

# Chronic Illness Patients' Perceptions of Quality of Care During Hospitalization: A Qualitative Study

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## Abstract

**Introduction:** The rising prevalence of patients living with chronic illnesses and frequent hospitalizations represent many challenges in delivering high-quality care. Assessing patients' perceptions and needs regarding the quality of health care services is a critical step in improving quality of care.

**Objective:** This study sought to explore the perception of quality of care from the perspectives and experiences of chronically ill patients during hospitalization.

**Methods:** This study was conducted using a qualitative descriptive design. Face-to-face semi-structured individual interviews were conducted with 15 chronically ill patients at their bedside during their current hospital admission. Analysis followed Braun and Clarke's thematic analysis approach.

**Results:** Overall patients were pleased with their hospitalization experience; however, they highlighted many aspects of care that can be addressed to improve the quality of care provided. Five themes were identified from the analysis as follows: defining quality of care; aspects related to the healthcare providers; unmet care needs; patient's involvement in healthcare decisions and care expectations and outcomes.

**Conclusion:** A key finding of this study was the association between quality of care and healthcare providers' skills, clinical competence, and attitudes. Poor communication and discoordination of care were the most significant impediment expressed. Actively involving patients in care may be effective when combined with meeting expectations. The findings of this study helped to identify the strength points and areas of improvement that are the cornerstone for developing tailored and patient-centered strategies to improve the quality of care during hospitalizations among chronically ill Saudis.

## Keywords

quality of care, perceptions, qualitative, Saudi Arabia

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## Introduction

Improving the quality of care is an important global priority as it is the cornerstone for producing better health outcomes and responding to changing population needs (World Health Organization, 2018a). It is one of the universally acknowledged principles of health policy and is always ranked at the top of the policymaker's agenda internationally (World Health Organization, 2018b). Quality of care is defined as the degree to which patient care and services increase the probability of desired patient outcomes and reduce the probability of undesired outcomes (Institute of Medicine, 1990). In this

definition, the care provided is expected to have a net benefit which means to do good more than harm, given the known

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risk when compared to the next best alternative care. In turn, that benefit is expected to reflect considerations of patient satisfaction and well-being, broad health status or quality of life measures, and the processes of patient–provider interaction and decision-making (Institute of Medicine, 1990).

Definitions of quality of care had been primarily shaped by healthcare professionals and researchers. However, there has been an increased recognition lately to the inclusion of patients' views on what constitutes a good quality of care (World Health Organization, 2018b). Since comprehensive, integrated, and patient centered approaches are crucial to improving the quality of care provided to patients, and their clinical outcomes, a critical aspect of developing and implementing these strategies is to explore the perceptions and needs of patients with respect to the quality of care delivery and services (Davy et al., 2015). Recently, there has been renewed interest in combining the perspectives of patients, healthcare providers, and organizations when defining and evaluating the quality of healthcare services (Busse et al., 2019). Evidence suggests that patients' perceptions of quality of care can provide important insights into the extent to which the healthcare system is responsive to their specific needs and expectations, which in turn can result in not only higher satisfaction but also increased confidence and willingness to adhere to treatment plans (Alrashdi, 2012; Members et al., 2020). It is worth noting that patients' perception of care should not be equated to patients' satisfaction with care despite the similarities between the two concepts. Patient satisfaction measurements are used to evaluate the levels of satisfaction with care, whereas patient perception measurements aim to determine patients' view of services provided and the outcome of treatments (Manary et al., 2013; World Health Organization, 2018a). Accordingly, policymakers and accreditation bodies require measurements of patients' experiences and perceptions as an essential determinant of the quality evaluation processes (Abbasi-Moghaddam et al., 2019). Effectiveness, patient-centeredness, patients' satisfaction, patient perceptions, and safety seem to be the universally accepted and used core elements or attributes of quality of care (World Health Organization, 2018b).

