staffs.

4.2 Study design

A quantitative cross-sectional descriptive study was used. The study was conducted between May to June 2010 E.C.

4.3 Source population

Source populations of the study were staffs of SPHMMC.

4.4 Study population

Health care professionals such as physicians (GP, specialists), nurses, midwives, radiographers, anesthetists, pharmacists and phlebotomists who are working in SPHMMC currently.

4.4.1 Inclusion criteria

- Health care professionals were included in the study if they are certified and licensed and those who are staffs of SPHMMC
- Those staffs who have a strong contact with the patients care.

4.4.2 Exclusion criteria

- Non clinician staffs of SPHMMC
- Those who are on undergraduate and postgraduate study
- Those staffs who don't have a strong contact with the patient directly; lab technicians

4.4.3 Sample size and sampling techniques

The study participants were sampled health care professionals working in SPHMMC. Single population proportion formula was used by assuming proportion of the population (p) is unknown therefore it's going to be 0.5 with confidence level 95% and margin of error (d)=5% to calculate the sample size for health professionals and hence the sample size was 400 and with the correctional factor its 307.

With the formula $n = \frac{a}{1 + 1/n(a-1)}$ where $a = Z^2 p(1-p)/d^2$

Health professionals were selected from each job category; doctors (specialists and GP), nurses, midwives, radiographers, anesthetists pharmacists and phlebotomists. Then study participants were selected proportionally from each category, using convenient stratified random sampling.

4.5 Sampling procedure

A total of 307 study participants were selected from the different specialties based on their proportion from total population using the formula $n_j = \frac{n}{N} N_j$ where n_j =sample size of the j^{th} stratum

N_j =population size of the j^{th} stratum

$n = n_1 + n_2 + \dots + n_k$ is the total sample size

$N = N_1 + N_2 + \dots + N_k$ is the total population size

Therefore 158 nurses, 67 GP, 37 specialists, 20 midwives, 8 Anesthetists, 7 pharmacists, 5 radiographers, 5 phlebotomists were involved in this study.

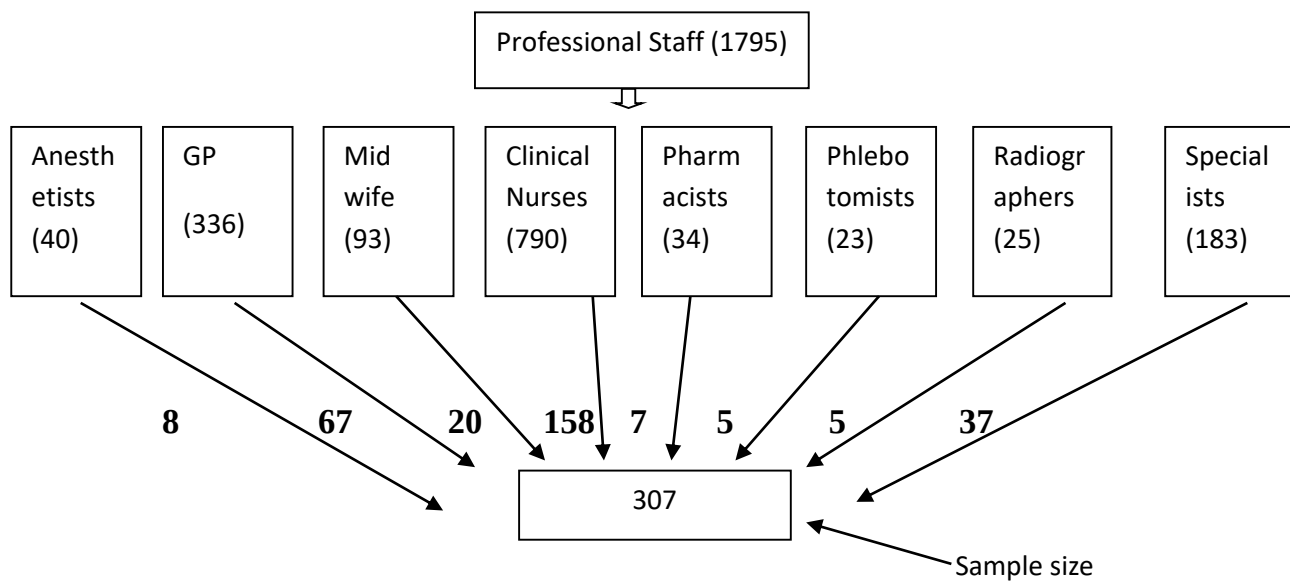


Figure 2: Schematic presentation of the sampling procedure used in the study, SPHMMC, May 2010.

