

ADDENDA
COST AND QUALITY OF CARE:
A COMPARATIVE STUDY OF PUBLIC AND PRIVATELY CONTRACTED
CHRONIC PSYCHIATRIC INSTITUTIONS

Kimberley Ann Porteus

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Contents

These addenda contain a detailed description of the tools, methods, and results used to evaluate quality of care in the six chronic psychiatric hospitals. The first set of addendum describes the methods and results of each quality of care assessment tool. The second addendum contains a copy of each of three primary instruments developed for the purpose of this study. Note that the interview schedules (patient, nurse, management, and departmental) are not included, but are available upon request.

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Addendum 1

Methods and Results

Addendum 1.1: Patient Record Abstraction

Methodology and Results

A. Methodology

1. Summary

The Patient Record Abstraction Protocol forms one component of the ward protocol completed at each chronic ward at the hospital.

Beyond confirming basic patient demographic information, the Patient Record Abstraction was designed to collect data to assess the quality of medical treatment services. Included in this analysis was an assessment of the match between diagnosis and medications, an analysis of medication dosages, and an analysis of the time elapsed since the last recording of standard medical routines.

Patient statistics were abstracted from patient files and medication cards in each chronic ward. Data abstracted include patient diagnosis, current medications, background information (date of admission, date of birth, gender, race), physical screening statistics (blood pressure, weight), and dates of most recent medical routines (date of physical screening, date of last physician notes.) Patient names were not abstracted.

Patient files were systematically sampled from shelves with the aim of reaching a 90% confidence level for each hospital and 5% margin of error at each of the six sites. (Due to difficulties in the field, at 2 sites the margin of error was 6% and 8% respectively).

Statistical analysis was descriptive and analytic (using chi square tests, and regression analysis.) A description of the analysis used, as well as the results, can be found in the results section below.

A complete copy of the Patient Record Abstraction Protocol can be found in Addendum 2: Quality of Care Tools.

2. Method

1. The size of the sample was calculated on the basis of total patient population to achieve 95% confidence level. The number of files abstracted and confidence levels achieved are demonstrated in the following table.

Table 1: Patient Record Abstraction: Confidence Levels Achieved

	PRI-1		PRI-2		PRI-3		PUB-1		PUB-2		PUB-HW	
	N	CL	N	CL	N	CL	N	CL	N	CL	N	CL
Patient Record Abstraction	351	95%	238	90%	142	90%	79	90%	187	90%	204	90%

CL = Confidence Level

2. Files were systematically sampled from file cabinets. Medications data was taken from current medication cards (usually kept with the medication trolleys.)
3. Nursing staff from the ward assisted in the process. Files abstracted by nursing staff were systematically checked by one of the research team to ensure accuracy.
4. The following notes relate to methods with reference to specific data items:
 - **Date of admission** was the most recent date of admission recorded.
 - **Birth dates** were often not available. When not available, birth date years were estimated using date of admission and recorded age at time of admission.
 - **Diagnosis:** Diagnosis was abstracted from summary pages in patient files (usually prepared by senior sisters). Researchers were encouraged to read subsequent doctor's notes, although a thorough review of doctor's notes was not possible. Diagnosis were recorded in the order they appeared in patient files. Final analysis did not assume any hierarchy of the diagnoses recorded.
 - **Medications:** Medications were abstracted from current medications cards (usually kept with the medication trolley.)
 - **Date of Last Entry:** This was the last date of a medical practitioner note (psychiatrist or medical officer) in the patient file. Dates from social worker notes were also used.
 - **File Organisation:** The rating of a file as either organised or not organised was based on whether or not the basic data from the abstraction sheet could be found or not. If the data could be found (even if the file was untidy or difficult to understand) the file was rated as organised. If data could not be found (even by ward nursing staff) the file was finally rated as unorganised.
5. **Medications Quality Queries:** The diagnosis and current medication data was presented to a psychiatrist, who was blinded regarding the hospital of origin. The psychiatrist queried patients' files on one of the following bases: 1) Medication not appropriate for diagnosis; 2) Medication dosage too high; 3) Polypharmacy; 4) Drug combination of concern; 5) Multiple or mismatched diagnoses.
6. **Medication Dosage Analysis:** The four most commonly prescribed medications were identified. Average dose per institution was calculated. A regression analysis compared average dosages across hospitals and institutions.

3. Limitations

1. **Nursing Staff Assistance:** Nursing staff at the ward level assisted in the completion of the record abstraction exercise. While the potential existed for bias to occur, results checked by researchers did not demonstrate systematic mistakes.
2. **Date of Admission:** Files are currently not organised to easily access the length of stay of a patient in the hospital. The date of admission recorded was the most recent date of admission. Note that patients are formally 'readmitted' after they abscond, or are discharged unsuccessfully. Length of stay statistics calculated from the date of admission should be understood within this context.
3. **Blood Pressure / Weight:** Blood pressure and weight data was collected at one hospital by primary health nurses in separate files. In this hospital, blood pressure and weight data was not abstracted.
4. **Diagnosis:** Diagnoses were abstracted from summary pages in patient files (usually prepared by senior sisters). While researchers were encouraged to read subsequent doctor's notes, recent changes in diagnosis may not have been detected. However, there was very little evidence of systematic diagnosis review in doctor's notes..
5. **Medications:** Only medications formally recorded on a patient's medication card were detected in the study. If nursing staff, for example, were overusing a standing order of sedatives, but not recording the administration of this drug, this would not be picked up in this data.
6. **Dates:** There was some evidence that dates (of screening procedures, and doctors notes) were systematically updated in preparation for our visit, particularly in the privately contracted hospitals. Results must be interpreted in this context.

4. Analysis

Central tendency was calculated using the mean, median, and mode, across each hospital and across each sector. These results can be found in the tables below.

A regression analysis was conducted on data examining the duration of stay, medication analysis, frequency of medical treatment routines, and the record keeping system.

The purpose for the regression analysis was to determine the extent of differences between sectors, not to develop reliable predictive models. Two regression models were used, one using individual hospitals, and the other public vs. privately contracted, as independent variables.

The assumptions and models used for this analysis are outlined in Chapter 1: Introduction.

B. Results

The following sections contain the results of the patient record abstraction analysis. The first section reports on patient demographic results including gender, race, age, and diagnosis distribution. The second section outlines duration of stay results. The third section contains the medication-diagnosis analysis (including medication quality queries and the medication dosage analysis). The final section contains an analysis of frequency of routine medical services, medical treatment services analysis.

The results of the regression analysis are reported in summary form to assist the reader with interpretation as follows:

Dependent Variable	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public ^A	PC	Hospital Regression	Public vs. PC Regression
Mean										
SD										
Median										
									R ² =XX F=XX Variable: Beta* Variable: Beta**	R ² =XX F=XX Variable: Beta***

• = significant < .05; ** = significant < .01; *** = significant < .001

The F and/or MCS value is given to demonstrate the significance of fit for the model. Under the F/MCS value is the beta values for variables demonstrating at least a minimal suggestion of significance. A table summarising the suggestion of effect and conclusions follow each summary table.

1. Demographic Results

1.1. Gender

Table 7 : Gender Breakdown by Institution.

	PRI1		PRI2		PRI3		PUB1		PUB2		PUBHW		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Female	0	0	54	22.8	42	29.6	27	34.6	58	31.0	72	35.3	253	21.1
Male	349	100	183	77.2	100	70.4	51	65.4	129	69.0	132	64.7	944	78.9
Total	349		237		142		78		187		204		1197	

- N=1197
- Gender details were missing on 4 patients
- Note that PRI1 is an exclusively male hospital.

Conclusions: All hospitals have fewer female than male patients.

1.2. Race

Table 8: Breakdown of race by institution

	PRI1		PRI2		PRI3		PUB1		PUB2		PUBHW		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Black	345	98.3	225	94.5	142	100	79	100	187	100	42	20.6	1020	84.9
Coloured	1	0.3	1	0.4	0	0	0	0	0	0	3	1.5	5	0.4
Indian	0	0	7	2.9	0	0	0	0	0	0	0	0	7	0.6
White	5	1.4	5	2.1	0	0	0	0	0	0	159	77.9	169	14.1
Total	351		238		142		79		187		204		1201	

Conclusions: Historically black hospitals continue to have a majority of black patients (94.5-100%).

Historically white hospital continues to have a majority of white patients (78%). Access to hospital care still reflects historical racial access patterns.

1.3. Age

Table 9: Age Category Breakdown by Institution

	PRI1	%	PRI2	%	PRI3	%	PUB1	%	PUB2	%	PUBH W	%	Total	%
0 to 5	0	0.0	0	0.0	0	0.0	0	0	1	0.6	0	0.0	1	0.1
6 to 14	0	0.0	2	0.9	4	3.0	5	7.9	2	1.2	2	1.1	15	1.4
15 to 19	1	0.3	3	1.4	23	17.0	5	7.9	8	4.7	2	1.1	42	3.8
20 to 60	253	77.8	189	85.5	94	69.6	47	74.6	112	65.9	136	71.6	831	75
> 60	71	21.8	27	12.2	14	10.4	6	9.5	47	27.6	50	26.3	215	19
Total	325		221		135		63		170		190		1104	

Table 10: Age Category Breakdown by Sector

	Public	%	Private	%	Total	%
0-5	1	0.1	0	0.0	1	0.1
6 to 14	9	1.3	6	1.4	15	1.4
15 to 19	27	3.9	15	3.6	42	3.8
20 to 60	536	78.2	295	70.4	831	75.3
> 60	112	16.4	103	24.6	215	19.5
	685		419		1104	

Conclusions

- Mean age indicates that need for psycho-geriatric services will be increasing in short to medium term.
- Mentally handicapped patients are younger than psychiatric patients.
- Suggestion that younger patients are more frequently admitted to chronic institutions in the Northern Province.

1.4. Diagnosis Distribution

Table 11: Diagnostic Distribution by Institution

	PRI1		PRI2		PRI3		PUB1		PUB2		PUB HW		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Dementia	13	3.1	8	2.6	0	0.0	2	1.9	11	4.8	5	2.0	39	2.5
Epilepsy	66	15.6	33	10.5	38	18.6	15	14.0	28	12.2	35	14.1	215	14.1
Medical	4	0.9	0	0.0	6	2.9	1	0.9	2	0.9	4	1.6	17	1.1
Mental Handicap	94	22.2	91	29.1	99	48.5	63	58.9	54	23.6	21	8.5	427	27.9
Mood	3	0.7	3	1.0	7	3.4	1	0.9	5	2.2	8	3.2	27	1.8
Organic	26	6.1	21	6.7	2	1.0	1	0.9	26	11.4	22	8.9	98	6.4
Other	24	5.7	27	8.6	8	3.9	5	4.7	17	7.4	12	4.8	93	6.1
Schizophrenia	178	42.0	113	36.1	37	18.1	17	15.9	71	31.0	132	53.2	548	35.8
Substance Abuse	16	3.8	17	5.4	7	3.4	2	1.9	15	6.6	9	3.6	66	4.3
Total	424	100.0	313	100.0	204	100.0	107	100.0	229	100.0	248	100.0	1530	100.0

Table 12: Diagnostic Distribution by Institution

	Private		Public		Total	
	N	%	N	%	N	%
Dementia	21	2.2	18	3.1	39	2.5
Epilepsy	137	14.5	78	13.4	215	14.1
Medical	10	1.1	7	1.2	17	1.1
M Handicap	289	30.5	138	23.6	427	27.9
Mood	13	1.4	14	2.4	27	1.8
Organic	49	5.2	49	8.4	98	6.4
Other	59	6.2	34	5.8	93	6.1
Schizophrenia	328	34.7	220	37.7	548	35.8
Substance Abuse	40	4.2	26	4.5	66	4.3
Total	946	100.0	584	100.0	1530	100.0

Public Sector statistics inclusive of historically white hospital.

Conclusions

- Primary diagnosis is Schizophrenia, followed by Mental Handicap and Epilepsy.
- The high frequency of Epilepsy (without confounding diagnosis) in chronic institutions is a cause for concern.
- No suggestion of difference in distribution of top three diagnosis across the public and privately contracted sector.
- Differences between hospitals suggests that there are more mentally handicapped patients and less schizophrenic patients in hospitals outside of Gauteng.
- There is a significantly higher proportion of mental handicap diagnosis for black patients than non-black patients, and statistically fewer diagnoses of schizophrenia for black patients than non-black patients.
- Psychogeriatric patients are significantly more likely to have a psychiatric diagnosis than a mentally handicap diagnosis.

2. Duration of Stay

Files are currently not organised to easily access the length of stay of a patient in the hospital. The date of admission recorded was the most recent date of admission. Note that patients are formally 'readmitted' after they abscond, or are discharged unsuccessfully. Length of stay statistics should be understood within this context.

Table 13: Regression Analysis: Length of Stay

Dependent Variable	PR1	PR2	PR3	PUB1	PUB2	PUBHW	Public [^]	PC	Hospital Regression	Public vs. PC Regression
Length of Stay	Me=4.4 Mn=13.2 SE=11.6	11.4 13.2 10.6	8.3 6.8 4.8	10.6 9.5 4.8	4.4 8.4 9.4	7.2 10.8 11.7	7.2 9 8.3	10.6 11.9 10	R ² = .17 F=.000*** PR3: -6.7*** PUB1: -3.6** PUB2: -4.2*** Schiz: 4.2*** MH: 6.6*** Geriatric: 6.9***	R ² = .12 F=.000*** Private: 2.6*** Schiz: 4.4** MH: 5.6*** Black: -1.8* Geriatric: 7.1***

* = significant < .05; ** = significant < .01; *** = significant < .001

[^] Public Sector statistics excluded the historically white hospital data to enable comparison.

Very Strong Suggestion	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Private: Longer Stay Schizophrenia: Longer Stay M Handicap: Longer Stay Geriatric: Longer Stay PR3, PUB1, PUB2: Shorter		Black: Shorter Stay*	Gender Epilepsy
Notes: Most of individual hospital effect consistent with sector (public : private) effect. However a shorter stay demonstrated in PR3 limits generalisability of sector effect results. Hospital effect suggests shorter length of stay in Northern Province hospitals.			
Historically White Regression: Effect not significant.			

Conclusions

- Significantly longer length of stay for patients in privately contracted hospitals.
- Significantly longer length of stay for schizophrenic patients and mentally handicap patients as compared to other diagnosis categories.
- Significantly longer length of stay for psychogeriatric patients.

3. Medical Treatment Services Analysis

3.1. Patients Not on Medications

Table 14: Regression Analysis: Proportion of Patients Not on Medications

Dependent Variable	PRI1		PRI2		PRI3		PUB 1		PUB 2		PUB HW		Total		Hospital Regression	Public vs. PC Regression
	N	%	N	%	N	%	N	%	N	%	N	%	N	%		
Not on Medication	90	25.6	44	18.5	25	17.6	25	31.6	4	2.1	8	3.9	196	16.3		
On Medication	261	74.4	194	81.5	117	82.4	54	68.4	183	97.9	196	96.1	1005	83.7		
Total	351		238		142		79		187		204		1201		MCS=.000*** PRI3: -5.6* PUB2: -2.9*** Epilepsy: -2.3*** MH: .91*** Schiz: -.73** Geriatric: .73** Black: 1.7***	MCS=.000*** Private: 1.0*** Epileptic: -2.2*** MH: 1.0*** Schiz: -.63** Female: -.53* Geriatric: .67**

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics excluded the historically white hospital data to enable comparison.

- The

Very Strong Suggestion	Strong Suggestion	Weak Suggestion of Effect	No Suggestion of Effect
Private: More Pts Not on Meds Epileptic: Fewer Pts Not on Meds MH: More Pts Not on Meds Schizophrenia: Fewer Pts Not on Meds Black: More Pts Not on Meds Geriatric: More Pts Not on Meds PUB2: Fewer Pts Not on Meds		Female: Fewer Pts Not on Meds PRI3: Fewer Pts Not on Meds	
Notes:			
Historically White Regression Analysis: Effect not significant.			

Conclusions

- Privately contracted hospitals have significantly more patients on no medications.
- There are significantly more black patients not on medications than non black patients
- There are significantly more mentally handicapped patients not on medications, and significantly fewer epileptic and schizophrenic patients not on medications as compared to other diagnostic groups.
- There are significantly more psychogeriatric patients not on medications.

3.2. Medications Quality Queries Analysis

3.2.1. Frequency of Query Analysis

This analysis evaluated the frequency of queries. Queries include (1) match between diagnosis and medications, (2) inappropriate medication dosage, (3) polypharmacy, (4) inappropriate medication combination, and (5) diagnoses queries. The following tables analyse each query type separately.

Table 15: Regression Analysis: Proportion of Patient Records Queried for Quality of Medication or Diagnosis

Dependent Variable	PRI1		PRI2		PRI3		PUB 1		PUB 2		PUB HW		Total		Hospital Regression	Public vs. PC Regression
	N	%	N	%	N	%	N	%	N	%	N	%	N	%		
No Query	271	77.2	179	75.2	91	64.1	47	59.5	121	64.7	138	67.6	847	70.5		
Query	80	22.8	59	24.8	51	35.9	32	40.5	66	35.3	66	32.4	354	29.5		
Total	351		238		142		79		187		204		1201		MCS=.000*** PUB2: .59** MH: .77***	MCS=.000*** MH: .79*** Private: -.49**

= significant < .05; ** = significant < .01; *** = significant < .001

Logistic regression model used.

Historically white hospital excluded from regression.

Very Strong Suggestion	Strong Suggestion	Weak Suggestion of Effect	No Suggestion of Effect
Private: Fewer Queries M Handicap: More Queries			Gender Race Epileptic Schizophrenia Geriatric
Notes: Individual hospital effect consistent with public-private effect.			
Historically White Regression Analysis: Effect not significant.			

3.2.2. Mismatch between Diagnosis and Medications

This analysis looked at the frequency of queries based on a mismatch between diagnosis and medications. All diagnostic categories included.

Table 16: Regression Analysis: Proportion of Patient Records Queried for Quality of Medication or Diagnosis

Dependent Variable	PRI2		PRI3		PUB 1		PUB 2		PRI1		PUB HW		Total		Hospital Regression	Public vs. PC Regression
	N	%	N	%	N	%	N	%	N	%	N	%	N	%		
Mismatch: Dx [†] and drugs	17	7.1	11	7.7	9	11.4	20	10.7	48	13.7	36	17.6	141	11.7		
Mismatch: Dx (MH) [‡] and drug	32	13.4	28	19.7	17	21.5	34	18.2	18	5.1	11	5.4	140	11.7		
Combined															MCS=.000*** MH: 1.0*** Schiz: -.51*	MCS=.000*** MH: .98*** Private: -.41* Schiz: -.52**

= significant < .05; ** = significant < .01; *** = significant < .001

Logistic regression model used; regression combined mismatch of mentally handicapped and other diagnoses.

Historically white hospital excluded from regression.

Very Strong Suggestion	Strong Suggestion	Weak Suggestion of Effect	No Suggestion of Effect
M Handicap: More Queries	Schizophrenia: Less Queries	Private: Fewer Queries	Gender Race Epileptic Geriatric
Notes: Individual hospital effect consistent with public-private effect.			
Historically White Regression Analysis: Weak suggestion of significance of effect (HW: .72*). That is, more queries at historically white hospital.			

3.2.3. Mismatch between Diagnosis and Medications: Mental Handicap

This analysis looked at the frequency of queries based on a mismatch between a mental handicap diagnosis and medications.

Table 17: Regression Analysis: Mismatch Queries Between Medications and Mental Handicap Diagnosis

Dependent Variable	PRI1		PRI2		PRI3		PUB 1		PUB 2		PUB HW		Total		Hospital Regression	Public vs. PC Regression
	N	%	N	%	N	%	N	%	N	%	N	%	N	%		
Mismatch: Dx (MH) [†] and drug	13	5.1	32	13.4	28	19.7	17	21.5	34	18.2	11	5.4	140	11.7	MCS=.000*** PRI2: .89** PRI3: 1.3*** PUB1: 1.4*** PUB2: 1.4*** Geriatric: -2.0***	MCS=.000*** Private: -.64* Female: .60*** Geriatric: -2.0***

= significant < .05; ** = significant < .01; *** = significant < .001

Logistic regression model used; diagnosis variables excluded from model.

Historically white hospital excluded from regression.

Very Strong Suggestion	Strong Suggestion	Weak Suggestion of Effect	No Suggestion of Effect
Geriatric: Fewer Queries PRI2, PRI3, PUB1, PUB2: More Queries Female: More Queries		Private: Fewer Queries	Race
Notes: Individual hospital effect consistent with public-private effect.			
Historically White Regression Analysis: Effect not significant.			

3.2.4. Mismatch between Diagnosis and Medications: Non- Mental Handicap

This analysis looked at the frequency of queries based on a mismatch between diagnosis (excluding mental handicap) and medications.

Table 18: Regression Analysis: Mismatch Queries Between Medications and Diagnosis

Dependent Variable	PRI1		PRI2		PRI3		PUB 1		PUB 2		PUB HW		Total		Hospital Regression	Public vs. PC Regression
	N	%	N	%	N	%	N	%	N	%	N	%	N	%		
Mismatch: Dx [†] and drugs	48	13.7	17	7.1	11	7.7	9	11.4	20	10.7	36	17.6	141	11.7	MCS=.180*** PRI2: -.78*	MCS= .800 None

= significant < .05; ** = significant < .01; *** = significant < .001

Logistic regression model used; regression excluded diagnoses variables.

Historically white hospital excluded from regression.

Very Strong Suggestion	Strong Suggestion	Weak Suggestion of Effect	No Suggestion of Effect
		PRI2: Fewer Queries	Public vs. Private Gender Race Geriatric
Notes: Individual hospital effect consistent with public-private effect.			
Historically White Regression Analysis: Strong suggestion of significance of effect (HW: .95**). That is, more queries at the historically white hospital.			

3.2.5. Drug Dosage

This analysis looked at the frequency of queries based on drug dosage. All diagnostic categories included.

Table 19: Regression Analysis: Drug Dosage Queries

Dependent Variable	PRI1		PRI2		PRI3		PUB 1		PUB 2		PUB HW		Total		Hospital Regression	Public vs. PC Regression
	N	%	N	%	N	%	N	%	N	%	N	%	N	%		
Drug Dosage	4	1.2	4	1.7	2	1.4	2	2.5	1	0.5	0	0	13	1.1		
Dose High															MCS: 324 PUB1: 2.1*	MCS: 416 none
Dose Low															MCS: 123 None	MCS: 173 Black: -4.3*

= significant < .05; ** = significant < .01; *** = significant < .001

Logistic regression model used; regression combined mismatch of mentally handicapped and other diagnoses.

Historically white hospital excluded from regression.

Very Strong Suggestion	Strong Suggestion	Weak Suggestion of Effect	No Suggestion of Effect
			Private vs. Public Gender Race Diagnosis (S, E, MH) Geriatric
Notes: None of regression models demonstrate significant fit.			
Historically White Regression Analysis: Effect not significant for either too high or too low dosage analysis.			

3.2.6. Polypharmacy

This analysis looked at the frequency of queries based on polypharmacy. All diagnostic categories included.

Table 20: Regression Analysis: Polypharmacy Queries

Dependent Variable	PRI1		PRI2		PRI3		PUB 1		PUB 2		PUB HW		Total		Hospital Regression	Public vs. PC Regression
	N	%	N	%	N	%	N	%	N	%	N	%	N	%		
Polypharmacy	6	1.7	3	1.3	2	1.4	4	5.1	1	0.5	5	2.5	21	1.7	MCS: 117 PUB1: 1.6*	MCS: 253 Epileptic: 1.3*

= significant < .05; ** = significant < .01; *** = significant < .001

Logistic regression model used.

Historically white hospital excluded from regression.

Very Strong Suggestion	Strong Suggestion	Weak Suggestion of Effect	No Suggestion of Effect
			Private vs. Public Gender Race Diagnosis (S, E, MH) Geriatric
Notes: None of regression models demonstrate significant fit.			
Historically White Regression Analysis: Effect not significant.			

3.2.7. Drug Combination Queries

This analysis looked at the frequency of queries based on drug combination queries. All diagnostic categories included.

Table 21: Regression Analysis: Drug Combination Queries

Dependent Variable	PRI1		PRI2		PRI3		PUB 1		PUB 2		PUB HW		Total		Hospital Regression	Public vs. PC Regression
	N	%	N	%	N	%	N	%	N	%	N	%	N	%		
Drug Combination	1	0.3	2	0.8	8	5.6	0	0	9	4.8	14	6.9	34	2.8	MCS: .000*** PRI3: 3.8*** PUB2: 3.1**	MCS: .005** Private: -.98*

= significant < .05; ** = significant < .01; *** = significant < .001

Logistic regression model used.

Historically white hospital excluded from regression.

Very Strong Suggestion	Strong Suggestion	Weak Suggestion of Effect	No Suggestion of Effect
PRI3, PUB2: More queries		Private: Less queries	Gender Race Geriatric Diagnosis
Notes:			
Historically White Regression Analysis: Effect not significant.			

3.2.8. Diagnosis Queries (Multiple, Mismatch etc.)

This analysis looked at the frequency of queries based on diagnosis (multiple diagnoses, questionable match between diagnoses.) All diagnostic categories included.

Table 22: Regression Analysis: Diagnosis Queries

Dependent Variable	PRI1		PRI2		PRI3		PUB 1		PUB 2		PUB HW		Total		Hospital Regression	Public vs. PC Regression
	N	%	N	%	N	%	N	%	N	%	N	%	N	%		
Diagnosis Query	3	0.9	1	0.4	0	0	0	0	1	0.5	0	0	5	0.4	MCS: .284 Geriatric: 2.2*	MCS: .187 Geriatric: 2.3*

= significant < .05; ** = significant < .01; *** = significant < .001

Logistic regression model used.

Historically white hospital excluded from regression.

Very Strong Suggestion	Strong Suggestion	Weak Suggestion of Effect (Geriatric: More queries)	No Suggestion of Effect Private vs. Public Gender Race Diagnosis (S, E, MH)
Notes: None of regression models demonstrate significant fit.			
Historically White Regression Analysis: Effect not significant.			

Conclusions

- The privately contracted hospitals had fewer medications/diagnosis queries overall.
- Mental handicap patients had more queries overall.
- Queries between medications and diagnoses: This was particularly a problem for patients with mental handicap diagnoses. (There was some suggestion that patients with schizophrenia as a diagnosis had fewer queries.) For mental handicap diagnoses, privately contracted hospitals had fewer queries, geriatric patients had fewer queries, and female patients had more queries. There were no differences in effect of queries for other (non mental handicap) diagnostic categories.
- There was no effect for drug dosage queries. The relatively low rate of dosage queries (lack of over-medication of patients) was a positive finding across sectors.
- There was no effect for polypharmacy queries. The relatively low rate of polypharmacy queries was a positive finding across sectors.
- There was a weak suggestion that there were less drug combination queries at privately contracted hospitals, although effect between individual hospitals was high.
- There was no effect for diagnoses queries. The relatively low rate of diagnoses queries was a positive finding across sectors.

3.3. Medication Dosages Analysis

Table 23: Medication Dosage Analysis: Moderate

Dependent Variable	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public ^a	PC	Hospital Regression	Public vs. PC Regression
freq. use	2	22	3	10	9	15	27	19		
Mean	25	25	41.7	36.3	36.1	32.5	26.9	36.2		
SD	0	6.7	14.4	24.6	13.2	14	9.0	19.5		
Median	25	25	50	25	25	37.5	25	25		
Mode	25	25	50	25	25	25	25	25		
									F= 27 None	F= 28 Private: -10.7**

* = significant < .05; ** = significant < .01; *** = significant < .001

^a Public Sector statistics excluded the historically white hospital data to enable comparison.

NB: p=0.09, Kruskal Wallis for hospital differences; p=0.03, Kruskal Wallis for sector differences

Very Strong Suggestion (Private: Lower Dosages)	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
			Gender Diagnosis Race
Notes: Regression model fit not significant.			
Historically White Regression Analysis: Effect not significant.			

Table 24: Medication Dosage Analysis: Serenace

Dependent Variable	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public^	PC	Hospital Regression	Public vs. PC Regression
freq. Use	21	5	8	2	12	58				
Mean	9	18	43.1	15	18.8	13.1	18.4	18.2		
SD	8.8	4.5	63.7	7.1	9.1	13.5	33.4	8.7		
Median	5	20	20	15	15	10	10	15		
Mode	5	20	20	10	15	10	20	15		
									F= 104 PRI3: 25.4* Female: 29.5*	F= 121 Female: 35.8**

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics excluded the historically white hospital data to enable comparison.

Very Strong Suggestion (Female: Higher Dosages)	Strong Suggestion of Effect	Weak Suggestion of Effect (PRI3: Higher Dosages)	No Suggestion of Effect
			Public vs. Private Diagnosis Race Age
Notes: Regression model fit not significant.			
Historically White Regression Analysis: Effect not significant.			

Table 25: Medication Dosage Analysis: Clopixol

Dependent Variable	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public^	PC	Hospital Regression	Public vs. PC Regression
freq. Use	58	1	10	0	3	9				
Mean	413.7	400	400	-	167	433.3	413	167		
SD	250.1	0	179.2	-	57.7	255	238.1	57.7		
Median	400	400	400	-	200	400				
Mode	200	400	400	-	200	400				
									F= 629 None	F= 438 None

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics excluded the historically white hospital data to enable comparison.

NB: p=0.2, Kruskal Wallis for hospital differences; p=0.076, ANOVA for sector differences.

Very Strong Suggestion	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
			Public vs. Private Gender Diagnosis Race Age
Notes: Regression model fit not significant.			
Historically White Regression Analysis: Effect not significant.			

Table 26: Medication Dosage Analysis: Tegretol

Dependent Variable	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public^	PC	Hospital Regression	Public vs. PC Regression
Freq. use	77	32	32	32	39	38				
Mean	678	509.4	640.6	668.8	616	668.4	631.2	640.8		
SD	272.2	192.4	295	246	238.3	220.7	268.9	241.2		
Median	600	400	600	700	600	600	600	600		
Mode	600	400	600	800	800	600	600	800		
									F=.005 PRI2: -178** Epileptic: 113**	F=.044 Epileptic: 106**

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics excluded the historically white hospital data to enable comparison.

NB: p=0.04, ANOVA for hospital differences; p=0.3, Kruskal Wallis for sector differences.

Very Strong Suggestion	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Epileptic: Higher Doses PRI2: Lower Doses			Public vs. Private Gender Schizophrenia Mental Handicap Race Age
Notes:			
Historically White Regression Analysis: Effect not significant.			

Table 27: Medication Dosage Analysis: Largactil

Dependent Variable	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public^	PC	Hospital Regression	Public vs. PC Regression
freq. use	3	94	9	6	16	1				
Mean	283.3	292.6	288.9	493.8	240.6	675.0	291	325		
SD	284.3	168.5	265.5	344.8	117.2	0	179	245		
Median	300	200	200	500	300	675	200	300		
Mode	50	400	50	600	300	675	200	300		
									F=.278 none	F=.931 none

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics excluded the historically white hospital data to enable comparison.

Very Strong Suggestion	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
			Public vs. Private Gender Diagnosis Race Age
Notes:			
Historically White Regression Analysis: Weak suggestion of significance of effect (HW: 491*).			

Conclusions

- No suggestion of significant effect between public and privately contracted sector. (Suggestion of difference in dosages of Modecate, but not accepted due to lack of fit of model.)

4. Frequency of Medical Treatment Routines

4.1 Medical Screening Routines: Blood Pressure

Table 28: Regression Analysis: Time Since Last BP Taken (in days) by Institution

Dependent Variable	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public [^]	PC	Hospital Regression	Public vs. PC Regression
Mean (SD)	21.7 (32.6)	132.5 (167.4)	7.6 (7.6)	706 (535)	35 (96)	-	132.2 (322.2)	45.8 (99.5)		
Median	8	83	7	509	16	-	31	14		
N	332	150	130	30	177	-	208	612	R ² =.509 F=.000*** PUB1: 57.1*** Schiz: -30.7* MH: -31.6* Female: 42.0** PRI-2: 98.6*** PUB-1: 678.2***	R ² =.051 F=.000*** Private: -77.4*** Female: 47.8**

* = significant < .05; ** = significant < .01; *** = significant < .001

[^] Public Sector statistics excluded the historically white hospital data to enable comparison.

† Only 30 observations were made at PUB1

‡ Only 1 observation was made at PUBHW

NB: PRI2 not included in regression analysis. Primary health nurses perform physical screening separately and data not recorded in patient files. Therefore date data from patient files is not considered reliable.

Very Strong Suggestion	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Private: More Recent Review PRI-2: Less Recent Review PUB-1: Less Recent Review	Female: Less Recent Review	Schizophrenia: Less Recent MH: Less Recent	Epilepsy Race
Notes: PUB1 demonstrates lack of physical screening procedures – difference to other hospital approximately a year. Sector effect limited by PRI-2 effect.			
Historically White Regression Analysis: Effect not significant.			

4.2 Medical Screening Routines: Weight

Table 29: Regression Analysis: Time Since Last Weight Taken (in months)

Dependent Variable	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public [^]	PC	Hospital Regression	Public vs. PC Regression
Mean (SD)	22.1 (33.3)	100.6 (106.0)	7.6 (8.9)	1376.3 (1422.0)	39.0 (117.2)	-	110.6 (448.1)	36.9 (66.2)		
Median	9	82	7	1005	16	-	16	13		
	346	135	119	10	177	-	188	500	R ² =.454 F=.031* PRI2: 74.6*** PUB1: 1351.8***	R ² =.021 F=.000*** Private: -70.6***

* = significant < .05; ** = significant < .01; *** = significant < .001

[^] Public Sector statistics excluded the historically white hospital data to enable comparison.

† Only 30 observations were made at PUB1

‡ Only 1 observation was made at PUBHW

NB: PRI2 not included in regression analysis. Primary health nurses perform physical screening separately and data not recorded in patient files. Therefore date data from patient files is not considered reliable.

Very Strong Suggestion	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Private: More Recent Review PRI2: Less Recent Review PUB1: Less Recent Review			Gender Schizophrenia: Mental Handicap Epilepsy Race
Notes: PUB1 demonstrates lack of physical screening procedures – difference to other hospital approximately two years. The lack of balanced data and hospital variance weakens sectoral effect.			
Historically White Regression Analysis: Effect not significant.			

Conclusions

- Strong suggestion that privately contracted hospitals achieve basic physical screening on a more regular basis than public hospitals. However, lack of balance within data and high levels of hospital variance weakens this effect.
- Only one hospital (PRI3) demonstrating monthly blood pressure and weight screening. However, qualitative evidence in this hospital suggests that files were systematically updated for our visit.
- One public sector hospital (PUB1) demonstrates dramatically worse screening practices than others. There were no working blood pressure machines nor scales at this hospital.