## Review of Literature

The rising prevalence of patients living with chronic illness along with growing public expectations of health systems represents many challenges in delivering high-quality care as these patients require ongoing medical attention (Hajat & Stein, 2018; Wang et al., 2016). In Saudi Arabia, the increased prevalence of chronic diseases is creating challenges for patients and healthcare systems (World Health Organization, 2018c). The Ministry of Health has invested tremendously in healthcare services provision, and quality of care has become an integral part of the healthcare policy agenda (Tyrovolas et al., 2020). However, such improvements

lacked an emphasis upon patient's participation in evaluating the quality of healthcare services provided, despite the growing body of evidence indicating that patients can play an integral part in improving care provision as they recognize the defects in their own care (Desmedt et al., 2018; Lang et al., 2016). Research on patients' perceptions of quality of care among chronically ill in Saudi Arabia is very limited; however, the predictors of patient satisfaction with healthcare services are emerging with a specific focus on primary healthcare settings (Alzaied & Alshammari, 2016; Elagi et al., 2019; Senitan & Gillespie, 2020). One of these few studies examined the perception of Saudi Arabia's population on the quality of healthcare delivery and services and found that more than 50% of participants ( $n = 1,232$ ) were satisfied with the accessibility, and quality of care provided. However, the level of satisfaction toward responsiveness and affordability was significantly low. In fact, 60% complained that doctors do not spend enough time with them, and 30% had concerns about the financial burdens caused by the cost of medical care (Alshareef et al., 2020). Within the same context, Alahmary (2014) compared patients' experiences in a community-based primary care system and an employer-based primary care system and concluded that enhancing the quality and continuity of patient–physician relationship can improve patients' experience of care. In addition, a recent systematic review conducted by Almutairi and Al Shamsi (2020) to identify the challenges to quality primary health care in Saudi Arabia highlighted the need for certain professional development strategies and organizational culture improvements to enhance the quality of primary healthcare system.

Assessment of quality of care provided to chronically ill patients has been traditionally carried out through quantitative approaches using indicators of satisfaction, expectations of care, and patients' clinical outcomes (Edvardsson & Innes, 2010; Glasgow et al., 2005). Such approaches use questionnaires that frame patients' subjective experiences with the care provided into preconceived ideas rather than providing in-depth understanding of the patients' experiences through qualitative approaches. No studies in Saudi Arabia have undertaken a qualitative approach to understand chronically ill patients' perceptions of quality of care during hospitalization, creating a significant gap in research. Therefore, this study sought to explore perceptions of quality of healthcare services from the perspective and experiences of patients with chronic illness in an acute care setting and to identify areas for quality improvements.

## Methods

### Research Design

A qualitative descriptive approach informed an understanding of chronically ill patients' perceptions toward quality of care while being hospitalized. Such an approach was deemed most appropriate for the current study as it provides

straightforward descriptions of experiences and perceptions especially when little is known about the topic under investigation (Sandelowski, 2010). Qualitative descriptive approach acknowledges that individuals' realities are multiple, subjective, and shaped by their life experiences (Kim et al., 2017). Face-to-face individual interviews were used to gather participants' responses at their bedside during their current hospital admission.

### **Research Question**

This study posed one research questions: What are the perceptions of chronically ill patients on the quality of healthcare services provided during hospitalization?

### **Setting and Sample**

The study was conducted in the medical and surgical units of an urban 300-bed hospital located in a central neighborhood of Jeddah, Saudi Arabia. The hospital provides a full range of services free of charge to the public including subspecialty medical and surgical facilities which were well suited to recruit a diverse sample into the study. Purposive sampling with the use of maximum variation technique (Creswell, 2013) was employed to recruit patients with variant characteristics to better capture their potential differences. The use of maximum variation sampling technique acknowledges the range of experiences that exist (Sandelowski, 2010) and thus enabled meaningful contribution toward the aim of the study. Research team was granted access to the medical record system to facilitate recruitment and confirm the diagnosis of patients before inviting them to participate. Thereafter, head nurses acted as gatekeepers and approached the patients and delivered the study information.

