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**Evaluation of in-patient Rehabilitation Services
in Gaza Governorates**

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Evaluation of In-patient Rehabilitation Services in Gaza Governorates

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Al-Quds University
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School of Public Health



Thesis approval

**Evaluation of in-patient Rehabilitation Services
in Gaza Governorates**

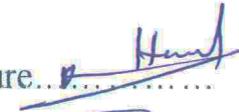
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Jerusalem-Palestine

1440 / 2018

Dedication

To the greatest man I have in my life, the sun of my life... my lovely father.

To the biggest heart with the most loving care, who sacrificed a lot for me to become what I am now, my mother.

To my brothers and sisters, Ahmed, Amal, Mahmoud, Amira and Amjad who supported me through each step of the way.

To the soul of my lovely Mira and Miriam.

To all those who encouraged, supported, and helped me all the way.

I dedicate this research for all of them ...

Mabadee Hamdan Al-Farra

22/12/2018

Declaration

I certify that this thesis submitted for the degree of Master, is the result of my own research, except where otherwise acknowledged, and this study (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed:

Mabadee Hamdan AL-Farra

...../...../....

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I would also like to thank all my family members, my father, my mother, my brothers, and sisters and the one who cares about me. All of you supported me when I faced difficult times. Words cannot express how grateful I am all of the sacrifices that you have made on my behalf. You provided me with the facilities being required and conducive conditions for my thesis.

Thank you,

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Abstract

Evaluation of In-patient Rehabilitation Services (IRSs) is important for the provision of quality rehabilitation services. This study explores the quality of the rehabilitation services provided to beneficiaries admitted to Al Amal and Al Wafa rehabilitation centers.

Triangulated study design was used, 263 beneficiaries/patients completed an interviewed questionnaire. In addition, two focus groups and 8 key informant interviews were conducted. Also, the records of the interviewed beneficiaries were reviewed (263). Quantitative data were analyzed using SPSS and qualitative data were analyzed using open coding thematic technique. Cronbach alpha readings for the used scales were high as it reached .847.

Findings reflected good scores in hotel hospital services, physiotherapy, occupational therapy, psychosocial, speech therapy, nursing patient-provider interaction and patient's satisfaction (72%), (71.2%) , (70.2%) , (69.4%) , (68.2%) , (71.2%) respectively. Regarding documentation completeness, the general patient's data, nursing care, occupational therapy, and physiotherapy were 100%, 86.3%, 80.8%, and 72.5% respectively. With regard to the outcome measures of mobility, self-care, activity, pain and experiencing less depression; there was tangible improvement at the discharge in comparison to the admission parameters, which indicates that the interventions at the rehabilitation centers have positive outcomes and the differences were statistically significant, as revealed by the results of the paired t-test.

Perceptions about hospital hotel services were statistically significantly, varied across governorates with Khanyounis eliciting the highest mean score while middle area elicited the lowest. Males statistically significantly had reported higher mean score and also the age group less than 30. Patients who reported that the therapists had spent enough time with them had elicited higher scores than their peer and the differences were statistically significant. To improve post-admission results, patients should receive occupational therapy, daily physiotherapy sessions, improve standards for physiotherapy and psychosocial therapy sessions and patients should receive on time sessions of physiotherapy, occupational therapy, and nursing services.

The study concludes that effectiveness of IRSs is high and satisfaction among patient is moderate; however, there is a room for further improvements. It is important to monitor these important moral related issues and to promote IRSs constantly

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List of Abbreviations

ADL	Active Daily Living
CVA	Cerebrovascular Accident
DALYS	Disability-Adjusted Life Year
FGD	Focus Group Discussion
FIM	Functional Independence Measure
GDP	Gross Domestic Product
GGs	Gaza Governorates
IRH	In-patient Rehabilitation Hospital
IRS	In-patient Rehabilitation Service
KII	Key-informant In-depth Interview
LSD	Least Significant Difference
MLN	Medicare Learning Network
MOH	Ministry Of Health
PCBS	Palestinian Central Bureau of Statistics
PRCS	Palestinian Red Crescent Society
PWD	Person With Disability
RAD	Referral Abroad Department
RTA	Road Traffic Accident
SCI	Spinal Cord Injury
SPSS	Statistical Package for the Social Sciences
WCPT	World Confederation for Physical Therapy
WHO	World Health Organization

Chapter 1

Introduction

1.1 Background

The care of Persons with Disabilities (PWDs) requires specific and integrated consequence of rehabilitation services. World Health Organization-WHO (2011, Page:3) defined rehabilitation as a set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments.

A specialized team provides the required rehabilitation for PWDs for a specific period of time. Single or multiple services can be delivered by an individual or the specialized team of rehabilitation providers, and can be provided from the acute or initial phase immediately following recognition of a health condition through to post-acute and maintenance phases (ibid).The rehabilitation process starts from hospital care to community rehabilitation. This process needs not to be expensive. It can improve health outcomes, reduces costs by shortening hospital stays, reduces disability, and improves the quality of life(ibid).The type of care of this team reveals the degree of nations' civilization. The degree of care of the PWDs is a basic standard for measuring the civilization and improvement of the nations (Abo Fadala, 2009). The care of PWDs is one of the priorities of modern states and organizations, which stems from the legitimacy of the right of the PWD to equal opportunities in all areas of life to live in dignity and freedom.