4.6 Data collection method

Structured questionnaire was developed by reviewing the few literatures available; the questionnaires were all most all self developed questionnaires. The questionnaire was prepared in English. Data collection was conducted through self-administered questionnaires after the questionnaires were pretested in 30 nurses working in Ras Desta Damtew memorial Hospital for their sequence, comprehension and duration of time to complete one questionnaire.

4.7 Study variables

Dependent variable- practice of CRC in SPHMMC

Independent variable

- Demographic-Age , Sex, Marital status, Educational background, Area of practice
- Interest
- Satisfaction
- Salary
- Chronic illness

- Substance abuse
- Knowledge and attitude on CRC
- Reinforcement
- Training on CRC
- Relationship with colleague
- Workload
- Material supply

4.8 Data Entry, cleaning and analysis

The quantitative data was cleaned and analyzed by using SPSS version 20. Summary measures such as frequency, mean and rates were applied. Forty-two questions were used to conduct this study and 30 of the questions were answered as Yes or No. Yes is coded as 1 and No as '0'. The others were coded accordingly.

Data cleaning was done in SPSS systematically by running each of frequencies to know missing data. So that the orderly numbered and categorized questionnaires were rechecked and corrected. And association was searched by cross tabulation chi –chart between the dependent and independent variable.

4.9 Data quality control assurance

The data quality was assured by collecting all data by the researcher itself clarifying the aim of the research and briefing unclear question to the respondents and ensuring the research questionnaires about being fully answered.

4.10 Ethical considerations

Letter of ethical clearance was secured from SPHMMC department of public health. Letter for cooperation was officially obtained. Informed verbal consent was obtained from each participant in the research and confidentiality was maintained. In order to assure confidentiality of the respondents name were not written on the questionnaire. All study participants were told about their participation would be on voluntary basis. The objectives of the study and the merits were communicated prior to asking the willingness to participate in the study. Privacy of clients was maintained.

4.11 Operational definition

High knowledge: those who knew 2-3 correct answer from the 3 knowledge questions.

Poor knowledge: those who knew 0-1 correct answer from the 3 knowledge question

Positive attitude: those who scored 2 of the 2 attitude question.

Negative attitude: those who scored below 2 among the attitude question.

Good practice: those who correctly answer 2-3 questions out of 3.

Poor practice: those who only answer 0-1 question out of 3 questions

Chapter five: Results

5.1. Socio- demographic characteristics

A total of 307 participant were included in this study, from this 150(48.9%) of the respondents were male and 157 (51.1%) of them were female.

Most of the respondents were between the age of 20-30 which accounts for 204(67.4%) of the total study population. 79 (25.7%) were in the age range of 31-40. The rest contributes those who are above 40.

Around 36.5% of them were single and the other 36.5% were in relationship while 21.2 % of the respondents were married, the other 7%, 3.6%, 1.6% were widowed, divorced and separated respectively.

Depending on their specialties most of those involved in the study unit are clinical Nurses which attribute to 158(51.5%), followed by general practitioners 67(21.8%), specialists 37(12.1%), midwives 20(6.5%), anesthetists 8(2.6%), pharmacists 7 (2.3%) as well as radiographer and phlebotomist accounting for 5(1.6%) of the total study unit.

Participant involved were practicing in different area of the hospital department 97(31.6%) were currently working in inpatient unit, while 92(30%) were in outpatient. Those who are working in the emergency unit were 59(19.2%) the other 6 (2%) were working in ICU. The rest work in other unspecified units or working in all the inpatient, outpatient or emergency unit.

Table 1: Distribution of respondents by various socio- demographic characteristics, SPHMMC, May 2010.