4.3. Frequency of Medical Contact

Table 30: Regression Analysis: Time Since Last Medical Practitioner Notes (in months)

Dependent Variable	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public [^]	PC	Hospital Regression	Public vs. PC Regression
Mean (SD)	6.1 (10.9)	6.5 (6.2)	32.9 (38.4)	5.3 (6.4)	3.2 (3.3)	3.0 (4.8)	9.5 (24.6)	4.7 (7.3)		
Median	4.1	3.9	19.0	2.7	2.1	1.3	4.8	2.8		
Mode	0.1	2.6	3.8	0.1	0.6	0.9	0.1	1.8		
									R ² =.185 F=.000** PUB1: 27.7***	R ² =.063 F=.000** Private: -9.6*** Black: 8.7***

* = significant < .05; ** = significant < .01; *** = significant < .001

[^] Public Sector statistics excluded the historically white hospital data to enable comparison.

Date of doctor (psychiatrist or MO) last entry abstracted from patient file notes.

Very Strong Suggestion	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Private: More recent Black: Less recent PUB1: Less recent			Diagnosis Gender
Notes: PUB1 demonstrates lack of regular medical personnel contact.			
Historically White Regression Analysis: Effect not significant.			

Conclusions

- Strong suggestion that patients at privately contracted hospitals have more regular contact with medical personnel.
- One public sector hospital (PUB1) demonstrates dramatically worse medical personnel contact of patients.

5. Patient Record Keeping System

Table 31: Regression Analysis: Proportion of Patient Records Queried for Quality of Medication or Diagnosis

Dependent Variable	PRI1		PRI2		PRI3		PUB1		PUB2		PUBHW		Public		Private		Hospital Regression	Public vs. PC Regression
	N	%	N	%	N	%	N	%	N	%	N	%			N	%		
Organised	339	96.6	222	93.3	138	97.2	29	36.7	176	94.1	180	88.2	699	96.3	205	79.2		
Not organised	9	10.2	14	5.9	4	2.8	49	62	5	2.7	7	8	27	3.7	54	20.8		
Not assessed	3	0.9	2	0.8	0	0	1	1.3	6	3.2	17	8.3						
Total	351		238		142		79		187		204		726		259		MCS=.000*** PUB1:-3.7***	MCS=.000*** MH: -1.1** Private: 2.2**

= significant < .05; ** = significant < .01; *** = significant < .001

Logistic regression model used.

Historically white hospital excluded from regression.

Very Strong Suggestion	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Private: More organised	M Handicap: Less Organised		Gender Schizophrenia: Epilepsy Race
Notes: While sector effect demonstrates privately contracted hospital advantage, most of effect explained by PUB1 which scores significantly lower than any other hospital in terms of file disorganisation.			
Historically White Regression Analysis: Weak suggestion of significance of effect (HW: -.84*). (HW files less organised than other hospitals.)			

Conclusions

- Suggestion that patient files are more organised in privately contracted sector; strong evidence of particular problem with file organisation in public hospital PUB1.

Addendum 1.1: Patient Record Abstraction

Methodology and Results

A. Methodology

1. Summary

The Nursing Staff Questionnaire forms one component of the ward protocol completed at each chronic ward at the hospital. The questionnaire was designed to assess nursing staff perceptions of quality of hospital operations.

The questionnaire was completed by nursing staff personnel at the ward level. The format of this questionnaire was based on the Community Oriented Programs Environment Scale (COPEs) of the Residential Substance Abuse and Psychiatric Programs Inventory (RESPPI) (Timko, 1994). The component questions and sub-scales have been modified almost entirely (See Chapter 1.)

The questionnaire consisted of 109 true-false questions. Questions are organised into sub-scales reflecting structural, process, and outcome indicators, as well as indicators from all levels of the Hierarchy of Objectives. See Table 1 below. The final page of the analysis was designed to facilitate additional written comments.

Statistical analysis included descriptive statistics of individual items, a factor analysis of component sub-scales, and a regression strategy synthesising four regression models.

A complete copy of the Nursing Staff Questionnaire can be found in Addendum 2: Quality of Care Tools.

Table 1: Nursing Staff Questionnaire Sub-Scales

Objective	Structure	Process / Programme	Outcome
Custodial Care	Management Ability HR Systems Nursing Staff Skill Confidence Support Satisfaction	Staff Patient Relationship Patient Access to Nursing Staff Personal Freedoms Patient Daily Life Order Ward Cleanliness Social Activities Nursing Staff Languages	Patient Busyness Patient Interactions Patient Pride
Psychiatric Rehabilitation	As above	Medical Services Medical Services Languages / Translators Patient Record Keeping System Condom Distribution	Patient Understanding of Medications
Patient Development for Discharge	As above Patient Leadership Structures	General Discharge Preparation Preparation for Employment Basic Self Care Development Occupational Therapy Programme Discharge Planning and Support	Patient Clarity of Circumstance Patient Responsibility Patient Clarity of Discharge
Socially Transformative	As above	Facilitation of Family Involvement Community Outreach	Family Involvement Family Attitude toward Patient Discharge

2. Administration of Questionnaire

The questionnaire was one part of the ward protocol that was completed at each chronic ward selected at the institution:

1. A meeting was organised with all nursing staff on duty for introductions, an explanation of the study, and a description of the questionnaire. This meeting includes the following points about the questionnaire:
 - Reason for questionnaire. It was emphasised that there are not 'right' or 'wrong' answers.
 - Confidentiality and voluntary nature of questionnaire
 - Reading of cover page, encouraging staff to retain cover page for future reference.
 - Instruction to omit *questions if they are unclear*.
 - Request to include additional comments on the last page of the questionnaire.
2. Questionnaire was then distributed to each member of the nursing staff directly, excluding student nurses.
3. Nursing staff returned questionnaire directly to researchers (i.e. not through senior staff, to reduce any fear of intimidation).

3. Sampling Method

The questionnaire was distributed to all nursing personnel in the ward at the time of the ward protocol, (excluding student nurses).

Table 2: Number of nurses sampled at different hospitals

Hospital	Total	Length of Service	% Sister ¹	% Staff Nurse ²	% Asst Nurse ³	% Resident Health Worker	% Not specified / other
PRI1	112	na ⁴	0	.10	.76	.01	.13
PRI2	64	Mn: 9.6 yrs ⁵ SE: 1.4 Median: 7.0	.09	.14	.44	.05	.28
PRI3	46	Mn: 6.0 yrs SE: .8 Median: 6.0	.06	.15	.59	.17	.02
PUB1	36	Mn: 7.5 yrs SE: 1.4 Median: 5.0	.08	.17	.58	na	.17
PUB2	77	Mn: 18.4 yrs SE: 1.2 Median: 21.5	.05	.12	.82	na	.01
PUBHW	47	Mn: 5.1 yrs SE: .7 Median: 4.0	.26	.21	.38	na	.15

4. Limitations

The following limitations should be noted:

- **Perceptions of Quality:** This questionnaire was designed to assess nursing staff *perceptions* of quality, not of quality itself. Nursing staff perceptions of quality are not necessarily a direct reflection of quality, as they are influenced by factors such as expectations of care, overall job satisfaction, job security and fear of victimisation.
- **Language and literacy:** The questionnaire was only made available in English⁶. This may have proven to be a struggle for some nursing staff, although the impact of this is minimised as most nursing staff have undergone training which conducted in English.

¹ Includes Sister and Senior Sister (S, SS)

² Includes Staff Nurse and Senior Staff Nurses (SN, SSN)

³ Includes Assistant Nurses and Senior Assistant Nurses (AN, SAN)

⁴ Length of employment was not asked on the Nursing Staff Questionnaire at PRI1. The item was included after the evaluation of this visit.

⁵ 40% of staff left 'length of employment' blank at PRI2 – significantly more than at other hospitals (PRI3 (9%), PUB1 (14%), PUB2 (1%), PUBHW (%)).

⁶ This may represent a significant limitations for nursing staff who are not literate or who are not fluent in English. This was probably a larger limitation in hospitals more rural, and further away from Gauteng (especially the two hospitals in the Northern Province.) This problem is not easily resolved. While some argue that written material should be translated in order to be more widely understood, still others argue that such translation does not in fact address the problem. This is based on the contention that the literacy rate within a vernacular is NOT significantly better than the literacy rate in English. This was accepted as a limitation within this study.

- **Confidentiality / Victimisation / Hospital Self-Protection:** While confidentiality was emphasised in the introduction, some staff may continue to provide answers which still reflect fears of identification. This is closely related to victimisation; at hospitals where there was a greater fear of staff victimisation, there may be a positive bias in the results.
- **Hospital Self-Protection:** Some hospitals viewed the study as a potential threat to the future of the hospital. There was evidence at some hospitals, particularly the privately contracted hospitals, that management had warned staff to portray the hospital favourably, for fear of losing their job. Staff at such hospitals would presumably answer questions more favourably.
- **'Test Taking Fear':** There was likely an effect from the socialisation around 'taking tests.' Although it was emphasised that there are no right answers, only truthful answers, there is a likelihood that some completed the answers according to what 'should be' rather than what 'is'.
- **Length of Questionnaire:** The questionnaire is long, which may impact on the accuracy of some data.
- **Double Negatives:** Questions which were posed in the negative were more difficult to understand, and thus the outcomes less reliable. Questions posed with double negatives are indicated with a 'DN' below. Particularly confusing questions were not included in the final analysis (see below: Questions Not Used.)

5. Scoring

5.1. Overview

The questionnaire contained 109 true-false questions. The questions were used as follows:

- Eighty three questions were aggregated into 25 sub-scales as described below. Sub-scales ranged from two to twelve questions. Sub-scales are outlined in detail in the tables below. These sub-scales were included in the factor analysis (see below).
 - Eleven questions were not incorporated into sub-scales. These questions commented on specific quality areas. These questions were not included in the factor analysis.
 - Fifteen questions were not used in the final analysis due to confusion of wording or lack of priority. (See Table: Questions Not Used for a
-

description of why each item was not included.)

Table 3: Sub-scales and questions used

Sub-Scales	Individual Questions
1. Senior Management	1. Patient Pride
2. Management HR Systems	2. Patient Busyness
3. Staff Support	3. Staff Skill Confidence
4. Staff Satisfaction	4. Condom Distribution
5. Staff Patient Relationship	5. Patient Leadership Structures
6. Patient Access to Nursing Staff	6. Basic Self Care Development
7. Personal Freedoms	7. Occupational Therapy Programme
8. Patient Daily Life Order	8. Family Attitude toward Patient Discharge (2 questions)
9. Ward Cleanliness	9. Community Outreach
10. Social Activities	10. Availability of Trained Translators
11. Nursing Staff Languages	
12. Patient Interactions	
13. Medical Services	
14. Medical Services Languages	
15. Patient Record Keeping System	
16. Patient Understanding of Medications	
17. High Level: Preparation for Employment	
18. General Discharge Preparation	
19. Patient Clarity of Circumstance	
20. Patient Responsibility	
21. Patient Clarity of Discharge	
22. Discharge Planning	
23. Discharge Support	
24. Discharge Support Planning	
25. Facilitation of Family Involvement	

5.2. Scoring

Answers to each question were coded as either '1' or '0' such that '1' represented a higher level of quality of care, and '0' a lower level. See example in the table below.

Table 4: Example of scoring

Example	Coding	=1
This hospital is clean.	'True' is coded as a '1' and 'False' is coded as a '0'.	T
This hospital is dirty	'False' is coded as a '1' and 'True' is coded as a '0'.	F

A clean hospital is considered higher quality than a dirty hospital. Answers coded as '1' indicate better quality.

The last digit of the item code in the tables below specifies the direction of this scoring. A 'T' indicates that a true answer was scored with a '1', while a 'F' indicates that a false answer was scored with a '1'.

5.3. Sub-Scale Scores

Scores for each question within a sub-scale were added together to calculate the sub-scale score.

6. Analysis

6.1. Descriptive Frequency Statistics

The mean and standard deviation of the mean was calculated for each individual item for each hospital and a cross the public and privately contracted sectors.

The median, mean, and standard deviation of the mean was calculated for each sub-scale, for each hospital, and across the public and privately contracted sectors.

These results can be found in the tables below.

6.2. Factor Analysis

The questionnaire contained over one hundred individual questions designed to assess nursing staff perceptions of the quality of care in the institution where they worked. In order to reduce the data on nursing perceptions of quality to a few manageable and separable aspects of quality, we undertook a factor analysis. The approach is discussed in Chapter 1: Introduction of the main report. The rotated factor matrix is illustrated in Table 6.

Table 6 Rotated Factor Matrix: Correlation coefficients between sub-scales and derived factors

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
SUMMAN	.75773	.29532	-.01952	-.02132	.00100
SUMMX	.47833	.32273	.39046	.23844	-.05418
SUMSUP	.61320	.33106	.00354	.20246	-.04504
SUMSAT	.72117	.22772	.04240	-.01562	.10319
SUMSYS	.07063	.19589	.05283	.01821	-.06886
SUMSPR	.16207	.12446	.78180	.04958	-.04132
SUMFRE	.15878	.36867	.23349	-.06308	.08601
SUMDLO	.39687	.26552	.46731	.26079	-.03122
SUMSR	.58629	.05916	.30337	-.09638	.26479
SUMCLN	.69513	-.02066	.16324	.31884	.03491
SUMPPR	.22367	.30449	.23859	.41996	.00639
SUMNA	.23399	.02344	.04854	.09987	.09176
SUMNLAN	.01192	-.14441	.26712	.17758	.15211
SUMCLR	.04316	.02644	.05078	.80380	.11444
SUMRSP	-.00958	.44046	.43640	.06351	-.02448
SUMMED	.11898	.24439	-.05235	.03386	-.06871
SUMDRLAN	.13523	-.11512	-.25182	.29495	-.10209
SUMCLRMD	.06338	.18143	.05515	.52675	.22579
SUMPRPA	.09504	.20737	-.00745	.03845	.81044
SUMPRPB	.33608	.62618	.20342	.21424	.03020
SUMDPL	.16609	.70483	-.03878	.11512	.06474
SUMCLRDX	.06103	.04937	-.01509	.23214	.81191
SUMDS	.26753	.39949	.22401	-.02399	.10509
SUMDSPLN	.22329	.72213	.08358	.15139	.16730
SUMFAM	.00211	.06555	.39259	.13951	.18480
SUMFFX	.16050	.65008	.24604	-.14399	.14328
	Factor 6	Factor 7	Factor 8		
SUMMAN	.14043	.15978	.07563		
SUMMX	-.10621	-.05038	.06778		
SUMSUP	.11753	.08573	-.21489		
SUMSAT	.09490	-.01901	.02207		
SUMSYS	.68174	.32007	.16021		
SUMSPR	.15202	.04334	-.03070		
SUMFRE	.05848	.58655	-.13083		
SUMDLO	-.01995	.00124	.07886		
SUMSR	-.07199	.08049	.16120		
SUMCLN	.25298	.10678	.14160		
SUMPPR	.13067	.03752	-.02953		
SUMNA	.75190	-.17792	-.10335		
SUMNLAN	.42528	.11638	.40841		
SUMCLR	.07422	.04136	-.00814		

SUMRSP	.19236	.01572	-.33707
SUMMED	.05063	-.10271	.75529
SUMDRLAN	.08878	.71001	-.12448
SUMCLRMD	.02104	.28283	.12270
SUMPRPA	-.02441	.09531	.10724
SUMPRPB	.15164	-.00305	.02383
SUMDPL	.13498	.00325	.08741
SUMCLRDX	.10676	-.03439	-.14871
SUMDS	-.06009	.16511	-.05545
SUMDSPIN	-.14563	-.00089	.09576
SUMFAM	-.04059	.48444	.15209
SUMFFX	.06730	.26164	.30039

6.3. Regression Analysis

A regression analysis was used to consider sectoral differences in light of hospital and ward based variables. The approach and assumptions underlying the regression strategy are discussed in Chapter 1: Introduction of the main report.

B. Results

The following sections contain the results of the analysis of the nursing staff questionnaire. The first section contains five tables demonstrating the results of the regression analysis of the five most meaningful factors. The following sections demonstrate the frequency data and regression analysis of individual questions and their corresponding sub-scales.

The results of the regression analysis are reported in summary form to assist the reader with interpretation as follows:

Code	Question	Notes	PRI1	PRI 2	PRI 3	PUB 1	PUB 2	PUB HW	Public ^	PC	Hosp Reg 1	Hosp Reg 2	Sector Reg 1	Sector Reg 2
	Q1		Mean SE Medn	Mean SE Medn	Mean SE Medn	Mean SE Medn	Mean SE Medn	Mean SE Medn	Mean SE Medn	Mean SE Medn				
	Q2		"	"	"	"	"	"						
	Q3		"	"	"	"	"	"						
SUM	Sub-scale	3 questions	Mean SE Medn								R ² = F= Var: B* Var: B** Var: B***	R ² = F=	R ² = F=	R ² = F=

The F and/or MCS value is given to demonstrate the significance of fit for the model.

Below the F/MCS value is the beta values for variables demonstrating at least a minimal suggestion of significance. This table is complemented with an additional table summarising the significant effects.

1. Factor Analysis Regression Results

Factor 1: Organisational: Human Resources / Management

Factor	Key Components	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
Human Resources Management	Management, Staff Satisfaction, and Staff Support (Ward Cleanliness)	F=.017 PUB1: -.60* Mix Ward: .59** Female: .57**	F=.017 Female: .45*	F=.025 Ward Mix: .37* Female: .58**	F=.030 Ward Mix: .50* Female: .53**
* = significant < .05; ** = significant < .01; *** = significant < .001					
^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.					
Very Strong Suggestion of Effect		Strong Suggestion of Effect		Weak Suggestion of Effect	
Female Ward: +		Mixed Wards: +		PUB1: -	
				No Suggestion of Effect	
				Public vs. Private Capacity Patient : Staff Ratio Ward Age MH Ward Sick Bay Wards Very High/Low Functioning Wards Nursing Rank	
Notes: Female wards were considered the best wards to work in, and seemingly nursing staff perceived management/organisation issues in significantly higher terms. Hospital / sector effect is limited to weak for hospital PUB1.					
Historically White Regression Analysis: Effect significant. (HW Model 1: F=.000, p=.000**, B=.66; HW Model 2: F=.000, p=.001**, B=.65)					

Factor 2: Discharge Programme

Factor	Key Components	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
Discharge Programme	Preparation for Discharge, Discharge Planning, Discharge Support Planning, Family involvement	F=.006 PRI3: -.52* MH Ward: .48*	F=.002 PSR: -.12*	F=.006 Mix Ward: -.56 Young: -.76*	F=.001 Young: -.83* Capacity: .002* PSR: -.05**
* = significant < .05; ** = significant < .01; *** = significant < .001 ^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.					
Very Strong Suggestion of Effect		Strong Suggestion of Effect		Weak Suggestion of Effect	
Patient : Staff Ratio: -		Young: -		Capacity: + Mixed Wards: - MH Ward: + PRI3: -	
				No Suggestion of Effect Public vs. Private Female Ward Geriatric Sick Bay Wards Very High/Low Functioning Wards Nursing Rank	
Notes: Patient : Staff ratios were strongest predictors, with higher patient staff ratios predicting lower scores. Hospital / sector effect is limited to none amongst historically black hospitals.					
Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.000, p=.63, B=.09; HW Model 2: F=.000, p=.80, B=.05)					

Factor 3: Staff Patient Relationship

Factor	Key Components	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
Staff Patient Relationship	One principle factor: Staff Patient Relationship	F=.000 PRI2: .97*** PUB1: 1.0*** PUB2: 1.0*** HI Function: -.80* MH Ward: .45* Sister: -.59*	F=.000 PRI3: 2.0** PUB1: 2.2*** PUB2: 2.3*** Sister: -.60* Capacity: .008***	F=.000 HI Function: -.63* Female: .44** Private: -.67***	F=.000 Sickbay: .46* Lo Function: -.39* MH Ward: .57* Female: .44** Sister: -.58* Capacity: .002** PSR: .05* Private: -1.2***

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Private: - Capacity: + PUB1, PUB2, PUB3: +	Very High Functioning Wards: - MH Ward: + Nursing Rank Sister: - Female: +	Very Lo Functioning Wards: - Patient: Staff Ratio: +	Gariatric Mixed Wards Young Sick Bay Wards

Notes: Strong suggestion of effect of privately contracted hospitals scoring lower than public hospitals. Most individual hospital effect consistent with public: private effect, although some effect between individual privately contracted hospitals, limiting effect. Unexpected direction of effect on capacity and patient: staff ratios, with each suggesting significance in the positive rather than negative direction.

Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.000, B=-.32, p=.08, .IW Model 2: F=.000, p=.18, B=-.26)

Factor 4: Patient Clarity

Factor	Key Components	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
Patient Clarity	Clarity of Circumstance, Clarity of Medications.	F=.000 PRI3: .62** PUB2: .77*** HI Function: 1.9*** MH Ward: -.39* Sister: .76**	F=.000 PRI3: 1.8** PUB2: 1.5** HI Function: 2.4*** MH Ward: -.65** Sister: .78**	F=.000 HI Function: 1.7*** Sister: .73** Private: -.44**	F=.000 HI Function: 1.6*** Mix Ward: -.41* Sister: .73** Capacity: -.002** PSR: .03*

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Very High Functioning Wards: + Nursing Rank Sister: + PUB2, PRI3: +	MH Ward: - Private: - Capacity: -	Mixed Wards: - Patient: Staff Ratio: +	Very Lo Functioning Wards: - Female: + Ward Age Sick Bay Wards

Notes: Strong suggestion of privately contracted hospitals scoring significantly lower on this factor. Most individual effect consistent with public: private effect, although PRI3 high scores limits generalisability of public: private effect to some extent.

Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.018, B=-.33, p=.08; HW Model 2: F=.021, p=.06, B=-.38)

Factor 5: High Level Patient Preparation for Discharge

Factor	Key Components	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
High Level Patient Preparation for Discharge	Patient Preparation for Employment Patient Clarity of Discharge Status	F=.002 PRI2: .48* PRI3: .65** MH: -.51*	F=.000 PRI2: .81** PRI3: 2.1** PUB1: 1.1* PUB2: .99* PSR: -.11* MH: -.86*** Sickbay: -.60* Low Function: .59*	F=.007 MH: -.53* Mix: .49** Female: .45*	F=.014 MH: -.51* Mix: .41* Female: .47**

* = significant < .05; ** = significant < .01; *** = significant < .001

Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
M Handicap Wards: - PRI2, PRI3: +	Female: + Mixed Wards: +	Sickbay Wards: - Very Low Functioning Wards: + Patient: Staff Ratio: - PUB1: +	Public vs. Private Very High Functioning Wards: - Ward Age Capacity: - Nursing Rank Sister: +

Notes: Significant effect between individual historically black hospitals.

Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.089, B=-.05, p=.78; HW Model 2: F=.121, p=.66, B=-.09)

Factor 6: Ward Nursing Duties

Factor	Key Components	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
Ward Nursing Duties	Access to Nursing Staff Patient Record Keeping System (Nursing Staff Languages)	F=.000 PRI2: -.45* PUB1: -1.0*** Sickbay: -1.0*** MH: -.52** Female: .47** Geriatric: -.93***	F=.000 PUB1: -1.1* Sickbay: -1.1*** MH: -.56* Female: .41* Geriatric: -.86***	F=.000 Geriatric: -.75 Private: .33*	F=.000 Sickbay: -.91*** MH: -.43* Mix: -.48** Geriatric: -.79*** Capacity: -.002** Private: .66***

* = significant < .05; ** = significant < .01; *** = significant < .001

Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Private: + Sickbay: - M Handicap: - PUB1: -	Female: + Capacity: -	Mixed Wards: - PRI2: +	Very High / Low Functioning Wards: - Patient: Staff Ratio Wards Nursing Rank Sister

Notes: Strong suggestion of effect of privately contracted hospitals scoring higher than public hospitals. Most effect between hospitals is consistent with public: private effect, weak suggestion of lower scores of PRI2 limits generalisability to some extent.

Historically White Regression Analysis: Very weak suggestions of significance of effect. (HW Model 1: F=.089, p=.20, B=-.23; HW Model 2: F=.000, p=.04, B=-.38)

Factor 8: Medical Treatment Services

Factor	Key Components	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
Medical Treatment Services	Medical Treatment Services	F=.000 PR12: .88*** Female: -.50**	F=.000 PR12: .61* PR13: 2.5*** PUB1: 1.6** PUB2: 1.6** Sickbay: -.74** Hi Function: 1.8** Female: -.66** PSR: -.118** Capacity: .009***	F=.008 Sickbay: -.43* Private: .29*	F=.000 Hi Function: .80* Capacity: .002**

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Female: + Capacity: + PR12, PR13: +	Sickbay: - Very High Functioning Wards: + Patient : Staff Ratio: - PUB1, PUB2: +	Private: +	Very Lo Functioning Wards Ward Age Mixed Wards MH Ward Nursing Rank Sister

Notes: Weak suggestion of privately contracted hospitals scoring significantly higher on this factor. High level of effect between individual hospitals, limiting generalisability of sector effect differences.

Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.073, B=-.14, p=.47; HW Model 2: F=.004, p=.09, B=.33)

2. Descriptive Statistics and Regression Model Analysis

Senior Management

Code	Question	Notes	PR1	PR2	PR3	PUB1	PUB2	PUB HW	Public Δ	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
MAN1-79F	The superintendent of this institution is not involved with the staff.	Superintendent (DN) Mn=.50 SE=.05 N=113	.58 .06 64	.67 .06 34	.24 .06 30	.62 .08 77	.63 .07 47	.58 .04 211	.51 .05 154	.58 .04 211	MCS: .004** PUB1: -1.6* PR2: .85* MH Ward: 1.2*	MCS: .000*** PR2: 2.3*** PR3: 4.3* PSR: -.30	MCS: .20 MH Ward: 1.1*	MCS: .33 MH Ward: 1.2*
MAN2-27T	I think the superintendent ⁷ of this institution does a good job at keeping the hospital organised and well run.	Superintendent .48 .05 113	.44 .06 64	.61 .09 34	.23 .08 30	.25 .05 77	.74 .07 47	.49 .04 211	.25 .04 154	.49 .04 211	MCS: .002** PUB1: -2.4** PUB2: -1.4*** Female Ward: .86*	MCS: .001** PSR: -.22* Sickbay: -1.8**	MCS: .002** Private: 1.4*** Sickbay: -1.1*	MCS: .001** Private: 1.9*** Sickbay: -1.1*
MAN3-63T	I think the senior matrons ⁸ of this institution do a good job at keeping the hospital organised and well run.	Senior Matron .50 .05 113	.53 .07 64	.50 .09 34	.43 .09 30	.48 .06 77	.76 .06 47	.51 .04 211	.47 .05 154	.51 .04 211	MCS: .23 Female Ward: 1.0* Geriatric: -.90*	MCS: .23	MSC: .19 Female Ward: .77*	MSC: .14 Female Ward: .74*
SUM MAN	Sub-scale	3 questions Md=1.0 Mn=1.4 SE=.12 N=113	2.0 1.5 .16 64	2.0 1.7 .19 34	0.0 .90 .21 30	1.0 1.3 .12 77	2.0 2.1 .14 47	2.0 1.5 .09 211	1.0 1.5 .09 154	2.0 1.5 .09 211	R ² = .25 F = .001 Capacity: .002* PSR: -.11*** Sick Bay: -.81*	R ² = .21 F = .096 Private: .40*	R ² = .23 F = .145 Private: .59**	

* = significant < .05; ** = significant < .01; *** = significant < .001

⁷ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect		Strong Suggestion of Effect		Weak Suggestion of Effect		No Suggestion of Effect	
Patient : Staff Ratio: -		(Private: +) PUB1: -		Capacity: + Sickbay Wards: -		Ward Age MH Ward Female Ward Mixed Wards Very High/Low Functioning Wards Nursing Rank	
Notes: Model fit only demonstrates significance of hospital regression models only. (Public vs. PC regression model fit insignificant.) While there is a strong suggestion of private hospitals scoring higher, suggestion is made weak due to insignificant model fit. Effect between individual hospitals consistent with public: private effect.							
Historically White Regression Analysis: Effect significant. (HW Model 1: F= .032, B=-.57, p=.01*; HW Model 2: F= .052, p=.02*, B=.56)							

⁷ The 'Superintendent' at the Lifecare hospitals is known as the 'Hospital Manager'. The questionnaire in Lifecare hospitals substituted 'Hospital Manager' for 'Superintendent' in this question.

⁸ The 'Senior Matron' at the Lifecare hospitals is known as the 'Nursing Services Manager'. The questionnaire in Lifecare hospitals substituted 'Nursing Services Manager' for 'Senior Matron' in this question.

Human Resources Management Systems

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Public A	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
MXSY1- 62T	There is a good programme of in-service training to support and develop staff.		Mid= 61 SE=.05 N=113	.64 .06 64	.27 .08 34	.40 .09 30	.78 .05 77	.85 .05 47	.67 .05 154	.56 .04 211				
MXSY2- 42T	Staff are rotated through different areas to prevent 'burn-out'.		.29 .04 113	.58 .07 64	.53 .09 34	.76 .08 30	.92 .03 77	.85 .05 47	.87 .03 154	.41 .04 211				
MXSY3- 54T	When I began the job there was an organised programme to orient me to my new job.		.82 .04 113	.72 .06 64	.64 .09 34	.77 .08 30	.91 .03 77	.83 .06 47	.87 .03 154	.76 .03 211				
SUM MX	Sub-scale	3 questions	Mid=2.0 Min=1.7 SE=.09	2.0 1.8 .14	1.0 1.4 .15	2.0 1.9 .15	3.0 2.5 .09	3.0 2.5 .11	3.0 2.4 .08	2.0 1.7 .07	R ² = .21 F= .000 PUB1: -.55* PUB2: .75** Lo Function: -.35* MH Ward: .72**	R ² = .23 F= .000 PUB1: 1.1* PUB2: 1.9** HI Function: 1.3* Capacity: .007** PSR: -.09*	R ² = .16 F= .000 Private: -.67*** MH Ward: .60**	R ² = .20 F= .000 Private: -.09* Capacity: .007** PSR: -.09* HI Function: 1.3*

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospitals' data to enable comparison.

Very Strong Suggestion of Effect			Strong Suggestion of Effect			Weak Suggestion of Effect			No Suggestion of Effect		
Capacity: +			Very High Functioning Wards: +			Very Lo Functioning: -			Ward Age		
MH Ward: +			Patient : Staff Ratio: -			PR13: -			Mixed Wards		
PUB2: +			Private: -			PUB1: +			Sickbay Wards		
									Female Ward		
									Nursing Rank		
Notes: Effect between individual hospitals consistent with public : private effect.											
Historically White Regression Analysis: Effect significant. (HW Model 1: F= .000, B= 51, p= .005**; HW Model 2: F= .000, B= -.44, p= .022*.)											

Nursing Staff Support

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Public Δ	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
SUP1-84T	I feel supported in my work here.	Core	Mn=.52 SE=.05 N=113	.46 .07 64	.48 .09 34	.48 .09 30	.54 .06 77	.68 .07 47	.52 .05 154	.50 .04 211				
SUP2-10T	My work is supervised very closely.	Supervision	.80 .04 113	.63 .06 64	.64 .09 34	.45 .06 30	.52 .06 77	.81 .06 47	.50 .05 154	.72 .03 211				
SUP3-12F	There is not enough time to work with other staff – we tend to do tasks on our own.	Support from colleagues	.63 .05 113	.50 .06 64	.72 .08 34	.52 .10 30	.38 .06 77	.70 .07 47	.42 .05 154	.60 .04 211				
SUP4-70T	I regularly discuss the problems and suggestions I have with my supervisor.	Support / relationship with supervisor	.77 .04 113	.85 .05 64	.68 .09 34	.87 .06 30	.93 .03 77	1.00 .07 47	.92 .03 154	.78 .03 211				
SUP5-118T	My supervisor is skilled and knowledgeable, and is able to provide valuable input into my job.	Supervisor skills and support	.86 .05 113	.64 .07 64	.55 .09 34	.57 .09 30	.66 .05 77	.91 .04 47	.64 .05 154	.64 .03 211				
SUP3-91T	The staff work well together – there is team spirit and a willingness to help each other out.	Support from colleagues	.83 .04 113	.85 .05 64	.76 .08 34	.64 .09 30	.74 .05 77	.94 .04 47	.71 .04 154	.82 .03 211				
SUP7-67T	I feel supported by other staff when there are problems I cannot handle.	Support from colleagues	.89 .03 113	.90 .04 64	.74 .08 34	.76 .08 30	.93 .03 77	.91 .04 47	.89 .03 154	.87 .02 211				
SUM SUP	Sub-scale	7 questions	5.0 4.9 .15	5.0 4.4 .27	5.0 4.3 .32	4.0 4.2 .32	5.0 4.7 .20	6.0 5.8 .16	5.0 4.5 .17	5.0 4.6 .13	R ² = .12 F = .000 PR12: .44* PUB2: -.65**	R ² = .14 F = .000 PUB1: -3.1** PUB2: -1.7* Female: 1.0*	R ² = .04 F = .296 Female: .67*	R ² = .07 F = .196 Female: .64* PSR: -.05*

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
	Female Ward: + PUB2: -	Patient: Staff Ratio: - PR12: + PUB1: -	Public vs. Private Capacity Very Lo / Hi Functioning Sickbay Wards Ward Age MH Ward / Psychiatric / Mixed Nursing Rank

Notes: Individual hospital effect more significant than sector (public : private) effect.