In-patient Rehabilitation Services (IRSs) are only achieved through professional interdisciplinary team of rehabilitation needs, which provides single or multiple rehabilitation services within hospital environment (Medicare Learning Network-MLN, 2012). IRSs are provided for the complex needed patients for nursing, medical and rehabilitative. There is a preadmission outcome screening, post-admission outcome evaluation and overall plan of care for every admitted patient in the In-patient Rehabilitation hospitals (IRHs). The rehabilitation team contains physiotherapist, occupational therapist, psychosocial therapist, speech therapist and nurse. The aim of this team is to raise regular, arranged, and documented communication among corrections to form, prioritize, and attain treatment goals (ibid).

There are two main IRHs in Gaza Governorates GGs, Al-Amal Hospital and Al-Wafa Hospital.

Evaluations and measurements of performance progressively play a role in health care reforms. Stakeholders need this information to guide their decisions in directing the health system towards better outcomes (Peter and Smith, 2008). Yet this study will handle the evaluation of IRHs in GGs.

The researcher conducted this study to evaluate the IRHs in GGs in order to appraise how things are working, which parts of program are working the best, and which bits have to change or improve. The following will illustrate the study objectives and explain the importance of IRHs evaluation.

1.2 Research Problem

The emergency situation in GGs that people live in as they are exposed to sequences of troubles that cause disability which need professional IRHs. This situation makes the IRHs conversional in GGs. According to Palestinian Central Bureau of Statistics (PCBS, 2011), the disability rate in 2011 was 2.7%; mobility disability type rate was 47.2%, which is the most common type in GGs. These PWDs generally have barriers in their everyday lives. The demand for IRHs is increasing for supporting PWDs.

According to the researcher knowledge, no studies have been conducted to assess the effectiveness of the provided services of IRSs and patient satisfaction in both IRHs in GGs. However, some studies evaluated separated dimensions of Al-Wafa Hospital. Under such situation, the researcher claimed that there was a need to fill this information gap by exploring the extent to which the RHSs are appropriate, meeting quality standards and how these services are perceived by beneficiaries. The outcomes of the study may help policy makers to identify areas of strengths and areas of weaknesses to improve the quality of the delivered health services.

1.3 Justification of the study

This study is the first study in its kind in its comprehensiveness and holistically.

Previous studies focused on some points in evaluation the rehabilitation services and focused only in Al-Wafa hospital. What makes this study unique in, that it includes all

points on covering effectiveness of the IRSs and patient satisfaction, and it was done in both IRHs in GGs; Al-Amal and Al-Wafa hospitals.

Being a PWD is a real challenge losing his/her ability, especially for those who lost it during their life without disability. This research discovered if the patients who received services from IRHs in GGs satisfied with the service, are some sub-groups benefiting but not others (for example, female versus male). Knowing what works would help IRHs managers to focus resources on the essential components of the services that benefit patients and PWD, knowing what does not work allows the managers to improve and strengthen their service delivery models. Not knowing what is working may waste valuable time and resources.

Sharing findings within the community could serve as a good IRH tool for building trust with families and community members.

Improving how healthcare rehabilitation providers deliver services to PWD increase likelihood that IRSs will achieve positive outcomes with center participants. Conducting this research can allow IRH managers to assess staff's performance, and figure out where staff members are succeeding and where they need more support or training. This research can also provide staff with opportunities to discuss the challenges they face.

This research helps every IRH in building an organization's capacity to conduct self-assessment, including conducting staff and program needs assessment and measuring staff performance. This will improve IRSs operations and improve outcomes for those served. Knowing how and for whom is effective and ways services can be strengthened are essential building blocks for the IRS's strategic plan.

The valuable tool for IRH managers who are seeking to strengthen the quality of their hospitals and improve outcomes for the patients and PWD they serve is program evaluation (Metz, 2007).

This study also would insight the managers and decision makers to make more accurate informal decisions regarding improving the effectiveness of quality. Program evaluation answers basic questions about a program's effectiveness, and evaluation data can be used to improve program services. This study explored the degree of effectiveness of IRSs at IRHs in GGs in Al-Amal hospital and Al-Wafa hospital. Findings of the study may help the decision makers to improve rehabilitation services, which may also help in dealing with the factors that affect effectiveness of services provided. It also filled important information gaps related to the degree of effectiveness of rehabilitation services within the IRHs in GGs.

On the other hand, this study guided the steps of other researchers in the field. Knowing that there are few evaluated studies, this study will benefit the body of knowledge. This research benefits everyone trying to make a difference in the lives of the PWD. Finally, this study benefit the researchers by increase their knowledge by use the study as a reference and the findings may encourage them build on it another studies.

The study influenced the researcher as she is working in the field of physiotherapy.

1.4 General Objective

The overall objective of this study is to evaluate the inpatient rehabilitation services in Gaza Governorates in Al-Amal Hospital and Al-Wafa Hospital.

1.5 Specific Objectives

1. To assess the effectiveness of in-patient rehabilitation services provided to patients in Gaza Governorate as perceived by the patients and the providers.
2. To appraise beneficiaries satisfaction about in-patient rehabilitation services.
3. To recognize areas of strength and areas of weakness in the in-patient rehabilitation services.
4. To set recommendations and suggestions that might promote in-patient rehabilitation services performance.

1.6 Research Questions

- 1- Is the in-patient rehabilitation service meets beneficiaries' needs?
- 2- What is the effect of the in-patient rehabilitation services in Gaza Governorates in improving the status of the beneficiaries?
- 3- How appropriate are the provided rehabilitation services in the in-patient rehabilitation center as perceived by beneficiaries and providers?
- 4- Does the in-patient rehabilitation services use appropriate assessment form with the patient?
- 5- What kind of tools are used during the sessions of the health providers of the in-patient rehabilitation centers?