Variable (n =307)		
Age	Frequency	Percent
20-30	207	67.4
31-40	79	25.7
41-50	16	5.2
51-60	5	1.6
Sex		
Male	150	48.9
Female	157	51.1

Marital status		
Single	112	36.5
Relationship	112	36.5
Married	65	21.2
Separated	5	1.6
Divorced	11	3.6
Widowed	2	7
Educational Background		
Midwife	20	6.5
Nurses	158	51.5
Anesthetist	8	2.6
Radiographer	5	1.6
Pharmacist	7	2.3
Phlebotomist	5	1.6
GP	67	21.8
Specialist	37	12.1

Area of Practice		
Inpatient	97	31.6
Outpatient	92	30.0
Emergency	59	19.2
ICU	6	2
All (inpatient, outpatient & emergency)	15	4.9
Other	38	12.4

5.2 Characteristics of other factors.

Among 307 respondents who were asked about whether they have ever heard of CRC and its characteristics 267 (87%) of them heard of it while 40 (13%) of them don't. Only 40 (13%) of those participants understand CRC as doing lists of your job description, others 93(30.3%) of them define CRC as being open, welcoming, giving comfort, reassuring the patient, not being threatening for the patient while 174 (56.7%) of them states it as deep awareness of the suffering of another which is coupled with a wish to relieve it.

Most of the participants 286 (93.2%) agreed on the importance of CRC while the rest do not. From these 201 (65.8%) of them mentioned that CRC is essential for the patient, the health professional as well as the health institution. The other 72 (23.4%) of respondents stated that it only benefit the patients.

With this understanding and the operational definition used 264(86%) of the respondents have a good knowledge and the rest 43(14%) of them in the contrary are poorly knowledgeable about the topic.

Table 2: Distribution of participants' response regarding the importance of CRC, SPHMMC, May 2010

For all	202	65.8%
For the patient	72	23.4%
For the health institution	2	0.7%
For the patient and health professional	4	1.3%
For health professional	6	1.9.%
Not important	21	6.8%

About 203 (66.1%) of the participants believe that their health care during their period of practice has been compassionate and respectful. While 64 (20.8%) of them stated they have never been compassionate or respectful. Furthermore 40 (13%) of the respondents claims not to be sure about their practice whether it was compassionate and respectful or not.

Over all 195(63.5%) of those who have participated in the study have good attitude while 112 (36.5%) of the respondents have a negative attitude regarding CRC.

Around 127 (41.4%) of the study participants claim to always take their patient condition in to their account, while 76(24.8%) take it into their account as often as possible, on the other side 69(22%), 29(9.4%) mentioned their consideration to occur sometimes and seldom respectively. About 6 (2%) of the respondents states to never consider the patient condition.

Most of the participants 257 (83.7%) considered the meaning of the illness of the patients while the rest don't. Two-hundred eighty (91.2%) of health professional involved in the study claims to assume responsibility for the care that they provide while 27 (8.8%) of them claims not to. In general 251 (81.8%) of the respondents seem are good CRC practice, while 56 (18.2%) have the opposite.

Among all the study participants 165 (53.7%) of them join the profession because of their personal interest. While 65 (21.2%) of them mentioned family interest to be the main reason they join. In addition to this 42(13.7%) of them oriented to the benefit, and the rest 35 (11.4%) were assigned by ministry of health.

Two-hundred twenty two (72.3%) of the respondents are satisfied with their profession where as the rest are not. In addition to this almost half of our study participants 156(50.8%) stated that they feel satisfied after work. Though the larger number of the respondents 160(52.1%) have no adequate time for rest after work. In the contrary 282 (91.2%) mentioned not to be satisfied with the salary they own, though 23 (7.5%) of the participant mentioned to be. And from those 232 (75.6%) of the respondents believe that they are not proportionally paid according to their workload. Due to this for most of the participants 246(80%) their salary will not provide them a chance of paying their bill and saving some. But regardless of this only 134 (43.6%) of them believe that increment in salary and incentives may enhance the practice of CRC while the rest don't give it a credit to have any impact.

Most of the participants 240 (78.2%) states that they have the adequate training on their specific profession while the rest don't think that way. With regard to continuous professional development training 162(52%) of the respondent have a positive response. In addition to this about the CRC training most of the study participants 214 (69.7%) do not have previous experience.