Historically White Regression Analysis: Effect significant. (HW Model 1: F=.001, B=-.94, p=.005**; HW Model 2: F=.000, B=-.72, p=.039**)

Nursing Staff Satisfaction

Code	Question	Notes	PRI1	PRI2	PRI3	PUB1	PUB2	PUB HW	Public ^a	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
SAT4-74T	On the whole, I feel satisfied with my job.	Core	Mn=42 SE=.05 N=113	.61 .07 64	.47 .09 34	.62 .09 30	.58 .06 77	.79 .06 47	.59 .05 154	.48 .04 211				
SAT2-17T	In general, I look forward to work when I get up in the morning.		.85 .03 113	.94 .03 64	.73 .08 34	.97 .03 30	.89 .04 77	.87 .05 47	.92 .03 154	.86 .02 211				
SAT1-53F	If I was offered a job (same responsibilities, salary, etc.) at a different mental health institution, I would take the job because I am not totally happy with the working environment here.	Low satisfaction related to working environment	.31 .05 113	.49 .06 64	.39 .09 34	.45 .11 30	.28 .05 77	.77 .06 47	.32 .05 154	.38 .03 211				
SAT3-109F	If I was offered a job at the same salary in another field of work I would take it because I do not like the working with patients with mental illness.	Lack of satisfaction related to working with mentally ill patients.	.82 .04 113	.91 .04 64	.82 .07 34	1.00 .00 30	.92 .03 77	.87 .05 47	.94 .02 154	.85 .03 211				
SUM SAT	Sub-scale	4 questions	2.0 2.3 .11	3.0 2.7 .15	2.0 2.3 .20	3.0 2.9 .17	3.0 2.6 .10	4.0 2.2 .15	3.0 2.7 .09	2.0 2.4 .08	R ² = .07 F = .006 Female: .42*	R ² = .07 F = .003 Female: .45*	R ² = .07 F = .003 Female: .48*	

* = significant < .05; ** = significant < .01; *** = significant < .001

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
	Female Ward: +		Public vs. Private Hospital Ward Age Capacity Patient : Staff Ratio Mixed Wards Very High / Lo Functioning Wards Sickbay Wards MH Ward Nursing Rank
Notes: Nursing staff in female wards demonstrate higher job satisfaction; no other variable significant. Historically White Regression Analysis: Effect significant. (HW Model 1: F=.001, B=-.68, p=.001***; HW Model 2: F=.001, B=-.57, p=.009***)			

Nursing Staff Skill Confidence

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub [^]	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
INSKL1-26T	I feel I have the skills to do my job well.	Assess staff self-evaluation of skills	.89 .04 113	.84 .05 64	.88 .06 34	.93 .05 30	.92 .03 77	.91 .03 47	.93 .03 154	.87 .02 211	MCS: .003 Lo Function: -1.7**	MCS: .006 Lo Function: -2.2**	MCS: .001 Lo Function: -1.7** Geriatric: 2.3*	MCS: .003 Lo Function: -1.7** Geriatric: 2.4*

* = significant < .05; ** = significant < .01; *** = significant < .001

[^] Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Very Low Functioning: -	Geriatric: +		Public vs. Private Hospital Ward Age Capacity Patient : Staff Ratio Mixed Wards Very High Functioning Wards Sickbay Wards Female Ward MH Ward Nursing Rank
Notes: Suggestion that nursing staff in very low functioning wards and psychogeriatric wards perceive themselves as less well skilled for their jobs than other nurses. No other variable significant.			
Historically White Regression Analysis: Effect not significant. (HW Model 1: MCS=.001, B=-.56, p=.44; HW Model 2: MCS=.002, B=-.67, p=.38)			

Patient Record Keeping System

Code	Question	Notes	PRI1	PRI2	PRI3	PUB1	PUB2	PUB HW	PUB ^A	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
SYS2-55T	I understand the patient record keeping system.	Record keeping system not evaluated	.80 .04 113	.90 .04 64	.87 .06 34	.57 .09 30	.94 .03 77	.85 .05 47	.83 .04 154	.84 .03 211				
SYS3-14T	I can reliably find the information I need about a patient from patient files.	Record keeping system not evaluated	.91 .03 113	.89 .04 64	.97 .03 34	.77 .08 30	.91 .03 77	.82 .06 47	.87 .03 154	.91 .02 211				
SYS4-68F	Doctors who are new to this ward find it difficult to understand the patient records at first.	Record keeping system not evaluated	.94 .02 113	.98 .02 64	.94 .04 34	.87 .06 30	.92 .03 77	.98 .02 47	.91 .02 154	.95 .02 211				
SYS1-29F	The patient files are disorganised and it is often difficult to find the information I need about a patient.	Record keeping system not evaluated	.45 .05 113	.39 .07 64	.81 .07 34	.24 .08 30	.43 .06 77	.53 .07 47	.38 .05 154	.49 .04 211				
SUM SYS	4 questions		3.0 3.0 .08	3.0 3.0 .10	4.0 3.3 .15	2.0 2.4 .16	3.0 3.1 .14	3.0 3.1 .14	3.0 2.9 .08	3.0 3.1 .06	R ² = .14 F = .000 PUB1: -.84*** Sickbay: -.47** Hi Function: -.66* Geriatric: -.32*	R ² = .15 F = .000 PRI3: 1.3* Sickbay: -.76*	R ² = .07 F = .008 Sickbay: -.46* Hi Function: -.78*	R ² = .09 F = .004 Hi Function: -.85* Mix: -.36 Capacity: -.002* Private: .37*

* = significant < .05; ** = significant < .01; *** = significant < .001

^A Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect		Strong Suggestion of Effect		Weak Suggestion of Effect		No Suggestion of Effect	
PUB1: -		Sickbay Wards: - Very Hi Functioning Wards: -		Private: + Geriatric: - Capacity: - Mixed Wards: - PRI3: +		Female Wards Nursing Rank Very Lo Functioning Wards Patient: Staff Ratio MH Wards Young	

Notes: Effect between individual hospitals consistent with public: private effect.

Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.014, B=.10, p=.51; HW Model 2: F=.011, B=.15, p=.37)

Patient Leadership Structures

Code	Question	Notes	PRI1	PRI2	PRI3	PUB1	PUB2	PUB3	PUB4	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
INPTLD-50F	There are no patient leadership structures in this hospital.		M ₁ = .24 SE = .04 N = 113	.45 .06 64	.38 .09 34	.31 .09 30	.51 .06 77	.48 .08 47	.46 .05 154	.33 .03 211	MCS: .001 MH Ward: 1.2* Female: 1.0*	MCS: .001 PRI2: 1.6*	MCS: .008 MH Ward: 1.1* Female: 1.2*	MCS: .013 Lo Function: -.84* MH Ward: 1.3* Female: 1.2**

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect			Strong Suggestion of Effect			Weak Suggestion of Effect			No Suggestion of Effect		
Female Wards: +						Very Lo Functioning Wards: -			Public vs. Privately Contracted		
MH Wards: +						PRI2: +			Ward Age		
									Sickbay Wards		
									Capacity		
									Mixed Wards		
									Nursing Rank		
									Very Hi Functioning Wards		
									Patient : Staff Ratio		

Notes: Hospital / sector effect is limited to none amongst historically black hospitals.

Historically White Regression Analysis: Effect significant. (HW Model 1: MCS=.007, B=-.08, p=.86; HW Model 2: MCS=.013, B=-.06, p=.90)

Custodial Care Sub-Scales

Staff Patient Relationship

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	PUB ^Δ	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
SPR1-90F	Patients complain too much and do not appreciate all the staff does for them.	Staff's sense of patient appreciation.	Mn=.55 SE=.05 N=113	.73 .06 64	.64 .09 34	.52 .10 30	.73 .05 77	.51 .07 47	.67 .05 154	.62 .03 211				
SPR2-72T	The staff eagerly help new patients get to know one another in this ward.		Mn=.89 SE=.03 N=113	.93 .03 64	.94 .04 34	.90 .06 30	.97 .02 77	1.00 .00 47	.95 .02 154	.91 .02 211				
SPR3-9F	I do not really enjoy spending time with patients.		Mn=.86 SE=.03 N=113	.98 .02 64	.79 .07 34	.97 .03 30	.95 .03 77	.96 .03 47	.95 .03 154	.89 .02 211				
SPR4-101T	Patients willingly participate in activities organised by the staff.		Mn=.72 SE=.04 N=113	.81 .05 64	.76 .08 34	.97 .03 30	.96 .02 77	.67 .07 47	.96 .02 154	.75 .03 211				
SPR5-77T	I like patients and enjoy the social time with them.		Mn=.96 SE=.02 N=113	.98 .02 64	1.00 .00 34	.97 .03 30	.97 .02 77	.96 .03 47	.97 .02 154	.98 .01 211				
SPR6-51T	I know the names all of the patients in my ward.		Mn=.79 SE=.04 N=113	.92 .04 64	.94 .04 34	.97 .03 30	.89 .04 77	.93 .04 47	.92 .03 154	.85 .03 211				
SPR7-40T	I enjoy working with patients here.		Mn=.96 SE=.03 N=113	.88 .05 64	.91 .05 34	1.00 .00 30	.92 .03 77	.91 .04 47	.94 .02 154	.87 .02 211				
SUM SPR	Sub-scale	7 questions	Mn=6.0 Mn=5.5 SE=.13 N=113	6.0 5.8 .17 64	6.0 5.8 .19 34	6.0 6.2 .12 30	6.0 6.3 .09 77	6.0 5.9 .16 47	6.0 6.29 .08 154	6.0 5.9 .16 211	R ² = .35 F= .000*** PUB2: .65*	R ² = .37 F= .000*** PR13: 1.9* PUB1: 1.4* PUB2: 1.8** Capacity: .007*	R ² = .32 F= .000*** Private: -.39*	R ² = .34 F= .000*** Private: -.61** Lo Function: -.48*

* = significant < .05; ** = significant < .01; *** = significant < .001

^Δ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Private: - PUB2: +		Capacity: + Very Lo Functioning Wards: - PUB1, PR13: +	Ward Age Sickbay Wards Female Wards Nursing Rank Very Hi Functioning Wards Patient: Staff Ratio MH Wards / Mixed Wards

Notes: Most effect between individual hospitals consistent with public: private effect. Weak suggestion of hospital effect inconsistent with public: private effect results (PR13+). Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.001, B=.15, p=.48; HW Model 2: F=.003, B=.17, p=.45)

Personal Freedoms

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub ^a	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
FRE2-32T	Patients can change their clothes when they want to.	Freedom of expression. Mn=.38 SE=.05 N=113	.54 .07 64	.53 .09 30	.53 .09 34	.47 .06 77	.52 .07 47	.49 .05 154	.45 .04 211	MCS: .000 Female: 2.2*** Young: 2.1* PR12: 2.9** PR13: 3.7* MH Ward: -1.3* Female: 1.5**	MCS: .000 Female: 2.2*** Young: 1.4* Mix: 7.6*	MCS: .000 Female: 2.2*** Young: 1.7*		
FRE11-61T	When a patient passes away, they are buried (or cremated) according to their family wishes.	Mn=.73 SE=.04 N=113	.80 .05 64	.75 .08 34	.75 .08 34	.97 .03 30	.84 .04 77	.81 .06 47	.88 .03 154	MCS: .013 PR12: 1.2* PUB1: 2.6* PUB2: 1.1* Hi Function: -1.8*	MCS: .000 Mix: .95* Female: 1.6*** PSR: -.41***	MCS: .000 Female: 1.7*** Private: 1.3** Capacity: -.004* PSR: -.11**		
FRE4-3T	Patients are allowed to wear jewellery, make-up, and other adornments.	Mn=.30 SE=.04 N=113	.49 .06 64	.78 .07 34	.78 .07 34	.65 .10 30	.33 .05 77	.70 .06 47	.41 .05 154	MCS: .000 PR13: 2.1*** Sickbay: 1.3** Female Ward: 2.0*** Lo Function: -.93* Geriatric: 1.0*	MCS: .023 PUB1: 3.7* Hi Function: -1.7* Private: -.9*	MCS: .036 Private: -1.2*		
FRE7-57F	Patients are not allowed to have the hairstyle of their choice.	Mn=.61 SE=.05 N=113	.65 .06 64	.79 .07 34	.79 .07 34	.83 .07 30	.56 .06 77	.87 .05 47	.64 .05 154	MCS: .000 Female Ward: 1.8***	MCS: .000 Mix: .95* Female Ward: 1.6*** Private: 1.3** Capacity: -.004* PSR: -.11**	MCS: .000 Female Ward: 1.7*** Private: 1.3** Capacity: -.004* PSR: -.11**		
FRE8-45F	Patients are never allowed to listen to the music of their choice.	Mn=.61 SE=.04 N=113	.67 .05 64	.94 .04 34	.94 .04 34	.87 .06 30	.66 .05 77	.96 .03 47	.72 .04 154	MCS: .000 PR13: 2.5* Sister: -1.9** MH Ward: 2.7* Female: 2.4*	MCS: .000 Sister: -1.6* MH Ward: 2.6* Mix: 1.1* Female: 2.4*** Geriatric: -1.0* Private: .84*	MCS: .000 Sister: -1.5* MH Ward: 2.4* Female: 2.5*** Geriatric: -1.3* Private: 1.6** Capacity: -.006*		
FRE5-100T	Patients are free to follow their own religious beliefs. That is, all patients are not expected to follow the same religion.	Mn=.80 SE=.04 N=113	.68 .06 64	.70 .08 34	.70 .08 34	.77 .08 30	.71 .05 77	.96 .03 47	.72 .04 154	MCS: .012 PR13: -1.2* Hi Function: -2.5** Lo Function: -.88* Geriatric: 1.3*	MCS: .012 Hi Function: -2.0** Geriatric: 1.3*	MCS: .008 Hi Function: -2.0* Geriatric: 1.4**		
FRE6-111T	Patients can use their personal income as they want to.	Mn=.60 SE=.05 N=113	.55 .07 64	.87 .06 34	.87 .06 34	.83 .07 30	.59 .06 77	.76 .06 47	.66 .05 154	MCS: .000 PUB2: -.86* Hi Function: -2.7* Lo Function: -1.7*** MH Ward: 1.8** Geriatric: 1.7***	MCS: .000 PR12: 2.0* Hi Function: -3.5* Lo Function: -1.3* Geriatric: 3.2**	MCS: .000 Hi Function: -3.8** Lo Function: -1.7*** MH Ward: 1.8*** Geriatric: 1.6*** Private: .86**		

FRE10-16T	Patients can walk in the hospital grounds whenever they want during the day.	Freedom of movement	Mn=.74 SE=.04 N=113	.51 .06 64	.52 .09 34	.87 .06 30	.55 .06 77	.76 .06 47	.64 .05 154	.63 .03 211	MCS: .000 PRI2: -1.5*** PRI3: -2.1*** PUB2: -1.2** Sickbay: -1.4** Mix: 1.0* Female: -1.1*	MCS: .000 PRI2: -1.4* Sickbay: -1.5* Female: -1.1*	MCS: .000 Female: -1.3**	MCS: .000 Sickbay: -2.0* MH Ward: -1.1* Female: -1.6*** Geriatric: .9* PSR: -.17***
FRE9-33T	Patients are allowed to go on weekend leave.	Weekend leave.	Mn=.77 SE=.04 N=113	.79 .05 64	.54 .10 34	.83 .07 30	.67 .05 77	.98 .02 47	.71 .04 154	.74 .03 211	MCS: .001 Geriatric: -1.0*	MCS: .002 Geriatric: -1.1*	MCS: .001 Lo Function: 1.0* Geriatric: -1.1**	MCS: .001 Geriatric: -1.1*
FRE12-119T	Patients are allowed to go on authorised leave of absence.	Weekend leave.	Mn=.92 SE=.03 N=113	.93 .03 64	.88 .06 34	.97 .03 30	.91 .03 77	.91 .04 47	.93 .03 154	.91 .02 211	MCS: .190 Lo Function: -1.8* Female: -1.6* Mix: -2.1*	MCS: .147	R ² = .33 Lo Function: -.15* Mix: -1.3*	MCS: .31 Lo Function: -1.4
SUM FRE	Sub-scale	10 questions	Mn=6.0 SE=.3 N=20	6.0 6.2 .27	7.0 6.9 .28	8.0 8.0 .23	7.0 6.2 .22	8.0 8.3 .26	7.0 6.7 .19	6.0 6.4 .14	R ² = .38 F = .000 PUB2: -.81* Lo Function: -.89* MH Ward: .94* Female Ward: 1.1**	R ² = .41 F = .000 Geriatric: .80*	R ² = .33 F = .000 Lo Function: -.80* MH Ward: .96* Female: 1.1** Young: 2.1**	R ² = .38 F = .000 Private: .54* PSR: .09** Hi Function: -1.6* Female Ward: 1.1** Young: 1.8* Geriatric: .80*

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Sub-scale Summary:

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Female Ward: +	Very Lo Functioning: - MH Ward: + Geriatric: + Young: + Patient: Staff Ratio: +	Private: + Very Hi Functioning Wards: - PUB2: -	Sickbay Wards Mixed Wards Nursing Rank Capacity: +
Notes: Limited effect between hospitals. Effect between individual hospitals consistent with public: private effect.			
Historically White Regression Analysis: Effect significant. (HW Model 1: F=.000, B=1.8, p=.000***; HW Model 2: F=.000, B=1.6, p=.000***)			

NB: Logistic regression analysis was conducted on individual items for purpose of more in-depth analysis in this area.

Patient Daily Life Order

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub ^a	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
DLO1-78T	Patients here follow a regular schedule every day.	Patient daily life order	Min=.70 SE=.04 N=113	.83 .05 64	.77 .08 34	.69 .09 30	.87 .04 77	.85 .05 47	.82 .04 154	.75 .03 211				
DLO2-13T	Patients activities are carefully planned.	Patient daily life order	Min=.56 SE=.05 N=113	.73 .03 64	.61 .04 34	.70 .09 30	.91 .03 77	.87 .05 47	.85 .03 154	.62 .03 211				
	Sub-scale	2 questions	Min=1.0 Min=1.2 SE=.07	2.0 1.5 .08	1.0 1.3 .13	1.5 1.4 .13	2.0 1.8 .06	2.0 1.7 .08	2.0 1.7 .06	1.0 1.3 .05	R ² = .42 F=.000 PUB2: .38*** HI Function: .49* MH Ward: .56*** Female Ward: .27*	R ² = .44 F=.000 Capacity: .005* PSR: -.06* PRI3: 1.0* PUB2: 1.2*** HI Function: 1.2** MH Ward: .34*	R ² = .37 F=.000 Private: -.24* Female Ward: .29* MH Ward: .54*** HI Function: .63**	R ² = .39 F=.000 Private: -.41** HI Function: .75** MH Ward: .60*** Female Ward: .27*

* = significant < .05, ** = significant < .01, *** = significant < .001

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Sub-scale Summary:

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Very HI Functioning Wards: + MH Wards: + Private: - PUB2: +	Female Wards: +	Capacity: + Patient : Staff Ratio: - PRI3: +	Ward Age Sickbay Wards Very Lo Functioning Wards Mixed Wards Nursing Rank
Notes: Effect between hospitals mostly consistent with public : private effect results. Only weak suggestion of hospital effect inconsistent with sector effect (PRI3: +).			
Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.000, B=.04, p=.73; HW Model 2: F=.000, B=.03, p=.81)			

Social Activities

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub ^a	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
DLO4-116F	This ward has very few social activities.		Mn=.23 SE=.04 N=113	.50 .07 64	.30 .08 34	.30 .09 30	.45 .06 77	.36 .07 47	.41 .05 154	.32 .03 211				
DLO5-106T	Patients are taken on regular outings (e.g. shopping, movies etc.)		Mn=.24 SE=.04 N=113	.60 .07 64	.61 .09 34	.73 .08 30	.41 .06 77	.58 .07 47	.50 .05 154	.40 .04 211				
SUM CR	Sub-scale	2 questions	.00 .45 .06	1.0 1.1 .11	1.0 .89 .13	1.0 1.0 .14	1.0 .6 .08	1.0 .91 .11	1.0 .91 .07	1.0 .70 .05	R ² = .22 F = .000 PRI2: .51*** Lo Function: -.34** MH Ward: .62*** Female Ward: .49***	R ² = .24 F = .000 PRI2: .84*** MH Ward: .56** Female Ward: .38**	R ² = .18 F = .000 Lo Function: -.27* MH Ward: .51*** Mix: .41*** Female Ward: .67***	R ² = .18 F = .000 Lo Function: -.30* MH Ward: .56*** Mix: .47*** Female: .66***

* = significant < .05; ** = significant < .01; *** = significant < .001

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Female Ward: + MH Ward: + Very Lo Functioning: - Mixed Wards: + PRI2: +			Public vs. Private Ward Age Capacity Patient : Staff Ratio Very High Functioning Wards Sickbay Wards Nursing Rank
Notes: Individual hospital effect more significant than sector (public : private) effect.			
Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.000, B=.09, p=.53; HW Model 2: F=.000, B=.13, p=.34)			

Ward Cleanliness

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub ^a	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
CLN1-25F	This place usually looks a bit messy.	Refers to 'this place' - e.g. ward or hospital generally.	Min=.23 SE=.04 N=113	.52 .07 64	.68 .09 34	.11 .06 30	.36 .06 77	.70 .07 47	.30 .04 154	.39 .03 211				
CLN2-52F	The community area (day room) is often untidy.	Confusion especially at hospital without day room equivalent area.	Min=.45 SE=.05 N=113	.68 .06 64	.79 .08 34	.33 .09 30	.67 .06 77	.89 .05 47	.58 .05 154	.58 .04 211				
CLN3-96T	The staff make sure this place is always neat.	Emphasises staff responsibility - scores higher.	Min=.86 SE=.03 N=113	.89 .04 64	.85 .06 34	.77 .08 30	.94 .03 77	.98 .02 47	.89 .03 154	.87 .02 211				
SUM CLN	Sub-scale	3 questions	Min=1.0 Max=1.5 SE=.09	2.0 2.0 .13	2.0 2.1 .17	1.0 1.2 .15	1.0 1.9 .10	3.0 2.3 .12	2 1.7 .09	2 1.7 .07	R ² = .36 F = .001 PR13: .54* PUB1: -.75** PUB2: .31* Young: .82*	R ² = .40 F = .000 PR12: .63* PR13: 2.2** PUB2: 1.2* Sickbay: -.91*** MH Ward: -.50* PSR: -.11**	R ² = .22 F = .121 Sickbay: -.50* Female Ward: .36*	R ² = .24 F = .093 Female Ward: .41*

* = significant < .05; ** = significant < .01; *** = significant < .001

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Sickbay Wards: - PR13: +	Patient : Staff Ratio: - PUB1: - PUB2: +	Young: + MH Ward: - PR12: +	Public vs. Private Capacity Very Lo/High Functioning Wards Mixed Wards Nursing Rank Female Ward
Notes: Individual hospital effect more significant than sector (public : private) effect. (Note implication of wording of question. Question which implies nursing staff responsibility scores significantly higher than more neutral questions concerning cleanliness.)			
Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.001, B=.32, p=.080; HW Model 2: F=.002, B=.37, p=.051)			

Patient Cleanliness

Code	Question	Notes	PRI1	PRI2	PRI3	PUB1	PUB2	PUB HW	Pub [^]	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
PTC1-69F	Some patients look untidy or messy.		Mn=.13 SE=.03 N=113	.48 .06 64	.45 .09 34	.23 .08 30	.31 .05 77	.64 .07 47	.29 .04 154	.29 .03 211	MCS: .000 PRI2: 1.5** PRI3: 1.8** PUB2: 1.3** Hi Function: 2.0* Female: 1.3*	MCS: .000 PRI2: 2.1* PRI3: 5.2** PUB2: 3.2* Hi Function: 3.1* Lo Function: 1.5*	MCS: .000 Hi Function: 1.6* Female: 1.6*** Mix: 1.3***	MCS: .000 Hi Function: 2.0* Female: 1.8*** PSR: ~.10* Mix: 1.2**

* = significant < .05; ** = significant < .01; *** = significant < .001

[^] Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect: Female Ward: + Mixed Wards: +	Strong Suggestion of Effect: Very High Functioning Wards: + PRI2, PRI3, PUB2: +	Weak Suggestion of Effect: Very Lo Functioning Wards: + Patient: Staff Ratio: -	No Suggestion of Effect: Public vs. Private Capacity Sickbay Wards Ward Age MH Ward Nursing Rank
Notes: Individual hospital effect more significant than sector (public: private) effect. Historically White Regression Analysis: Effect significant. (HW Model 1: MCS=.000, B=1.4, p=.001**; HW Model 2: MCS=.001, B=1.6, p=.000***);			

Patient Busyness

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub ^A	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
DLO3-112T	Patients are busy most of the time.		Min=.25 SE=.04 N=113	.34 .06 64	.12 .06 34	.33 .09 30	.05 .03 77	.20 .06 47	.15 .03 154	.24 .03 211	MCS = .000 PUB2: -1.3* Hi Function: 2.8**	MCS = .000 Hi Function: 3.6*	MCS = .002 Hi Function: 2.9**	MCS = .001 Hi Function: 2.8**

* = significant < .05; ** = significant < .01; *** = significant < .001

^A Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Very High Functioning Wards: +		PUB2: -	Public vs. Private Capacity Sickbay Wards Ward Age MH Ward Female Ward Mixed Wards Patient : Staff Ratio Very Lo Functioning Ward Nursing Rank
Notes: Only factor suggesting patient busyness score is ward high functional level. Historically White Regression Analysis: Effect not significant. (HW Model 1: MCS=.004, B=-.94, p=.08; HW Model 2: MCS=.003, B=-.82, p=.14)			

Patient Access to Nursing Staff

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub ^A	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
NA1-24F	Staff have little time to talk with patients or spend extra time with patients beyond the daily required tasks of bathing, feeding, cleaning, etc.	Time spent with patients beyond daily requirements.	Mn=.56 SE=.05 N=113	.62 .06 64	.60 .09 34	.54 .10 30	.75 .05 77	.83 .06 47	.69 .05 154	.59 .03 211				
NA2-38F	Staff spend the time after meals and medications talking to one another – this is not the time to be with patients.	Time spent with patients beyond daily requirements.	Mn=.82 SE=.04 N=113	.90 .04 64	.81 .07 34	.69 .09 30	.71 .05 77	.89 .05 47	.70 .04 154	.85 .03 211				
NA3-18T	Patients can speak with nursing staff when they need to.		Mn=.97 SE=.02 N=113	1.00 .00 64	.88 .06 34	1.00 .00 30	.96 .02 77	.98 .02 47	.97 .02 154	.97 .01 211				
SUM NA	Sub-scale	2 questions	Md=.00 Mn=.14 SE=.04	2.5 2.0 .07	2.0 2.1 .16	2.0 2.2 .13	3.0 2.4 .09	3.0 2.7 .00	2.0 2.3 .07	2.0 2.3 .05	R ² = .40 F=.000 PR13: -.36* PUB1: -.52* Sickbay: -.68*** Female Ward: .39** Geriatric: -.56***	R ² = .40 F=.000 Sickbay: -.65** Female Ward: .39** Geriatric: -.56***	R ² = .37 F=.000 Sickbay: -.57*** Female Ward: .27* Geriatric: -.51***	R ² = .38 F=.000 Sickbay: -.69*** Female Ward: .26* Geriatric: -.47***

* = significant < .05; ** = significant < .01; *** = significant < .001

^A Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Sickbay Wards: + Female Ward: + Geriatric Ward: -		PR13, PUB1: -	Public vs. Private Capacity Young MH Ward Mixed Wards Very High Functioning Wards Patient : Staff Ratio Very Lo Functioning Ward Nursing Rank
Notes: Individual hospital effect more significant than sector (public : private) effect. Historically White Regression Analysis: Effect significant. (HW Model 1: F=.000, B=.35, p=.007**; HW Model 2: F=.000, B=.31, p=.021*)			

Nursing Staff Languages

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub [^]	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
LANG-8F	Sometimes nurses cannot communicate with a patient because there is no nurse who can speak the patient's language.	Nurses Mn= 63 SE= .05 N=113	.97 .03 64	.97 .02 64	.97 .03 34	.80 .07 30	.74 .05 77	.80 .06 47	.76 .04 154	.79 .03 211				
LANG-71T	Patients can use a language of their choice (a language they can speak fluently) to communicate with nursing staff.	Nurses Mn= 94 SE= .02 N=113	.95 .03 64	.95 .03 64	.97 .03 34	1.00 .00 30	.99 .01 77	.96 .03 47	.99 .01 154	.95 .02 211				
SUM NILAN	Sub-scale 2 questions	Md=2.0 Mn=1.6 SE=.05	2.0 1.9 .05	2.0 1.9 .04	2.0 1.9 .05	2.0 1.8 .07	2.0 1.7 .06	2.0 1.7 .07	2.0 1.7 .05	2.0 1.7 .03	R ² = .13 F= .000 PRI3: .31** Geriatric: -2.6**	R ² = .16 F= .000 PRI2: .40** PRI3: 1.0** PUB1: .54* Sickbay: -.37** PSR: -.05**	R ² = .11 F= .000 Female: .25** Geriatric: -.29*	R ² = .34 F= .000 Sickbay: -.22* Mix: .16* Female: .23** Geriatric: -.27**

* = significant < .05; ** = significant < .01; *** = significant < .001

[^] Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect		Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Geriatric Ward: -		Sickbay Wards: +	Mixed Wards: -	Public vs. Private
Female Ward: +		Patient: Staff Ratio: -	PUB1: +	Capacity
PRU3: +		PR12: +		Young
				MH Ward
				Very High Functioning Wards
				Very Lo Functioning Ward
				Nursing Rank

Notes: Individual hospital effect more significant than sector (public: private) effect.

Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.001, B=.04, p=.64; HW Model 2: F=.003, B=.03, p=.76)

Patient Relationships / Interactions

Code	Question	Notes	PR1	PR2	PR3	PUB1	PUB2	PUB HW	Pub ^A	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
PPR1-46F	There is not much interaction between patients in this ward.	Patient Interaction. Negative.	Mn=.37 SE=.05 N=113	.77 .06 64	.81 .08 34	.52 .10 30	.72 .05 77	.74 .07 47	.67 .05 154	.55 .04 211				
PPR2-93F	There is not much group spirit among patients in this ward.	Group spirit	Mn=.44 SE=.05 N=113	.80 .05 64	.58 .09 34	.57 .09 30	.70 .05 77	.48 .08 47	.66 .05 154	.57 .04 211				
PPR3-59T	Discussions between patients are active and lively.	Patient discussions	Mn=.57 SE=.05 N=113	.74 .06 64	.67 .08 34	.67 .09 30	.69 .05 77	.73 .07 47	.69 .05 154	.64 .03 211				
SUM PPR	Sub-scale	2 questions	Mn=1.0 Mn=1.4 SE=.04	2.0 2.1 .11	2.0 1.9 .16	1.5 1.8 .15	2.0 2.0 .09	2.0 1.9 .13	2.0 1.9 .08	2.0 1.7 .07	R ² = .43 F=.000 PR12: .80*** PR13: .71*** PUB2: .61*** Hi Function: 1.0*** MH Ward: .51**	R ² = .46 F=.000 PR12: 1.0*** PR13: 2.2*** PUB1: 1.0*** PUB2: 1.5*** Hi Function: 1.6*** Geriatric: .41* Capacity: .005* PSR: -.10**	R ² = .33 F=.000 Hi Function: 1.1*** MH Ward: .42* Female Ward: .47**	R ² = .36 F=.000 Hi Function: 1.3*** MH Ward: .58** Female Ward: .49* PSR: -.04**

* = significant < .05; ** = significant < .01; *** = significant < .001

^A Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Very High Functioning Wards: + Patient : Staff Ratio: - MH Ward: + PR12, PR13, PUB2: +	Female Ward: +	Geriatric: + Capacity: + PUB1: +	Public vs. Private Sickbay Wards Young Mixed Wards Very Lo Functioning Ward Nursing Rank
Notes: Individual hospital effect more significant than sector (public : private) effect. Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.000, B=-.23, p=.17; HW Model 2: F=.000, B=-.15, p=.38)			

Patient Pride in Hospital

Code	Question	Notes	PR1	PR2	PR3	PUB1	PUB2	PUB HW	Pub ^a	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
INPR1-65T	The patients are proud of this hospital.	Patient pride in hospital Mn=.30 SE=.04 N=113	.62 .06 64	.62 .06 64	.78 .07 34	.67 .09 30	.60 .06 77	.64 .07 47	.62 .05 154	.47 .04 211	MCS: .000 PRI2: 1.2** PRI3: 1.7** PUB2: 1.3* PUB1: .90* MH Ward: 1.4**	MCS: .000 PRI2: 1.9** PRI3: 8.3*** PUB2: 4.5*** PUB1: 4.6*** Sickbay: -2.6*** HI Function: 4.0** Geriatric: 1.4* Capacity: .02** PSR: -.41***	MCS: .000 Sickbay: -1.2* MH Ward: 1.3** Female: 1.1** Mix: 1.5***	MCS: .000 MH Ward: 1.5** Female: 1.1** Mix: 1.3**

* = significant < .05; ** = significant < .01; *** = significant < .001

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
MH Ward: + Female Ward: + Sickbay Ward: - Mixed Wards: + PRI2, PRI3, PUB1, PUB2: +	Very High Functioning Wards: + Patient : Staff Ratio: - Capacity: +	Geriatric: +	Public vs. Private Young Very Lo Functioning Ward Nursing Rank
Notes: Individual hospital effect more significant than sector (public : private) effect.			
Historically White Regression Analysis: Effect not significant. (HW Model 1: MCS=.000, B=-.18, p=.68; HW Model 2: MCS=.000, B=-.16, p=.72)			

Patient Clarity

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub^A	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
CLR1-48F	The majority of patients do not understand their diagnoses.	Diagnosis Mh=.04 SE=.02 N=113	.10	.04	.07	.03	.25	.24	.19	.08				
CLR5-19F	Many patients do not understand why they are here.	Circumstance Mh=.10 SE=.03 N=113	.16	.05	.08	.07	.05	.07	.26	.14				
SUM CLR	Sub-scale	2 questions Mh=.00 SE=.14 N=113	.00	.25	.42	.20	.55	.72	.45	.22	R ² = .38 F = .000 Sick Bay: -.32** Sister: .39**	R ² = .38 F = .000 Sick Bay: -.32** Sister: .40**	R ² = .31 F = .000 Private: -.19* Sick Bay: -.24* Sister: .36*	R ² = .34 F = .000 Sister: .34* Capacity: -.001*

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect Nursing Rank Sister: + PUB2: +	Strong Suggestion of Effect Sickbay Wards: +	Weak Suggestion of Effect Private: - Capacity: -	No Suggestion of Effect Ward Age MH Ward Very High Functioning Wards Very Lo Functioning Ward Female Ward Patient: Staff Ratio Mixed Wards
Notes: Effect between individual hospitals consistent with public: private effect.			
Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.000, B=-.12, p=.27; HW Model 2: F=.000, B=-.19, p=.08)			

Patient Responsibility

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub [^]	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
RSP2-87T	Patients take responsibility in this ward.		Mn= .33 SE= .05 N=113	.18 .05 64	.36 .09 34	.34 .09 30	.59 .06 77	.34 .07 47	.52 .05 154	.29 .03 211				
RSP3-35F	Patients tend to lose their sense of responsibility when they are here.		Mn= .25 SE= .04 N=113	.40 .07 64	.41 .09 34	.33 .09 30	.42 .06 77	.19 .06 47	.40 .05 154	.32 .03 211				
RSP4-76T	Patients can decide what they wear each day.	Not included in sub-scale calculation	Mn= .18 SE= .04 N=113	.32 .06 64	.22 .07 34	.43 .09 30	.22 .05 77	.74 .06 47	.28 .04 154	.23 .03 211				
RSP5-5T	Patients often take charge of activities.		Mn= .41 SE= .05 N=113	.40 .06 64	.34 .09 34	.66 .09 30	.63 .06 77	.49 .07 47	.63 .05 154	.40 .03 211				
SUM RSP	Sub-scale	2 questions	Md=1.0 Mn= .96 SE= .08	1.0 .91 .12	1.0 1.1 .16	1.0 1.3 .15	1.0 1.6 .10	1.0 1.0 .13	1.0 1.5 .09	1.0 .97 .06	R ² = .11 F = .001 PUB2: .59***	R ² = .10 F = .001	R ² = .10 F = .001 Private: -.47*	R ² = .10 F = .000 Private: -.52*

* = significant < .05; ** = significant < .01; *** = significant < .001

[^] Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
PUB2: +	Private: -		Ward Age MH Ward Very High Functioning Wards Very Lo Functioning Ward Female Ward Patient : Staff Ratio Mixed Wards Nursing Rank Sickbay Wards Capacity
Notes: Effect between individual hospitals consistent with public : private effect. Historically White Regression Analysis: Effect not significant. (HW Model 1: F= 170, B=-.19, p= .31; HW Model 2: F=.030, B=-.29, p=.12)			