### **Inclusion and Exclusion Criteria**

Eligibility criteria included Saudi adults over the age of 18 who have been diagnosed with chronic diseases; were hospitalized for at least three days during the time of data collection; and were able to provide informed consent and participate in face-to-face interviews. For the purpose of this study, chronic diseases were conceptualized as diseases that last for more than one year and require ongoing medical care. Patients with chronic illness whose current length of stay was less than three days or had cognitive deficits or serious preexisting physical condition that would affect their ability to be interviewed were excluded from the study.

### **Ethical Considerations**

This study was conducted in accordance with the Declaration of Helsinki (Rickham, 1964). Ethical approvals were obtained from the research ethics committee at the Faculty of Nursing

(Ref No. 2B.50) and the local hospital in Saudi Arabia (A01456). Written informed consent was obtained from each participant before the start of the interviews. Participants were assured that participation is completely voluntary, and they had the right to refuse to participate or withdraw at any time without giving a reason. To preserve the confidentiality and anonymity of research data, participants were identified by code numbers instead of their names on the demographic information sheet and interview transcripts. The research team was working with anonymized data, and audio recordings were stored in an encrypted password-protected computer.

### **Data Collection**

Face-to-face individual interviews were conducted with patients at their bedside during their current hospitalization. All the interviews were conducted in Arabic language by four nursing researchers R. A., R.M., E.A., and R.A., who were trained extensively on interviewing techniques and operational definitions of the research by a senior qualitative researcher (A.T.). Semistructured interview guide was developed based on the current literature and the researchers' past experiences to ensure consistency of the information obtained (Table 1). Interview topics explored patient's current experiences of healthcare in relation to their conditions, interactions with healthcare providers and their expectations. Although the main focus of the researchers was on the participants, sometimes relatives who were present during the interviews participated in the interviews. Data collected from relatives was transcribed in a different font and color to highlight their input. Adding this information from relatives appeared crucial to ensure in-depth understanding of the entire experience. Interviews lasted between 30 and 45 min and were digitally recorded to protect participant's words as much as possible. Field notes were recorded simultaneously to capture the context and augment the interview data. Recruitment continued until data saturation of identified themes was reached at 15 interviews, and collecting new data no longer sparked new insights (Saunders et al., 2018).

### **Data Analysis**

Audio recording of interviews was transcribed verbatim and then translated to English by the research team who are fluent bilingually. A backward translation by an independent translator was performed to ensure no meaning was lost during the process of translation. Transcripts were analyzed thematically using Braun and Clarke analysis approach (Braun & Clarke, 2006) to identify the major themes that reflect participants' experience. Interviews were conducted until saturation was reached, and no new information was provided with additional data. The first interview was piloted to identify areas for improvement and few changes to the interview guide were done; piloted interview was included in the

**Table 1.** Semistructured Interview Guide.*Initial open-ended questions (assessment of awareness and knowledge base)*

- When did you first noticed change in your health?
- How long have you been diagnosed with your chronic illness?
- Why were you recently hospitalized?
- Any previous hospitalizations?
- Tell me about your overall experience during this hospitalization?

*Intermediate questions: (indicators of quality of care)*

- How can you define the quality of care from your point of view?
- How do you think you can be satisfied with the quality of care?
- Why is it important to you to receive the best quality of care?
- Tell me about the treatments you received during this hospitalization?
- How would you describe your experience with the healthcare team?
- Where you involved in the treatment plan/decision-making?
- What do you think they can do to improve the quality of the services provided to you?
- Do they make appropriate referrals to meet your needs?
- Is there a continuity of care?
- Can you tell me about your perception regarding the nurse/ physician teamwork?
- Prompt: ease of getting answers to your questions, provided you with information that helps to make a decision? are they supportive, professional, and friendly?
- Did you face any difficulties communicating with the healthcare team?