- 6 - What is the duration of the session of every patient receiving service from in-patient rehabilitation services?
- 7- How the interaction between the patient and the health provider goes?
- 8- What are the main problems facing the health providers in providing the rehabilitation services to the patients?
- 9- What are the areas of strength in the in-patient rehabilitation services?
- 10- What are the areas that need promotion in the in-patient rehabilitation services?

1.7 Context of the study

1.7.1 GGs Demography

The Gaza Strip is a very narrow and considered as one of the most populated areas in the world (5,154 persons/km² along the coast of the Mediterranean Sea (360 km²). Its position on the crossroads from Africa to Asia made it a target for occupiers over the centuries. It is very crowded place with the area of 365 sq. Km (PCBS, 2016). The total population of GGs is 1.88 million of which 956 thousand males and 925 thousand females. GGs divided into five governorates: the North, Gaza, Deir El Balah, Khan Younis and Rafah governorate (ibid). A very crowded context needs highly qualified IRHs for PWDs.

1.7.2 Socioeconomic states in GGs

The wars and blockade of GGs from Israel military which still has the upper hand on borders and control travels in and out Gaza and also has the power over entry of goods related to trade and commercial market. The most significant socio-economic determinants in GGs are the stress, the unemployment, and poverty that clearly have an impact on people's health. Being a PWD who needs IRH in GGs, this means a lot of money, and according to the poverty, many can't integrate IRHs. Although there are IRHs in GGs, but they are still not available for every patient who needs them.

The situation for 1,88 Palestinian living in Gaza is worse than ever been (PCBS, 2015). The Israeli restriction since 2007 and war 2014 are causing a sever deterioration in all living conditions. The Palestinian economy has not advanced. According PCBS (2015), unemployment rate increased to 27.2% in 2016 compared with 26.2% in 2015. In 2014, Palestinian real gross domestic product (GDP) per capita was at virtually the same level as it was in 1999, with Gaza's real GDP per capita standing at only 71% of its 1999 level. The

unemployment crisis in GGs is highest rates in the world particularly acute, where it has reached 42%, with 58% of its youth (aged between 15 and 29) without work (Lynk, 2016). In addition, an old study for Hamdan (2006) reported that almost one third of the families in Tulkarm and Qalqilia of PWDs have more than one PWD. Problems facing PWD are economic difficulties (36%) is the main one, followed by 26.7% as psychological, 5.7% as medical, 4.1% as social and 15% related to other types of problems. Nevertheless, the major problem facing the family in taking care of the disabled is also economic (63.9%), followed by psychological 10.5%, medical 5%, social .5%, and by 8.1% that is related to other types of problems.

Another study for Abu Arisheh and Efrat (2016) showed that there is another economic trouble in Palestinian Authority, which is the severely limitability to fund medical treatments outside GGs in cases where the necessary treatment is unavailable within it.

This poor socioeconomic situation in GG left the PWD who need IRSs unable to join these services because they can't pay for them.

1.7.3 Political status of GGs

The security situation in Gaza remains unpredictable and politically unstable because of the current Israeli occupation, while the Israeli army different kinds of violations and military invasions with human rights abuses. The scope of the conflict exceeded all expectations and contingency plans, where available, were insufficient to manage the challenges imposed on centralized systems and individual health facilities. The chronically deteriorated status of the health system certainly reduced the quality of services provided throughout and after the conflict. The blockade of Gaza is currently the longest standing measure of collective punishment of the Palestinian people. It imposed in 2007, has left the vast majority of 1.8 million populations of Gaza unable to live normally.

According to World Health Organization WHO (2014), health sector development is severely constraining by the Israeli blockade. Which is leading to limited quality of health service facilities, severe deterioration of medical equipment and inability to appropriately maintain equipment in the absence of emergency parts, and reduced tertiary sector capacity-leading to costly referrals of patients outside of GGs, lack of training opportunities for medical staff and more.

This deterioration in healthcare system in GG affects also the IRSs by shortage of drugs and equipment that they need for providing the better effect services.

1.7.4 Health status and disability

According to Lynk (2016), the non-payment or underpayment of healthcare provider's salaries, the shortage of the essential drugs and equipment and the prolonged fuel cuts from healthcare facilities lead to continues in deterioration in healthcare facilities. This left thousands of Gazans with major physical disabilities and acquired mental health problems in the result of the recent conflicts facing an alarm. Observing the downward slide of living conditions, one leading human rights organization has stated that “life in Gaza is like life in a collapsing third-world country, a reality that is not the result of a natural calamity, but purely man-made”

In 2011, PCBS reported that 2.7% of individuals in Palestine suffered from at least one disability. Mobility is the most common (48.4%) disability type in Palestine then the disability of slow learning that has the percentage of 26.7% in GGs (ibid).

A study for Abu Arisheh and Efrat (2016) showed that more than 2,200 of Gazan people were killed, and 11,000 were wounded in war 2014 in GG, lifting 2.4% of Gaza's people, or 42,240 people, live with some type of disability, mostly (47.2%) movement restrictions. It added approximately one hundred young aged new amputees to tens of others who were left amputated by previous wars and operations. In addition to this, more than one thousands of Gazan people need rehabilitation due to the injury to their limbs after being hit during war 2014. The hundreds of amputees and people with limb injuries from the March great return 2018 have joined hundreds of others who were hit in previous wars and operations—in 2014, 2012, 2009 and even earlier.