Increased number of the respondents 169 (55%) provide care for about 21-50 patients per day followed by 20 patients per day which accounts for 105 (34.2%) of them. Twenty nine (9.4%) of the participants takes

care of 50-100 health seekers and a very few of them 4 (1.3) claims to care for more than 100 patients per day.

Large number of this study participants 249 (83.1) mentioned not to have a chronic illness which affect their day to day activity nor have to take substances to function normally. From those 52 (16.9%) of participants who states that they have to take substance to function normally 33 (10.7) of them have to smoke cigarette whereas the use of chat alone or together with the cigarettes smoking was seen in a very few of them.

The other independent variable which was thought to be a factor was relationship with colleagues with regard to this most of the participants seems to have a good relationship with the other staffs while 31 (10.1%) of those do not.

About 177 (57.7%) of the study respondents states not to have adequate administrative support for their practice in their hospital stay and the rest opposes them.

Two hundred sixty two (85.3%) of the health professionals involved in the study mention that they have a standard policy, protocol and guideline in their clinical area of practice, on the other side the rest 45(14.7%) claims not ever heard about it before.

With regard to reward and punishment most of the study participant states neither to be punished nor rewarded for their practice in the hospital

Table 3: Distribution of respondents regarding reward and punishment given with respect to their practice with the patient care, SPHMMC, May 2010.

	Rewarded		Punished	
	Frequency	percent	Frequency	Percent
Yes	37	12.1	24	7.8
No	270	87.9	283	92.2
Total	307	100	307	100

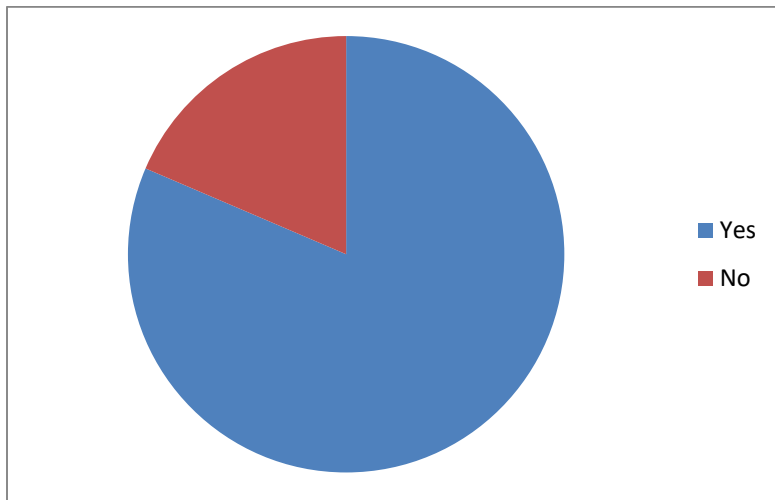


Figure 3: Distribution of respondents' response

regarding the applicability of scope of practice in SPHMMC, May 2010.

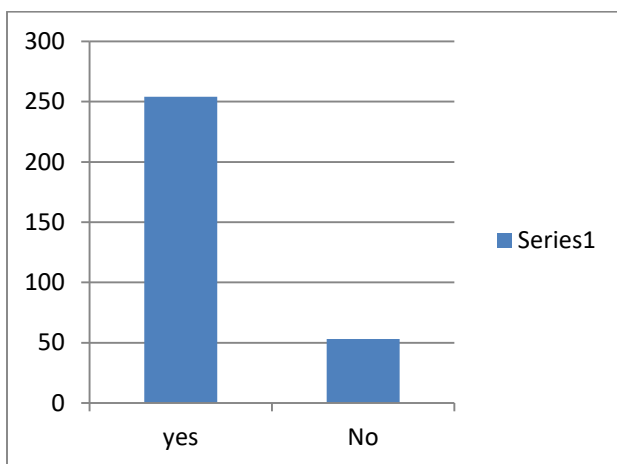


Figure 4: A bar graph of the provision of job description among study participants. SPHMMC, May 2010

Most of the respondents 264(81.4%) states to have someone to consult whenever they have difficulty in their clinical practice while 43(14%) of them do not.

A large number of the study participants 239(77.9%) complains of not to have adequate medical equipments to help their patients.

From the socio demographic factors sex has a significant association with the practice of CRC, though age and educational background has no any correlation with the CRC.