*Ending questions:*

- What was your expectation on the quality of healthcare services?
- Where are these based on experience?
- What aspects of care do you find the most helpful?
- What aspects of care do you find the least helpful?
- Is there anything else you want to add?
- After having these experiences, what advice would you give to someone like you who suffers from chronic condition?
- Is there something that you might not think about before that occurred to you during this interview?
- Is there anything you think I should know to understand your experience?
- Do you have any questions?

analysis. Analysis was conducted using the following steps: (1) the research team read and reread all the interviews to become familiarized and immersed with the data while noting down initial thoughts. (2) Each transcript was initially coded by the research team using a systematic search method, and each code was given equal attention in the coding process. (3) Following that, the initial codes were collected and then compared to identify the similarities and differences. (4) Themes and subthemes were generated through an inclusive and comprehensive coding process. (5) Themes were checked several times during an analytic meeting with the entire research team to ensure consistency and make sure that the identified themes best represent the data. Quotations from the original data were used in the results to illustrate the themes and ensure that interpretation was grounded in the data.

Multiple strategies were adopted in this study to ensure trustworthiness of the data (Shenton, 2004). Credibility of the findings was ensured through the use of a peer-checking process. Whereas the audio recording of interviews increased the confirmability of findings. Analytic meetings with the research team were carried out regularly

to ensure that one perspective does not dominate and confirmed the reliability of the findings. Finally, clearly describing and documenting the process of analysis ensured transparency.

## Results

A total of 15 semistructured individual interviews were conducted with Saudi adult patients who have been living with chronic illnesses during their hospital admission. Demographic characteristics of study participants are presented in Table 2. Overall, participants were pleased with their hospitalization experience and the quality of healthcare delivery. However, they highlighted many aspects of care that can be addressed to improve the quality of care provided.

Five major themes yielded from the analysis describe patients' perceptions of the quality of healthcare services: (a) defining quality of care, (b) aspects related to the healthcare provider, (c) unmet care needs, (d) patients' involvement in healthcare decision, and (e) care expectations and outcomes. Each theme is described below and illustrated with quotations from the data that are set in

**Table 2.** Demographic Characteristics of Participants.

Number of participants	15	Percentage
Gender		
Male	9	60%
Female	6	40%
Age		
20–39	2	13%
40–59	9	60%
≥60	4	27%
Marital status		
Single	5	33%
Married	9	60%
Divorced	1	7%
Level of education		
Less than high school	8	53%
High school or equivalent	3	20%
College graduate	4	27%
Occupational status		
Paid employment	4	27%
Temporarily not working	3	20%
Retired	7	47%
Unemployed	1	7%
Diagnosis		
Diabetes Miletus *	9	60%
Hypertension*	12	80%
Rheumatoid arthritis	1	7%
Sickle cell anemia	1	7%
Kidney disease	2	13%
Stroke	3	20%
Length of time since diagnosis		
Less than 2 years	3	20%
2–5 years	2	13%
6–10 years	6	40%
>10 years	4	27%
Mode of admission		
Emergency department	13	87%
Primary health care.	2	13%
No. of previous hospitalizations		
Less than 2	1	7%
2–5	12	80%
6–10	1	7%
>10	1	7%

italics in the text. Some overarching themes were reported with subthemes to enhance clarity. The process of categorizing the themes and subthemes is further illustrated in Table 3.

### Theme 1: Defining Quality of Care

This was a major theme that was raised by all respondents which helped gain insight into their interpretation of the term “quality of care.” Considering the complexity of the concept, participants defined the quality in different ways based on their experiences and expectations and associated it mostly with healthcare providers. For most participants,

quality of healthcare services was based majorly on providing patient with the best possible nursing care:

“Quality is defined by the nurses ... if nursing care is effective, safe, and coordinated with other healthcare providers, I will know the quality of the services I receive.” (P01).