Psychiatric Rehabilitation Sub-Scales

Medical Services

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub ^a	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
MED1-97F	Some patients do not see a psychiatrist for over a year.	Psychiatrist (low level expectations) Mn=82 SE=.04 N=113	.90 .04 64	.97 .03 34	.40 .09 30	.82 .04 77	.91 .04 47	.70 .04 154	.86 .02 211					
MED2-49T	Patients are reviewed for discharge at least once a year.	Discharge Review Mn=51 SE=.05 N=113	.74 .06 64	.52 .10 34	.47 .09 30	.42 .06 77	.44 .07 47	.43 .05 154	.58 .04 211					
MED3-7T	Patients diagnoses are formally reviewed by a psychiatrist at least once a year.	Diagnosis Review Mn=52 SE=.05 N=113	.65 .06 64	.42 .09 34	.59 .09 30	.32 .05 77	.48 .07 47	.40 .05 154	.55 .04 211					
MED4-104T	Patients are seen by a medical practitioner at least once a month.	Medical Practitioner Mn=67 SE=.05 N=113	.67 .06 64	.43 .09 34	.60 .09 30	.69 .05 77	.72 .07 47	.66 .05 154	.63 .04 211					
SUM MED	Sub-scale	2 questions Md=2.0 Mn=2.4 SE=.11	3.0 2.7 .14	2.0 2.1 .20	2.0 2.0 .27	2.0 2.2 .11	3.0 2.7 .24	2.0 1.6 .10	1.0 1.6 .10		R ² = .28 F = .026	R ² = .31 F = .039 Capacity: .006* HI Function: 1.7**	R ² = .24 F = .091 HI Function: .87*	R ² = .30 F = .018 Capacity: .003** HI Function: 1.2**

* = significant < .05; ** = significant < .01; *** = significant < .001

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect Very High Functioning Wards: + Capacity: +	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect Public vs. Private
			Hospital Ward Age MH Ward Very Lo Functioning Ward Female Ward Patient : Staff Ratio Mixed Wards Nursing Rank Sickbay Ward
Notes: No hospital or sector effect. Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.056, B=.29, p=.19; HW Model 2: F=.011, B=.47, p=.053)			

Medical Services Languages

Code	Question	Notes	PR1	PR12	PR13	PUB1	PUB2	PUB HW	Pub ^A	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
LAN1-23F	Some patients cannot speak directly to a psychiatrist in the language of their choice (a language they can speak fluently).	Psychiatrist languages.	Mn=15 SE=.03 N=113	.13 .04 64	.68 .09 34	.21 .08 30	.10 .04 77	.21 .06 47	.13 .03 154	.22 .03 211				
LAN2-113T	All patients can speak directly to medical officers in a language of their choice (in a language they can speak fluently).	Medical Officer languages.	Mn=51 SE=.05 N=113	.30 .06 64	.97 .03 34	.53 .09 30	.35 .05 77	.57 .07 47	.40 .05 154	.52 .04 211				
LAN3-60F	The cleaning staff often serve as interpreters for clinical staff.	Cleaning staff as interpreters	Mn=78 SE=.04 N=113	.68 .06 64	.77 .08 34	.70 .09 30	.73 .05 77	.85 .05 47	.72 .05 154	.75 .03 211				
LAN4-39F	The nursing staff often serve as interpreters for medical practitioners and other clinical staff.	Nurses as interpreters	Mn=05 SE=.02 N=113	.03 .02 64	.27 .08 34	.04 .04 30	.03 .02 77	.04 .03 47	.03 .02 154	.08 .02 211				
SUM DRLAN	Sub-scale	2 questions	Md=1.0 Mn=1.4 SE=.08	1.0 1.0 .11	3.0 2.5 .19	1.0 1.4 .16	1.0 1.2 .09	2.0 1.7 .13	2.0 1.6 .10	1.0 1.6 .10	R ² = .48 PRI2: -.62*** PRI3: .82*** PUB2: -.42*** Sister: .58**	R ² = .51 Geriatric: .41* Sister: .63**	R ² = .33 Private: .40** Geriatric: .45** Sister: .49* Ward MH: .38* Lo Function: -.47**	R ² = .51 Private: 1.2*** Capacity: -.005*** Geriatric: .37* Sister: .64** Hi Function: -.58* Lo Function: -.31*

* = significant < .05; ** = significant < .01; *** = significant < .001

^A Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Private: + Nursing Rank Sister: + Capacity: - Geriatric Ward: + PRI2: - PRI3: +	Very Lo Functioning Ward: - PUB2: -	MH Ward: + Very High Functioning Wards: -	Female Ward Patient: Staff Ratio Mixed Wards Sickbay Ward Young
Notes: Effect between individual hospitals more complicated than public: private effect, weakening strength of public: private effect results. Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.001, B=.06, p=.74; HW Model 2: F=.000, B=-.09, p=.63)			

Availability of Trained Translators

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub ^a	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
LANB-108T	There is a fully trained and qualified translator readily available for any clinical staff who cannot speak the language of a patient.	Availability of Translators Min=.09 SE=.03 N=113	.09 .03 N=113	.25 .06 64	.18 .07 34	.20 .07 30	.12 .04 77	.24 .06 47	.14 .03 154	.15 .03 211	MCS: .005 PRI2: 1.7**	MCS: .005 PRI2: 3.3** Female: -2.0*	MCS: .024 Geriatric: -2.3*	MCS: .02 Geriatric: -2.5*

* = significant < .05; ** = significant < .01; *** = significant < .001

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
PR12: +	Geriatric: -	Female: -	Public vs. Private MH Ward Very H/L Lo Functioning Ward Patient: Staff Ratio Mixed Wards Nursing Rank Sickbay Ward Capacity Young
Notes: There were no trained translators at historically black hospitals. The higher scores of PRI2 are consistent with a systematic over-estimation of scores perceived in PRI2.			
Historically White Regression Analysis: Effect significant. (HW Model 1: MCS=.0031 B=1.7, p=.005**; HW Model 2: MCS=.031, B=1.3, p=.014*)			

Patient Understanding of Medications

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub ^a	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
CLR4-117F	Most patients who take medications do not understand the side effects of their medications.	Medications Mn=.10 SE=.03 N=113	.14 .05 64	.24 .08 34	.07 .05 30	.10 .04 77	.26 .07 47	.09 .03 154	.14 .02 211					
CLR6-181T	Patients know what medications they are on.	Medications Mn=.41 SE=.05 N=113	.45 .07 64	.70 .09 34	.50 .09 30	.56 .06 77	.80 .06 47	.54 .05 154	.47 .04 211					
CLR7-95T	Most of the patients who take medications know why they are taking medication.	Medications Mn=.51 SE=.05 N=113	.64 .06 64	.66 .09 34	.50 .09 30	.68 .05 77	.66 .07 47	.64 .05 154	.57 .04 211					
SJM CLRMD	2 questions	2 questions Mn=1.0 SE=.09	1.0 1.2 .12	2.0 1.5 .16	1.0 1.1 .17	1.0 1.4 .10	2.0 1.7 .16	1.0 1.3 .09	1.0 1.1 .07		R ² = .40 F = .000 PR13: .76*** PUB2: .32* HI Function: 1.4*** MH Ward: -.55** Female Ward: .39* Geriatric: -.32*	R ² = .42 F = .000 PR13: 2.2*** PUB2: 1.2** HI Function: 1.9*** MH Ward: -.86*** PSR: -.02*	R ² = .33 F = .000 HI Function: 1.0** MH Ward: -.39* Female Ward: .35*	R ² = .39 F = .000 Capacity: -.003*** HI Function: .87** MH Ward: -.41* Female Ward: .42**

* = significant < .05; ** = significant < .01; *** = significant < .001

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Very High Functioning Wards: + Capacity: - MH Ward: - Female Ward: + PR13, PUB2: +		Geriatric: - Patient: Staff Ratio: -	Public vs. Private Very Lo Functioning Ward Female Ward Mixed Wards Nursing Rank Sickbay Ward Young
Notes: Individual hospital effect more significant than sector (public: private) effect.			
Historically White Regression Analysis: Effect not significant. (HW Model 1: F = .000, B = .01, p = .95; HW Model 2: F = .000, B = -.07, p = .70)			

Condom Distribution

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Pub^A	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
INSEX1-81F	Patients are not provided with condoms.	Condom distribution. Mn=.11 SE=.03 N=113	.37 .06 64	.06 .04 34	.03 .03 30	.26 .05 77	.85 .05 47	.20 .04 154	.18 .03 211	MCS=.000 PRI2: 2.3* PRI3: -5.3* PUB1: -4.3* Hi Function: -4.6** Female: 1.3* Capacity: -.02*	MCS=.000 Female: 1.5***	MCS=.000 Female: 1.4**		

* = significant < .05; ** = significant < .01; *** = significant < .001

[^] Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Female: +	Very High Functioning: - PRI2: +	Capacity: -.02 PRI3, PUB1: -	Public vs. Private MH Ward Very Lo Functioning Ward Patient : Staff Ratio Mixed Wards Nursing Rank Sickbay Ward Young
Notes: Individual hospital effect more significant than sector (public : private) effect.			
Historically White Regression Analysis: Effect significant. (HW Model 1: MCS=.000, B=3.8, p=.000***; HW Model 2: MCS=.000, B=4.1, p=.000***)			

Patient Development for Discharge Sub-Scales

Practical Preparation

High Level: Preparation for Employment

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Public ^a	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2	
PRPA1-36T	Patients in this ward are taught skills that will assist them in finding a job in the future (for example, how to make a job application, how to prepare for a job interview etc.)	HIGH LEVEL—preparation for employment	Mn=.10 SE=.03 N=113	.56 .06 64	.25 .08 34	.20 .07 30	.29 .05 77	.30 .07 47	.26 .04 154	.26 .03 211					
PRPA2-80F	This hospital does not prepare many patients for employment.	HIGH LEVEL—preparation for employment	Mn=.18 SE=.04 N=113	.38 .07 64	.21 .07 34	.38 .09 30	.11 .04 77	.49 .08 47	.18 .04 154	.24 .03 211					
SUM PRPA	Sub-scale	2 questions	0 .27 .05	1.0 .89 .10	0 .73 .28	.5 .57 .11	0 .39 .07	1.0 .77 .11	0 .44 .06	0 .53 .06	R ² = .13 F=.000 PR12: .64*** PR13: .55** MH Ward: -.36* Sister: -.55**	R ² = .18 F=.000 PR12: 1.0*** PR13: 2.7*** PUB1: 1.5*** PUB2: 1.4*** Sickbay: -.78*** Lo Function: .56** MH Ward: -.85*** Female: -.37* Sister: -.52* Geriatric: .31* Capacity: .006** PSR: -.15**	R ² = .07 F=.02 MH Ward: -.40* Mix: .33* Sister: -.48* Sickbay: -.34* MH Ward: -.46** Mix: .31* Sister: -.45**		

* = significant < .05; ** = significant < .01; *** = significant < .001

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
MH Ward: - Nursing Rank Sister: - Sickbay Ward: - PUB1, PUB2, PR13: +	Mixed Wards: + Very Lo Functioning Ward: + Capacity: + Patient: Staff Ratio: -	Female Ward: - Geriatric: +	Public vs. Private Female Ward: + Young Very High Functioning Wards
Notes: Individual hospital effect more significant than sector (public: private) effect. Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.012, B=.07, p=.63; HW Model 2: F=.016, B=.15, p=.33)			

General Discharge Preparation (Medium Level)

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Public ^a	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
PRPB1-30T	This hospital prepares patients to live outside in the community.	MEDIUM LEVEL – general discharge preparation Mn=.53 SE=.05 N=113	.61 .06 64	.41 .09 34	.43 .09 30	.83 .04 77	.70 .07 47	.72 .04 154	.54 .04 211					
PRPB2-1F	Patients do not talk much about what they will be doing after they leave the hospital.	MEDIUM LEVEL – general discharge preparation Mn=.34 SE=.05 N=113	.31 .06 64	.45 .09 34	.38 .09 30	.36 .06 77	.23 .06 47	.36 .05 154	.35 .03 211					
PRPB3-56F	This hospital is not successful at preparing patients for discharge.	MEDIUM LEVEL – general discharge preparation Mn=.50 SE=.05 N=113	.45 .06 64	.52 .09 34	.41 .10 30	.71 .05 77	.59 .07 47	.63 .05 154	.49 .04 211					
PRPB4-73T	This hospital prepares patients for discharge.	MEDIUM LEVEL – general discharge preparation Mn=.72 SE=.04 N=113	.77 .06 64	.50 .09 34	.48 .09 30	.88 .04 77	.80 .06 47	.77 .04 154	.70 .03 211					
PRPB5-64T	Patients are taught skills designed to help them live effectively within their family or in the community in the future (e.g. cooking, cleaning, budgeting, how to resolve conflicts etc.)	MEDIUM LEVEL – general discharge preparation Mn=.44 SE=.05 N=113	.71 .06 64	.58 .09 34	.57 .09 30	.51 .06 77	.48 .07 47	.53 .05 154	.54 .04 211					
SUM PRPB	Sub-scale	5 questions Mn=.74 SE=.16	2.5 2.7 .17	2.0 2.4 .30	2.0 2.2 .26	3.0 3.3 .13	3.0 2.7 .22	3.0 3.0 .13	3.0 2.5 .11		R ² = .15 F = .000 Sickbay: -.80* Female: .53* Sister: -.76*	R ² = .20 F = .000 PRI2: 1.1** Lo Function: -.56* Sickbay: -1.7*** Mix: -.72* PSR: -.20*	R ² = .14 F = .000 Sickbay: -.76* Lo Function: -.56* Sister: -.80* Young: -1.0*	R ² = .16 F = .000 Sickbay: -1.1** Young: -.80* PSR: -.05*

* = significant < .05; ** = significant < .01; *** = significant < .001

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect		Strong Suggestion of Effect		Weak Suggestion of Effect		No Suggestion of Effect	
Sickbay Ward: -		Nursing Rank Sister: -		Female Ward: +		Public vs. Private	
		Patient: Staff Ratio: -		Mixed Wards: -		Geriatric	
		Young: -		Very Lo Functioning Ward: -		Capacity:	
		PRI2: +		PRI3: +		Very High Functioning Wards MH Ward:	

Notes: Individual hospital effect more significant than sector (public: private) effect.

Historically White Regression Analysis: Effect not significant. (HW Model 1: F = .000, B = -.167, p = .55; HW Model 2: F = .000, B = -.45, p = .11)

Low Level: Basic Self-Care Development

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Public ^	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
PRPC1-75T	This hospital makes sure that patients develop basic life skills such as bathing, dressing, and eating.	LOW LEVEL - basic self care	Mr=.82 SE=.04 N=113	.84 .05 64	.85 .06 34	.93 .05 30	.95 .03 77	.93 .04 47	.94 .02 154	.83 .03 211	MCS= .04	MCS=.03	MCS=.01	MCS=.02

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
			Public vs. Private Capacity MH Ward Very Hi / Lo Functioning Ward Patient : Staff Ratio Mixed Wards Nursing Rank Sickbay Ward Ward Age Female Ward
Notes: No factor significant.			
Historically White Regression Analysis: Effect not significant. (HW Model 1: MCS=.012, B=.35, p=.84; HW Model 2: MCS=.020, B=.03, p=.96)			

Discharge Planning

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB3	Public ^	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
DPL1- 105T	There is a formal and organised process of discharge planning in this ward whereby patients, family, and staff participate in regular discussions about the timing and requirements for discharge.	Highest level of planning – formal, organised, involving patient and family.	Mn=.51 SE=.05 N=113	.45 .07 64	.32 .09 34	.38 .10 30	.61 .06 77	.58 .08 47	.56 .05 154	.47 .04 211				
DPL2- 43T	There is an organised and regular process to plan the discharge of patients whereby patients and staff discuss what the patient needs in order to leave the hospital.	Planning involving organised discussions with patients.	Mn=.57 SE=.05 N=113	.72 .06 64	.43 .09 34	.36 .09 30	.81 .05 77	.67 .07 47	.68 .05 154	.60 .03 211				
DPL3- 66F	There is not an organised programme to plan for patient discharge – patients and staff rarely sit down and discuss what is required for a patient to leave this hospital.	Planning at level of sitting down and talking with patient.	Mn=.50 SE=.05 N=113	.66 .07 64	.52 .09 34	.42 .10 30	.45 .06 77	.72 .07 47	.44 .05 154	.55 .04 211				
SUM	Sub-scale	2 questions	Mn=2.0 Mn=1.7 SE=.16	1.0 1.6 .13	1.0 1.2 .18	1.0 1.0 .18	2.0 1.8 .11	2.0 1.9 .16	2.0 1.6 .10	1.0 1.6 .10	R ² = .31 F = .000 PRI3: -.62* MH Ward: .85**	R ² = .35 F = .000 Sick Bay: -.88* Young: -1.2* PSR: -.16**	R ² = .27 F = .000 MH Ward: .80** Young: -1.5**	R ² = .31 F = .000 MH Ward: .69* Young: -1.6** PSR: -.05*

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Patient : Staff Ratio: - Young: - MH Ward: +		Sickbay Ward: - PRI3: -	Public vs. Private Capacity Very Hi / Lo Functioning Ward Mixed Wards Nursing Rank Geriatric Female Ward
Notes: Hospital / sector effect is limited to none amongst historically black hospitals. Historically White Regression Analysis: Effect not significant. (HW Model 1: F = .008, B = .29, p = .060; HW Model 2: F = .002, B = .31, p = .053)			

Patient Clarity of Discharge Status

Code	Question	Notes	PR11	PR12	PR13	PUR1	PUR2	PUB HW	Public ^a	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
CLR2-28F	Most patients never know when they will be considered ready to leave the hospital.	Discharge status Mn=.06 SE=.02 N=113	.07 .03 64	.16 .07 34	.07 .05 30	.18 .04 77	.21 .06 47	.15 .03 154	.08 .02 211					
CLR3-37F	Most patients do not understand what is required of them in order for them to leave the hospital.	Discharge requirements Mn=.13 SE=.03 N=113	.17 .05 64	.23 .08 34	.10 .06 30	.30 .05 77	.26 .07 47	.25 .04 154	.15 .03 211					
	Sub-scale	2 questions Md=.00 Mn=.19 SE=.04	.00 .23 .07	.00 .61 .31	.00 .17 .07	.00 .48 .07	.00 .47 .10	.00 .39 .06	.00 .27 .06		R ² = .30 F = .007 Female Ward: .40**	R ² = .32 F = .006 PR13: 1.1* Sick Bay: -.48* MH Ward: -.45* Lo Function: .43* Sister: .40**	R ² = .20 F = .172 Female Ward: .28*	R ² = .25 F = .043 Capacity: -.002** Female Ward: .33*

* = significant < .05; ** = significant < .01; *** = significant < .001

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
	Female Ward: + Nursing Rank Sister: + Capacity: -	Sickbay Ward: - MH Ward: - Very Lo Functioning Ward: + PR13: +	Public vs. Private Very Hi Functioning Ward Patient: Staff Ratio Mixed Wards Ward Age
Notes: Hospital / sector effect is limited to none amongst historically black hospitals.			
Historically White Regression Analysis: Effect not significant. (H1W Model 1: F = .204, B = .02, p = .88; H1W Model 2: F = .057, B = -.06, p = .69)			

Occupational Therapy Programme

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Public [^]	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
INOT1-89T	All patients are involved in an occupational therapy programme at least once a week.	Extent of patients involved in OT. Counted as OT Programme	Mo= .43 SE= .05 N=113	.68 .06 64	.45 .09 34	.45 .09 30	.39 .06 77	.54 .07 47	.41 .05 154	.51 .04 211	MCS=.000 PRI2: 1.8*** Hi Function: -2.5* Mix: -1.1*	MCS=.00C PRI2: 1.6* PRI3: 6.8*** PUB2: 3.8** PUB1: 4.6*** Capacity: .02*** PSR: -.33**	MCS: .03 Hi Function: -.21* Private: .68*	MCS: .002 Capacity: .005**

* = significant < .05; ** = significant < .01; *** = significant < .001

[^] Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect		Strong Suggestion of Effect		Weak Suggestion of Effect		No Suggestion of Effect	
Capacity: <		Patient : Staff Ratio: -		Mixed Wards: -		MH Ward	
PRI2, PRI3, PUB1: +		Very Hi Functioning: -		Private: +		Very Lo Functioning Ward	
		PUB2: +				Nursing Rank	
						Sickbay Ward	
						Ward Age	
						Female Ward	
Notes: Effect between individual hospitals more complicated than public : private effect, limiting generalisability of public : private effect results.							
Historically White Regression Analysis: Effect not significant. (HW Model 1: MCS=.363, B=.68, p=.091; HW Model 2: MCS=.006, B=1.2, p=.006)							

Discharge Support

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Public [^]	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
DS1-110T	This hospital maintains regular contact with patients for the first six months after discharge.	Patient contact after discharge. Mn=.16 SE=.04 N=113	.16 .05 64	.24 .08 34	.28 .08 30	.23 .05 77	.48 .07 47	.24 .04 154	.17 .03 211					
DS2-94F	When a patient leaves the hospital I usually do not hear about the patient again unless he or she is readmitted.	Patient contact after discharge. Mn=.18 SE=.04 N=113	.17 .05 64	.23 .08 34	.38 .09 30	.09 .03 77	.17 .06 47	.17 .04 154	.18 .03 211					
DS3-31F	This hospital usually does not have regular contact with the families of patients after discharge.	Family contact after discharge. Mn=.34 SE=.05 N=113	.43 .07 64	.35 .09 34	.41 .10 30	.50 .06 77	.46 .07 47	.48 .05 154	.37 .03 211					
SUM DS	Sub-scale	3 questions Md=.00 Mn=.64 SE=.08	.00 .65 .11	.50 .78 .17	1.0 1.0 .19	1.0 .81 .09	1.0 1.1 .14	1.0 .86 .08	.00 .67 .06	R ² = .22 F = .019 Geriatric: .34*	R ² = .23 F = .039		R ² = .04 F = .013	R ² = .18 F = .013

* = significant < .05; ** = significant < .01; *** = significant < .001

[^] Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
		Geriatric: +	Public vs. Private MH Ward Very Hi / Lo Functioning Ward Patient -Staff Ratio Nursing Rank Sickbay Ward Capacity Young Mixed Wards Female Ward
Notes: Hospital / sector effect is limited to none, amongst historically black hospitals.			
Historically White Regression Analysis: Effect not significant. (HW Model 1: F = .018, B = .20, p = .24; HW Model 2: F = .020, B = .16, p = .25)			

Discharge Support Planning

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Public ^a	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
INDS1-58T	Plans are made for patient accommodation before a patient is discharged.	Queries procedure relevant only when a patient is actually discharged.	Mn=.59 SE=.05 N=113	.80 .05 64	.38 .09 34	.53 .09 30	.62 .06 77	.83 .06 47	.60 .05 154	.62 .03 211				
INDS2-85T	This hospital makes sure that patients have social support before being discharged.	Queries procedure relevant only when a patient is actually discharged. ⁹	Mn=.65 SE=.05 N=113	.72 .06 64	.63 .09 34	.71 .09 30	.66 .05 77	.87 .05 47	.68 .05 154	.67 .03 211				
SUM	Sub-scale	2 questions	Md=2.0 Mn=1.2 SE=.08	2.0 1.4 .09	1.0 1.0 .15	1.0 1.2 .15	2.0 1.3 .10	2.0 1.7 .09	2.0 1.4 .07	2.0 1.3 .06	R ² = .05 F = .013 Hi Function: .48*	R ² = .11 F = .008 PRI2: .63** PRI3: 2.0** PUB1: 1.1* PUB2: 1.3** Hi Function: .95* Geriatric: .41* Capacity: .007** PSR: -.15***	R ² = .03 F = .024 Hi Function: .56***	R ² = .06 F = .004 Capacity: .002** PSR: -.03* Hi Function: .65***

* = significant < .05; ** = significant < .01; *** = significant < .001

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Very Hi Functioning: + Capacity: + Patient-Staff Ratio: -	PR12, PR13, PUB2: +	Geriatric: + PUB1: +	Public vs. Private MH Ward Very Lo Functioning Ward Nursing Rank Sickbay Ward Young Mixed Wards Female Ward
Notes: Individual hospital effect more significant than sector (public : private) effect. Historically White Regression Analysis: Effect not significant. (HW Model 1: F= .007, B= .29, p=.060; HW Model 2: F= .002, B= .31, p=.054)			

⁹ This may in fact prevent the discharge of patients who may be otherwise ready.

Family and Community Services Sub-Scales

Perceptions of Family Attitudes Toward Patient Discharge

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Public A	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
INFAM1-99T	Most families of patients would like the patients to be discharged and to go home.	Comment on family relationship to patient discharge Mn= .54 SE= .05 N=113	.67 .06 64	.50 .09 34	.10 .06 30	.53 .06 77	.28 .07 47	.41 .05 154	.57 .04 211	MCS: .000 PRI2: 2.9** Geriatric: 2.4** PSR: -.23*	MCS: .000 MH Ward: .88* Young: -2.4* Geriatric: 1.0* Private: .62*	MCS: .003 MH Ward: .92* Young: -2.4* Geriatric: 1.1**	MCS: .002 MH Ward: .88* Young: -2.4* Geriatric: 1.0* Private: .62*	MCS: .003 MH Ward: .92* Young: -2.4* Geriatric: 1.1**
INFAM2-44F	Many chronic patients at this hospital could be discharged but their families don't want them at home.	Comment on family relationship to patient discharge Mn= .21 SE= .04 N=113	.27 .06 64	.31 .09 34	.25 .08 30	.05 .03 77	.11 .05 47	.11 .03 154	.24 .03 211	MCS: .000 MH Ward: 2.2** PRI2: 1.0* PUB2: -1.6* MH Ward: 1.9***	MCS: .000 MH Ward: 1.2* Private: .88* Mix: 1.4**	MCS: .000 MH: 1.5*** Mix: 1.7***		

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

FAM1

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Geriatric: + PRI2: +	MH Ward: + Young: - PUB1: -	Patient - Staff Ratio: - Private: +	Very Lo Functioning Ward Nursing Rank Sickbay Ward Young Capacity: + Very Hi Functioning: + Mixed Wards Female Ward

Notes: Individual hospital effect consistent with sector (public: private) effect.

Historically White Regression Analysis: Effect significant. (HW Model 1: MCS=.000, B=-1.3, p=.002**; HW Model 2: MCS=.000, B=-1.2, p=.011*)

FAM2

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
MH Ward: + Mixed Ward: +		Private: + PRI2: + PUB2: -	Very Hi / Lo Functioning Ward Nursing Rank Sickbay Ward Capacity Patient - Staff Ratio Ward Age Mixed Wards Female Ward

Notes: Individual hospital effect consistent with sector (public: private) effect.

Historically White Regression Analysis: Effect not significant. (HW Model 1: MCS=.011*, B=-.48*, p=.38; HW Model 2: MCS=.002, B=-.16, p=.79)

Family Involvement

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Public Δ	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
INFAM3-103T	The majority of patient families understand the patient diagnoses and prognoses.	Families understand diagnosis	Ma=.31 SE=.04 N=113	.54 .07 64	.72 .08 34	.53 .09 30	.40 .06 77	.55 .07 47	.44 .05 154	.45 .04 211	MCS=.000 PRI2: 1.2** PRI3: 1.6**	MCS=.000 PRI2: 2.2** PRI3: 6.3** PUB1: 2.6* PUB2: 3.0** Lo Function: 1.4** Geriatric: 1.2* Capacity: .01* PSR: -.33*	MCS: .002 Mix: 1.3**	MCS: .003 Mix: 1.1**
INFAM4-2T	Families of patients regularly visit patients at this hospital.	Families visit	Ma=.66 SE=.05 N=113	.83 .05 64	.73 .08 34	.69 .09 30	.75 .05 77	.51 .07 47	.74 .04 154	.72 .03 211				
SUM FAM	Sub-scale	2 questions	Ma=1.0 Ma=.95 SE=.07	1.0 1.3 .08	2.0 1.4 .13	1.0 1.2 .12	1.0 1.3 .14	1.0 1.1 .12	1.0 1.2 .08	1.0 1.1 .05	R ² =.05 F=.221 PRI2: .44** PUB2: .40** Hi Function: -.61*	R ² =.08 F=.338 PRI3: 1.5* PUB2: 1.1*	R ² =.03 F=.666	R ² =.05 F=.988 Hi Function: -.61* Mix: .32*

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect (PUB2: +)	Strong Suggestion of Effect (PRI2: +)	Weak Suggestion of Effect (PRI3: +) (Very Hi Functioning Wards: -)	No Suggestion of Effect
			Public vs. Private MH / Mixed / Psychiatric Ward Very Lo Functioning Ward Nursing Rank Patient - Staff Ratio Sickbay Ward Capacity Ward Age Female Ward
Notes: No models demonstrate significance. Individual hospital effect more significant than sector (public: private) effect. Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.720, B=-.06, p=.729, HW Model 2: F=.971, B=-.14, p=.38)			

Facilitation of Family Involvement

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Public A	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
INFFC1-92T	Families are kept regularly informed of patient progress.		Mn=.55 SE=.05 N=113	.63 .07 64	.61 .09 34	.52 .09 30	.66 .05 77	.68 .07 47	.62 .05 154	.58 .04 211				
DPL4-20T	This hospital actively involves families in planning for patient discharge – that is, staff regularly discuss patient progress and what is required for discharge with the families of patients.	Involving families in discharge planning.	Mn=.65 SE=.06 N=113	.76 .05 64	.68 .09 34	.63 .09 30	.77 .05 77	.80 .06 47	.73 .04 154	.69 .03 211				
FRE1-86T	Patients can use a phone to call family or friends.		Mn=.54 SE=.05 N=113	.31 .06 64	.41 .09 34	.20 .07 30	.23 .05 77	.59 .07 47	.22 .04 154	.45 .04 211				
SUM FFX	Sub-scale	3 questions	Md=2.0 Mn=1.7 SE=.11	2.0 1.6 .13	2.0 1.6 .18	1.0 1.3 .15	2.0 1.6 .11	2.0 2.0 .13	2.0 1.7 .13	2.0 1.6 .07	R ² = .06 F = .014 Lo Function: -.41* MH Ward: .46*	R ² = .09 F = .021 PRI3: 2.3** PUB1: 1.2* PUB2: 1.3* Female: -.67** Capacity: .008** PSR: -.14**	R ² = .02 F = .013 Lo Function: -.37*	R ² = .05 F = .017 Lo Function: -.37*

* = significant < .05, ** = significant < .01, *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Very Lo Functioning Ward: - Female Ward: - Capacity: + Patient -Staff Ratio: - PRI3: +	Very Lo Functioning Ward: - Female Ward: - Capacity: + Patient -Staff Ratio: - PRI3: +	MH Ward: + PUB1, PUB2: +	Public vs. Private Very Hi Functioning Nursing Rank Sickbay Ward Mixed Wards: + Ward Age
Notes: Individual hospital effect is more significant than sector (public : private) effect. Historically White Regression Analysis: Effect not significant. (HW Model 1: F=.001, B=-.41, p=.031; HW Model 2: F=.002, B=-.46, p=.021*)			

Community Outreach

Code	Question	Notes	PR11	PR12	PR13	PUB1	PUB2	PUB HW	Public ^A	PC	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
INCOM 1-28T	This hospital actively attempts to find out about existing community structures and support for patients (i.e. health, welfare, social, NGO organisations) in order to increase the number of patients who can be discharged.	Community contact. Mn=.52 SE=.05 N=113	.57 .07 64	.39 .09 34	.48 .09 30	.61 .06 77	.68 .07 47	.57 .05 154	.52 .04 211	MCS=.002 Hi Function: 1.7** Lo Function: -.93**	MCS: .000 PRI3: 2.6* PUB2: 1.6* Sickbay: -1.8** Hi Function: 3.4*** Geriatric: 1.2** Capacity: .01** PSR: -.29***	MCS: .001 Hi Function: 1.9** Lo Function: -.92*	MCS: .000 Sickbay: -1.1* Hi Function: 2.1** Lo Function: -.81* PSR: -.10	

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion of Effect	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Patient : Staff Ratio: - Very Hi Functioning: + Very Lo Functioning Ward: -	Sickbay Ward: - Geriatric: + Capacity: +	PRI3, PUB2: +	Public vs. PC MH Ward Nursing Rank Mixed Wards Young Female Ward
Notes: Individual hospital effect is more significant than sector (public: private) effect.			
Historically White Regression Analysis: Effect not significant. (HW Model 1: MCS=.001, B=-.51, p=.28; HW Model 2: MCS=.000, B=-.78, p=.12)			

Questions Not Used

Code	Question	Reason
NU1-11F	A lot of patients just seem to be passing time here.	Can be interpreted in many ways as it is not a standard South African expression (i.e. patients are not mentally ill and they are just here due to food and shelter, or patients are not busy)
NU2-22T	Patients are expected to take leadership here (for example, organise activities etc.)	Does not directly reflect 'patient responsibility'. That is, patients can be 'expected' to take responsibility, and still not take any.
NU3-15F	The skills patients learn in this hospital will not be very useful in finding a job outside the hospital in the future	Complicated version of question which has two clearer versions.
INSEX 2-21T	Patients are allowed to make intimate friendships (including healthy sexual relationships) here.	Not analysed for 'quality' as MH Act 'prohibits' patient sex
FRE3-115T	Different religious traditions are respected at this hospital (for example, Muslim and Jewish patients can see their respective religious leaders; traditions of various religious days are respected (fasting, other rituals.)	Suggestion of Jewish and Muslim traditions inappropriate for patient majority of patient population and thus confused interpretation of question.
RSP7-4F	Very few patients offer to help out in this ward.	Complicated syntax: 'very few'.
INACT 1-36F	Patients are not very active – they spend most of their day watching TV or sitting around.	Syntax proved confusing at hospitals without TV's.
INCLR 1-6T	If patients break a rule, they know what the consequences will be.	??Rules and consequences.
RSP1-102T	Very few patients have responsibility here.	Confusing syntax - 'very few'.
INAPT 1-83T	Patients are rarely kept waiting when they have appointments with staff.	Negative.
ORG1-41F	Things are sometimes disorganised around here.	General hospital order. (Double negative) Not priority question.
ORG2-114T	This is a very well organised hospital.	General hospital order. Not priority question.
SW1-107F	Often patients do not see a social worker for over three months.	Complicated wording (often... do not). (DN)
LAN9-47T	All patients can speak to a social worker in a language of their choice (a language they can speak fluently.)	Language assessment achieved through S/W interview.
LAN7-82T	Some patients cannot speak directly with an occupational therapist in a language of their choice (a language they can speak fluently.)	Language assessment achieved through OT interview. Possibly confusion with word 'directly'. Double negative.