Professionals' knowledge about CRC and their attitude towards it has also a significant association with the p value of 0.00.

Professional satisfaction, having adequate training on the specific specialty of an individual also shows to have a significant association with practice of CRC. In addition to this training on CRC also affects the practice of CRC in SPHMMC with the p value of 0.00 from those who have taken CRC training once in their life time there was no one who was found to practice poorly.

The other association with the practice of CRC on this study was seen with the continuous professional development training again with the p value of 0.00.

This study also shows that there is a high association between the practice of CRC and number of patient that a single healthcare provider provide per day though there was no association seen with the amount of time that the staffs take to rest. CRC has also a significant association with the professionals feeling after work with the p value of 0.00.

Though it's expected that salary satisfaction or dissatisfaction affects the practice of CRC the study shows that there is no significant association between the two but the participant assumption about the proportion of their salary to their work load seems to have association with their practice in their hospital stay with the p value of 0.00. In addition to this the consideration that being provided with incentives can affect the practice of CRC and has a significant association with the actual practice of CRC. More over a significant correlation was seen between being able to pay ones bill and being able to save some with the CRC implementation.

Having chronic illness and substance use are the other possible factors with which a significant relationship was seen with the p value of 0.00. Relationship with colleagues is another factor which shows a significant association with the CRC practice.

Administrative support, reward system, provision with the professional's specific job description and scope also seems to have a significant association with p value of 0.00.

Having someone around for consultation at the time of difficulty also shows to have a correlation with the practice of CRC with the p value being 0.01.

Despite the assumption that not having all the necessary equipment for health provision may affect the practice of CRC, no association was seen with it.

Table 4: Chi- square, cross tabulation table with p value, COR,AOR and p value of the multivariate regression. SPHMMC, May 2010.

Variable	Pearson chi-square value	COR	AOR	p-value
Gender	0.004	12.6(CI=1.4-9.6)	14.1	0.02
Knowledge	0.000	18.9(CI=0.9-11.4)	11.6	0.01
Attitude	0.000	25.8(CI=1.1-12.5)	23.4	0.04
Professional satisfaction	0.000	16.6(CI=2.5-5.3)		
Training on CRC	0.000	22.6(CI=3.1-8.3)	22.7	0.03
Specialty training	0.002	36.8(CI=1.7-14.9)		
Continuous professional development training	0.000	14.5(CI=2.5-6.8)	16.8	0.02
Number of patients per day	0.004	17.3(CI=1.8-9.7)	21.6	0.04
Professional feeling after work	0.000	33.1(CI=1.8-17.7)		
Salary proportional to workload	0.000	11.8(CI=2.1-4.6)	9.4	0.01
Incentives	0.000	31.8(CI=1.9-8.6)		
Chronic illness	0.000	28.8 (CI=2.7-11.4)		
Substance use	0.000	34.6(CI=3.2-26.3)		
Relationship with colleagues	0.000	19.9(CI(2.4-17.1)		
Administrative support, reward system	0.004	27.5(CI=3.3-14.8)		
Provision with job description and scope	0.000	19.1(CI=0.8-7.5)	12.9	0.01
Consultation	0.001	34(CI=1.7-18)		

Most of the study participants have a good knowledge while few of them don't. More over around 195 (63.5%) of them have a good attitude even if 112 (36.5%) of them have a negative one. Regardless of the attitude of our participant it was found that around 251 (81.8%) of the participants seems to practice CRC. And both the knowledge and attitude found to have association with the practice of CRC but in a study done in Tigray region the general experience of patients towards caring, respectful and compassion health care practice experience was found to be good in 55% of the respondents and poor in the 45% of respondents. And the research suggest that much should be done to improve practice of CRC through Policy, guideline development and continuous training for all health professional and community awareness. Training as a way of improvement for CRC practice was also found in the current study.

The idea that nurses can be taught how to be compassionate is a contentious issue and despite dividing opinion amongst participants of the study, it has been cited by the recent report as priority for nursing (7).