For other participants, essential components of good quality of care were the availability of resources including staff and equipment along with personal requirements of hygiene and cleanliness

“Good quality care for me is when there is a good cleaning and hygiene services. Also how skilled are the doctors and nurses; the availability of equipment and medications” (P12). “Caring, hygiene, dealing with patients professionally and in a better way “(P14).

### Theme 2: Aspects Related to Healthcare Providers

When participants were asked which aspects of care are the most important to them, they all prioritized aspects related to healthcare providers including nurses and physicians. All participants prioritized the attitudes, skills, and competencies of healthcare providers as the most essential components of good quality care. The following subthemes represent a more detailed way of what attributes and qualities of healthcare providers participants perceived: a) attitudes and skills, b) communication concerns, and c) insufficient advice.

*Attitudes and Skills.* Throughout the interviews, participants identified healthcare providers’ manners, attitudes, and clinical skills and competencies as key factors that shaped their perceptions of the quality of care provided during their hospitalization. However, such perceptions were not always positive. For instance, unresponsiveness from nurses’ side was commonly reported by participants, particularly with medication administration: “When I call the nurses to give me the painkiller, they do not answer... Yesterday I asked the nurse for my painkiller injection but she kept postponing and I couldn’t sleep” (P07). In contrast, some participants complemented the professionalism of nurses and their continuity in providing care and fast response. They expressed complete trust in their clinical competence and knowledge. One participant reflects: “when I call the nurses, they respond very quickly and provide whatever care needed immediately... they know exactly what they are doing, and this makes me feel safe.” (P01).

Although participants view healthcare providers as caring and respectful, negative attitudes were also reported. This includes lack of professionalism, lack of honesty in delivering information, and bad manners: “some of the doctors and nurses have a really bad attitude, I know they’re good at their work, but they have to have manners and behave

**Table 3.** Categorizing Themes and Subthemes.

Codes	Subthemes	Themes
<ul style="list-style-type: none"> <li>• Quality of care definition.</li> <li>• Quality of healthcare meaning</li> <li>• Unresponsiveness from HCP.</li> <li>• Poor nursing skills.</li> <li>• Negative attitudes</li> <li>• Heavy workload</li> <li>• communication between patients and HCP</li> <li>• communication between HCP themselves</li> <li>• Inaccessibility of physicians.</li> <li>• Lack of advice</li> <li>• Unclear information</li> <li>• Continuity of care.</li> <li>• Poor care coordination.</li> <li>• Delays in providing care.</li> <li>• Patients Involvement in healthcare decision.</li> <li>• Patients involvement in treatment plan.</li> <li>• Family participation in care.</li> <li>• Higher expectation.</li> <li>• Aspire for the best quality.</li> <li>• Satisfaction when needs are met.</li> </ul>	<ul style="list-style-type: none"> <li>• Attitudes and skills.</li> <li>• Communication concerns.</li> <li>Insufficient advice.</li> </ul>	<ul style="list-style-type: none"> <li>Defining quality of care.</li> <li>Aspects related to healthcare providers:</li> <li>Unmet care need.</li> <li>Patient involvement in health care decision</li> <li>Care expectations and Outcomes.</li> </ul>

*appropriately with patients ... they have to be honest and respectful ... but their attitudes are bad as I said*" (P06). *"some doctors are unprofessional at all. They never deliver the information in a way that's tolerable"* (caregiver14). Heavy workload on healthcare providers and multiple tasks was believed to be the reason that led to insufficient care, which is reflected in the following quotes: *"They try to provide good and efficient care, but we excuse them when they are busy ... Imagine how many other patients they are taking care of ... this is a heavy load"* (P08).

"Increasing the number of staff working every shift is a must because they can't get their work done ..., A nurse once told me that she is really overloaded and can't get all the work done by the end of the shift. I believe this explains the delays in appointments and referrals" (P10). Another participant elaborated: "They are just connecting lines here and here, trying to juggle between things and getting the work done. This can lead to medical errors if they don't slow down and give their complete undivided attention to every single patient. I know it is harder said than done" (P12).