A study of Aljeesh and et al. (2016) reported that rapid modifications in Palestinian people caused in an epidemiological transition and a rapid increasing burden of chronic diseases. In 2010, Disability-Adjusted Life Years (DALYS) lost due to chronic diseases in GGs were estimated as (57/1000 DALYs), considering that each one DALY is thought of as one lost year of ideal healthy life (ibid).

According to PCBS (2014), In Palestine, there are public attitudes towards PWDs that caused 8.7% of PWDs avoid engaging in any activities: 7.7% in the GGs. Also, 34.2% of PWDs stated that they don't have a modified home or work place according to their disability type: 38.4% in the GGs. In addition, according to (PCBS, 2015), in 2011, almost 37.6% of PWDs in Palestine did not join schools with percentage of 42.2% in GGs.

1.7.5 Rehabilitation services in Palestine

According to Worldbank (2005), there are three main levels of rehabilitation services in the West Bank and Gaza Strip: national, intermediate, and community.

1- The National Level:

It provides both long-term and costly services. They are characterized by an ability to provide emergency and tertiary care services. In addition, they have highly qualified healthcare providers and specialized teams of professional providers (e.g., orthopedic surgeons, and physiotherapists); having a range of specialized medical services that might include physiotherapy, occupational therapy, laboratory services, medicines, nursing, and psychosocial care. (ibid)

These institutions are:

Bethlehem Arab Society for Rehabilitation– Bethlehem; West Bank.

Abu Rayya Rehabilitation Center – Ramallah; West Bank.

Princess Basmah Rehabilitation Center – Jerusalem.

Al-Wafa Medical Rehabilitation Center – Gaza Strip.

Al-Amal Center – Gaza Strip. (ibid)

2- The Intermediate Level:

These services include diagnosis and treatment, and provision of or referral for social, educational, vocational, and other services. This level of care is provided primarily through Non-Governmental Organizations (NGOs) and UNRWA, although the Ministry of Health(MOH) also provide intermediate level services (ibid).

3- Community Level - Community Base Rehabilitation Programs (CBR Programs):

CBR address basic physical and mental health intervention needs. It includes individual case planning with the individual and prostheses, his/her family members, and community volunteers; provision of or referral for technical aids; raising community awareness regarding disabilities and the needs of the disabled population; and prevention activities to decrease the incidence of disabilities. These services are provided by NGO's, which tend to specialize in one or a number of disabilities (ibid).

1.7.6 IRHs in GGs

There are two main hospitals for providing the IRSs in GGs. These two hospitals are Alamal hospital and Alwafa hospital:

1.7.6.1 Al-Amal City Hospital, Palestine – Khanyounis

This hospital was opened in 1996 to accomplish all the needs and demands of the surrounding community. The vision of the hospital is believing in god and then following the seven principals of the Palestinian Red Crescent Society (PRCS), in which the equity of serving all people. The hospital has many departments. In-patient rehabilitation department is one of them. It is the only one in southern GGs. It was established in Khanyounis city on May, 2013 with vision to help people who exposed to an injury or disease that caused temporary and permanent disabilities for having better life as normal as possible. It has 45 bed for providing the in-patient rehabilitation services. The rehabilitation center has inpatient and outpatient departments. The inpatient department for several types of disabilities resulting from spinal cord injuries, brain strokes, brain injuries, neuromuscular diseases, fractures, rheumatic diseases and amputation for all ages. It provides rehabilitative services for PWD with professional physiotherapist, occupational therapist, and psychotherapist, specialized rehabilitation doctor, nursing, hearing rehabilitation, and playing therapy. (Ministry Of Health_MOH_PRCS, 2013)

1.7.6.2 Al-Wafa rehabilitation center

According to Hillis (2008), Al-Wafa hospital was established in 1996 as a non-governmental, non-profit, charitable hospital to meet the urgent needs of the community aiming at improving the life of special needs in the Gaza Strip. The hospital has the following departments: medical department, nursing, physiotherapy, occupational therapy, speech therapy and cognitive rehabilitation. This hospital offers its services by outpatient and inpatient departments, the inpatient department for several types of disabilities resulting from spinal cord injuries, brain strokes, brain injuries, neuromuscular diseases, fractures, rheumatic diseases, and amputation for all ages.

In war 2014, AL-Wafa Hospital in Gaza has been destroyed, as well as all the surrounding buildings in the periphery, substantiating a WHO report from 21 July 2014 maintaining the hospital was evacuated after repeated air strikes and 14 inpatients, all with disabilities, were sent to other hospitals (UNITAR, 2014).

1.8 Operational definitions

1.8.1 Rehabilitation services

The services provided for the needed inpatient services which contains the healthcare services and hotel services.

1.8.2 Inpatient rehabilitation service

It is only accomplished through professional interdisciplinary team of rehabilitation needs, which provides single or multiple rehabilitation services within hospital environment. It's provided for the complex needed patients for nursing, medical and rehabilitative (MLN, 2012).

1.8.3 Healthcare provider

The person who provides healthcare service to another person who needs it, as a professional such as physiotherapist, physician, occupational therapist and psychosocial therapist, speech therapist and nurse in Al-Amal and Al-Wafa hospitals.

1.8.4 Patient

The person who attended and is registered in IRHs at GGs; at Al-Amal and Al-Wafa hospitals who received the services in the year 2017; females and males in age who impacts from the process and receives the IRSs.

1.8.5 Patient satisfaction

It is the patient's feeling of agree about the service they receive.