Addendum 1.3: Observer Evaluation

Methodology and Results

A. Method

1. Summary

The Observer Evaluation forms one component of the ward protocol completed at each chronic ward at the hospital. The tool is designed to provide a framework for a detailed observer investigation of each ward. It consists of a cover page, the 'Observer Evaluation', and the 'Observer Checklist'.

- The cover page was designed to capture additional observations and reflections of the researcher during the ward visit.
- The 'Observer Evaluation' rates aspects of the hospital including facility, patients, and staff. Each item is rated on a 0 to 4 Lickert scale, providing a 0 to 4 rating scale. The tool was based on the Community Oriented Programs Environment Scale (COPES) of the Residential Substance Abuse and Psychiatric Programs Inventory (RESPPPI) (Timko, 1994), in terms of both content and design.
- The 'Observer Checklist' rates equipment, facilities, supplies, and practices. Each item is rated on a 0 to 2 Lickert scale.

The observer evaluation was completed independently by one to two researchers per ward during the site visits. Final evaluations were reached by consensus by the research team after completion of site visits.

Statistical analysis included descriptive statistics of individual items, a factor analysis, and a regression strategy synthesising four regression models. The approach is similar to that employed in the analysis of the Nursing Staff Questionnaire (see Addendum 1.2). A complete copy of the Observer Evaluation can be found in Addendum 2: Quality of Care Tools.

2. Method

1. For the majority of wards, two researchers independently completed the observer evaluation at each ward.
2. The observer evaluation was completed at the end of the ward visit (after the researcher had spent at least three hours in the ward). After the rest of the ward protocol was completed, the researcher walked around the ward for the final observation and completed the questionnaire. Whenever possible, the researcher asked to walk the wards free from senior ward nursing staff.
3. The researcher could ask questions of junior staff and / or patients to answer items which were not readily clear (such as availability of pyjamas.)¹
4. Researchers wrote written comments and reflections about the ward on the covering page.

Table 1: Number of On Site Observer Evaluations

	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Avg. N
Number of Observer Evaluations	18	13	22	24	20	25	20

5. All researchers in the team completed a 'Hospital Wide' Observer Evaluation at the conclusion of the site visit, summarising qualities of the hospital as a whole.
6. After each site visits, two researchers (who were present at all visits) completed 'Hospital Wide' ratings for all hospital, with an emphasis on relative use of the rating scales.
7. After all site visits, all researchers held a group session to complete final sets of Observer Evaluations. Ratings were agreed by group discussion and consensus.² The group had access to written comments but not original ratings when discussing the final set of ratings.
8. Consensus ratings were used in the final analysis described below, as these ratings avoided the complications of inter-rater reliability (see limitations below) which would exist if site visit ratings were used.

¹ This was also an opportunity to discuss ward life more informally with junior staff and patients. See Informal Interview.

² Differences in perceptions which emerged were discussed to try to reach consensus. If there was still disagreement about a score, the middle of these two scores was taken. Thus a disagreement between a 2 and a 3 was resolved to be 2.5.

3. Limitations

The following limitations should be noted:

- **Multiple Researchers:** Only two of the four researchers were at all 6 site visits. The remaining two researchers visited 3 sites each.
- **Expectations of Researchers:** Researcher's own expectations for quality impact usage of rating scales.
- **Distance Between and Order of Site Visits:** The site visits were separated by several weeks, and thus consistent and equilibrated use of the scale, even with the same researcher, was often difficult. The order of site visits impacted on the research team's expectation of quality.

The impact of these limitations were minimised by the use of final group evaluations (see methods above) rather than individual site visit evaluations.

4. Analysis

The median and average score for each item was calculated for each hospital and across the public and privately contracted sectors. The results are organised according to the factor analysis results. See results tables below.

The factor and regression analysis strategy of the observer evaluation was the same as that employed for the Nursing Staff Questionnaire. See Chapter 1: Introduction and Addendum 1.2: Nursing Staff Questionnaire for a detailed description of this analysis strategy. The rotated factor matrix is illustrated in Table 3.

Table 3. Rotated Factor Matrix: Correlation between factors and component subscales

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
GROUNDS	.53489	.62763	.25811	.18135	.12239
BLDG	.70776	.47930	.29403	.12566	.23635
OUTREC	.71555	.42100	.30890	.20175	.10135
INREC	.82931	.29035	.19085	.17797	.12031
NOISE	.22016	.10111	.69940	.07016	.16066
ODOUR	.25978	.60730	.49462	.27729	.13956
LIGHT	.30496	.72585	-.03278	.15575	.36420
CLNWALL	.16074	.54075	.63050	.16216	.19880
CNDWALL	.36191	.50369	.57030	.05031	.11774
FURN	.48279	.56899	.31358	.15736	.30668
WINDOW	.35170	.74724	.04758	.14145	.26367
VIEW	.49932	.66656	.23184	.19319	.12872
CLNTOIL	.18030	.65474	.46385	.17724	.08495
VARIA	.80960	.15410	.12371	.32524	.16826
PRSN	.82354	.13768	.14266	.35073	.13179
DIST	.85549	.19685	.20120	.23122	.20174
FACILITY	.71747	.48591	.31865	.14565	.18042
PGROOM	.41327	.15492	.68005	.17875	.27857
PCLOCLN	.45682	.15127	.71617	.13799	.20601
PCLOCND	.74756	.17819	.39406	.12067	.27414
PINTER	.31729	.15035	.11054	.83160	.02494
PBVE	.23448	.15099	.09257	.84330	.06850
PQUALINT	-.06778	.59500	.08939	.48768	.22338
PACTIVE	.27298	.09878	.18705	.68228	.16609
PENERGY	.14108	.15882	.09348	.81269	.14223
STF PAT	-.04589	.25741	.07773	.38332	.70213
STFORG	.29067	.35771	.26033	.23614	.55920

STF_STF	.22863	.05903	.15221	-.02916	.78292
STF_ENTH	.09330	.22412	.37272	.19025	.60552
STF_QNT	.50644	-.04629	.36135	.03524	.53338
STF_CMFT	.29277	.29852	.15118	.09262	.61337
WP	.21698	.06552	-.01887	.41831	.40969
OVERALL	.72670	.35924	.34805	.22954	.24619

B. Results

The following sections contain the results of the analysis of the observer evaluation. The results are organised according to the factor analysis outcomes. The last sections contain results of individual questions which were not incorporated into the principle five factors.

The results of the regression analysis are reported in summary form to assist the reader with interpretation as follows:

Code	Question	Notes	PRI1	PRI2	PRI3	PUB 1	PUB 2	PUB HW	Public ^	PC	Hosp Reg 1	Hosp Reg 2	Sector Reg 1	Sector Reg 2
	Q1		Mean SE Medn	Mean SE Medn	Mean SE Medn	Mean SE Medn	Mean SE Medn	Mean SE Medn	Mean SE Medn	Mean SE Medn				
	Q2		"	"	"	"	"	"						
	Q3		"	"	"	"	"	"						
SUM	Sub-scale	3 questions	Mean SE Medn								R ² F= Var: B* Var: B** Var: B***	R ² = F=	R ² = F=	R ² = F=

The F and/or MCS value is given to demonstrate the significance of fit for the model. Below the F/MCS value is the beta values for variables demonstrating at least a minimal suggestion of significance. This table is complemented with an additional table summarising the significant effects.

Table 7: Factor 1: Physical Infrastructure

Factor	Key Components	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
Physical Infrastructure	Buildings, Outdoor Recreational Facilities, Indoor Recreational Facilities, Variation, Personalisation, Distinctiveness, Overall Facility Rating, Overall Hospital Rating, (Condition of Patient Clothes).	p of F=.000 PRI2: -1.6*** PRI3: -2.9*** PUB1: -3.3*** PUB2: -1.9***	p of F=.000 PRI2: -2.6*** PRI3: -3.4*** PUB1: -3.0*** PUB2: -1.9** MH Ward: .78 ^c	p of F=.193 HI Function: 1.4* Private: -.87*	p of F=.013 HI Funk: 2.0*** Capacity: .008** Private: -2.0**

* = significant < .05; ** = significant < .01; *** = significant < .001

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Very Hi Functioning Wards: + PRI2, PRI3, PUB2, PUB3: -	Private: - Capacity: +	MH Wards: +	Patient : Staff Ratio Mixed Wards Ward Age Sick Bay Wards Female Ward Very Lo Functioning Wards Nursing Rank
Notes: Individual hospital effect demonstrates higher scores for PC1 (reference hospital), weakening generalisability of Public : Private effect results.			
Historically White Regression Analysis: Effect significant. (HW:HB Model 1: p of F=.000, p=.001**, B=1.9; HW:HB Model 2: : p of F=.000, p=.000***, B=2.1)			

Table 8: Physical Infrastructure: Descriptive Statistics

Question	Notes	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public ^a	PC
Buildings		Md=.50 Mn=.38 SE=.08	.00 .17 .17	2.0 2.0 .00	.00 .00 .00	.00 .20 .13	4.0 4.0 .00	.00 .11 .08	.50 .91 .19
Outdoor Recreational Facilities		Md=.25 Mn=.38 SE=.16	.00 .25 .25	2.0 1.8 .25	.00 .00 .00	.00 .00 .00	4.0 4.0 .00	.00 .00 .00	.50 .84 .19
Indoor Recreational Facilities		Md=.00 Mn=.13 SE=.13	.00 .00 .00	.00 .06 .06	.00 .00 .00	.00 .00 .00	4.0 4.0 .00	.00 .00 .00	.00 .07 .05
Variation		Md=.00 Mn=.00 SE=.00	.00 .00 .00	.00 .00 .00	.00 .00 .00	.00 .00 .00	2.0 2.3 .41	.00 .00 .00	.00 .00 .00
Personalisation		Md=.00 Mn=.00 SE=.00	.00 .00 .00	.00 .00 .00	.00 .00 .00	.00 .00 .00	2.5 2.3 .41	.00 .00 .00	.00 .00 .00
Distinctiveness		Md=.00 Mn=.00 SE=.00	.00 .00 .00	.00 .00 .00	.00 .00 .00	.00 .00 .00	2.0 2.6 .28	.00 .00 .00	.00 .00 .00
Overall Facility Rating		Md=.50 Mn=.69 SE=.19	.00 .33 .21	1.0 .81 .09	.00 .25 .13	.00 .15 .11	4.0 3.8 .12	.00 .19 .08	.50 .64 .10
Overall Hospital Rating		Md=.00 Mn=.31 SE=.19	.00 .25 .17	1.0 .81 .09	.00 .25 .19	.00 .10 .07	4.0 3.7 .14	.00 .17 .19	.50 .48 .10

^a Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Table 9: Factor 2: Physical 'Environment'

Factor	Key Components	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
Physical 'Environment'	Grounds, Odour, Lighting, Windows, View, (Cleanliness of Toilets)	p of F=.000 PRI2: -1.5*** PUB2: -2.1*** Mix Ward: .51** Geriatric: .77*	p of F=.000 PUB2: -2.1*	p of F=.107 Mix Ward: 1.3*	p of F=.003 Lo Function: 1.3* Capacity: -.011*

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
PRI2, PUB2: -	Mixed Wards: +	Very Lo Functioning Wards: + Geriatric: + Capacity: -	Public vs. Private Female Ward Patient : Staff Ratio MH Ward Young Sick Bay Wards Very Hi Functioning Wards Nursing Rank
Notes: Individual hospital effect more significant than sector effect.			
Historically White Regression Analysis: Effect significant. (HW:HB Model 1: p of F=.000, p=.004**, B=.63; HW:HB Model 2: : p of F=.000, p=.02*, B=.57)			

Table 10: Physical 'Environment': Descriptive Statistics

Question	Notes	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public^	PC
Grounds		Md=.00 Mn=.44 SE=.26	.00 .33 .33	4.0 4.0 .00	.00 .00 .00	.00 .00 .00	4.0 4.0 .00	.00 .00 .00	.75 1.7 .40
Odour		Md=1.0 Mn=1.4 SE=.25	.00 .83 .54	3.0 2.9 .23	1.8 2.0 .35	.75 1.1 .35	4.0 3.6 .22	1.5 1.5 .27	2.0 1.8 .26
Lighting		Md=2.0 Mn=1.7 SE=.28	1.0 1.7 .42	2.5 2.7 .09	2.0 2.0 .00	1.0 1.2 .26	4.0 3.6 .15	2.0 1.5 .17	2.3 2.1 .18
Windows		Md=1.3 Mn=1.6 SE=.27	1.0 1.7 .42	3.0 3.1 .13	2.0 2.0 .00	1.0 1.1 .18	4.0 3.9 .06	2.0 1.5 .15	2.8 2.2 .22
View		Md=.50 Mn=.63 SE=.23	.00 .50 .34	3.5 3.5 .00	2.0 2.0 .00	1.0 1.0 .00	4.0 4.0 .00	1.0 1.4 .12	1.0 1.6 .33
Toilet Cleanliness		Md=1.0 Mn=1.1 SE=.23	.50 1.0 .52	2.5 2.4 .18	2.0 2.5 .38	.00 .70 .31	4.0 3.5 .20	1.8 1.5 .32	1.8 1.6 .22

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Table 11: Factor 3: Cleanliness

Factor	Key Components	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
Cleanliness	Patient Grooming, Cleanliness of Patient Clothing, Cleanliness of Wall, Condition of Walls, (Noise)	p of F=.157 PRI2: -1.5*	p of F=.002 Capacity: -.013** MH Ward: -1.2* Geriatric: -1.0* Mix Ward: -.79*	p of F=.347 Female: .97*	p of F=.000 MH Ward: -1.3* Capacity: -.011*** Geriatric: -1.1** Private: .93*

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
Capacity: -	MH Ward: - Geriatric: - Mixed Wards: -	Private: + PRI2: -	Patient : Staff Ratio Very High /Functioning Wards Very Lo Functioning Wards Nursing Rank Sister Female Young Sick Bay Wards
Notes: Weak suggestion of privately contracted hospital scoring higher. Weak suggestion of PRI2 scoring lower than the remaining historically black hospitals, limiting generalisability of public : private effect results.			
Historically White Regression Analysis: Weak suggestion of significance of effect. (HW:HB Model 1: p of F=.000, p=.03*, B=.47; HW:HB Model 2: : p of F=.000, p=.14, B=.35)			

Table12: Cleanliness: Descriptive Statistics

Question	Notes	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public^	PC
Patient Grooming		Md=1.0 Mn=1.1 SE=.20	.25 .75 .40	2.0 1.9 .18	1.0 1.6 .42	1.3 1.5 .18	4.0 3.8 .12	1.0 1.6 .21	1.3 1.3 .17
Cleanliness of Patient Clothing		Md=1.0 Mn=1.1 SE=.23	1.0 1.0 .37	3.0 2.4 .29	1.0 1.4 .39	1.8 1.8 .24	4.0 3.7 .14	1.5 1.6 .22	1.3 1.6 .21
Cleanliness of Walls		Md=1.5 Mn=1.7 SE=.25	.50 1.3 .70	3.0 2.8 .23	2.5 2.6 .27	1.3 1.4 .42	4.0 3.6 .16	2.3 1.9 .29	2.5 2.0 .24
Condition of Walls		Md=1.3 Mn=1.1 SE=.16	.50 1.2 .44	2.5 2.5 .00	2.0 1.8 .16	1.0 1.5 .32	4.0 3.6 .20	1.5 1.6 .19	1.5 1.6 .19

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Table 13: Factor 4: Patient Functioning

Factor	Key Components	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
Patient Functioning	Frequency of Patient Interactions, Frequency of Brief Verbal Exchanges, Quality of Patient Interactions, Patient Activity Levels, Patient Energy	p of F=.029 PUB1: 1.3* Lo Function: -1.3*	p of F=.002 PUB1: 1.6* Hi Functioning: 1.2** Lo Functioning: -1.5** Geriatric: -1.1*	p of F=.067	p of F=.191 Lo Functioning: -1.4*

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
	Very Lo Functioning Wards: - Very High Functioning Wards: + PUB1: +	Geriatric: -	Public vs. PC Female Nursing Rank Young MH Ward Mixed Wards Patient : Staff Ratio Capacity Sick Bay Wards

Notes: Effect of patient functioning variables as predicted.

Historically White Regression Analysis: Effect significant. (HW:HB Model 1: p of F=.000, p=.86, B=.03; HW:HB Model 2: p of F=.000, p=.65, B=-.10)

Table 14: Patient Functioning

Question	Notes	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public^	PC
Patient Activity		Md=.00 Mn=.31 SE=.31	.00 .17 .17	1.0 .81 .25	.00 .50 .38	.00 .00 .00	2.5 2.3 .44	.00 .22 .17	.00 .45 .16
Patient Energy		Md=1.0 Mn=1.3 SE=.41	.75 1.0 .34	2.5 2.1 .38	2.5 2.5 .42	1.0 .90 .27	4.0 3.1 .39	1.5 1.6 .30	1.0 1.5 .24
Patient Brief Verbal Exchanges		Md=1.3 Mn=1.4 SE=.45	1.8 1.8 .38	3.0 2.7 .36	1.0 1.6 .39	.50 .80 .30	4.0 2.9 .46	1.0 1.1 .25	1.5 1.8 .24
Patient Interactions (Frequency)		Md=1.8 Mn=1.5 SE=.41	2.0 1.9 .49	2.0 1.6 .32	1.8 2.0 .53	.50 .80 .29	4.0 3.1 .47	1.0 1.3 .31	2.0 1.6 .22
Patient Interactions (Quality)		Md=1.8 Mn=1.8 SE=.30	1.3 1.6 .33	3.0 3.1 .23	3.0 2.6 .18	2.0 1.6 .22	3.0 2.8 .38	2.0 2.1 .19	2.0 2.2 .22

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Table 15: Factor 5: Staff Functioning

Factor	Key Components	Hospital Regression 1	Hospital Regression 2	Public vs. PC Regression 1	Public vs. PC Regression 2
Staff Functioning	Staff 'Organisation', Staff - Staff Interactions, Staff - Patient Relationship, Staff Enthusiasm, Staff Quantity, Staff Comfort Levels	p of F= .105 PRI2: -.15** PUB2: -.12*	p of F= .131 Capacity: -.011*	p of F= .571	p of F= .073 Capacity: -.009***

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion (Capacity: -)	Strong Suggestion of Effect PRI2: - PUB2: -	Weak Suggestion of Effect	No Suggestion of Effect Public vs. PC Female Nursing Rank Ward Age MH Ward Mixed Wards Patient : Staff Ratio Very Hi / Lo Functioning Sick Bay Wards
Notes: No regression model demonstrated significant fit, except HW:HB model (below.) Individual hospital effect more significant than sector effect.			
Historically White Regression Analysis: Weak suggestion of significance of effect. (HW:HB Model 1: p of F=.007, p=.01*, B=.57; HW:HB Model 2: : p of F=.000, p=.64, B=.12)			

Table 16: Staff Functioning: Descriptive Statistics

Question	Notes	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Public^	PC
Quality of Staff Interactions		Md=1.0	1.0	2.5	1.0	1.0	3.0	1.0	1.0
		Mn=1.3	1.2	1.9	1.4	1.5	3.2	1.4	1.5
		SE=.28	.48	.39	.28	.35	.25	.23	.23
Staff Patient Relationship		Md=1.0	.00	3.0	2.5	1.3	3.0	1.5	.8
		Mn=1.3	.67	2.6	2.4	1.4	3.3	1.8	1.6
		SE=.33	.42	.26	.56	.35	.19	.33	.25
Staff Enthusiasm		Md=.50	.00	2.3	1.0	.00	2.0	.25	1.0
		Mn=.63	.33	2.0	1.4	.30	2.1	.78	1.1
		SE=.13	.25	.21	.50	.13	.17	.26	.19
Staff Comfort Levels		Md= -	.00	2.5	2.0	1.0	3.0	1.0	1.5
		Mn= -	.42	2.1	1.9	1.2	3.1	1.5	1.4
		SE= -	.27	.28	.28	.25	.18	.20	.30
Quantity		Md=.50	.00	.50	1.0	1.3	3.0	1.0	.50
		Mn=.50	.33	.56	.69	1.3	2.9	1.0	.48
		SE=.16	.21	.22	.16	.15	.09	.13	.11

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Table 17: Ward Programme

Question	Notes	PRI1	PRI2	PRI3	PUB1	PUB2	PUBH W	Public ^	PC	Hospital Regression 2	Public vs. PC Regression 2
Ward Programme	This item was analysed separately (it was not a component of principle factors above.)	Mc=.00 Mn=.31 SE=.31	.00 .00 .00	.13 .13 .05	.00 .00 .00	.00 .00 .00	.50 .72 .31	.00 .00 .00	.00 .16 .11	R ² : .46 PRI3: -.94 PUB1: -.72* PUB2: -.66** Capacity: -.004* PSR: .06*	R ² : .27 Hi Functioning: .55*

* = significant < .05; ** = significant < .01; *** = significant < .001

^ Public Sector statistics were calculated excluding the historically white hospital data to enable comparison.

Very Strong Suggestion	Strong Suggestion of Effect	Weak Suggestion of Effect	No Suggestion of Effect
	PUB2: - PUB1: - PRI3: -	Capacity: - Patient Staff Ratio: + Very Hi Functioning: +	Public Private Ward Age Sickbay Wards: - MH Ward Female Ward Mixed Wards Very Lo Functioning Wards Nursing Rank
Notes: Individual hospital effect more significant than sector effect.			
Historically White Regression Analysis: Effect significant.. (HW:HB Model 1: p of F=.000, p=.002**, B=.49; HW:HB Model 2: p of F=.001, p=.10, B=.30)			

Addendum 1.4: Senior Ward Nurse Interview

Methodology and Results

A. Methodology

1. Summary

The Senior Ward Nurse Interview formed one component of the ward protocol completed at each chronic ward at the hospital. A copy of the complete Senior Nurse Interview Protocol can be found in Addendum 2: Quality of Care Tools.

This interview protocol was designed to explore aspects of ward and hospital life according to the perspective of the senior nurse at the ward level (the nurse in charge at the ward level).¹ The protocol consists of semi-structured and structured questions. The protocol is divided into three sections:

1. **Semi-Structured Interview Questions.** These are open ended questions covering 11 areas of ward and hospital life. Nurses answered questions broadly. Interviewer subsequently rated answers according to a rating scale provided ('Interview Based Ratings').
2. **Ward Senior Nurse Checklist.** These are rapid checklist items covering facilities, supplies, and patient procedures.
3. **Services Questions.** This was a three page set of questions covering treatment services, activities, and languages. The format of these questions was based on the format of the Residential Substance Abuse and Psychiatric Programs Inventory (RESPPI) (Timko, 1994). The 'Languages' scoring system was developed specifically for this study..

2. Method

The interviews took between 1 and 2 hours to conduct. The following method was followed:

1. The 'Senior Ward Nurse' (SVN) was the nurse in charge at the ward level.
2. Interviews were confidential and voluntary. The interviewer read the cover page and ensured consent. The cover page, outlining the project, confidentiality, and future contact numbers was left with the nurse.

¹ Note that this interview was originally called the 'Senior Sister Interview.' However, at several hospital there was not a sister in charge of a ward. In such cases the senior nurse in charge of the ward was interviewed. Thus, it is more appropriately termed the senior ward nurse interview.

3. Interviews were conducted in a private room to ensure confidentiality.
4. At the end of the interview, the interviewer rated several areas covered in the interview according to prescribed rating scales.
5. At the conclusion of the interview, the researcher wrote additional notes to assist interpretation of results.

Table 1: Number of Senior Ward Nurse Interviews

	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Avg N
Number of SWN Interviews	8	7	9	9	9	10	9

3. Limitations

The following limitations to this protocol are noted:

1. **Senior Nurse Bias:** The nurse in charge was often a senior level nurse. This level of staff tended to have a strong association with management, and strong self-interest in the ward and hospital appearing 'good.' Ward Senior Nurses appeared to have a tendency to exaggerate the services provided, and seemed less comfortable discussing problems with the ward and hospital.
2. **Test Taking Response:** The structured questions often elicited a 'test taking response'. That is, instead of answering according to experience, answers reflected what was considered to be the 'right' answer. Whereas a nurse may discuss problems more openly in a less structured setting, s/he tended to provide what s/he perceived as the 'right answer' when asked in a more structured setting.
3. **Services Questions:** This was the final part of a very long interview. By this time interviewees were tired and eager to finish. The rapid completion may compromise the validity of data from this section, particularly with questions which were difficult to understand. The quality analysis therefore only incorporates the most clear questions from this section.

4. Analysis

- 4.1. **Qualitative Data:** Qualitative data from the senior nurse interview was used to evaluate hospital quality. Table 2 illustrates the qualitative data drawn from the senior nurse interviews.
- 4.2. **Quantitative Data:** Frequency statistics were calculated for interview based ratings, checklist ratings, and services questionnaire ratings. These results are outlined below.

Table 2: Senior Ward Nurse Interviews: Qualitative Data

Question Area	Notes
Patient Statistics	Background statistics: Check on statistics provided by management in the Institutional Profile Form
Nursing Staff Allocation	Costing: Used to calculate costing by cost centres.
Ward Programme	Comment on senior nurse evaluation of ward programme.
OT Programme	Comment on senior nurse evaluation of OT programme
Discharge Programme	Comment on developmental, planning, and support aspects of discharge programme.
Social Worker Programme	Comment on senior nurse evaluation of SW programme.
Languages	Comment on senior nurse evaluation of language barriers between nurses and patients.
Family Involvement	Comment on family involvement, and barriers to increased family involvement.
Institutional Assessment	Comment on senior nurse general hospital assessment.
Management Assessment	Comment on nursing assessment of senior management.
Job Satisfaction	Comment on source of nurse satisfaction and dissatisfaction.
Seclusion / Restraints	Comment on use of seclusion / restraints
Mistreatment/Abuse (By Staff/Patients)	Comment on definition, incidents, and management of mistreatment and abuse of patients.
Race	Comment on role race / race relations in hospital functioning.
Sex	Comment on patient sex, sexual bargaining, STD's, and condom distribution.
Comparison of State and LifeCare	Comment on senior nurse perception of quality differences between state and LifeCare institutions.
Transfers Between State and LifeCare	Comment on transfer relationship between state and LifeCare institutions.

B. Results

1. Services Ratings

Table 3: Services Ratings

Dependent Variable	PRI1 (N=8)	PRI2 (N=7)	PRI3 (N=9)	PUB1 (N=9)	PUB2 (N=9)	PUBHW (N=10)	Public (N=18)	Private (N=24)	HW (N=10)	Total
Ward Programme: Weak	60%	67%	100%	89%	89%	60%	89%	75%	60%	79%
OT Programme: Weak	88%	43%	100%	22%	89%	50%	56%	79%	50%	65%
Discharge Programme: Weak	75%	100%	100%	89%	89%	80%	89%	92%	80%	89%
Social Worker Programme: Weak	50%	43%	100%	100%	44%	30%	72%	67%	30%	62%
Family Involvement: Weak	50%	71%	56%	89%	89%	80%	89%	58%	80%	73%

N=52

Family involvement differences between public and private sector is not significant (Fisher's exact test, $p=0.14$)

2. Perception of Management and Job Satisfaction

Table 4: Management and Satisfaction Ratings

Dependent Variable	PRI1 (N=8)	PRI2 (N=7)	PRI3 (N=9)	PUB1 (N=9)	PUB2 (N=9)	PUBHW (N=10)	Public (N=18)	Private (N=24)	HW (N=10)	Total
Perception of Management: Poor	25%	43%	67%	100%	56%	40%	78%	46%	40%	56%
Job Satisfaction: Poor	38%	43%	44%	56%	33%	10%	45%	42%	10%	37%

N=52

Public sector staff had a significantly poorer perception of management than did private sector (Chi square test, $p=0.05$).

3. Basic Daily Care Routines

Table 5: Basic Daily Care Routines

Dependent Variable	PRI1 (N=8)	PRI2 (N=7)	PRI3 (N=9)	PUB1 (N=9)	PUB2 (N=9)	PUBHW (N=10)	Public (N=18)	Private (N=24)	HW (N=10)	Total (N=52)
Patients bathe 2 or more times /week	100%	71%	89%	100%	100%	100%	100%	95%	100%	92%
Patients change clothes 2 or more times/week	88%	86%	89%	89%	100%	100%	94%	95%	100%	87%
Bedding changed at least once a week	100%	86%	78%	100%	100%	100%	100%	95%	100%	94%

N=52

4. Clinical Services

Table 6: Clinical Services

	Private (N=22)	Public N=18	HW N=10
Doctors Keep to Scheduled Hours	91%	94%	100%
Doctors on call for medical care	77%	50%	100%
Doctors respond to call	91%	44%	100%
Regularly scheduled psychologist hours	9%	17%	70%
Psychiatrist / psychologist on call	64%	39%	60%

N=50

Source: Services Questionnaire

There was a strong sense among researchers that these items were overestimated by senior ward nurses.

5. Amenities

5.1 Ward Amenities

Table 7: Ward Amenities

Dependent Variable	PRI1 (N=8)	PRI2 (N=7)	PRI3 (N=9)	PUB1 (N=9)	PUB2 (N=9)	PUBHW (N=10)	Public (N=18)	Private (N=24)	HW (N=10)	Total (N=52)
Water: Fully Reliable Supply of Clean Potable Water	88%	67%	88%	33%	100%	100%	67%	82%	100%	77%
Warm Water: Consistently Available	63%	22%	44%	33%	63%	60%	39%	43%	60%	42%
Electricity: Fully Reliable	50%	57%	56%	100%	67%	100%	83%	59%	100%	73%
Telephone: Available for Patient Use	75%	14%	44%	22%	22%	100%	22%	50%	100%	48%
Space: Not Very Crowded	88%	57%	67%	67%	100%	100%	50%	50%	100%	81%

N=52

5.2 Food

Table 8: Quality of Food

Dependent Variable	PRI1 (N=8)	PRI2 (N=7)	PRI3 (N=9)	PUB1 (N=9)	PUB2 (N=9)	PUBHW (N=10)	Public (N=18)	Private (N=24)	HW (N=10)	Total (N=52)
Quantity: Patients have enough food	63%	71%	44%	78%	22%	100%	50%	64%	100%	64%
Quality: Food quality good	63%	29%	22%	0%	33%	100%	17%	41%	100%	85%

N=52

5.3 Toilets

Table 9: Amenities: Toilets

Dependent Variable	PRI1 (N=8)	PRI2 (N=7)	PRI3 (N=9)	PUB1 (N=9)	PUB2 (N=9)	PUBHW (N=10)	Public (N=18)	Private (N=24)	HW (N=10)	Total (N=52)
Quantity: Patients can usually use toilet when they want to	75%	86%	67%	78%	100%	100%	89%	82%	100%	85%
Quality: Toilets in good working order for all patients	50%	57%	78%	78%	22%	90%	50%	68%	100%	64%

N=52

6. Additional Counseling Services

Table 10: Spiritual and Legal Counseling Services

	Private N=22	Public N=18	Hist White N=10
Religious or spiritual counseling	64%	39%	80%
Legal advice or counseling	0%	0%	0%

N=50

Source: Services Questionnaire

7. Recreational Activities

Table 11: Patient Recreational Activities

	Private N=22	Public N=18	Hist White N=10
Exercise	48%	50%	50%
Organised recreation	71%	50%	40%
Movies or videos	33%	39%	10%
Classes or lectures	33%	17%	10%
Cards or other games	62%	56%	70%
Religious services	81%	89%	100%
Arts and crafts	48%	33%	0%
Club or social group	19%	6%	0%
Discussion groups	33%	39%	20%

N=50

Source: Services Questionnaire

There was a strong sense among researchers that these items were overestimated among researchers.

8. Languages

Language scores are calculated from the language matrix included in the interview. Scores are a reflection of language ability weighted by patient population speaking the language.²

Table 12: Language scores

Item	Comment Area	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW
Nurses Language Rating	Languages spoken by nurses, weighted by patient languages	1	1	1	1	.98	1
OT Language Ratings	Languages spoken by OT workers, weighted by patient languages	.85	.12	1	1	.98	.76
Social Worker Languages Rating	Languages spoken by Social Workers, weighted by patient languages	.99	.02	na	na	.98	.76
Psychiatrist Languages Rating	Languages spoken by psychiatrists, weighted by patient languages	.04	.01	1	1	.13	.76
MO Language Rating	Languages spoken by MO's, weighted by patient languages	.51	.02	1	0	.61	.76

² Ward scores were weighted by patients in ward speaking a language. For hospitals with very different size wards, ward scores were weighted by proportion of patient population.

Addendum 1.1: Patient Record Abstraction

Methodology and Results

A. Methodology

1. Summary

The Patient Interview formed one component of the ward protocol completed at each chronic ward at the hospital.

There is a great deal of controversy about the importance of involving patients in quality of care assessments. The literature particularly warns against formal interviews and questionnaires due to the power of suggestion inherent in these tools. The literature motivates for a more open ended qualitative tool to incorporate patient perspectives. The interview protocol was designed accordingly.

The interview is designed to explore aspects of hospital life as perceived by the patient. The patient interview protocol contains two sections: open ended questions and the patient checklist.

One patient from each chronic ward was interviewed. Although this sample size limits sample confidence, it provides some patient perspective in checking, contradicting, or explaining quality indicators.

2. Selection Method

The following selection method was used to identify a patient in the ward to be interviewed:

1. The senior sister from each ward was asked to identify ten names of patients who she considered to be capable of being interviewed. She was asked to not select patients who were overly positive or overly negative about the hospital service.
2. Researcher randomly selected a name from this sample.
3. If researcher found patient reluctant to be interviewed, an alternate patient could be chosen.¹

Table 1: Number of Patient Interviews

	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW	Avg. N
Number of Patient Interviews	7	9	7	6	10	11	8

¹ The need to select an alternate patient did not happen in the course of the site visits. Patients were willing and eager to discuss hospital life.

3. Interview Method

The patient interview protocol was designed to facilitate open ended discussion between the patient and interviewer. The interviews were conducted in an 'informal' / 'conversational' way. The interviewers were trained to allow the patient to guide the discussion within the given topic area. Although the interviewer took notes during these interviews, training emphasised eye contact with the patient and de-emphasised focusing on the protocol itself. The following method was followed:

1. One patient from each chronic ward was selected according to the selection criteria above.
2. The interviewer asked patient for consent to interview, and read them the cover letter explaining the study. This cover was left with patients for future reference.
3. Interviews were conducted in a private room to ensure confidentiality.
4. Interviews were conducted in the language of patient choice.
5. At the end of the interview, the interviewer rated several areas covered in the conversation according to prescribed rating scales.
6. At the conclusion of the interview, the researcher rated patient coherency and wrote additional notes to assist interpretation of results.
7. Cross Researcher Validity: Four researchers did patient interviews across six sites. At the conclusion of the site visits, one researcher re-rated all of the ratings according to the notes taken to ensure consistency of rating across interviewers. These ratings were used in the analysis. The difference in scores from on-site and after-site visits are shown in the following table.