**Communication Concerns.** This subtheme includes issues with communication between patients and healthcare providers and between healthcare providers themselves. The majority of participants expressed poor communication between the healthcare workers including nurses and physician which was perceived as a barrier to good quality of care: *"I was feeling better and wanted to be discharged from the hospital, but they told me to wait until they get confirmation from the*

*doctor. They had to send an email to the doctor. This was the only way to contact him, if I needed anything, they would email him"* (P03).

"There is difficulty in this, yesterday when I was down in the ICU I was asking when I am going to be transferred up here, I was shouting and calling but they just passed in front of me without answering ... That's impossible, impossible ... you know yesterday I was asking for the doctor from 5:30 pm until 11:00 pm. It is kind of impossible to reach for the doctor whenever I need. I only can see him once a day during the rounds ... that set" (P04)

**Insufficient Advice.** Patient teaching and advice was perceived by participants as one of the patient's rights, nonetheless, such right was lacking most of the time. They spoke at length about situations where advice and proper teaching were needed but not received: *"some doctors don't deliver a clear and good information; you feel like they don't understand."* Conflicting advice was also reported by some participants: *"I was scheduled for a scan and was supposed to fast, but no one told when to start fasting and for how long. The nurse just came in and said that now is the time to fast. They can't show up on a sudden and say it's time. I was not prepared to start fasting"* (P06).

### Theme 3: Unmet Care Needs

Unmet healthcare needs are determined as the difference between the necessary services to be provided and the

actual services received. Interview data showed that the majority of participants agreed that their essential healthcare needs were met but expressed a need for improved continuity and coordination of care: *“every single step takes long. For example, they said my scan will be on Tuesday, then they said no that was for another patient not you, yours will be later. I kept on fasting for every scan for almost 12 h and then it gets either cancelled or postponed... I’m here for almost two weeks now just because of this scan”* (P03).

Delays in care were also reported frequently by participants as negatively affecting their outcomes. These delays included test results and long queued appointments: *“The doctors pass by us every day once or twice. But the problems is delays in having the results. How come he is the doctor and does not have the results!?”* (P05). *“I have been hospitalized for over a month now. Last month I did an MRI, but the result took too long ... and while the results came, I became worse, they took so long. If the results came in earlier, I might’ve been better”* (P03). Another participant complained about not being able to book a near appointment: *“we suffer from very far queued appointments in general hospitals, the opposite of private. Here we wait two or three months for our appointments. This causes deterioration in our health”* (P08).

#### Theme 4: Patients Involvement in Healthcare Decisions

It is argued that patient participation in healthcare decisions and being considered as an equal partner is expected to enhance the quality of life and patients’ outcomes (Vahdat et al., 2014). In the present study, more than half of the participants were grateful for their involvement in the healthcare decisions: *“Honestly when I first came the anaesthesiologist, he told me everything about the procedure, the same thing for the surgeon, he gave me all the information about my case and the operation, even when I finished, I will be wearing a belt and walk, clarified all the points and steps. I knew exactly what to expect after the operation. And that made me feel involved and prepared”* (P11). Another participant commented: *“They discuss everything in detail, for example, they make me understand the difference between the supplements I take and why they give them to me, I remember when I was first got diagnosed with kidney failure and needed to start on dialysis I refused and wanted time to think. They told me that it may be temporary and involved me in making the treatment plan. That was really important for me”* (P09).

On the contrary, few participants disagreed, particularly when it came to nurses: *“The only one who discussed the treatment plan with me was the surgeon... The nurses are only connecting lines here and here [pointing at his arms] they don’t speak to me like a human being.. even when I was scared and needed some reassurance”* (P12). In addition, family members discussed the need for family

involvement in health care decisions which is currently lacking: *“There was a discussion between me, the family and the consultant that I don’t want to talk about but asked me to sign papers three days ago to intubate my father and I refused. They just come to us to sign papers. Never to inform us on any updates or include us in any healthcare decisions”* (caregiver 14).