1.8.6 Physiotherapy

Physical therapy is an intellectually, physically, and psychologically demanding profession, but it is an extremely rewarding career in utilizing professional skills for those in need. Both Al-Amal and Al-Wafa hospitals deliver physiotherapy to the hospitalized patients inside inpatient healthcare departments (World Confederation for Physical Therapy-WCPT, 2015).

1.8.7 Occupational therapy

Occupational therapy is managing adaptations applied to the patients' environment; teaching patient how, through occupation, regaining functioning and daily living skills; enabling patients to perform purposeful and meaningful occupations that may help their

recovery; and promoting health and well-being in preventive interventions (Söderback, 2008).

1.8.8 Psychosocial therapy

Psychosocial and counseling are interactions between a therapist and one or more patients according to its condition (Sharaf, 2010).

1.8.9 Speech therapy

Speech therapy is serving adults with disease/injury with cognitive communication disorders, which make speech therapists important members of the healthcare team (Riedema&Turkstra, 2018).

1.8.10 Rehabilitation nursing

Rehabilitation nurses work with patients who are recovering from chronic illnesses, injuries, or disabilities. They help patients move to further independence, build strength and mobility, and adapt to their situations in order to care for themselves as much as possible (Petiprin, 2016).

Chapter 2

Literature Review

This chapter summarizes the arguments, studies and claims pertaining to the main study concepts, which are the rehabilitation, perceived effectiveness, and IRS presented in the reviewed scholar, reports and local studies. This is described after introducing the conceptual framework of this study, which presents the primary domains that researcher, examined and analyzed.

2.1 Conceptual Framework

Conceptual framework is a tool that researchers use to guide their studies. It enables researchers to find links and relations between the existing literature and their own research goals and objectives (Miles and Huberman, 1994). It explains either graphically or in a narrative way the main variables and domains to be studied and presumed relationship among them (ibid). According to Donabedian model, structure, process, and outcome are considered the main three dimensions that could be used to assess quality (Donabedian, 1980).

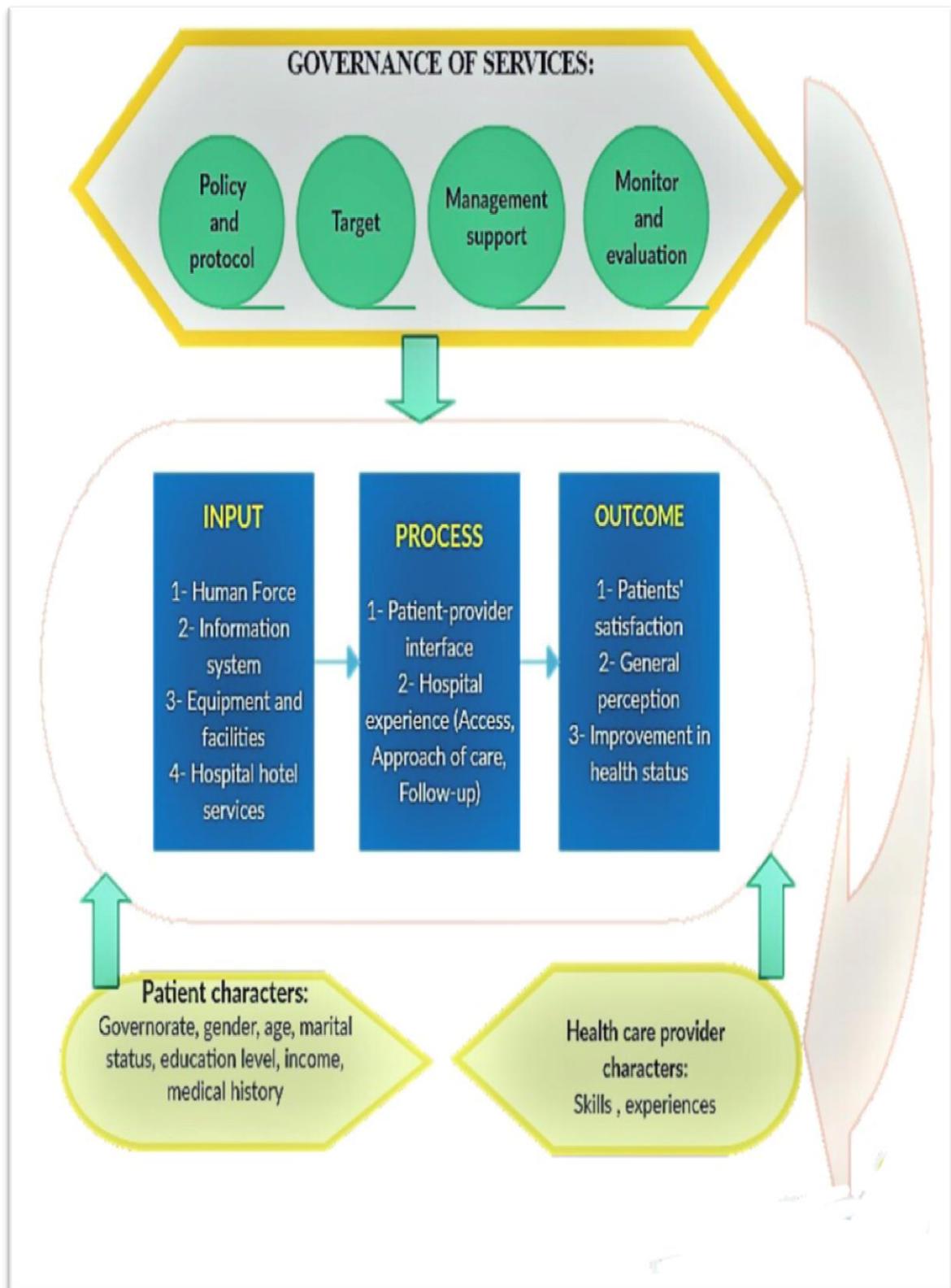


Figure (2.1): Conceptual framework- Self developed

2.1.1 Input

Input characteristics are important characteristics, which include human force, information system, equipment and facilities, and hospital hotel services factors. Based on Donabedian principles, this is the input of the work. These include the below.