Compassion takes time and commitment from practitioners. Time is an important element to establish a compassionate connection between nursing staffs and patients. The demand on nurses' time has often been cited as a barrier to the forming of compassion within relationship (7) which we don't analyze in the current study but our study also shows that it needs ambitious interest and commitment to provide a health care accompanied by a compassionate and respectful care. It requires commitment to be advanced in one's own specialty, to be continuously trained with professional development training and even training on CRC.

This study shows that most of the health professionals are committed for the profession though they think that the salary they are provided with is not proportional to their work load or regardless of the existence of other factors which impede its practice.

Patients want to feel cared for and listened to and it is based on the action of the nurses. It begins with nurses providing compassionate, patient centered care. Compassion provides a sense to patient that their condition and concerns are being heard recognized and acted upon. Compassion allows a patient to feel cared for, respected and trust that the nurse has his or her best interest in mind that a nurse truly cares they begin to allow you in offering the small details that may lead to a diagnosis or information that could help out better care for him or for her. (9)

Therefore compassionate care has to be provided in whatever expense for a better life and better scientific researches.

Patient perceptions of hospital care are strongly associated with missed nursing care which in turn is related to poor professional nurse staffing and poor hospital work environment improving staffing in hospitals and holds promise for enhancing patient satisfaction. (10)

On a study done in Germany 10 determinants of global patient satisfaction were identified which are the outcome of treatment followed by nursing kindness result of this study have implication for health providers aiming at improving the service quality of care. .In total 6595/80% patients rated the global satisfaction with hospital stay related to all performed service with grouped median score as 5.4 and kindness of hospitals scores 5.3.(12)

Chapter seven: Strength and limitation of the study

7.1 Strength of the study

- This is one of few studies, which assess factors affecting the practice of compassionate and respectful care. Hence; the study identified some of the possible factors which are associated with the practice. And with this the study may fill the gap on this study area
- The study tries to participate every specialty which is thought to have a significant impact on the health care of the patients who went to the study area

7.2 Limitation of the study

- It is a cross sectional study; therefore the exact reason for the factors how they affect the practice is difficult to determine
- It is only a quantitative data therefore some issues cannot significantly be explained by this research
- Since the study was institutional based, that might undermine generalizing the result to the general population
- Absence of adequate literatures on the topic which hinders further discussion of the result

Chapter eight: Conclusion

The study tried to assess factors affecting the practice of CRC in SPHMMC professional staffs. Therefore, possible factors were picked with this study and these are gender, knowledge regarding CRC and attitude towards practice of CRC. Training whether profession specific or with regard to CRC are also the other possible factors.

Furthermore salary and incentives as well as knowing your specific job description and your scope of practice have also a great association with the practice of CRC.

Chapter nine: Recommendations

FMOH

- Empowering women to join the medical profession.

SPHMMC Medical service vice provost / FMOH

- Providing adequate training and continuous development training on the area of the professionals' specialty will encourage practice of CRC.
- A greater emphasis should also be given to train professionals with the concept of CRC so as to increase the knowledge and to create a positive attitude among our health professionals
- Minimizing the number of patient that a given health provider provide care per day

SPHMMC Human resource directorate, Nursing Directorate /FMOH

- Providing professionals with their specific job description and scope of practice with adequate administrative support may reinforce the professionals to be compassionate and respectful on their life of medical practice.
- Paying salary which is proportional to their workload will have a positive impact on the practice of CRC
- Encouraging professionals with incentives and reward system may also have the same outcome.

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Annexes

QUESTIONARIES FOR ASSESING FACTORS AFFECTING THE PRACTICE OF CRC/ COMPASSIONATE RESPECTFUL CARING IN SPHMMC.

Dear respondents,

I am an Intern at St. Paul's Hospital Millennium Medical College and I am conducting a research with the title given above. As part of my research processes I have prepared a set of question to be answered by voluntary participants, which are meant only to achieve the study objective. I am requesting you to respond honestly and genuinely for the following questions. By this I declare that the identity of any participant will be through randomly set code name and will not be disclosed under any circumstance. The questionnaires take only 10-15 minutes to answer. Your participation is voluntary and you are kindly requested to answer every question and you may stop at any time you want. So I need your genuine cooperation. If you need any clarification, do not hesitate to ask the investigator assigned for you.

Would you be willing to participate?

1. If yes, proceed to the next page
2. If No pass to the next participant

N.B-Please mark your chosen answer with the sign (✓) in the box provided.