#### Theme 5: Care Expectations and Outcomes

Participants shared their expectations about the healthcare services’ quality, and most of them expected more than what were provided: *“I know that this hospital has a very good reputation, but I was shocked when I was first admitted. I thought that they are going to respond fast when the patient calls and see if the patient needs anything ... I saw the reality and I was expecting more than this.”* (P04). Another participant elaborated on the fact that excellent service and quality of care is the expectation of all Saudis since we live in a wealthy country. He states: *“That’s what every citizen wants, we live in a wealthy country and the government is spending so much on the hospitals and healthcare industry, millions in fact, so they have to provide an excellent service!”*

Satisfaction with provided care was also discussed by many participants: *“I think this time was better compared to my previous hospitalizations... I see good care and I am satisfied with it”* (P01). “Some participants had bad expectations due to previous experience with hospitalization: *“I had to adjust my expectations with the care provided because of my previous experience with hospitalization... particularly with nursing care.”*

## Discussion

To the best of our knowledge, this is the first qualitative study that sought to explore the perceptions of chronically ill patients on the quality of healthcare services in Saudi Arabia. The novel insights this study unveiled shed a light on an underexplored area and provided empirical evidence to further our understanding of how patients conceptualize and describe their expectations of good quality healthcare services during hospitalization. Such a thorough understanding of patients’ perception could not have been possible through methods other than qualitative research. The most significant findings emphasized that healthcare quality is closely connected to the perceptions of healthcare providers’ skills and attitudes such as physicians, nurses, and other specialists. However, other challenges with quality of care provided to chronically ill patient were also uncovered, of which some were reported for the first time for Saudis.

An initial aim of the study was to explore the perspectives of patients on how to define quality of care which emerged as the first theme of the analysis. It was defined from the perspective of good hygiene for some patients, while others measured the quality of healthcare services through the

quality of nursing care, which was reported for the very first time in the Saudi context. Consistent findings were reported in a study that aimed to explore cancer patients' experience with multimodal treatments, and how the participants identified the nurse navigator as a resource for information, emotional support, and improved continuity of care (Duthie et al., 2017). Another definition of quality of care from the patient's perspective was reported in a study exploring renal patients' perspective on safety during hospitalization, which defined high-quality care as individualized, patient-centered care and associated with the patient's specific needs (New et al., 2019).

An overarching theme that emerged from the analysis of the data was participants' perception of good quality care and being care for through positive relationships and interactions with healthcare providers. Their experiences, however, were not always positive ones. Such findings are consistent with another study that reported frustration among patients from the late nursing response, at the same time participants complain of heavy workload on the staff as a leading cause to poor quality services from participants' point of view (New et al., 2019). Yet, perceptions of the association between poor nursing skills and clinical competence and its effect on health outcomes are reported for the first time in the current study.

Communication either between healthcare providers or patients was discussed in a previous study, which emphasized the importance of good communication as a component of high-quality care because of its positive effect on health outcomes. On the other hand, poor communication has a negative effect on healthcare quality. Two different studies reported similar findings to the current study in which participants complained of obvious poor communication between the healthcare providers and its effect on the participants' satisfaction and health outcomes (New et al., 2019; Senitan & Gillespie, 2020).

One of the important domains that fall under patient education is giving instructions before starting any medical procedure. Our findings showed that participants did not get enough information and instructions before any procedure. However, some participants reported conflicting advice from different health care providers about the preprocedure instructions. This finding is reported for the first time and goes at odds with the current literature that showed that cancer patients were getting a clear, concise information and were pleased with the given advice (Duthie et al., 2017).