2.1.1.1 Human force factor

Human force factors include number of healthcare providers who are providing the service, kind of service they provide and distribution of type. These factors are playing central role in input that affect the effectiveness of care.

2.1.1.2 Information system factor

This is the factor of how recording the registering the patient from the first time he/she arrives to IRH to receive the service and the fullness of documentation of patients files. This factor is also vital in the input.

2.1.1.3 Equipment and facility factor

These factors are significant factors of input, because they affect the effectiveness of work. These factors include health care facilities and physical facilities. Such as the materials and equipment that are used during the sessions of physiotherapy, occupational therapy and the tools that are used during the psychosocial, speech therapy and nursing care sessions.

2.1.1.4. Hospital hotel services factor

This essential input factor refers to room-bedding clean, access to drinking water, access to hot water for shower, quiet ward, entertainment in the rooms, suitable meal, bathroom cleaning, room temperature, available medicine, convergent furniture, and security.

2.1.2 Process

These characteristics show what is done for the patient including patient-provider interface factor and hospital experience. These are the activities held by healthcare providers and patients, focusing on ethical norms of good care. According to Danabedian principle, these characteristics affect the process of the work.

2.1.2.1 Patient-provider interface factor

This main process factor describes the service delivery includes contact time that the health provider spend with the patient each session, number of sessions per a day, the quality of session, type of service in the provided treatment, the way of communication between patient and provider, patient expectation, patient satisfaction and patient perception in IRSS (Mead & Bower, 2000).

2.1.2.2 Hospital experience factor

This critical process factor describes the patients' experience during the hospitalization period. It includes three main points; referral process, approach of care and follow-up after discharge.

2.1.2.2.1 Access to care factor- Referral

Accessibility factor is a central process factor that shows the possibility of reaching and receiving the required services and information. It shows how patient can access the IRHs using the referral system or paying. It explains the referral in charge healthcare provider, the place of referral, if there was any problem during the referral process, the type of problems, waiting times in days to receive a decision from RAD, using any personal connection, number of visits and calls to RAD, patients' perception about fairness of RAD and the completeness of plan of treatment. This factor is important to achieve the desired outcomes

2.1.2.2.2 Approach of care factor

This is key process factor that expresses if there was someone stayed with the patient during hospitalization period, if yes what the main reasons that causes this person to stay with the patient. In addition, it describes if the daily hygiene process of the patient.

2.1.2.2.3 Follow-up after discharge factor

This central process factor defines the referral of discharged patient to other CBR, the place of referral, receiving services from other organizations, if the patient is familiar to his/her long term plan, and whether the patients home is adapted to suit his/her new capabilities.

2.1.3 Outcome

These characteristics show how the patient responds to the care he/she received and reflects the impact of the service on pre-admission and post-discharge outcome results of health status of the patient. These factors include; patients' satisfaction, improvement in health status and general patients' perception. Based on Danabedian principle these factors are the outcome factors and reflects the effectiveness of the services.

2.1.3.1 Patients' satisfaction factor

This outcome factor is important because healthcare providers rely on source of information that concentrates on the patients' perspective. Patient satisfaction remains an important concept for health care providers (Nelson, 1990).

2.1.3.2 Improvement in health status

This focal outcome factor shows patients' outcome results pre-admission and post-discharging from IRHs.

2.1.3.3 General perception factor

This main outcome factor describes the hospital culture as all. Also, describes patient's judging healthcare provider involving other healthcare providers and caregivers in patients' care when needed. In addition, defines patient's judging medical staff teaching patient about improving their health. Also, expresses patient's judging hospital's appearance, working as a team, staff availability around the patient when he/she needs them, and recommending hospital to others.

2.1.4 Patient characteristics factor

This main factor describes the patient's characters including; socio-demographic factors that contain the living governorate, age, gender, level of education, income status, and marital status affect the health status and medical history.

2.1.5 Health care provider characteristics

This prominent factor shows the skills and experience of healthcare provider which affect the delivered care for patient (Mead & Bower, 2000).

2.1.6 Governance of services factor

This great factor describes management support, monitor and evaluation, target, and policy and protocol.

2.1.6.1 Management support factor

This factor plays a significant role in IRSs. A well-organized and effective strategy for knowledge management in healthcare can help organizations achieve their goals.

2.1.6.2 Program monitoring and evaluation factor

This crucial one shows the availability of monitor and evaluation plan that based upon a simple framework, selected indicators, and a plan for collecting data, reporting, and analysis. Is there M&E staff? The tools and methods used in M&E.

2.1.6.3 Targeted patient factor

This factor shows the main patient criteria who receiving services from IRHs.

2.1.6.4 Policy and protocol factor

This essential factor defines the availability protocols of each service of IRSs. Moreover, describes the main guidelines of IRSs.

2.2 Literature review

2.2.1 Rehabilitation

Granting rehabilitation definition has still not been universally approved, it is now standard that definitions could refer to structure (the operational characteristics of a rehabilitation service), process (how rehabilitation hospitals work), and outcome (the aims of rehabilitation hospitals).

Rehabilitation: is “a set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments” (WHO, 2011 P: 3).