4. Limitations

- **Patient Satisfaction:** The literature discussing patient satisfaction concludes that satisfaction is often more of a function of patient expectations and life experiences rather than a reflection of institutional care per se. This was experienced in this study with many patients indicating high satisfaction in response to low expectations. (*'This place is good. I eat and have a place to sleep.'*)
 - **Psychiatric Patients:** While acutely ill psychiatric patients may provide information which is of limited validity, stable patients are able to provide valid data. Scores were weighted according to an interviewer assessment of the patient's ability to give valid information. (See scoring and analysis below.)
 - **Selection Method:** The selection method does not necessarily select a 'typical' patient as patients are chosen from those that the nursing staff consider 'capable of an interview.' These patients tended to be the highest functioning in the wards, and the most engaged in hospital activities. Further, given the nurse role in the selection process, the patients selected may have had more favourable perceptions of the hospital than the 'typical' patient.
-

5. Analysis

- 5.1. **Qualitative Data:** Qualitative data from the patient interview was used to evaluate hospital quality. While the sample size is not representative, the interviews provide a source of patient perspective for checking, contradicting, or explaining quality indicators.
- 5.2. **Quantitative Data:** Frequency statistics were calculated for ratings across sectors. These results are outlined below.

B. Results

1. Profile of Patients Interviewed

- **Mental Status:** 10% of patients were assessed by the interviewer to be only capable of giving information of limited validity.
- **Race:** 80% (39/49) of patients interviewed were black; 14% were white (7/49); 4% (1/49) were coloured.
- **Gender:** 71% (35/49) of patients interviewed were male; 29% (14/49) were female.

2. Services Ratings

Table 2: Services Ratings (By Sector)

	Private N=23	Public N=16	Hist White N=10
Staff Patient Relationship: Negative	9%	13%	10%
Ward Programme: Weak	70%	87%	89%
Discharge programme: weak	95%	100%	11%
Medical treatment services: weak	25%	75%	80%

N=49

3. Hospital Life Ratings

Table 3: Hospital Life Ratings (By Sector)

	Private N=23	Public N=16	Hist White N=10
Patient Daily Schedule: Inactive	61%	56%	50%
Patient Clarity of Circumstance: Unclear	39%	40%	20%
Patient Clarity of Medications: Unclear	68%	70%	30%
Family never visits	40%	54%	60%
Patient has no change envisaged in future plans	5%	45%	0%

N=49

4. Basic Daily Care Routines

Table 4: Daily Life Ratings (By Sector)

	Private N=23	Public N=16	Hist White N=10
Patients bathe 2 or more times /week	100%	100%	100%
Patients change clothes 2 or more times/week	90%	93%	100%
Bedding changed at least once a week	95%	71%	100%

N=49

5. Patient Amenities:

5.1. Clothes and Linen

Table 5: Clothes and Linen Ratings (By Sector)

	Private N=23	Public N=16	Hist White N=10
Patients have shoes of reasonable quality/wear	13%	33%	80%
Patients have clothes of reasonable quality	13%	82%	80%
Patients provided with winter clothes	86%	75%	80%
Patients have pyjamas	67%	53%	100%
Linen is clean, ironed, neat	94%	78%	70%
Mattress linen correctly placed	81%	100%	100%
All patients have pillows	63%	64%	100%
Patients have own beds available always	95%	86%	100%
Patients provided with enough winter blankets	95%	69%	100%

N=49

5.2. Food

Table 6: Food Ratings (By Sector)

	Private N=23	Public N=16	Hist White N=10
Quantity: Patients have enough food	86%	87%	70%
Quality: Food quality good	38%	73%	60%

N=49

5.3. Toilets

Table 7: Amenities: Toilets (By Sector)

	Private N=23	Public N=16	Hist White N=10
Quantity: Patients can usually use toilet when they want to	100%	93%	100%
Quality: Toilets in good working order for all patients	56%	87%	90%
Cleanliness: Toilets are clean	86%	100%	80%

N=49

5.4. Miscellaneous Amenities

Table 8: Patient Amenities Ratings (By Sector)

	Private N=23	Public N=16	Hist White N=10
Adequate bedroom heating in winter	86%	27%	56%
Telephone available for patient use	37%	13%	70%

N=49

Addendum 1.6: Interviews with Management, Union, and Departments

Methodology and Results

1. Superintendent Interview

1.1. Summary

This detailed interview is designed to explore senior administrative management's insight and analysis of the strategic issues facing the operations of the hospital including an analysis of institutional strengths and weaknesses, financial management, personnel management, management autonomy, mistreatment and abuse etc. The interview protocol contained semi-structured and structured questions. A complete copy of the interview protocol can be found in Addendum 2: Quality of Care Tools.

1.2 Method

The 'superintendent' is the senior administrative manager at the hospital.¹ In the public sector this is the 'superintendent'; in the private sector this is the 'hospital manager.' The interviews took approximately two hours.

The superintendent was interviewed on the first day of the visit, by two researchers. The same two researchers interviewed the superintendent at all hospitals. Immediately after the interview, each researcher rated management according to the ratings provided.

1.3. Analysis

Qualitative data from the Superintendent interview was incorporated into the qualitative analysis of hospital operations and management functioning. Superintendent interview ratings were used to compare skill areas of management across hospitals.

¹ In PUB2 three management levels were interviewed – the hospital management, the psychiatric section management, and the ward based psychiatric section management. Ratings were averaged to calculate final hospital ratings.

1.4. Results

Table 1.6-1: Superintendent Interview Ratings

	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW
Financial Management	Moderate	Very Weak	Weak	Weak	Moderate	Very Strong
Strategic Management	Strong	Very Weak	Strong	Very Weak	Weak	Very Strong
Personnel Management	Moderate	Very Weak	Strong	Very Weak	Very Weak	Very Strong
Relationship with Staff	Moderate	Very Weak	Strong	Very Weak	Very Weak	Strong
Creativity / Problem Solving	Weak	Very Weak	Strong	Very Weak	Weak	Very Strong
Understand of Mental Health	Moderate	Very Weak	Weak	Very Weak	Moderate	Very Strong
Empowerment	Strong	Very Weak	Moderate	Very Weak	Weak	Very Strong
Autonomy	Moderate	Very Weak	Weak	Very Weak	Weak	Moderate

0=Very Weak; 1=weak; 2=moderate; 3=strong; 4=very strong.

2. Senior Matron Interview

2.1. Summary

This detailed interview is designed to explore senior nursing management's insight and analysis of the strategic issues facing the operations of the hospital including an analysis of institutional strengths and weaknesses, financial management, personnel management, management autonomy, mistreatment and abuse, and patient services. The interview protocol contained semi-structured and structured questions. A complete copy of the interview protocol can be found in Addendum 2: Quality of Care Tools.

2.2 Method

One to two senior matrons were interviewed at each hospital. In the private sector, both the 'Nursing Services Manager' and the most senior matron were interviewed.

The interview took approximately one hour. Immediately after the interview, the researcher rated nursing management according to the ratings provided. Interview ratings were averaged to produce final ratings when more than one 'senior matron' was interviewed.

2.3. Analysis

Qualitative data from the Senior Matron interview was incorporated into the qualitative analysis of hospital operations and management functioning. Matron interview ratings were used to compare skill areas of management across hospitals.

2.4. Results

Table A1.6-2: Senior Matron Interview Ratings

	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW
Financial Management	Weak	Very Weak	Very Weak	Very Weak	Very Weak	Strong
Strategic Management	Moderate	Weak	Very Weak	Weak	Weak	Very Strong
Personnel Management	Moderate	Weak	Weak	Weak	Moderate	Very Strong
Relationship with Staff	Moderate	Weak	Weak	Moderate	Moderate	Very Strong
Creativity / Problem Solving	Moderate	Weak	Weak	Weak	Weak	Very Strong
Understand of Mental Health	Strong	Moderate	Strong	Strong	Strong	Very Strong
Empowerment	Weak	Weak	Weak	Very Weak	Moderate	Very Strong
Autonomy	Weak	Very Weak	Weak	Weak	Moderate	.63

0=Very weak; 1=weak; 2=moderate; 3=strong; 4=very strong.

3. Union Interview

3.1. Summary

This detailed interview is designed to explore the insight and analysis of representatives of organised labour of the strategic issues facing the operations of the hospital including an analysis of institutional strengths and weaknesses, management, working conditions, staff satisfaction, and patient services. The interview protocol contained semi-structured and structured questions. A complete copy of the interview protocol can be found in Addendum 2: Quality of Care Tools.

3.2 Method

Representatives from all organised labour groups officially recognised at the hospital were interviewed. At privately contracted hospitals, a representative from the 'non-union' body was also interviewed. The interview took approximately one hour. Interview ratings were averaged to produce final ratings when more than one 'union' representative was interviewed.

3.3. Analysis

Qualitative data from the Union Representative interview was incorporated into the qualitative analysis of hospital operations and management functioning.

3.4. Results

Table A1.6-3: Union Representative Interview Ratings

	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW
Senior Management Assessment	Weak	Very Weak	Weak	Moderate	Very Weak	Weak
Staff Satisfaction	Very Weak	Very Weak	Very Weak	Weak	Very Weak	Weak

0=Very weak; 1=weak; 2=moderate; 3=strong; 4=very strong.

4. Occupational Therapy Department

4.1. Summary

This detailed interview is designed to explore the operations of the occupational therapy department, and the perceptions of the occupational therapy department on hospital operations more broadly. The interview was followed by a detailed tour of OT facilities and operations. The interview protocol contained semi-structured and structured questions. A complete copy of the interview protocol can be found in Addendum 2: Quality of Care Tools.

4.2 Method

The head of the Occupational Therapy Department was interviewed. In some hospitals, the department head chose to include other OT workers in the interview. The interview was followed by a detail tour of OT facilities and operations.² The same researcher conducted the OT interview across site visits.

The interview and tour took approximately two hours to complete. Immediately after the interview, the researcher rated the OT programme according to a rating scale provided.

4.3. Analysis

Qualitative data from the Occupational Therapy interview was incorporated into the qualitative analysis of hospital operations, particular in terms of patient development services. Occupational therapy interview ratings were used to compare the occupational therapy programme across hospitals.

4.4. Results

Table A1.6-4: Occupational Therapy Interview Ratings

	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW
Breadth of daily programme	Very Weak	Weak	Very Weak	Moderate	Weak	Weak
Breadth of weekly programme	Very Weak	Weak	Weak	Moderate	Weak	Weak
Quality of Actual Training	Very Weak	Weak	Very Weak	Very Strong	Strong	Weak
Relationship between OT and ward programmes	Weak	Weak	Weak	Moderate	Very Weak	Weak
OT awareness of OT objectives	Very Strong	Very Strong	Moderate	Very Strong	Very Strong	Strong
OT awareness of role of OT in chronic mental health	Very Strong	Strong	Moderate	Very Strong	Very Strong	Very Strong
OT within Multi-Disciplinary Team	Very Weak	Very Weak	Very Weak	Very Weak	Very Weak	Very Weak

0=Very weak; 1=weak; 2=moderate; 3=strong; 4=very strong.

² There was no tour at PRI-1 as the head of the OT Department considered the facilities and operations too weak to add insight to the operations of the programme.

5. Social Worker Department

5.1. Summary

This detailed interview is designed to explore the operations of the social worker department, and the perceptions of the social worker department on hospital operations more broadly. The interview protocol contained semi-structured and structured questions. A complete copy of the interview protocol can be found in Addendum 2: Quality of Care Tools.

5.2 Method

The head of the Social Worker Department was interviewed. In some hospitals, the department head chose to include other social workers in the interview. The same researcher conducted the Social Worker Interview across site visits.

The interview and tour took approximately one and a half hours to complete. Immediately after the interview, the researcher rated the Social Worker Programme interview according to a rating scale provided.

5.3. Analysis

Qualitative data from the Social Worker Interview was incorporated into the qualitative analysis of hospital operations, particular in terms of patient development for discharge, and socially transformative services. Social worker interview ratings were used to compare the social worker programme across hospitals.

5.4. Results

Table A1.6-5: Social Worker Interview Ratings

	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW
Discharge Preparation	Strong	Very Weak	na	na	Very Weak	Weak
Chronic Patient Involvement	Moderate	Weak	na	na	Very Weak	Moderate
Community Co-ordination / Linkages	Weak	Moderate	na	na	Moderate	Moderate
SW within Multidisciplinary Team	Weak	.38	na	na	Very Weak	Strong
Relationship to Ward Programme	Moderate	Very Weak	na	na	Very Weak	Moderate
Awareness of S/W Objectives	Moderate	Weak	na	na	Weak	Moderate
Awareness of role of S/W in Chronic Patient Rehabilitation	Strong	Strong	na	na	Moderate	Strong
Discharge Planning	Strong	Very Weak	na	na	Very Weak	Moderate
Social Worker Family Contact	Strong	Weak	na	na	Weak	Moderate

0=Very weak; 1=weak; 2=moderate; 3=strong; 4=very strong.

NB: PRI3 and PUB1 did not have social workers.

6. Psychiatrist Interview

6.1. Summary

This detailed interview is designed to explore the psychiatric treatment services, and the perceptions of the psychiatrist on hospital operations more broadly. The interview protocol contained semi-structured and structured questions. A complete copy of the interview protocol can be found in Addendum 2: Quality of Care Tools.

6.2. Method

The primary psychiatrist was interviewed. This either included the head of the psychiatry department or the psychiatrist who spent most time at the hospital. Note that a psychiatrist interview was not possible in two of the hospitals. In these hospitals one psychiatrist visits every fortnight, and was not available at the time of the visit.

The interview took approximately one and a half hours to complete. Immediately after the interview, the researcher rated the psychiatrist interview according to a rating scale provided.

6.3. Analysis

Qualitative data from the psychiatrist interview was incorporated into the qualitative analysis of hospital operations, particular in terms of health treatment services. Psychiatrist interview ratings were used to compare the psychiatric services across hospitals.

6.4. Results

Table A1.6-6: Psychiatrist Interview Ratings

	PRI1	PRI2	PRI3	PUB1	PUB2	PUBHW
Psychiatrist : Patient Ratio Rating	Very Weak		na	na	Very Weak	Moderate
Assessment of Newly Admitted Patients	Strong		na	na	Moderate	Moderate
Chronic Patient Care: Regularity of Patient Visits	Moderate		na	na	Very Strong	Moderate
Diagnoses Review	Strong		na	na	Strong	Moderate
Frequency of Medication Review	Strong		na	na	Strong	Moderate
Role of Multidisciplinary Team	Weak		na	na	Very Weak	Moderate
Attitude / Approach Toward Patient Discharge	Weak		na	na	Very Strong	Moderate
Appropriate Standards for Use of Medications	na		na	na	Very Strong	Strong
View Toward Balance Between Medications and Other Therapeutic Care	Moderate		na	na	Weak	Moderate

Very weak; 1=weak; 2=moderate; 3=strong; 4=very strong.

NB: PRI3 and PUB1 did not have dedicated psychiatric services. One psychiatrist, servicing chronic institutions across the province, serviced these institutions. This psychiatrist was not available at the time of the site visits.

7. Medical Officer Interview

7.1. Summary

This detailed interview is designed to explore the medical treatment services, and the perceptions of the medical officer on hospital operations more broadly. The interview protocol contained semi-structured and structured questions. A complete copy of the interview protocol can be found in Addendum 2: Quality of Care Tools.

7.2. Method

The medical officer spending most time in the chronic psychiatric wards was interviewed. Note that a medical officer interview was not possible in one public hospital as there was no dedicated or consistent medical officer providing care at this hospital³.

The interview took approximately one and a half hours to complete. Immediately after the interview, the researcher rated the medical officer interview according to a rating scale provided.

7.3. Analysis

Qualitative data from the medical officer interview was incorporated into the qualitative analysis of hospital operations, particular in terms of health treatment services. Medical officer interview ratings were used to compare the medical treatment services across hospitals.

7.4. Results

Table A1.6-7: Medical Officer Interview Ratings

Question	PRI-1	PRI2	PRI3	PUB1	PUB2	PUBHW
MO : Patient Ratio Rating	Very Weak	Very Weak	Very Weak	na	Very Weak	Very Strong
Dentist : Patient Ratio Rating	na	Moderate	Very Weak	na	Weak	Very Strong
Medical Needs of Newly Admitted Patients	Very Weak	Moderate	Very Weak	na	Strong	Very Strong
Medical Needs of Unstable Physically Ill Patients	Weak	Moderate	Weak	na	Strong	Strong
Chronic Patient Care: Regularity of contacts	Very Weak	Weak	Very Weak	na	Very Weak	na
Physical Screening	Strong	Weak	Very Weak	na	Very Weak	na
STD Management	Very Weak	Weak	Weak	na	Very Weak	Weak
TB Management	na	Weak	Strong	na	Very Strong	Moderate
Infectious Disease Control	na	Very Strong	Weak	na	Very Weak	Moderate
Referral Procedures	Weak	Moderate	Moderate	na	Moderate	Moderate
Awareness / Understanding of Medical Needs of Chronic Psychiatric Patients	Strong	Moderate	Moderate	na	Weak	Strong
Nutritional Counselling	No	No	No	No	No	No

Very weak; 1=weak; 2=moderate; 3=strong; 4=very strong.

NB: There are not dedicated or consistent medical officer services at PUB1. There was not a medical officer available for interview at the time of the visit.

Na = not answered

³ A medical officer from the local hospital is supposed to come once every fortnight. This is reportedly not happening consistently. Patients go to the local hospital for urgent care requirements.

Addendum 2
Quality of Care Tools

Institution:

Date:

Medications Review Protocol

Ward

Record Number

Date of Admission

(last date of admissions)

Gender (M/F)

Date of Birth

Race (B/C/I/W)

Physiologic: Take last recorded measurements. Indicate the date of measurement under each box.

Weight

Blood Pressure

(Date)

(Date)

Diagnoses

NB: current diagnoses

1)

2)

3)

Medication	Dosage (e.g. in mg's etc.)	Frequency (e.g. BD, TDS, nocte)	Route (PO, IMI, PRN)
1)			
2)			
3)			
4)			
5)			

Date of Last Entry
(from doctors notes)Is File Organised / Readable?
(circle (Y)es or (N)o)

Y / N

Observer Evaluation

Cover Sheet

Date:

Institution:

Ward

Name of Observer:

Please take a few minutes after the observation to write notes, reflections, and impressions from ward.

Notes:

Section I: Rating of Overall Site

1. How attractive are the site grounds?

- | | | |
|----------------------------|------------------------------|---|
| ☐ 4 | Very attractive | There is landscaping or very attractive natural growth; grounds are well-maintained with no litter or weeds, and with clean and neatly trimmed paths. |
| ☐ 3 | Somewhat attractive | |
| ☐ 2 | Ordinary | Grounds are ordinary looking; there is little landscaping or some weeds or litter. |
| ☐ 1 | Somewhat unattractive | |
| ☐ 0 | Unattractive | There are no grounds or grounds show little or no maintenance -- grounds have uncut grass, weeds, or litter. |

2. How attractive are the site buildings?

- | | | |
|----------------------------|------------------------------|--|
| ☐ 4 | Very attractive | The buildings have an interesting and attractive design and excellent maintenance. |
| ☐ 3 | Somewhat attractive | |
| ☐ 2 | Ordinary | The buildings are not notable in either design or maintenance. |
| ☐ 1 | Somewhat unattractive | |
| ☐ 0 | Very unattractive | The buildings are very unattractive or deteriorated. |

Note to observer: If there are two or more parts of the facility which look dramatically different (one old building, one new building) rate each separately and include an explanation of your observation.

3. How attractive are the outdoor recreational facilities?

- | | | |
|----------------------------|------------------------------|---|
| ☐ 4 | Very attractive | There is plenty of diverse outdoor recreational facilities including an outdoor sitting area with table and chairs, a well maintained playing field and garden. |
| ☐ 3 | Somewhat attractive | |
| ☐ 2 | Ordinary | The outdoor recreational facilities are not notable in either facility content or maintenance. |
| ☐ 1 | Somewhat unattractive | |
| ☐ 0 | Very unattractive | There are no outdoor recreational facilities, or the facilities are extremely limited, and unmaintained. |

4. How attractive are the indoor recreational facilities?

- | | | |
|----------------------------|------------------------------|--|
| ☐ 4 | Very attractive | There is a great deal of indoor recreational space, with diverse facilities and special facilities such as a pool table, libraries, magazines. |
| ☐ 3 | Somewhat attractive | |
| ☐ 2 | Ordinary | There is some room for sitting, playing cards, watching tv, but the room is not noticeably pleasant or remarkable. |
| ☐ 1 | Somewhat unattractive | |
| ☐ 0 | Very unattractive | Indoor recreational facilities are non existent or extremely limited and unpleasant |

ADDITIONAL SPECIAL RECREATIONAL FACILITIES/EQUIPMENT (pool table, gym, library etc)

Section II: Rating of Environmental Characteristics

Part 1. Directions: Rate the bedroom area and the common room according to the criteria below. Enter your rating (0, 1, 2, 3, 4) in the appropriate space below.

1. NOISE LEVEL

- | | | | |
|---|--------------|-------------------------|---|
| 4 | ⁴ | Very quiet | Noticeable absence of sounds, even when area is being used by many patients |
| 3 | ³ | Quiet | Some sounds are present, but it would be easy to concentrate on reading. |
| 2 | ² | Slightly noisy | Sounds or occasional loud interruptions are present. |
| 1 | ¹ | Moderately noisy | Sounds are loud and distracting such as sustained noise from buzzers or cleaning equipment. |
| 0 | ⁰ | Very noisy | Unbearable. |

Enter your rating (0, 1, 2, 3, 4) for noise level:

Bedroom Area

Common Room /
Lounge Area

2. ODOURS

- | | | | |
|---|--------------|---------------------------------|--|
| 4 | ⁴ | Fresh | Air has plenty of fresh odour, such as might be found outdoors, building is well ventilated. |
| 3 | ³ | No odours | Nothing is noticeably displeasing or objectionable about the air; it is 'normal'. |
| 2 | ² | Slightly objectionable | Air is slightly tainted with subtle odours; it seems stale, close, musty, or medicinal. |
| 1 | ¹ | Moderately objectionable | Unpleasant odours are apparent; building is poorly ventilated, if at all |
| 0 | ⁰ | Very objectionable | Unbearable. |

Enter your rating (0, 1, 2, 3, 4) for odours:

Bedroom Area

Common Room /
Lounge Area

3. LIGHTING

- | | | | |
|---|--------------|--------------------------|--|
| 4 | ⁴ | Very good lighting | Brightly illuminated but without glare; reading would be easy in all areas. |
| 3 | ³ | Good lighting | Lighting is basically good, but is low, uneven, or glaring in some areas; reading would be easy in most areas. |
| 2 | ² | Barely adequate lighting | Lighting is low, uneven, or glaring; reading would be difficult or be possible only in some areas. |
| 1 | ¹ | Inadequate lighting | Lighting is very poor or glaring in most areas; reading would be difficult or impossible. |
| 0 | ⁰ | Dark | Essentially dark. Impossible to read. |

Enter your rating (0, 1, 2, 3, 4) for lighting:

Bedroom Area

Common Room /
Lounge Area

4. CLEANLINESS OF WALLS AND FLOORS (OR CARPETS)

- | | | | |
|---|--------------|------------------|--|
| 4 | ⁴ | Very clean | Walls and floors are very clean or immaculate; floors are polished. |
| 3 | ³ | Clean | |
| 2 | ² | Slightly dirty | Some walls or floors need cleaning; dust, litter, smudges / fingerprints and/or stains are noticeable. |
| 1 | ¹ | Moderately dirty | |
| 0 | ⁰ | Very dirty | Very dirty, unbearable, unsanitary. |

Enter your rating (0, 1, 2, 3, 4) for cleanliness or walls and floors:

Bedroom Area

Common Room /
Lounge Area

5. CONDITION OF WALLS AND FLOORS (OR CARPETS)

- | | | | |
|---|--------------|---------------------------------|--|
| 4 | ⁴ | Very good / excellent condition | Walls and floors look new or appear to be recently installed or painted |
| 3 | ³ | Good condition | |
| 2 | ² | Fair condition | Walls or floors show wear but only in heavily used areas. |
| 1 | ¹ | Poor condition | |
| 0 | ⁰ | Very poor condition | Walls or floors show a great deal of wear / bare patches. Definitely should be replaced. |

Enter your rating (0, 1, 2, 3, 4) for condition of walls and floors:

Bedroom Area

Common Room /
Lounge Area

6. CONDITION OF FURNITURE

- | | | | |
|---|--------------|---------------------------------|---|
| 4 | ⁴ | Very good / excellent condition | Furniture is like new -- well kept, spotless, highly polished, and without stains |
| 3 | ³ | Good condition | |
| 2 | ² | Fair condition | Furniture is older but still structurally sound and moderately clean. |
| 1 | ¹ | Poor condition | |
| 0 | ⁰ | Very poor condition | Furniture is old and in very poor repair or broken. Should be urgently replaced. |

Enter your rating (0, 1, 2, 3, 4) for condition of furniture:

Bedroom Area

Common Room /
Lounge Area

7. WINDOW AREAS

- | | | | |
|---|--------------|------------------|--|
| 4 | ⁴ | Ample windows | Area has many or large windows that give an open feeling. |
| 3 | ³ | Adequate windows | Windows are sufficient to allow good light; no closed in feeling |
| 2 | ² | Few windows | Area light only on sunny days. |
| 1 | ¹ | Very few windows | Area tends to be dark even on sunny days; closed in feeling. |
| 0 | ⁰ | No windows | No windows or the windows are non-functional. |

Enter your rating (0, 1, 2, 3, 4) for window areas:

Bedroom Area

Common Room /
Lounge Area

8. VIEW FROM WINDOWS -- ATTRACTIVENESS

- | | | | |
|---|--------------|-----------------------|---|
| 4 | ⁴ | Very attractive | View is of a very pleasant and attractive setting such as a park, well kept facility grounds with trees, grass, open space. |
| 3 | ³ | Somewhat attractive | |
| 2 | ² | Ordinary | View is not noticeably attractive or unattractive; windows look out onto an ordinary street or lawn or other ward building. |
| 1 | ¹ | Somewhat unattractive | |
| 0 | ⁰ | Unattractive | No view. No windows, or windows look directly onto another building wall, or some other unpleasant scene. |

Enter your rating (0, 1, 2, 3, 4) for view from windows:

Bedroom Area

Common Room /
Lounge Area

Section II: Rating of Environmental Characteristics

9. CLEANLINESS OF TOILET FACILITIES

- | | | | |
|---|--------------|---|--|
| 4 | ⁴ | Very clean: Toilets are recently cleaned. | Toilets have been recently cleaned and are sparkling. Immaculate -- no grime in the corners etc. |
| 3 | ³ | Clean | |
| 2 | ² | Moderate | Toilets are clean and relatively hygienic, but there is some grime in the corners etc. reflecting long term use. |
| 1 | | Dirty | |
| 0 | ⁰ | Very dirty / unhygienic | Unhygienic. |

Part 2: Patient Bedrooms. Directions: Check the appropriate box.

10. VARIATION IN DESIGN OF PATIENTS' ROOMS

- | | | | |
|--------------------------|--------------|------------------------|---|
| ☐ | ⁴ | Total variation | All patient rooms are totally different in terms of size, shape, decor. |
| ☐ | ³ | Considerable variation | |
| ☐ | ² | Moderate variation | Rooms are distinct, but the same general decor appears throughout. |
| ☐ | ¹ | Little variation | |
| ☐ | ⁰ | No variation | Rooms are essentially identical. |

11. PERSONALISATION OF PATIENTS' ROOMS

- | | | | |
|--------------------------|--------------|------------------------------|--|
| ☐ | ⁴ | Total personalisation | All patient bedrooms are totally personalised, giving the impression of a 'bedroom at home'. |
| ☐ | ³ | Considerable personalisation | |
| ☐ | ² | Moderate personalisation | Many patients have added some personal objects such as rugs, picture, decorations |
| ☐ | ¹ | Little personalisation | |
| ☐ | ⁰ | No personalisation | No personalisation. Rooms are either identical, or only have institutional decor. |

Section II: Rating of Environmental Characteristics

Part 3: Rating the Facility as a Whole. Directions: Check the appropriate box.

12. DISTINCTIVENESS OF ALL LIVING SPACES

☐	⁴	Total distinctiveness	All patient rooms are distinct giving impression of personalised bedrooms at a home.
☐	³	Considerable distinctiveness	An effort has been made to vary the decor from room to room.
☐	²	Moderate distinctiveness	Furnishings vary from room to room but the overall room design is the same; walls and floor coverings show little variation.
☐	¹	Little distinctiveness	Very little variation, even in furnishings; ward is somewhat institutional although some areas such as the lounge or lobby are distinct.
☐	⁰	No distinctiveness	Ward has a very institutional appearance; areas are totally similar.

13. OVERALL ATTRACTIVENESS OF THE FACILITY

☐	⁴	Very attractive	Overall effect is favourable; there is a sense of comfort, newness.
☐	³	Attractive	
☐	²	Ordinary	Neither positive nor negative features stand out.
☐	¹	Unattractive	
☐	⁰	Very unattractive	Nightmare.

Section III: Rating of Patients

Directions: Check the appropriate box.

1. PERSONAL GROOMING (Rate only those patients in the general living areas.)

- | | | |
|----------------------------|---------------------|---|
| ☐ 4 | Very well groomed | Patients appear well washed and their hair looks neatly combed; men are clean shaven or have trimmed beards or mustaches. |
| ☐ 3 | Well groomed | |
| ☐ 2 | Some well groomed | Some patients are reasonably clean but others are not; overall, patients' appearance is barely presentable. |
| ☐ 1 | Poorly groomed | |
| ☐ 0 | Very poorly groomed | Patients are very poorly groomed. Not presentable. Patients appear as if they have not been well groomed for some time. |

2. CLEANLINESS OF CLOTHING (Rate only those patients in the general living areas.)

- | | | |
|----------------------------|---------------------|---|
| ☐ 4 | Very neat and clean | Patients' clothes are freshly laundered and ironed. |
| ☐ 3 | Neat and clean | |
| ☐ 2 | Slightly soiled | Patients' clothes are somewhat wrinkled and/or dirty but still appear satisfactory. |
| ☐ 1 | Soiled | |
| ☐ 0 | Severely soiled | Patients clothes are severely wrinkled, and / or dirty. |

3. CONDITION OF CLOTHING (Rate only those patients in the general living areas.)

- | | | |
|----------------------------|---------------------|---|
| ☐ 4 | Very good condition | Patients' clothes are in new or very good condition. |
| ☐ 3 | Good condition | |
| ☐ 2 | Average | Patients' clothes are somewhat worn or patched but still appear satisfactory. |
| ☐ 1 | Worn | |
| ☐ 0 | Severely worn | Patients clothes are severely worn, torn. |

4. INTERACTION OF PATIENTS

- | | | |
|----------------------------|--------------------------|--|
| ☐ 4 | Considerable interaction | The majority of the patients are seen interacting. |
| ☐ 3 | Moderate interaction | |
| ☐ 2 | Some interaction | Some patients are seen interacting but many are alone. |
| ☐ 1 | Very little interaction | |
| ☐ 0 | No interaction | No interaction between patients. |

5. BRIEF VERBAL EXCHANGES

☐	4	Very frequent	Patients generally greet each other or exchange a few words when they meet or sit next to each other.
☐	3	Frequent	Patients sometimes greet each other and sometimes do not.
☐	2	Somewhat infrequent	Some patients greet each other but many seem to keep to themselves.
☐	1	Very infrequent	Most patients seem withdrawn and unaware of each other.
☐	0	None	No verbal exchanges.

6. QUALITY OF INTERACTIONS AND BRIEF VERBAL EXCHANGES

☐	4	Very friendly	Patients interact with each other in a warm, friendly, and caring manner that suggests they know each other personally.
☐	3	Friendly	Patients interact in a friendly way and are comfortable with one another; they appear to know each other fairly well.
☐	2	Somewhat impersonal	Patients are polite to each other but are not noticeably warm and friendly; they do not seem to know very much about each other.
☐	1	Mildly conflictual	Patients are abrupt, uneasy, or tense around each other.
☐	0	Very conflictual / Hostile	Patients are very conflictual or hostile with each other.

7. GENERAL AMOUNT OF CONSTRUCTIVE ACTIVITY

☐	4	Very high	Most patients are involved in constructive activities most of the time by reading, playing cards, visiting, and so on.
☐	3	High	
☐	2	Somewhat low	Some patients seem to be involved in constructive activity but many are inactive.
☐	1	Moderately low	
☐	0	Very low	Very few or no patients are involved in constructive activity. Patients are sitting or lying around.

8. LEVEL OF ENERGY

☐	4	Very high	Patients seem to have a lot of energy; they move around quickly and are animated when they talk.
☐	3	High	Most patients seem reasonably lively.
☐	2	Somewhat low	Some patients tend to talk or walk away slowly, as though extra effort is needed.
☐	1	Very low	
☐	0	None	Patients do not have any energy. They do not seem to have the necessary energy to talk or move; they have weak voices and walk at a slow pace.

Section III: Rating of Staff

Directions: Check the appropriate box.

1. QUALITY OF INTERACTION WITH PATIENTS

- | | | |
|---------------------------------------|--------------------------------|--|
| ☐ ⁴ | Very individualised | Staff seem to know patients very well; they make a special effort to get to know patients well and care for patients in personal ways. |
| ☐ ³ | Individualised | |
| ☐ ² | Somewhat individualised | Staff do not seem to know the patients very well, but attention is given in a caring manner. |
| ☐ ¹ | Somewhat impersonal | |
| ☐ ⁰ | Very impersonal | Staff do not seem to know patients individually, and contact is formal, abrupt, condescending, and sometimes hostile. |

2. ORGANISATION

- | | | |
|---------------------------------------|------------------------------|--|
| ☐ ⁴ | Very well organised | The staff organise the ward very well; staff members meet all basic needs as well as co-ordinate a well organised ward programme. |
| ☐ ³ | Well organised | |
| ☐ ² | Organised | Staff organise the ward in such a manner that all patient's basic needs are met, but only involve themselves in organising limited activities between patients |
| ☐ ¹ | Slightly disorganised | |
| ☐ ⁰ | Very disorganised | Staff are clearly disorganised. Patients basic needs are sometimes not met as a consequence of staff disorganisation. |

3. QUALITY OF INTERACTION WITH OTHER STAFF

- | | | |
|---------------------------------------|--|--|
| ☐ ⁴ | Very personal interaction | Staff seem to know each other very well and to be friends as well as co-workers |
| ☐ ³ | Personal interaction | Staff interact with each other in a warm, personal manner. |
| ☐ ² | Warm professional interaction | Much of the staff's contact with one another occurs as part of their duties, but contact is personalised and informal. |
| ☐ ¹ | Formal professional interaction | Most of the staff's contact with each other occurs as part of their duties and is formal. Sense of some underlying bad feelings among staff. |
| ☐ ⁰ | Antagonistic / conflictual | Clear antagonism / bad feelings between staff. |

4. ENTHUSIASM

☐ 4	Very high	Staff members seem to be very dedicated to their work and proud of their patients' and ward's accomplishments.
☐ 3	High	Staff members seem to be enthusiastic about and enjoy their work.
☐ 2	Moderate	On the whole, staff members seem happy with their jobs.
☐ 1	Slightly low	Some staff members seem pleased to be at work, but others are slow or reluctant to complete their tasks.
☐ 0	Very low	Clear sense of low satisfaction and enthusiasm among the majority of the staff

5. QUANTITY OF STAFFING

☐ 4	More than enough	The ward is very well staffed, with seemingly too many staff available.
☐ 3	Plentiful	The ward is very well staffed with enough staff members available to meet patients physical and emotional needs.
☐ 2	Adequate	Staffing seems just barely sufficient for the ward to run smoothly. Physical needs may be met but many emotional needs are probably not met.
☐ 1	Somewhat inadequate	There do not seem to be enough staff members to manage the ward. Some physical and emotional needs of patients are not met.
☐ 0	Very inadequate	There is a clear shortage of staff; staff members seem over worked – both physical and emotional needs of patients are compromised.