Personal information

1. Age -----
2. Sex ☐ Male ☐ Female
3. Marital status ☐ Single ☐ In relationship ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
4. Educational background
 - Midwife ☐
 - Nurses ☐
 - Anesthetist ☐
 - Radiographer ☐
 - Pharmacist ☐
 - Phlebotomist ☐
 - General practitioner ☐
 - Specialists ☐
5. Where is the clinical area you are practicing?
 - Inpatient ☐
 - Out patient ☐
 - Emergency ☐
 - ICU ☐
 - Other , please specify-----

KAP

6. Have you ever heard the word CRC? ☐ Yes ☐ No
7. What do you understand about CRC?
 - ☐ • Deep awareness of the suffering of another which is coupled with a wish to relieve it.
 - ☐ • Being open, welcoming, giving comfort, reassuring the patient, not being threatening for the patient
 - ☐ • Doing what is listed on your job description.

8. Do you believe CRC is important for quality health care? ☐ Yes ☐ No
9. For whom do you think CRC will be important?
- For the patient ☐
 - For the health professional ☐
 - For health institution ☐
 - For all ☐
10. Do you believe your health care practice during the period of your practice has been compassionate and respectful? ☐ Yes ☐ No ☐ I don't Know
11. Have you ever take the patient condition in to account in your care?
- Always ☐
 - Often ☐
 - Sometimes ☐
 - Seldom ☐
 - Never ☐
12. Have you ever considered the meaning of the illness of the patient? ☐ Yes ☐ No
13. Have you ever assumed responsibility for your care as far as you are able? ☐ Yes ☐ No

Factors

14. What is the reason you join your profession?
- Personal interest ☐
 - Family interest ☐
 - Benefit oriented ☐
 - Assigned by MOE/ministry of education ☐
 - Other, please specify-----
15. Are you satisfied with your profession? ☐ Yes ☐ No ☐ Some how
16. Do you think you have adequate training on the field of your practice? ☐ Yes ☐ No
17. Have you ever be trained on CRC? ☐ Yes ☐ No
18. Have you had chance to have continuous professional development training on your course of practice? ☐ Yes ☐ No

19. For how many patients do you give care per day on average

- <20 ☐
- 21-50 ☐
- 50-100 ☐
- >100 ☐

20. Do you have adequate time of rest after work? ☐ Yes ☐ No

21. What do you feel after work?

- Satisfied ☐
- Tired ☐
- exhausted ☐

22. Are you satisfied with your salary? ☐ Yes ☐ No

23. Do you believe the money you earn is proportional to your work load? ☐ Yes ☐ No

24. Do you have any incentive from your institution? ☐ Yes ☐ No

25. Do you think your salary and incentives that you are provided with can increase your satisfaction with your work? Yes ☐ No ☐

26. Do you have your own house? ☐ Yes ☐ No

27. Do you have your own car? ☐ Yes ☐ No

28. Does the institution you are working in provide you transportation service? ☐ Yes ☐ No

29. Can your salary afford all your bills and make you able to save some? ☐ Yes ☐ No

30. Do you have to work extra time to cover your expenses? ☐ Yes ☐ No

31. Do you have any chronic illness which affects you day to day activity? ☐ Yes ☐ No

32. Do you have to take substances to function normally? ☐ Yes ☐ No

If yes

- Smoking ☐
- Alcohol use ☐
- Khat chewing ☐
- other , please specify-----

33. Do you have a good relationship with your colleague? ☐ Yes ☐ No

34. Do you think the administrative support is adequate for your practice? ☐ Yes ☐ No

35. Do you have standard policy, protocol and guideline in your clinical area of practice?
☐ Yes ☐ No

36. Have you ever been rewarded for your compassionate practice? ☐ Yes ☐ No
37. Have you ever been punished for your disrespectful care? ☐ Yes ☐ No
38. Have you been provided with your job description? ☐ Yes ☐ No
39. Have you been provided your scope of practice? ☐ Yes ☐ No
40. Do you have someone to consult whenever you have difficulty in your clinical practice?
 ☐ Yes ☐ No
41. Do you have all the medical equipments to help the patient? ☐ Yes ☐ No

Thank you!!