2.2.2 Disability

Disability is the umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors). It results from the communication between persons with impairments and attitudinal and environmental obstacles that obstruct their full and effective sharing in society on an equal basis with others (WHO, 2011).

PWDs include those who have long-term physical, mental, intellectual, or sensory impairments that hinder their full involvement in society like others. Some disabilities are present at birth or manifest during infancy and early childhood. Other disabilities are acquired later in life. Causes of disability may be disease, illness, hereditary disorders, accident or injury, work-related or conflict-related, or a consequence of old age (Disability Policy Advisor-DPA, 2013).

2.2.3 Rehabilitation hospitals

The target of IRHs is providing intensive IRSs to patients recovering from illness, injury, or surgery. In conducting a medical review for a separate evaluation to identify adverse events in inpatient rehab hospitals, physician reviewers found a small number of hospital stays in which the patients appeared to be unsuited for intensive therapy (Murrin, 2016).

Evaluation is an important part of the health services management. It can smooth the successful achievement of the service and help decision maker about the future of the service. Health services evaluation is a process of collecting and analyzing information in order to understand the progress, success and effectiveness of the health care facility (Moynihan, 2004).

2.2.4 In-patient rehabilitation

A hospital is a healthcare facility providing patient treatment with specialized staff and equipment. It is a vital part of health care system and reason for a large part of a government's health care budget. It plays an important role in health care quality and outcomes. Health care effectiveness and efficiency variation increased the demand for value from patients, and patient safety has placed the assessment of hospital performance high on the agenda of policy makers, patients, payers and regulators around the world (Cercione and O'Brine, 2010).

IRHs deliver demanding rehabilitation services using an interdisciplinary team in a hospital environment. Admission to an IRH is suitable for patients with complex nursing, medical management, and rehabilitative needs. This complexity must be such that the rehabilitation goals indicated in the preadmission screening, the post-admission physician evaluation, and the overall plan of care can only be accomplished through periodic meetings of the team. The purpose of this team is to foster regular, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals (MLN, 2012).

2.2.5 Component of IRSs

2.2.5.1 Physiotherapy

Physical therapy is an intellectually, physically, and psychologically demanding profession, but it is a really satisfying career in engaging professional skills for those in need. IRHs deliver physiotherapy to the hospitalized patients inside different healthcare departments (WCPT, 2015). A study for Partridge (2001) showed that most rehabilitation teams should have physiotherapy as one component that patients with stroke receiving more physiotherapy achieve more recovery from disability.

It is the service provided by a physiotherapist. It includes assessment, evaluation, diagnosis, prognosis, plan of treatment and re-evaluation. It is concerned with identifying and maximizing quality of life and movement potential within the domains of improvement, prevention, treatment, habilitation, and rehabilitation. This includes physical, psychological, emotional, and social wellbeing. It involves the interaction between physiotherapist, patients, other health providers, families, caregivers, and communities in a process where movement is assessed and goals are agreed upon, using knowledge and skills unique to physiotherapists (WCPT, 2007).

Regarding equipment and material using during physiotherapy session, a study for Assfa (2009) made a review on physiotherapy sessions at al-Wafa hospital found that most of patients received daily physiotherapy session, half of them receive sessions in the gym and two thirds of patients receive electrical therapy during sessions. A Randomized Clinical Trial study of Elsodany (2017) was conducted among the stroke survival showed that patients who treated by both electrotherapy with orthosis have been improved in balance and gait than traditional physiotherapy treatment alone. Similarly, Foundation (2010), reported that one or more of the following interventions should be used for people with reduced strength; progressive resistance exercises, electrical stimulation and electromyography biofeedback in conjunction with conventional therapy.

Regarding to time of session, many studies were conducted. Wittwer (2000), explained that physiotherapists are required to record treatment time. Another study of Stroke Association (2012) showed that patients should receive at least 45 minutes of physiotherapy per day (plus any other types of therapy patients need). Similarly, another study was conducted by Foundation (2010) in United Kingdom recommended that patients in the early stages of recovery of stroke should have as much therapy as they are willing and able to tolerate but stipulate a minimum of 45 minutes daily for each therapy that is required. Another study for inpatient rehabilitation following stroke patients recommended that patients should receive 37 min of active therapy from both physiotherapists and occupational therapists (Foley et al., 2012). According to Hush et al. (2012), the physiotherapists' communication skills, correlated strongly with global satisfaction.

Regarding to number of physiotherapist according to number of patients: in Portugal Portuguese Association of Physiotherapists (2015) reported that number of practicing physiotherapists: 6,9 per patient. The duration of physiotherapy session for over 30 min but booked in a 30 min time slot and weighted average for the number of patients seen by a physiotherapist in an 8 hour day is 12.7(Chorzewski, 2016).

2.2.5.2 Occupational therapy

The major roles of the occupational therapist are to manage adaptations applied to the patients' environment; to teach patient how, through occupation, to regain functioning and daily living skills; to enable patients to perform purposeful and meaningful occupations that may help their recovery; and to promote health and well-being in preventive interventions (Söderback, 2008). Similarly, a study for Richardson (2009) was conducted in Tacoma, America, showed that occupational therapist who treats stroke patients starts with evaluation of a patient's roles, tasks and activities that is important for the patient. When a patient has physical needs, the occupational therapist can evaluate the ability to perform Active Daily Living ADL, such as dressing, washing, and toileting. When assessing a patient, occupational therapists look at the physiological, psychological, and environmental components of the injury.