6. COMFORT / RELAXATION OF STAFF MEMBERS

☐ 4	Very high	Staff members seem to have plenty of time to get their work done, and often have time to stop and relax; they work at a very low stress levels.
☐ 3	High	
☐ 2	Moderate	Staff members seem to be under some pressure to finish all their work on time and keep up with ward schedules; sometimes work pile sup, but they usually catch up.
☐ 1	Low	
☐ 0	Very low	Staff members are under an extreme amount of time pressure. They are unable to keep up with ward schedules and work piles up.

Section IV: Ward Programme Rating

1. WARD PROGRAMME

- | | | |
|--------------------------|--------------------------------|---|
| ☐ | ⁴ Strong | Highly organised ward programme involving the majority of the patients during most of the daytime hours, with diverse activities (e.g. outings, recreational, vocational, educational.) |
| ☐ | ³ Somewhat strong | |
| ☐ | ² Somewhat weak | Ward programme that involves some patients for some part of each day |
| ☐ | ¹ Weak | |
| ☐ | ⁰ No ward programme | No organised ward programme. |

Section V: Summary Rating

Directions: Check the appropriate box.

1. OVERALL ACCEPTABILITY OF THE HOSPITAL

- | | | |
|--------------------------|------------------------------------|--|
| ☐ | ⁴ Very acceptable | I would feel good about placing a person here. |
| ☐ | ³ Acceptable | |
| ☐ | ² Ordinary | I would not feel particularly good nor particularly bad about placing a person here. |
| ☐ | ¹ Slightly unacceptable | |
| ☐ | ⁰ Unacceptable | Nightmare |

Nursing Staff Questionnaire

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Of course, the input of nurses is very important to this study. We ask that you please complete the following questionnaire about this hospital. It should take less than 30 minutes to complete.

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Please return this questionnaire to the sealed box in your ward marked, 'CHP QUESTIONNAIRE'.

If you wish to contact us at a later date with any questions you may have, you may contact us at the Centre for Health Policy as follows:

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Khosi Sibeko	(011) 489 - 9947
Kim Porteus	(011) 489 - 9953
Liz Dartnall	(011) 489 - 9938
Fran Clews	(011) 489 - 9955

Thank you very much for your co-operation!

Institution:		Ward:	
Date:			

Position:		Length of Employment at Hospital	
e.g. Senior Sister, Sister, Senior Staff Nurse, Staff Nurse, Senior Assistant Nurse, Assistant Nurse etc.		Length of Time Working in Ward	

Instructions: Read each statement listed below carefully. For each statement, decide whether the statement is true or false, and tick the appropriate box.

	True	False	
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		1 Patients do not talk much about what they will be doing after they leave the hospital.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		2 Families of patients regularly visit patients at this hospital.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		3 Patients are allowed to wear jewellery, make-up, and other adornments.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		4 Very few patients offer to help out in this ward.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		5 Patients often take charge of activities.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		6 If patients break a rule, they know what the consequences will be.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		7 Patients diagnoses are formally reviewed by a psychiatrist at least once a year.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		8 Sometimes nurses cannot communicate with a patient because there is no nurse who can speak the patient's language.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		9 I do not really enjoy spending time with patients.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		10 My work is supervised very closely.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		11 A lot of patients just seem to be passing time here.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		12 There is not enough time to work with other staff -- we tend to do tasks on our own.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		13 Patients activities are carefully planned.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		14 I can reliably find the information I need about a patient from patient files.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>		15 The skills patients learn in this hospital will not be very useful in finding a job outside the hospital in the future.

True	False	
☐	☐	16 Patients can walk in the hospital grounds whenever they want during the day.
☐	☐	17 In general, I look forward to work when I get up in the morning.
☐	☐	18 Patients can speak with nursing staff when they need to.
☐	☐	19 Many patients do not understand why they are here.
☐	☐	20 This hospital actively involves families in planning for patient discharge -- that is, staff regularly discuss patient progress and what is required for discharge with the families of patients.
☐	☐	21 Patients are allowed to make intimate friendships (including healthy sexual relationships) here.
☐	☐	22 Patients are expected to take leadership here (for example, organise activities etc.)
☐	☐	23 Some patients cannot speak directly to a psychiatrist in the language of their choice (a language they can speak fluently).
☐	☐	24 Staff have little time to talk with patients or spend extra time with patients beyond the daily required tasks of bathing, feeding, cleaning, etc.
☐	☐	25 This place usually looks a bit messy.
☐	☐	26 I feel I have the skills to do my job well.
☐	☐	27 I think the Superintendent of this institution does a good job at keeping the hospital organised and well run.
☐	☐	28 This hospital actively attempts to find out about existing community structures and support for patients (i.e. health, welfare, social, NGO organisations) in order to increase the number of patients who can be discharged.
☐	☐	29 The patient files are disorganised and it is often difficult to find the information I need about a patient.
☐	☐	30 This hospital prepares patients to live outside in the community.
☐	☐	31 This hospital usually does not have regular contact with the families of patients after discharge.
☐	☐	32 Patients can change their clothes when they want to.
☐	☐	33 Patients are allowed to go on weekend leave.
☐	☐	34 Patients are not very active -- they spend most of their day watching TV or sitting around.
☐	☐	35 Patients tend to lose their sense of responsibility when they are here.

True	False	
☐	☐	36 Patients in this ward are taught skills that will assist them in finding a job in the future (for example, how to make a job application, how to prepare for a job interview etc.)
☐	☐	37 Most patients do not understand what is required of them in order for them to leave the hospital.
☐	☐	38 Staff spend the time after meals and medications talking to one another -- this is not the time to be with patients.
☐	☐	39 The nursing staff often serve as interpreters for medical practitioners and other clinical staff.
☐	☐	40 I enjoy working with patients here.
☐	☐	41 Things are sometimes disorganised around here.
☐	☐	42 Staff are rotated through different areas to prevent 'burn-out'.
☐	☐	43 There is an organised and regular process to plan the discharge of patients whereby patients and staff discuss what the patient needs in order to leave the hospital.
☐	☐	44 Many chronic patients at this hospital could be discharged but their families don't want them at home.
☐	☐	45 Patients are never allowed to listen to the music of their choice.
☐	☐	46 There is not much interaction between patients in this ward.
☐	☐	47 All patients can speak to a social worker in a language of their choice (a language they can speak fluently.)
☐	☐	48 The majority of patients do not understand their diagnoses.
☐	☐	49 Patients are reviewed for discharge at least once a year.
☐	☐	50 There are no patient leadership structures in this hospital.
☐	☐	51 I know the names all of the patients in my ward.
☐	☐	52 The community area (day care area) is often untidy.
☐	☐	53 If I was offered a job (same responsibilities, salary, etc.) at a different mental health institution, I would take the job because I am not totally happy with the working environment here.
☐	☐	54 When I began the job there was an organised programme to orient me to my new job.
☐	☐	55 I understand the patient record keeping system.

True False

--	--

56 This hospital is not successful at preparing patients for discharge.

--	--

57 Patients are not allowed to have the hairstyle of their choice.

--	--

58 Plans are made for patient accommodation before a patient is discharged.

--	--

59 Discussions between patients are active and lively.

--	--

60 The cleaning staff often serve as interpreters for clinical staff.

--	--

61 When a patient passes away, they are buried (or cremated) according to their family wishes.

--	--

62 There is a good programme of inservice training to support and develop staff.

--	--

63 I think the Matrons of this institution do a good job at keeping the hospital organised and well run.

--	--

64 Patients are taught skills designed to help them live effectively within their family or in the community in the future (e.g. cooking, cleaning, budgeting, how to resolve conflicts etc.)

--	--

65 The patients are proud of this hospital.

--	--

66 There is not an organised programme to plan for patient discharge -- patients and staff rarely sit down and discuss what is required for a patient to leave this hospital.

--	--

67 I feel supported by other staff when there are problems I cannot handle.

--	--

68 Doctors who are new to this ward find it difficult to understand the patient records at first.

--	--

69 Some patients look untidy or messy.

--	--

70 I regularly discuss the problems and suggestions I have with my supervisor.

--	--

71 Patients can use a language of their choice (a language they can speak fluently) to communicate with nursing staff.

--	--

72 The staff eagerly help new patients get to know one another in this ward.

--	--

73 This hospital prepares patients for discharge.

--	--

74 On the whole, I feel satisfied with my job.

--	--

75 This hospital makes sure that patients develop basic life skills such as bathing, dressing, and eating.

True	False	
☐	☐	76 Patients can decide what they wear each day.
☐	☐	77 I like patients and enjoy the social time with them.
☐	☐	78 Patients here follow a regular schedule every day.
☐	☐	79 The Superintendent of this institution is not involved with the staff.
☐	☐	80 This hospital does not prepare many patients for employment.
☐	☐	81 Patients are not provided with condoms
☐	☐	82 Some patients cannot speak directly with an occupational therapist in a language of their choice (a language they can speak fluently.)
☐	☐	83 Patients are rarely kept waiting when they have appointments with staff.
☐	☐	84 I feel supported in my work here.
☐	☐	85 This hospital makes sure that patients have social support before being discharged.
☐	☐	86 Patients can use a phone to call family or friends.
☐	☐	87 Patients take responsibility in this ward.
☐	☐	88 Patients know what medications they are on.
☐	☐	89 All patients are involved in an occupational therapy programme (either at the occupational therapy facility or in the ward) at least once a week.
☐	☐	90 Patients complain too much and do not appreciate all the staff does for them.
☐	☐	91 The staff work well together -- there is team spirit and a willingness to help each other out.
☐	☐	92 Families are kept regularly informed of patient progress.
☐	☐	93 There is not much group spirit among patients in this ward.
☐	☐	94 When a patient leaves the hospital I usually do not hear about the patient again unless he or she is readmitted.
☐	☐	95 Most of the patients who take medications know why they are taking medication.
☐	☐	96 The staff make sure this place is always neat.
☐	☐	97 Some patients do not see a psychiatrist for over a year.

True False

- | True | False | |
|--------------------------|--------------------------|--|
| ☐ | ☐ | 98 Most patients never know when they will be considered ready to leave the hospital. |
| ☐ | ☐ | 99 Most families of patients would like the patients to be discharged and to go home. |
| ☐ | ☐ | 100 Patients are free to follow their own religious beliefs. That is, all patients are not expected to follow the same religion. |
| ☐ | ☐ | 101 Patients willingly participate in activities organised by the staff. |
| ☐ | ☐ | 102 Very few patients have responsibility here. |
| ☐ | ☐ | 103 The majority of patient families understand the patient diagnoses and prognoses. |
| ☐ | ☐ | 104 Patients are seen by a medical practitioner at least once a month. |
| ☐ | ☐ | 105 There is a formal and organised process of discharge planning in this ward whereby patients, family, and staff participate in regular discussions about the timing and requirements for discharge. |
| ☐ | ☐ | 106 Patients are taken on regular outings / excursions (e.g. shopping, movies etc.) |
| ☐ | ☐ | 107 Often patients do not see a social worker for over three months. |
| ☐ | ☐ | 108 There is a fully trained and qualified translator readily available for any clinical staff who cannot speak the language of a patient. |
| ☐ | ☐ | 109 If I was offered a job at the same salary in another field of work I would take it because I do not like the working with patients with mental illness. |
| ☐ | ☐ | 110 This hospital maintains regular contact with patients for the first six months after discharge. |
| ☐ | ☐ | 111 Patients can use their personal income as they want to. |
| ☐ | ☐ | 112 Patients are busy most of the time. |
| ☐ | ☐ | 113 All patients can speak directly to medical officers in a language of their choice (in a language they can speak fluently). |
| ☐ | ☐ | 114 This is a very well organised hospital. |
| ☐ | ☐ | 115 Different religions are respected at this hospital (for example, Muslim and Jewish patients can see their respective religious leaders; traditions of various religious days are respected (fasting, other rituals.) |
| ☐ | ☐ | 116 This ward has very few social activities. |
| ☐ | ☐ | 117 Most patients who take medications do not understand the side effects of their medications. |
| ☐ | ☐ | 118 My supervisor is skilled and knowledgeable, and is able to provide valuable input into my job. |
| ☐ | ☐ | 119 Patients are allowed to go on authorised leave of absence. |

Comments: The input of the nursing staff in the wards is very important to us -- please write any additional information you think would be useful to understand life at this ward or work at this hospital. These comments will be strictly confidential!!

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Liz Dartnall	(011) 489 - 9938
Fran Clews	(011) 489 - 9955

Thank you very much for your co-operation!

Institution:		Ward:	
Date:			

Position:		Length of Employment at Hospital	
e.g. Senior Sister, Sister, Senior Staff Nurse, Staff Nurse, Senior Assistant Nurse, Assistant Nurse etc.		Length of Time Working in Ward	

Instructions: Read each statement listed below carefully. For each statement, decide whether the statement is true or false, and tick the appropriate box.

True	False	
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	1 Patients do not talk much about what they will be doing after they leave the hospital.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	2 Families of patients regularly visit patients at this hospital.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	3 Patients are allowed to wear jewellery, make-up, and other adornments.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	4 Very few patients offer to help out in this ward.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	5 Patients often take charge of activities.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	6 If patients break a rule, they know what the consequences will be.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	7 Patients diagnoses are formally reviewed by a psychiatrist at least once a year.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	8 Sometimes nurses cannot communicate with a patient because there is no nurse who can speak the patient's language.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	9 I do not really enjoy spending time with patients.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	10 My work is supervised very closely.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	11 A lot of patients just seem to be passing time here.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	12 There is not enough time to work with other staff -- we tend to do tasks on our own.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	13 Patients activities are carefully planned.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	14 I can reliably find the information I need about a patient from patient files.
<input style="width: 40px; height: 25px;" type="checkbox"/>	<input style="width: 40px; height: 25px;" type="checkbox"/>	15 The skills patients learn in this hospital will not be very useful in finding a job outside the hospital in the future.

True	False	
☐	☐	16 Patients can walk in the hospital grounds whenever they want during the day.
☐	☐	17 In general, I look forward to work when I get up in the morning.
☐	☐	18 Patients can speak with nursing staff when they need to.
☐	☐	19 Many patients do not understand why they are here.
☐	☐	20 This hospital actively involves families in planning for patient discharge -- that is, staff regularly discuss patient progress and what is required for discharge with the families of patients.
☐	☐	21 Patients are allowed to make intimate friendships (including healthy sexual relationships) here.
☐	☐	22 Patients are expected to take leadership here (for example, organise activities etc.)
☐	☐	23 Some patients cannot speak directly to a psychiatrist in the language of their choice (a language they can speak fluently).
☐	☐	24 Staff have little time to talk with patients or spend extra time with patients beyond the daily required tasks of bathing, feeding, cleaning, etc.
☐	☐	25 This place usually looks a bit messy.
☐	☐	26 I feel I have the skills to do my job well.
☐	☐	27 I think the Hospital Manager of this institution does a good job at keeping the hospital organised and well run.
☐	☐	28 This hospital actively attempts to find out about existing community structures and support for patients (i.e. health, welfare, social, NGO organisations) in order to increase the number of patients who can be discharged.
☐	☐	29 The patient files are disorganised and it is often difficult to find the information I need about a patient.
☐	☐	30 This hospital prepares patients to live outside in the community.
☐	☐	31 This hospital usually does not have regular contact with the families of patients after discharge.
☐	☐	32 Patients can change their clothes when they want to.
☐	☐	33 Patients are allowed to go on weekend leave.
☐	☐	34 Patients are not very active -- they spend most of their day watching TV or sitting around.
☐	☐	35 Patients tend to lose their sense of responsibility when they are here.

True	False	
☐	☐	36 Patients in this ward are taught skills that will assist them in finding a job in the future (for example, how to make a job application, how to prepare for a job interview etc.)
☐	☐	37 Most patients do not understand what is required of them in order for them to leave the hospital.
☐	☐	38 Staff spend the time after meals and medications talking to one another -- this is not the time to be with patients.
☐	☐	39 The nursing staff often serve as interpreters for medical practitioners and other clinical staff.
☐	☐	40 I enjoy working with patients here.
☐	☐	41 Things are sometimes disorganised around here.
☐	☐	42 Staff are rotated through different areas to prevent 'burn-out'.
☐	☐	43 There is an organised and regular process to plan the discharge of patients whereby patients and staff discuss what the patient needs in order to leave the hospital.
☐	☐	44 Many chronic patients at this hospital could be discharged but their families don't want them at home.
☐	☐	45 Patients are never allowed to listen to the music of their choice.
☐	☐	46 There is not much interaction between patients in this ward.
☐	☐	47 All patients can speak to a social worker in a language of their choice (a language they can speak fluently.)
☐	☐	48 The majority of patients do not understand their diagnoses.
☐	☐	49 Patients are reviewed for discharge at least once a year.
☐	☐	50 There are no patient leadership structures in this hospital.
☐	☐	51 I know the names all of the patients in my ward.
☐	☐	52 The community area (day care area) is often untidy.
☐	☐	53 If I was offered a job (same responsibilities, salary, etc.) at a different mental health institution, I would take the job because I am not totally happy with the working environment here.
☐	☐	54 When I began the job there was an organised programme to orient me to my new job.
☐	☐	55 I understand the patient record keeping system.

True False

- | | | |
|--------------------------|--------------------------|---|
| ☐ | ☐ | 56 This hospital is not successful at preparing patients for discharge. |
| ☐ | ☐ | 57 Patients are not allowed to have the hairstyle of their choice. |
| ☐ | ☐ | 58 Plans are made for patient accommodation before a patient is discharged. |
| ☐ | ☐ | 59 Discussions between patients are active and lively. |
| ☐ | ☐ | 60 The cleaning staff often serve as interpreters for clinical staff. |
| ☐ | ☐ | 61 When a patient passes away, they are buried (or cremated) according to their family wishes. |
| ☐ | ☐ | 62 There is a good programme of inservice training to support and develop staff. |
| ☐ | ☐ | 63 I think the Nursing Service Managers of this institution do a good job at keeping the hospital organised and well run. |
| ☐ | ☐ | 64 Patients are taught skills designed to help them live effectively within their family or in the community in the future (e.g. cooking, cleaning, budgeting, how to resolve conflicts etc.) |
| ☐ | ☐ | 65 The patients are proud of this hospital. |
| ☐ | ☐ | 66 There is not an organised programme to plan for patient discharge -- patients and staff rarely sit down and discuss what is required for a patient to leave this hospital. |
| ☐ | ☐ | 67 I feel supported by other staff when there are problems I cannot handle. |
| ☐ | ☐ | 68 Doctors who are new to this ward find it difficult to understand the patient records at first. |
| ☐ | ☐ | 69 Some patients look untidy or messy. |
| ☐ | ☐ | 70 I regularly discuss the problems and suggestions I have with my supervisor. |
| ☐ | ☐ | 71 Patients can use a language of their choice (a language they can speak fluently) to communicate with nursing staff. |
| ☐ | ☐ | 72 The staff eagerly help new patients get to know one another in this ward. |
| ☐ | ☐ | 73 This hospital prepares patients for discharge. |
| ☐ | ☐ | 74 On the whole, I feel satisfied with my job. |
| ☐ | ☐ | 75 This hospital makes sure that patients develop basic life skills such as bathing, dressing, and eating. |

True	False	
☐	☐	76 Patients can decide what they wear each day.
☐	☐	77 I like patients and enjoy the social time with them.
☐	☐	78 Patients here follow a regular schedule every day.
☐	☐	79 The Hospital Manager of this institution is not involved with the staff.
☐	☐	80 This hospital does not prepare many patients for employment.
☐	☐	81 Patients are not provided with condoms
☐	☐	82 Some patients cannot speak directly with an occupational therapist in a language of their choice (a language they can speak fluently.)
☐	☐	83 Patients are rarely kept waiting when they have appointments with staff.
☐	☐	84 I feel supported in my work here.
☐	☐	85 This hospital makes sure that patients have social support before being discharged.
☐	☐	86 Patients can use a phone to call family or friends.
☐	☐	87 Patients take responsibility in this ward.
☐	☐	88 Patients know what medications they are on.
☐	☐	89 All patients are involved in an occupational therapy programme (either at the occupational therapy facility or in the ward) at least once a week.
☐	☐	90 Patients complain too much and do not appreciate all the staff does for them.
☐	☐	91 The staff work well together -- there is team spirit and a willingness to help each other out.
☐	☐	92 Families are kept regularly informed of patient progress.
☐	☐	93 There is not much group spirit among patients in this ward.
☐	☐	94 When a patient leaves the hospital I usually do not hear about the patient again unless he or she is readmitted.
☐	☐	95 Most of the patients who take medications know why they are taking medication.
☐	☐	96 The staff make sure this place is always neat.
☐	☐	97 Some patients do not see a psychiatrist for over a year.

True	False	
☐	☐	98 Most patients never know when they will be considered ready to leave the hospital.
☐	☐	99 Most families of patients would like the patients to be discharged and to go home.
☐	☐	100 Patients are free to follow their own religious beliefs. That is, all patients are not expected to follow the same religion.
☐	☐	101 Patients willingly participate in activities organised by the staff.
☐	☐	102 Very few patients have responsibility here.
☐	☐	103 The majority of patient families understand the patient diagnoses and prognoses.
☐	☐	104 Patients are seen by a medical practitioner at least once a month.
☐	☐	105 There is a formal and organised process of discharge planning in this ward whereby patients, family, and staff participate in regular discussions about the timing and requirements for discharge.
☐	☐	106 Patients are taken on regular outings / excursions (e.g. shopping, movies etc.)
☐	☐	107 Often patients do not see a social worker for over three months.
☐	☐	108 There is a fully trained and qualified translator readily available for any clinical staff who cannot speak the language of a patient.
☐	☐	109 If I was offered a job at the same salary in another field of work I would take it because I do not like the working with patients with mental illness.
☐	☐	110 This hospital maintains regular contact with patients for the first six months after discharge.
☐	☐	111 Patients can use their personal income as they want to.
☐	☐	112 Patients are busy most of the time.
☐	☐	113 All patients can speak directly to medical officers in a language of their choice (in a language they can speak fluently).
☐	☐	114 This is a very well organised hospital.
☐	☐	115 Different religions are respected at this hospital (for example, Muslim and Jewish patients can see their respective religious leaders; traditions of various religious days are respected (fasting, other rituals.)
☐	☐	116 This ward has very few social activities.
☐	☐	117 Most patients who take medications do not understand the side effects of their medications.
☐	☐	118 My supervisor is skilled and knowledgeable, and is able to provide valuable input into my job.
☐	☐	119 Patients are allowed to go on authorised leave of absence.

Senior Sister Interview Protocol

This interview is a part of a study conducted by the Centre for Health Policy. The Centre for Health Policy is a research unit attached to the Department of Community Health, University of Witwatersrand.

We are currently studying service provision within chronic mental health institutions throughout the country.

The input of clinical staff is very important to this study. We would like to interview you about your perceptions and experiences from working at this hospital. If you agree to this interview, we would discuss with you various issues concerning your work here. It will take less than one hour.

Participation in this interview will carry no risk for you, regarding your position at work. We will maintain full anonymity and confidentiality of what you say in the interview. All of this discussion will be kept **STRICTLY CONFIDENTIAL**. The discussion will be anonymous, and no individual names will be documented (note that we do not even write your name on this form!)

The potential benefit to you is that we hope that through this study we will identify strengths and weaknesses of service provision to chronically mentally ill patients so that services to these patients may be improved in the future.

Participation in this interview is voluntary and you are free to refuse to participate, or withdraw your consent to participate, at any time. If you should feel uncomfortable with the interview at any point in time, please tell me so that we can stop the interview. Stopping the interview at any time will not affect your job in any way as we will not inform anybody at this hospital whether the interview was completed or not.

If you wish to contact us at a later date with any questions you may have, you may contact us at the Centre for Health Policy as follows:

Tonyson Lee	(011) 489 - 9954
Kim Porteus	(011) 489 - 9953
Khosi Sibeko	(011) 489 - 9947
Liz Dartnall	(011) 489 - 9938
Fran Clews	(011) 489 - 9955

Thank you very much for your co-operation!

Institution:		Ward:	
Date:		Researcher:	

Position:		Length of Employment at Hospital	
e.g. (Senior) Sister, (Senior) Staff Nurse, (Senior) Asst. Nurse, OT, Social Worker, Matron)		Length of Time Working in Ward	

A. Background Data

1. What type of ward is this? Briefly describe the character of this ward. (Probe: low / middle / high functioning? closed? male? female? mentally handicapped? chronic? acute? etc.)

2. Patient Profile. How many patients are currently in this ward? How many of these patients are chronic psychiatric patients? How many are mentally handicapped? How many are other (acute, observational etc.) (Note to interviewer: Explain our definitions of these terms carefully as stated below. Note also that the total of chronic psychiatric, mentally handicapped, and other must equal the total patients in the ward.)

Chronic Patient: A patient who has been in continuous institutional care for a year or more, either in your institution, or another institution. (Note: If your definition of 'chronic' differs from this definition, please contact us so that we can agree the best way forward.)

Acute Patient: A patient who has not been in continuous institutional care for a year. See above.

Psychiatric Patient A patient admitted with a psychiatric diagnosis (e.g. schizophrenia, depression, dementia)

Mental Handicap Patients who have a significantly sub-average general intellectual functioning existing with deficits in adaptive behaviour, with an onset before 18 years old

Total Patients in Ward		Chronic Psychiatric	
Mental Handicap		Other (acute, observational)	

3. Nursing Staff Time Allocation. If there are different categories of patients in this ward (see above) approximately how much nursing staff time is dedicated to each category of patients. (Note to interviewer: we know this question may be difficult to answer, but it is necessary for the costing study -- emphasise that we only are expecting an approximation for this question.)

Chronic Psychiatric	%	Mentally Handicapped	%
Other (acute, observational)	%		

7. Services

Notes to interviewer: The following questions are about patient development services provided at the hospital, namely ward programme, OT programme, discharge programme, and social worker programme. After discussing each service area, rate the service according to the rating scale provided.

Ward Programme:

1.1 Is there a ward programme in this ward?

Y

N

1.2 Describe a typical weekly schedule. For each activity, how many patients participate?

Day	Activities	No. Patients
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

1.3 What is your general assessment of the ward programme here?

1.4 If there is no ward programme, what does a typical patient in this ward do each day?

INTERVIEWER RATING: RATE THE WARD PROGRAMME AS FOLLOWS:

- | | | |
|----------------------------|--------------------------|---|
| ☐ 4 | Very Strong | Highly organised ward programme involving the majority of the patients during most of the daytime hours with diverse activities (e.g. outings, recreational, vocational, educational) |
| ☐ 3 | Strong | |
| ☐ 2 | Moderate | Ward programme that involves some patients for some part of each day |
| ☐ 1 | Weak | |
| ☐ 0 | Very weak or none | No organised ward programme |

2. Occupational Therapy Programme

Note to Interviewer: An occupational therapy programme can either be located in a central facility, or located within the ward programme. In order to qualify as a 'OT programme' a ward activity would have to have the input of an occupational therapist (i.e. the design / planning of activity, input, regular monitoring etc.)

- 2.1 Do patients from this ward participate in an occupational therapy programme? ☐ Y ☐ N
- 2.2 What percent of patients in this ward participate in these activities? Percent:
- 2.3 How often on average do these patient participate in OT activities? (Frequency e.g. hrs/week)
- 2.4 What is your overall assessment of the occupational therapy programme?

INTERVIEWER RATING: RATE THE OCCUPATIONAL THERAPY PROGRAMME AS FOLLOWS:

- | | | | |
|--------------------------|---|--------------------------|---|
| ☐ | 4 | Very Strong | Majority of patients Strong focus on developing skills applicable to the job market (computer, admin, maintenance). |
| ☐ | 3 | Strong | |
| ☐ | 2 | Moderate | Some patients involved in OT programme. Skills developed but not entirely relevant to outside survival skills |
| ☐ | 1 | Weak | |
| ☐ | 0 | Very weak or none | Very few or no patients involved in OT programme. No skills developed. |

Comments:

Discharge Programme

Note to Interviewer: this includes organised discharge planning, development programmes etc.

3.1 What percent of chronic patients in this ward are discharged from this hospital each year?

3.2 Are patients in this ward prepared for discharge?

3 If yes, what does this hospital do to prepare patients to leave? [If no] Why not? (Probe: not the objective?, not enough staff?, disorganisation?, someone else's job and they aren't doing it etc.)

4 What is your overall assessment of the discharge programme here?

INTERVIEWER RATING: RATE THE DISCHARGE PROGRAMME AS FOLLOWS:

- | | | |
|--------------------------------|--------------------------|--|
| <input type="text" value="4"/> | Very Strong | Patients receive comprehensive training, preparation, planning for discharge |
| <input type="text" value="3"/> | Strong | |
| <input type="text" value="2"/> | Moderate | Some patients receive some training, preparation, planning for discharge. |
| <input type="text" value="1"/> | Weak / Minimal | |
| <input type="text" value="0"/> | Very weak or none | No discharge planning or preparation |

Comments:

4. **Social Worker Programme**

4.1 Do patients from this ward see a social worker?

☐ Y

☐ N

4.2 If yes, what percent of patients in this ward see a social worker? If no, why not?

Percent:

4.3 How often on average do these patient see a social worker? (Frequency)

4.4 What is your overall assessment of the social workers at this hospital?

RATE THE SOCIAL WORKER PROGRAMME AS FOLLOWS:

4 Very Strong

Social workers regularly visit patients (at least once per month), are in regular contact with family, and actively communicate with community structures.

3 Strong

2 Moderate

Social workers visit patients infrequently (less than once every three months) but give some attention to involve family and community in patient care.

1 Weak

0 Very weak or none

No social worker programme, or patients never see social worker.

Comments:

Languages

5.1 Can patients communicate with nursing staff here in a language of their choice? (language of fluency)

5.2 Do you think some patients in this ward have trouble communicating with staff because they do not speak the same language?

Y	N
---	---

5.3 [If yes] Approximately how many?

5.4 Which patient languages are a problem for nursing staff here? What do you do when there are no nurses who can speak a patient's language?

C. Family Involvement

1. Family Involvement

1.1 What percent of patients in this ward receive visitors (family or friends) in a typical month?

Percent:

1.2 Why do you think more families don't come to visit?

RATE THE FAMILY INVOLVEMENT AS FOLLOWS:

- | | | |
|----------------------|--------------|--|
| <input type="text"/> | ³ | Over 75% of patient in the ward receive visitors(i.e. more than 3/4) |
| <input type="text"/> | ² | 50 - 74% of patients in the ward receive visitors(i.e. 1/2 to 3/4) |
| <input type="text"/> | ¹ | 25 - 49 % of patients in the ward receive visitors (i.e. 1/4 to 1/2) |
| <input type="text"/> | ⁰ | 0 to 24% of patients in the ward receive visitors (i.e. less than 1/4) |

Comments:

D. Assessment of Institution

1. Are you satisfied with the treatment of patients in this hospital?

Y

N

If not, what are the problems?

2. What are three positive aspects or strengths of this hospital? That is, three things about this hospital which are done particularly well, or aspects you feel proud about?

a)

b)

c)

3. What are the three most serious weaknesses at this hospital? That is, what are three aspects of this hospital you would most like to see improved?

a)

b)

c)

E. Assessment of Management

1. What is your assessment of the senior management at this hospital?

2. Does management support you in your work?

Y

N

How do they support you?

RATE THE STAFF PERCEPTION OF MANAGEMENT AS FOLLOWS:

4 Excellent

Excellent Staff talks positively about management without hesitation

3 Good

2 Average

Staff do not speak particularly positively or negatively about management.

1 Poor

0 Very poor

Staff speaks extremely negatively about the management of this institution.

Comments:

Job Satisfaction

1. Is this hospital a good place to work?

Y

N

2. Are you satisfied with your job?

Y

N

What do you like the most about this job? (What is the most positive aspect of this job?)

What do you like the least about this job? (What is the most negative aspect of this job?)

THE JOB SATISFACTION AS FOLLOWS:

- | | | |
|----------------------------|-------------------------|---|
| ☐ 4 | Highly satisfied | Staff talk enthusiastically about their job and the hospital. |
| ☐ 3 | Satisfied | |
| ☐ 2 | Average | Staff speak neither very positively nor very negatively about their job and the hospital. |
| ☐ 1 | Unsatisfied | |
| ☐ 0 | Very unsatisfied | Staff speak extremely negatively about the job and the hospital. They express an active interest in leaving |

Comments:

G. Seclusion / Restraints

1. How many patients in a typical month will be placed in seclusion?

No

2. For how long on average?

Time:

3. What reasons or situations may result in patients being placed in seclusion?

4. Are patients ever put in restraints?

Y

N

5. [If so] Could please describe how often? For how long? For what reasons?

How often?

For how long on average?

For what reasons?

H. Mistreatment / Abuse

i. **MISTREATMENT / ABUSE OF PATIENTS BY STAFF**

1. What is your understanding of mistreatment of patients-- that is, what things can be considered mistreatment?

RATE AS FOLLOWS:

- ☐ Severe physical abuse only (Slaps are not seen as abuse.)
- ☐ Any type of physical abuse (Verbal / emotional abuse is not considered / recognised as abuse.)
- ☐ Physical and / or verbal abuse
- ☐ Multiple forms and complex -- physical, verbal, emotional (ignoring patients), over medication.

2. There is quite a lot of talk of mistreatment and abuse of patients in mental health hospitals. Have there been any incidents of mistreatment or abuse at this institution?

Y

N

If so, could you please describe three incidents you remember most clearly, over the past two years

1)

2)

3)

3. Are there mechanisms available for patients to report incidents of mistreatment or abuse?

Y

N

If so, what are these mechanisms?

4. Were any steps taken by management to address any of the three incidents above?

Y

N

What were these steps?

Do you think that mistreatment / abuse is a major issue at this hospital?

Y

N

How large do you think this issue really is? (Probe: Do they happen every day? weekly? monthly? Is it a fairly broad problem involving many staff, or a small problem involving a few staff in particular incidents)

[If yes] Why do you think mistreatment / abuse occurs at this hospital? [If no] Why is there no abuse in this hospital? Would staff feel free to discuss this issue even if it did occur?

MISTREATMENT / ABUSE OF PATIENTS BY PATIENTS

Many mental health institutions, both in South Africa and overseas, have a difficult time protecting more aggressive patients from less aggressive patients. And in fact patients are mistreated by other patients.