Unmet care needs in the present study were conceptualized as a lack of care coordination. Findings showed a variation in the perceptions of coordination of care. The majority of the participants had the perception of a well-coordinated care during hospitalization, nonetheless, few of the participants complained of early discharge that has not been expected due to poor coordination between healthcare providers which led to negative outcomes on their health condition and delay in providing care. Unlike another study that

was carried out in Saudi Arabia, which aimed to evaluate the connection among patients' demographics, the standards of physician-patient care coordination, and general satisfaction score in primary healthcare centers showed that participants received a well-coordinated care with medium satisfaction (Senitan & Gillespie, 2020).

The literature on improving quality of care often emphasizes the importance of patients' involvement in care decisions (Bombard et al., 2018). Our study found that participants who have not been involved in the treatment plan and decisions reported that they feel anxious and frustrated and demanded being involved. Although they are willing to know more about their condition, enough information has not been delivered to them and was kept in the dark. These findings complement those reported by Duthie et al. (2017) study in which patients felt heard and being known when they were invited to participate in the decision-making process with the whole healthcare team. However, the results showed that if a patient becomes severely ill, healthcare providers would include the family in the treatment plan and decisions. This was reported for the first time and provided novel insight into the Saudi context.

With regard to the final theme, health expectations and outcomes, participant expected more than what has been provided to them. They believed that is part of their right as citizens of a wealthy country that spends plenty on the healthcare system. This goes at odds with another study that aimed to understand how patients conceptualize and describe their expectations of health care (El-Haddad et al., 2020). The results showed that many participants expected less than what was provided to them either as a result of previous experience or due to their health conditions and prognoses. In the current study, a high level of satisfaction came along with good care, and when needs are met, complementing the findings of a previous Saudi study conducted in the context of primary healthcare (Senitan & Gillespie, 2020).

## Implications for Practice

The current body of literature investigating chronically ill patients' perception of quality of care during hospitalization among Saudis is lacking. Thus, the findings of this study have many potential implications for practice and policy development. In terms of practice, the findings provided insights about patients' perceptions and experiences of the care provided by healthcare providers. It highlighted that health care providers need to involve their patients in their own care plan considering them as equal partners, as well as in the decision-making process by adding additional information that would facilitate the process. Practicing nurses and physicians can use these novel insights to enhance the care they provide and improve the overall patients' experiences. Policymakers can modify the healthcare quality services based on the findings of this current study to reach patient's expectations and to know the current deficit in health care system. Recommendations for



policy makers may include increasing the number of nursing staff in each shift and establishing a proper system of care coordination between all healthcare providers to prevent delays and discontinuation of care. Further research, perhaps a quantitative cross-sectional design based on the findings of this study can be carried out to test the generalizability of these findings. A large sample from different settings and regions in Saudi Arabia is recommended to augment our findings and can be utilized to inform policy and practice.

## Limitations

This study, despite its attempts to accomplish the aim and establish rigor has certain limitations. Firstly, the study was conducted at a single general hospital located in Jeddah, Saudi Arabia. Yet, participants were recruited from different units in which chronically ill patients were hospitalized. As such, results may not be applicable to other hospitals or patients' populations. Future similar studies may aim to recruit patients from multiple settings at different hospitals to maximize the variation of the sample. Secondly, the nature of the individual face-to-face bedside interview we used to collect data might have also influenced the participants' response to some extent even if the data collectors were not part of the treating team. This was addressed by a detailed explanation from the research team of the study procedures and assuring the participants of complete anonymization and confidentiality of the sample.

## Conclusion

Quality of care during hospitalization is of utmost importance for improved patients' outcomes and is currently at the heart of health policy agendas globally. Empirical research has shown that incorporating patients' perceptions of what constitutes good or bad quality of care delivery and services is essential to provide comprehensive and patient-centered healthcare. In addition, the complexity of the quality-of-care concept supports the need for deeper and in-depth understanding of patients' perceptions regarding the current quality of care. This qualitative study explored chronically ill patients' perceptions of quality of care during hospitalization to address this gap by identifying the strength points and areas for further improvements which are the cornerstone of developing tailored and patient-centered strategies to improve the quality of care during hospitalizations among chronically ill Saudis.


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