1 Is this a problem in this ward?

Y

N

[If yes] Please explain.

I. Miscellaneous

1. Race

The history of apartheid is not long behind us. And most chronic mental health institutions have had to undergo rapid changes during the past five years. Some institutions find that issues of race are still problematic -- either between patients and staff, between staff, or between staff and management.

1.1 Are there any such problems in this hospital?

Y	N	?
---	---	---

[If yes] Please explain

[illegible]

1. Do patients of different racial backgrounds receive the same care at this hospital?

Y	N	?
---	---	---

[If no] Please explain

1. No. Please explain.

1.3 The majority of patients in this hospital are [white / black]. Why do you think this is so?

1.4 Do you believe that patients coming from different racial backgrounds have equal access to chronic care at this hospital?

Y	N	?
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[If no] Please explain

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466
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2 **Sex**

2 Many mental institutions, both in South Africa and overseas, have a difficult time protecting some patients from the more sexually active patients. Is this a problem in this hospital?

☐ Y

☐ N

☐ ?

[If yes] Please explain

2 Is there sex between patients here?

☐ Y

☐ N

☐ ?

Please explain the common scenario leading to patients having sex with each other. (Probe to what extent this involves sexual bargaining / assault.)

2.3 Are STD's a major problem here?

☐ Y

☐ N

☐ ?

If so, please describe.

J. Comparison of State and Lifecare Institutions

1. Quality of Care Comparison

1.1 Have you had any direct experience with (state/Lifecare) institutions?

Y

N

[If yes] What is this experience?

1.2 Do you think there is a difference in quality of care at this institutions?

Y

N

?

What is this difference?

2. Patient Transfers

2.1 Are patients ever transferred from (state/Lifecare) hospitals to this hospital?

Y

N

?

[If yes] Under what circumstances?

2.2 Are patients ever transferred from this hospital to (state/Lifecare) hospitals?

Y

N

?

[If yes] Under what circumstances

K. Vision

1. Are there any patients who would be discharged if they had a family to live with or place to go?
(Probe their analysis of the balance between social factors and organic mental health.)

SENIOR SISTER CHECKLIST

Clean potable running water

☐ ² Fully reliable supply

☐ ⁰ Not fully reliable

Warm water

☐ ² Warm water consistently available for patient bathing.

☐ ¹ Warm water inconsistently available for patient bathing.

☐ ⁰ Warm water never available for patient bathing.

Electricity

☐ ² Fully reliable electricity source.

☐ ¹ Infrequent power failures.

☐ ⁰ Frequent power failures.

Phone

☐ ² Ward phone or public phone available for patient use.

☐ ⁰ Ward phone or public phone not available for patient use.

Toilets: Working Order

☐ ² Toilets in good working order for all patients

☐ ¹ Some toilet facilities are not functioning properly, but majority are functional.

☐ ⁰ The majority of toilets are not functional, causing a problem for patients.

Toilets Quantity

☐ ² There are enough toilets here. Patients can usually use the toilet when they want to.

☐ ⁰ There are not enough toilets here. Patients usually have to wait when they need to use the toilet.

Space

☐ ² Plenty of space for patients – space does not seem to be an issue.

☐ ¹ Some evidence that space is a problem.

☐ ⁰ Very crowded – space is too small for number patients.

PATIENT DAILY LIFE CHECKLIST

Frequency of Bathing

- ☐ ² Patients bathe daily
- ☐ ¹ Patients bathe at least two times per week.
- ☐ ⁰ Patients bathe less than twice per week.

Frequency of Clothing Change

- ☐ ² Patients change their clothes daily.
- ☐ ¹ Patients change their clothes at least two times per week.
- ☐ ⁰ Patients change their clothes less than twice per week.

Frequency of Change of Bedding

- ☐ ² Bedding is changed at least once a week.
- ☐ ⁰ Bedding is changed less than once a week.

FOOD

Quantity

- ☐ ² Patients have enough food.
- ☐ ¹ Some patients complain of having too little food.
- ☐ ⁰ There is a regular problem of quantity of food.

Quality

- ☐ ² The food is good – well rounded in terms of carbohydrates, meat, vegetables etc.
- ☐ ¹ There is some evidence of problems with quality of food provided
- ☐ ⁰ There is gross problem with the quality of food – lack of meat, vegetable, etc.

SERVICES QUESTIONNAIRE

Institution:	Ward:
Position:	No. Patients in Ward

Part I: Treatment

Below is a list of treatments. For each item, indicate whether or not the treatment is provided in your ward. Tick 'yes' if the treatment is provided. Tick 'no' if the treatment is not provided. Then indicate how many patients receive this treatment in a TYPICAL week. Please take care not to overestimate your answers. Think about a typical week. If a treatment is provided, but not used in a typical week, you should indicate '0' in the last column.

	Yes	No	PERCENT of patients who receive this treatment at least once in a TYPICAL week
1. Group counselling or psychotherapy			%
2. Individual counselling or psychotherapy			%
3. Social skills training			%
4. Self help / mutual support groups (e.g. AA)			%
5. Physiotherapy			%
6. Occupational Training (Job Training)			%
7. Patients in Ward Currently Working (please briefly describe this work in the space provided below)			%
8. Discharge planning			%
9. Electroconvulsive Therapy (ECT)			%

Brief Description of Work (from item 7 above)

Note the following definitions:

- **Occupational Therapy** is a programme, often run or co-ordinated by an occupational therapist, designed to increase patient functioning. It can include diverse activities such as arts and crafts, wood working, cooking, sports, and job training.
- **Occupational Training / Job Training** is a programme dedicated to training patients in skills to get a job in the future. This can include the development of skills relevant in the job market (clerical skills, maintenance skills, etc.) as well as life skills designed to train a patient on how to get a job (preparation for an interview, job searches etc.)
- **Patients in Ward Currently Working** this should be full time work for pay. Indicate in the box provided the nature of work. Is it sheltered / institutionalised work (e.g. making plastic flowers) or work which provides patient with employment responsibility (administrative, full time maintenance with responsibility, work out of hospital grounds etc.)
- **Discharge Planning** implies a formal, organised, and regular programme involving patients and staff in planning for patient discharge.

Part II: Services

A. Weekly Services

Below is a list of services. Indicate whether or not the service is provided in your ward. Tick 'yes' if the service is provided. Tick 'no' if the service is not provided. For the items indicated, write how many patients receive this service in a TYPICAL MONTH. Please take care not to overestimate your answers. Think about a typical week. If a service is provided, but not used in a typical week, you should indicate '0' in the last column.

	Yes	No	PERCENT of patients who receive this treatment at least once in a TYPICAL MONTH
1. Regularly scheduled doctors' hours for medical care	☐	☐	
2. Do doctors keep to scheduled hours?	☐	☐	
3. Doctor on call for medical care.	☐	☐	
4. Do doctors respond to call?	☐	☐	
5. Regularly scheduled psychiatrists' hours?	☐	☐	
6. Regularly scheduled psychologist hours?	☐	☐	
7. Regularly scheduled social worker hours?	☐	☐	
8. Psychiatrist and/or psychologist on call	☐	☐	
9. Assistance patients to take their medicine	☐	☐	

B. Monthly Services

Below is another list of services. Tick 'yes' if the service is provided. Tick 'no' if the service is not provided. Then indicate how many patients receive this service in a TYPICAL MONTH.

	Yes	No	Number of patients who receive this treatment at least once in a TYPICAL MONTH
1. Religious or spiritual counselling	☐	☐	
2. Legal advice or counselling	☐	☐	
3. Vocational / educational counselling	☐	☐	
4. Nutrition counselling	☐	☐	
5. AIDS counselling	☐	☐	

Part III: Activities

Below is a list of activities. Tick 'yes' if this patients in this ward engage in this activity. Tick 'no' if patients in this ward do not engage in this activity. Then indicate how many patients engage in this activity in a TYPICAL MONTH.

	Yes	No	PERCENT of patients who receive this treatment at least once in a TYPICAL MONTH
1. Exercise or other physical activity (e.g. walking, swimming)	☐	☐	
2. Organised recreation (e.g. throwing a ball, ping-pong)	☐	☐	
3. Movies or videos	☐	☐	
4. Classes or lectures (other than those given as part of therapy)	☐	☐	
5. Cards or other games	☐	☐	
6. Religious services	☐	☐	
7. Arts and crafts	☐	☐	
8. Club or social group I	☐	☐	
9. Discussion groups (other than those held as part of therapy)	☐	☐	
10. Television	☐	☐	

Part IV: Languages

Step 1: Indicate what percent of patients in this WARD speak this language as their primary language / language of fluency.

	Zulu	Sotho	Xhosa	Local	English	Afrikaans
1. Patients (%)	%	%	%	%	%	%

Step 2: In the remaining columns, make a tick if there are members of the indicated staff available at this ward to speak the language *fluently*.

	Zulu	Sotho	Xhosa	Local	English	Afrikaans
2. Nursing Staff (TICK IF YES)	☐	☐	☐	☐	☐	☐
3. Social Workers (TICK IF YES)	☐	☐	☐	☐	☐	☐
4. Medical Officers (TICK IF YES)	☐	☐	☐	☐	☐	☐
5. Psychiatrists (TICK IF YES)	☐	☐	☐	☐	☐	☐
6. Occupational Therapists (TICK if YES)	☐	☐	☐	☐	☐	☐
7. Trained Translators ¹	☐	☐	☐	☐	☐	☐

¹ Note for Interviewer: INCLUDE TRAINED TRANSLATORS ONLY!! DO NOT INCLUDE NURSING STAFF, CLEANING STAFF WHO PROVIDE TRANSLATION INFORMALLY

Please take 10 to 15 minutes to write notes, reflections and impressions from this interview.

Interview Summary

Patient Interview Protocol

Hello, my name is _____.

This interview is a part of a study conducted by the Centre for Health Policy. The Centre for Health Policy is a research unit attached to the Department of Community Health, University of Witwatersrand.

We are currently studying service provision within chronic mental health institutions throughout the country.

The input of patients is very important to this study. We would like to discuss your experiences living at this hospital. If you agree to this interview, we would discuss with you various issues concerning living here. It will take less than one hour.

All of this discussion will be kept **STRICTLY CONFIDENTIAL**. The discussion will be anonymous, and no individual names will be documented (note that we do not even write your name on this form!) You should feel free to discuss this hospital and your experiences at this hospital freely, for nobody besides you and I will be told what you say during this interview. We stress that no one in this hospital or this ward will be given information about what individual patients tell us.

The potential benefit to you is that we hope that through this study we will identify strengths and weaknesses of service to patients such as yourself, so that services to patients like yourself may be improved in the future.

Participation in this interview is voluntary and you are free to refuse to participate at any time. If you should feel uncomfortable with the interview at any point in time, please tell me so that we can stop the interview. I will respect this request and I will not tell ward staff that the interview was not completed.

Thank you very much for your co-operation!

Institution:		Ward:	
Date:		Researcher:	

Note to Interviewer: Conduct this interview as a discussion. Allow the patient to talk, to tell 'their story' as much as possible. Do not focus on this interview schedule. Use the following outline to guide your interview. We would like patient input in all of the following areas. Read the ratings at the end of the protocol. Please complete these ratings directly after your interview -- before leaving the ward! (This allows you to go back to the patient with questions if you cannot answer certain areas.)

A. Their Story -- Patient Life

Note to Interviewer: Begin the interview in a very open way. Your objective here is to get the patient talking about life at this hospital -- whatever story he or she thinks is important to tell.

- We are really trying to understand life here in this ward and at this hospital. What is it like to be a patient here?

Possible Probes: Do you think that being in this hospital is helping you? Would you rather be here or home? Why? [If at home, what prevents you from going home?]

B. Assessment of Hospital

- Are patients treated well here?
- What are the good things about this hospital (try to elicit at least three).
- What are the and things about this hospital, or areas you would like to see improved (try to elicit at least three)

C. Aspects of Hospital Life

1. Patient Daily Life / Schedule

- What do you do each day from the time you wake up in the morning to the time you go to sleep at night?

Possible Probe: Is this the same for other patients? Are other patients more busy or less busy?

2. Staff Patient Relationship

- How do you get on with the nurses here?

(Possible Probes: Do the nursing staff work well here? Do you feel that the staff here understand you? Can you speak with a nurse when you need to?)

3. Languages

- Can you speak with staff here in a language of your choice?

Possible Probes: Do you ever have problems speaking with staff because of language? Do you think other patients experience problems communicating with staff because of language?)

4. Patient Clarity and Understanding

- How long have you been here?
- What is the reason you are here?
- Are you currently taking medications?
- Have the staff explained to you why you are taking medications? What did they tell you?

5. Family Involvement

- How often does a member of the family or a close friend come to visit you here?

6. Services

6.1. Ward Programme

- Do the staff organise activities and things for you to do each day?

Possible Probes: outings, recreational, vocational, educational) What do you think about the programme? Is it interesting or not so interesting? Is it organised or not so organised?

6.2. Discharge Programme

- Are patients in this ward prepared for discharge? [if yes] What does this hospital do to prepare you for leaving?

6.3. Health Treatment Services

- When did you last see a doctor? Was it helpful? In what way?
- When did you last see a social worker? Was it helpful? In what way?
- When did you last see an occupational therapist? Was it helpful? In what way?

7. Mistreatment / Abuse

7.1 Mistreatment of Patients by Staff

- Patients in other hospitals talk about incidents of mistreatment of patients and abuse of patients. Have you or any other patient had bad experiences with staff or other patients? If so, could you please describe three incidents you remember most clearly.

Probes for Patient Who Respond Well: Were any steps taken by management to address any of the three incidents above? Can patients report bad experiences or mistreatment? How large do you think this issue really is? (Probe: Do they happen every day? weekly? monthly? Is it a fairly broad problem involving many staff, or a small problem involving a few staff in particular incidents)

7.2 Mistreatment of Patients by Patients

- Do some patients treat other patients badly? If so, could you please explain what happens?

Possible Probes: Do you feel safe in this ward?

8. Future / Closing

- What do you hope to be doing five years from now?

Other Comments or Notes:

PATIENT INTERVIEW RATINGS

Instructions: Please complete the following ratings directly after the interview. Do not leave the ward. This allows you to go back to the patient if necessary. Note that these areas match areas above. Consult with notes to complete the following ratings.

1. Patient Daily Schedule¹

RATE PATIENT DAILY SCHEDULE AS FOLLOWS:

- ☐ ⁴ Very Busy and Active
- ☐ ³ Busy and Active
- ☐ ² Moderate
- ☐ ¹ Inactive
- ☐ ⁰ Very inactive

Comments:

2. Staff Patient Relationship

RATE STAFF PATIENT RELATIONSHIP AS FOLLOWS:

- ☐ ⁴ Very positive Patient talks extremely warmly / positively about staff.
- ☐ ³ Positive
- ☐ ² Moderate Patient is neither very positive nor very negative in their description of staff
- ☐ ¹ Negative
- ☐ ⁰ Very negative Patient talks extremely negatively / antagonistically about staff.

Comments:

3. Languages: NO RATING

4. Patient Clarity

4.1 RATE PATIENT UNDERSTANDING OF CIRCUMSTANCE FOLLOWS:

- ☐ ⁴ Very clear
- ☐ ³ Clear
- ☐ ² Moderate
- ☐ ¹ Unclear
- ☐ ⁰ Very unclear

4.2. RATE UNDERSTANDING OF MEDICATIONS AS FOLLOWS:

- ☐ ⁴ Very clear Patient provides clear description of purpose and side effects of medications taken
- ☐ ³ Clear
- ☐ ² Moderate Basic understanding of purpose of medications (e.g. 'because I am not well, not coping')
- ☐ ¹ Unclear
- ☐ ⁰ Very Unclear No understanding of purpose or side effects of medications taken

Comment:

¹ Rate this according to both the patient's explanation for his/her own daily life, as well as the patient's assessment of other patients in the ward (See questions above)

5. Family Involvement

RATE FAMILY VISITS AS FOLLOWS:

- ☐ ³ At least once a month
- ☐ ² At least once every three months
- ☐ ¹ At least once a year
- ☐ ⁰ Never

Comments:

6. Services

6.1. Ward Programme

RATE THE WARD PROGRAMME AS FOLLOWS:

- ☐ ⁴ Very Strong Highly organised ward programme involving the majority of the patients during most of the daytime hours, with diverse activities (e.g. outings, recreational, vocational, educational)
- ☐ ³ Strong
- ☐ ² Moderate Ward programme that involves some patients for some part of each day
- ☐ ¹ Weak
- ☐ ⁰ Very weak or none No organised ward programme.

Comments:

6.2. Discharge Programme

RATE THE DISCHARGE PROGRAMME AS FOLLOWS:

- ☐ ⁴ Very Strong Patients receive comprehensive training, preparation, planning for discharge
- ☐ ³ Strong
- ☐ ² Moderate Some patients receive some training, preparation, planning for discharge.
- ☐ ¹ Weak
- ☐ ⁰ Very weak or none No discharge planning or preparation.

Comments:

6.3. Health Treatment Services

RATE THE HEALTH TREATMENT SERVICES AS FOLLOWS:

- ☐ ⁴ Very Strong
- ☐ ³ Strong
- ☐ ² Moderate
- ☐ ¹ Weak
- ☐ ⁰ Very weak or none

Comments:

7. Mistreatment / Abuse: NO RATING

8. Future / Closing

RATE PATIENT FUTURE PLAN AS FOLLOWS:

- ☐ ⁴ Out of hospital -- clear active plan / vision
- ☐ ³ Out of hospital -- some plan / vision
- ☐ ² Out of hospital -- unclear plan / vision
- ☐ ¹ In hospital with some level of improvement goals
- ☐ ⁰ Unclear / No change

Comments:

PATIENT CHECKLIST

Note to Interviewer: these should be answered with reference to this patients' experiences.

A. PATIENT DAILY LIFE

Frequency of Bathing: How often do you bathe?

- ☐ ² Patients bathe daily
- ☐ ¹ Patients bathe at least two times per week.
- ☐ ⁰ Patients bathe less than twice per week.

Frequency of Clothing Change: How often do you change your clothes?

- ☐ ² Patients change their clothes daily.
- ☐ ¹ Patients change their clothes at least two times per week.
- ☐ ⁰ Patients change their clothes less than twice per week.

Frequency of Change of Bedding: How often is the linen / sheets on your bed changed?

- ☐ ² Bedding is changed at least once a week and more regularly as needed (e.g. when patient urinates in bed etc.)
- ☐ ⁰ Bedding is changed less than once a week or not according to patient need (e.g. not when patient urinates in bed etc.)

B FACILITY

1. Warm water: Is warm water available for bathing?

- ☐ ² Warm water consistently available for patient bathing.
- ☐ ¹ Warm water inconsistently available for patient bathing.
- ☐ ⁰ Warm water never available for patient bathing.

2. Heating during winter: Is your bedroom heated during winter?

- ☐ ² There is adequate heating in patient bedrooms during the winter.
- ☐ ¹ There is barely adequate heating in patient bedrooms during winter the winter.
- ☐ ⁰ There is no heating or inadequate heating in patient bedrooms during winter.

3. Phone: Is there a phone you can use?

- ☐ ² Ward phone available for patient use.
- ☐ ¹ Public phone available for patient use.
- ☐ ⁰ Ward phone or public phone not available for patient use.

4. Toilets

4.1 Toilets Quantity

- ☐ ² There are enough toilets here. Patients can usually use the toilet when they want to.
- ☐ ⁰ There are not enough toilets here. Patients usually have to wait when they need to use the toilet.

4.2 Toilets: Working Order

- ☐ ² Toilets in good working order for all patients
- ☐ ¹ Some toilet facilities are not functioning properly, but majority are functional.
- ☐ ⁰ The majority of toilets are not functional, causing a problem for patients.

4.3 Toilet Cleanliness

- ☐ ² Toilets are very clean.
- ☐ ¹ Toilets are clean, but some evidence of odours, uncleanliness.
- ☐ ⁰ Toilets are not clean.

C. Patient Amenities

1. Shoes

- ☐ ² Patients wearing shoes of reasonable quality / wear.
- ☐ ¹ Patients wearing shoes of very low quality (e.g. more like slippers than shoes, or shoes of disrepair)
- ☐ ⁰ Many patients not wearing shoes

2. Clothes

2.1 Clothing

- ☐ ² Patients wearing clothes of reasonable quality.
- ☐ ¹ Patients wearing clothes of low quality
- ☐ ⁰ Patients wearing clothes of very low quality. (e.g. worn, torn.)

2.2 Winter Clothes: Do you have warm clothes in winter?

- ☐ ² Patients provided with winter clothes.
- ☐ ¹ Patients provided with winter clothes -- but not fully satisfactory.
- ☐ ⁰ Patients not provided with winter clothes -- clear evidence of patients cold in winter.

2.3 Pyjamas

- ☐ ² Patients have pyjamas or clothes to wear while sleeping (if they want to).
- ☐ ⁰ Patients do not have pyjamas or clothes to wear while sleeping.

3. Bedding

3.1 Linen (pull aside bedcovers)

- ☐ ² Linen clean, ironed, neat.
- ☐ ¹ Linen not completely clean, ironed, or neat.
- ☐ ⁰ Linen dirty, un-ironed, torn.

3.2 Mattress Linen (Fitted Sheets)

- ☐ ² Fitted sheets on mattresses or sheet properly covering mattresses.
- ☐ ⁰ No sheet properly covering mattresses.

3.3 Pillows

- ☐ ² All patients have pillows.
- ☐ ¹ More than 50% of patients have pillows, but not all.
- ☐ ⁰ Less than 50% of patients have pillows.

3.4 Beds: (Where do you sleep? Have you ever slept on the floor?)

- ☐ ² Patients sleep on beds and have never slept on the floor or shared a single bed over the past year.
- ☐ ¹ Patients sleep in beds but have infrequently slept on the floor or had to share a single bed over the last year.
- ☐ ⁰ Patients sleep on the floor or share single beds.

3.5 Winter Blankets: (Do you have enough blankets in winter?)

- ☐ ² Patients provided with enough winter blankets
- ☐ ¹ Patients provided with barely adequate winter blankets.
- ☐ ⁰ Many patients cold in the winter due to lack of blankets.

4. FOOD

4.1 Quantity (Are you given enough food here?)

- ☐ ² Patients have enough food.
- ☐ ¹ Evidence that some patients have too little food.
- ☐ ⁰ There is a regular problem of quantity of food.

4.2 Quality (How is the food?)

☐ ²

The food is good -- well rounded in terms of carbohydrates, meat, vegetables etc.

☐ ¹

There is some evidence of problems with quality of food provided

☐ ⁰

There is gross problem with the quality of food -- lack of meat, vegetable, etc.

5. Toilet Paper

☐ ²

Toilet paper is available in all toilets.

☐ ¹

Toilet paper available from nurses upon request.

☐ ⁰

No toilet paper.

Background Data

Sex:

Race:

Insight and Judgement

- 1 Patient shows insight
- 2 Patient shows judgement
- 2 Is the patient in touch with reality.

Please explain

Interviewer Assessment of Patient Status**Particularly Clear / Coherent**

Patient is particularly clear and coherent — seems 'normal'. A great deal of reliability should be assumed.

Ordinary

Patient is not markedly clear (not 'normal') and not particularly unclear (not in a psychotic episode etc.)

Particularly Questionable

Patient particularly questionable / unreliable. Psychotic episode, or particularly 'out of touch'. A greater deal of unreliability should be assumed

Orientation**Oriented to time.**

Does patient know what year it is?

Oriented to person

Does patient know who he/she is?

Oriented to place

Does patient know where he/she is?

Diagnosis:

Note: obtain diagnosis from patient file, NOT patient directly.

Please take 10 to 15 minutes to write notes, reflections, and impressions from this interview.

Interview Summary:

Superintendent Interview Protocol

This interview is a part of a study conducted by the Centre for Health Policy. The Centre for Health Policy is a research unit attached to the Department of Community Health, University of Witwatersrand.

We are currently studying service provision within chronic mental health institutions throughout the country.

The input of management is very important to this study. We would like to interview you about your perceptions and experiences from working at this hospital. If you agree to this interview, we would discuss with you various issues concerning your work here. It will take less than one hour.

Participation in this interview will carry no risk for you, regarding your position at work. We will maintain full anonymity and confidentiality of what you say in the interview. All of this discussion will be kept **STRICTLY CONFIDENTIAL**. The discussion will be anonymous, and no individual names will be documented (note that we do not even write your name on this form!)

The potential benefit to you is that we hope that through this study we will identify strengths and weaknesses of service provision to chronically mentally ill patients so that we can improve services to these patients in the future.

Participation in this interview is voluntary and you are free to refuse to participate, or withdraw your consent to participate, at any time. If you should feel uncomfortable with the interview at any point in time, please tell me so that we can stop the interview. Stopping the interview at any time will not affect your job in any way as we will not inform anybody at this hospital whether the interview was completed or not.

If you wish to contact us at a later date with any questions you may have, you may contact us at the Centre for Health Policy as follows:

Tennyson Lee	(011) 489 - 9954
Kim Porteus	(011) 489 - 9953
Khosi Sibeko	(011) 489 - 9947
Liz Dartnall	(011) 489 - 9938
Fran Clews	(011) 489 - 9955

Thank you very much for your co-operation!

NOTE TO INTERVIEWER: Before conducting this interview, review the checklist at the end of this interview protocol. Complete the ratings below directly after the interview.

Institution:			
Date:		Researcher:	

Position:	Length of Employment at Hospital
e.g. (Senior) Sister, (Senior) Staff Nurse, (Sen) Asst. Nurse, OT, Social Worker, Matron, Superintendent etc.)	Length of Time Working in Job

A. Services

1. Discharge Programme

1.1 What percent of chronic patients in this ward are discharged from this hospital each year?

1.2 Are patients in this ward prepared for discharge?

Y	N
----------	----------

1.3 If yes, what does this hospital do to prepare patients to leave? [If no] Why not? (Probe: not the objective?, not enough staff?, disorganisation?, someone else's job and they aren't doing it etc.)

1.4 What is your overall assessment of the discharge programme here?

INTERVIEWER RATING: RATE THE DISCHARGE PROGRAMME AS FOLLOWS:

	4 Very Strong	Patients receive comprehensive training, preparation, planning for discharge
	3 Strong	
	2 Moderate	Some patients receive some training, preparation, planning for discharge
	1 Weak / Minimal	
	0 Very weak or none	No discharge planning or preparation

Comments:

B. Staff Time Allocation

1. **Management Time Allocation.** Could you please approximate what percent of the overall time spent on management of this hospital is dedicated to the following patient categories.
(Note to interviewer: we know this question may be difficult to answer, but it is necessary for the costing study – emphasise that we only are expecting an approximation for this question.)

Chronic Psychiatric	%	Mentally Handicapped	%
Other (acute, observational)	%		

C. Assessment of Institution

1. What are the top management problems or challenges in this institution.
2. What are the objectives for care of chronic patients at this hospital?
3. Do you have a written set of policy guidelines for patient care? If so, could we see it?
4. Are you satisfied with the treatment of patients in this hospital? If not, what are the problems?
5. What are three positive aspects or strengths of this hospital? That is, three things about this hospital which are done particularly well, or aspects you feel proud about?
 - a)
 - b)
 - c)
6. What are the three most serious weaknesses at this hospital? That is, what are three aspects of this hospital you would most like to see improved?
 - a)
 - b)
 - c)

D. Management

1. Financial Management
E. Management

1. Financial Management

1.1 What is the total hospital budget for this year?

1.2 What is the projected budget for next year? (Probe if large discrepancies.)

1.3 What are the indirect costs of running this hospital?

2. Staff Management

2.1. Staff Quantity: In your assessment are there enough staff at this institution? If not, what areas require more? What aspects of patient care are compromised by this shortage? Why are more not hired?

2.2 Staff Satisfaction: What is the general level of staff satisfaction at this hospital? What are the issues which cause any dissatisfaction among staff here?

2.3. What are the staff hours at this hospital?

3. Autonomy

3.1 Do you feel that you have sufficient autonomy to manage this hospital successfully?

☐ Y ☐ N

If not, what areas specifically could you manage better with more autonomy?

3.2 Do you have autonomy to make decisions / take action in the following areas. Describe what procedures / protocol you have to follow in order to make decisions or take action in these areas.

a) Hiring and Firing

☐ Y ☐ N

Comment

b) Staff Disciplinary Procedures

☐ Y ☐ N

Comment

c) Equipment and vehicle repair

☐ Y ☐ N

Comments

d) Determining financial priorities / purchasing decisions

☐ Y ☐ N

Comments

RATE THE MANAGEMENT AUTONOMY AS FOLLOWS:

☐	⁴ Fully autonomous	Fully autonomous -- complete autonomy to make financial, staff and other decisions facing the hospital. No indication that lack of autonomy is restricting management in any way.
☐	³ Mostly autonomous	For the most part management has autonomy to make financial, staff, and other management decisions facing the hospital.
☐	² Partially autonomous	Management has some sense of autonomy on a day to day level -- but quite restricted when it comes to longer term strategic decisions.
☐	¹ Little autonomy	Lack of autonomy seen to restrict management performance.
☐	⁰ Total lack of autonomy	Total lack of management autonomy -- management is unable to make basic financial / staff decisions on their own. Management feels totally restricted on a day to day basis.

D. Mistreatment / Abuse

i. MISTREATMENT / ABUSE OF PATIENTS BY STAFF

1. What is your understanding of mistreatment of patients-- that is, what things can be considered mistreatment?

RATE AS FOLLOWS:

- ☐ Severe physical abuse only (Slaps are not seen as abuse.)
- ☐ Any type of physical abuse (Verbal / emotional abuse is not considered / recognised as abuse.)
- ☐ Physical and / or verbal abuse
- ☐ Multiple forms and complex -- physical, verbal, emotional (ignoring patients), over medication.

2. There is quite a lot of talk of mistreatment and abuse of patients in mental health hospitals. Have there been any incidents of mistreatment or abuse at this institution?

Y

N

If so, could you please describe three incidents you remember most clearly, over the past two years

1)

2)

3)

3. Are there mechanisms available for patients to report incidents of mistreatment or abuse?

Y

N

If so, what are these mechanisms?

4. Were any steps taken by management to address any of the three incidents above?

Y

N

What were these steps?

5. Do you think that mistreatment / abuse is a major issue at this hospital?

Y

N

How large do you think this issue really is? (Probe Do they happen every day? weekly? monthly? Is it a fairly broad problem involving many staff, or a small problem involving a few staff in particular incidents)

6. [If yes] Why do you think mistreatment / abuse occurs at this hospital? [If no] Why is there no abuse in this hospital? Would staff feel free to discuss this issue even if it did occur?

ii. **MISTREATMENT / ABUSE OF PATIENTS BY PATIENTS**

Many mental health institutions, both in South Africa and overseas, have a difficult time protecting more aggressive patients from less aggressive patients. And in fact patients are mistreated by other patients.

1 Is this a problem in this ward?

☐ Y

☐ N

[If yes] Please explain.

F. Miscellaneous

1. Race

The history of apartheid is not long behind us. And most chronic mental health institutions have had to undergo rapid changes during the past five years. Some institutions find that issues of race are still problematic -- either between patients and staff, between staff, or between staff and management.

1.1 Are there any such problems in this hospital?

☐ Y

☐ N

☐ ?

[If yes] Please explain

1.2 Do patients of different racial backgrounds receive the same care at this hospital?

☐ Y

☐ N

☐ ?

[If no] Please explain

1.3 The majority of patients in this hospital are [white / black]. Why do you think this is so?

1.4 Do you believe that patients of different racial backgrounds have equal access to chronic care at this hospital?

☐ Y

☐ N

☐ ?

[If no] Please explain

G. Comparison of State and Lifecare Institutions

1. Quality of Care Comparison

1.1 Have you had any direct experience with (state/Lifecare) institutions?

Y

N

[If yes] What is this experience?

1.2 Do you think there is a difference in quality of care at this institutions?

Y

N

?

What is this difference?

2. Patient Transfers

2.1 Are patients ever transferred from (state/Lifecare) hospitals to this hospital?

Y

N

?

[If yes] Under what circumstances?

2.2 Are patients ever transferred from this hospital to (state/Lifecare) hospitals?

Y

N

?

[If yes] Under what circumstances

H. Vision

1. If you were given the job of the Director for Mental Health and were responsible for designing a new mental health system and infrastructure for the future, what would it look like?

Management Checklists

Instructions: This checklist should be read before the interview as a guide to a open ended discussion with management during the interview. Complete the ratings below directly after the interview.

I. General Management Assessment

1. Management's awareness of financial management issues:

- ☐ ² Fully conversant with financial situation and explanations for financial situation
- ☐ ¹ Partially aware of above issues.
- ☐ ⁰ Poor awareness of financial and/or other critical management issues.

2. Management's awareness and fluency of other strategic management issues. (For example, staff satisfaction, issues around the transformation of the mental health system and how institution fits into the wider political situation, issues of discharge and relationship to development of community structures etc.)

- ☐ ² Fully in touch with critical issues in management.
- ☐ ¹ Partially aware of above issues.
- ☐ ⁰ Poor awareness of critical management issues.

3. Management's sense of creativity / problem solving. (Including innovative ideas in solving past problems, innovative ideas around involvement of family / community, increasing staff satisfaction, patient care.)

- ☐ ² Strong evidence of creative and innovative approach to management challenges.
- ☐ ¹ Some sense of creativity and innovation in approach to management challenges.
- ☐ ⁰ No sense of creativity or innovation in approach to management challenges.

1. Management's understanding of issues of mental health care. (Including understanding of clinical management, fluency with diagnoses / medications, relationship between social workers, OT, clinicians in patient care. etc.)

- ☐ ² Fully fluent and aware of issues of clinical mental health care management.
- ☐ ¹ Partially aware of above issues.
- ☐ ⁰ Poor awareness or understanding in clinical mental health care management.

II. Management of Abuse / Mistreatment

5. Management's willingness to discuss issues of staff and patients mistreatment / incidents of abuse. (Including physical abuse, emotional abuse (stealing, shouting etc.), drug trade.)

- ☐ ² Open and willing to discuss this area, and discuss the problems openly.
- ☐ ¹ Willing to admit there is an occasional problem, but resistant to discussing the in detail.
- ☐ ⁰ Unwilling to discuss, claims there are no problems.

6. Patient complaints / suggestions

- ☐ ² No mechanism for complaints / suggestions
- ☐ ¹ Possible to complain, but not simple, annoys
- ☐ ⁰ Clear system for complaints / suggestions

7. Management's follow up of patient complaints.

- ☐ ² All complaints followed up. Police notified in cases of criminal abuse (physical abuse, drug trade.)
- ☐ ¹ All complaints followed up. No referral to police service.
- ☐ ⁰ Not all complaints are followed up, or followed up in a non systematic way.

Please take 10 to 15 minutes to write notes, reflections and impressions from this interview.

Interviewer Notes / Reflection / Impressions:

Author Porteus K A

Name of thesis Addenda Cost And Quality Of Care: A Comparative Study Of Public And Privately Contracted Chronic Psychiatric Institutions Porteus K A 1998

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