Palestinian study was conducted by Assfa (2009) among patients at Al-wafa hospital, showed that almost two third of patients received occupational therapy and 69.5% of the mused assisted equipment during the sessions.

It is important that the occupational therapy session suit a patient's needs (Olsson and Lundborg, 2015). It was reported that minimum of one hour per day as much physical therapy (physiotherapy and occupational therapy) should be provided for patients undergoing active rehabilitation, at least five days a week (Foundation, 2010). Similarly, a study to Foley (2012) was informed that the standard for occupational therapy is one hour per a day.

Several studies have explored the patient-provider interaction. Treatment plans are most effective when the occupational therapist communicates with the patient about his/her treatment plan and involves them in the decision making process (Richardson, 2009). A study to Eyssen (2011) explored that there is significant positive correlations between the Canadian occupational performance measure scores and the sickness impact profile,

disability and impact profile, and impact on participation and autonomy scores. In addition, Wressle and et al. (1999) have revealed that the capability of the Canadian occupational performance measure to detect changes in perceived occupational performance issues is supported in a patient-centered approach, patient, and therapists work together to define the occupational performance problem, the focus of and need for treatment and the preferred outcomes. Also, according to Richardson (2009), it is essential that an occupational therapist build a functional relationship with the patient.

An average of 7.25 occupational therapist sessions per patient over a four- to eight-week period is an indication of the cost-effectiveness of IRHs (MacRae, 1984).

2.2.5.3 Psychosocial therapy

Psychosocial and counseling are interactions between a therapist and one or more patients. The purpose is to help the patient with problems that may have aspects that are related to disorders of thinking, emotional suffering, or problems of behavior. Therapists may use their knowledge of theory of personality and psychotherapy or counseling to help the patient/client improve functioning. The therapist's approach to helping must be legally and ethically approved (Sharaf, 2010).

A study for Shedler (2010) showed the seven stages of psychotherapy process. The first is focus on affect and expression of emotion. Second stage is exploration of attempts to avoid distressing thoughts and feelings. Third stage is identification of recurring themes and patterns. Forth stage is discussion of experience (developmental focus). Fifth stage is focus on interpersonal relations. Sixth stage is focus on the therapy relationship and finally is exploration of fantasy life.

A study of Gillham (2011) has showed that general difficulties coping and perceived consequences for the person's lifestyle and identity. Psychosocial therapists could provide support. Anxiety disorders are a very prevalent modifiable condition associated with risk of stroke increased by 24% (Pérez et al., 2017). Langhorne (2000) reported that complication after stroke are anxiety (14%) and managing depression (64.1%). Also, Hackett (2005) described that depression is common, but for some patients it may be short-lasting and can remit as the patient recovers function. Another study for Langhorne (2000) reported that around third of patients are depressed post stroke and one of complication after stroke; psychological—depression.

In addition, a study for Braun and et al. (2006) reported that treatment periods varied from 2 to 6 weeks, frequencies ranged from multiple sessions per day to 3 times a week. According to Priebe and et al. (2011), the communication between clinician and patient is the basis of psychiatric treatment. Cognitive impairment is found in a substantial portion of stroke survivors, affecting more than one third of stroke survivors at 3 and 12 months after stroke (Winstein, 2016). A recently study for Rufa'I and et al. (2018), showed that post stroke depression is a common neuropsychiatric mood disorder believed to be under-diagnosed among stroke survivors. A study for Goerling, (2010) offered that the psychosocial course of treatment should be determined according to the patient's needs.

2.2.5.4 Speech therapy

Speech therapists are important members of the healthcare team because they are serving adults with traumatic brain injury with cognitive communication disorders (Riedema and Turkstra, 2018). Stroke can result in acute hearing loss. This may be present in as many as 21% of patients with posterior circulation ischemia,386 often resulting from ischemia in the distribution of the anterior inferior cerebellar artery, and in most cases is attributable to infarction in the inner ear. Most patients show partial or complete recovery by 1 year after stroke (Winstein, 2016). A study for Dragga (2015) reported that aphasia is present in 21%–38% of acute stroke patients while dysphagia occurred in more than one-third of consecutive patients admitted to a neurorehabilitation hospital following stroke; however, other studies have found a wide incidence, between 29% and 81% (ibid).

According to time of speech therapy session, Bhogal (2003) study was reported that intense therapy over a short amount of time can improve outcomes of speech and language therapy for stroke patients with aphasia. Similarly, Karges and Smallfied (2009) study was conducted among individuals who received IRSs for stroke at IRH. They were stayed just over 2 weeks and improved on average by 20 points on the Functional Independence Measure FIM, they were seen for skilled occupational therapy, physiotherapy, and speech therapy for about 30 minutes per session, 1.5 times per day, and received therapy services for 5 to 6 days per week on average. In addition, a study for Foley and et al. (2012) reported that speech therapy session should be 13 min per day. A single speech therapist in an IRH might be responsible for around 20 patients at any given time (News and World Report, 2018).

2.2.5.5 Nursing

This intensive therapy requires endurance that some patients receiving post-acute care do not have, potentially causing those patients to be better suited for an alternate setting such as a skilled nursing facility (Murrin, 2016).

A study for Petiprin (2016) showed that rehabilitation nurses work with patients who are recovering from chronic illnesses, injuries or disabilities. They help patients move to further independence, build strength and mobility, and adapt to their situations in order to care for themselves as much as possible. Also, Kourkouta and Papathanasiou (2014) revealed that good communication between nurses and patients is essential for the successful outcome of individualized nursing care of each patient.

A study for Spetz and et al. (2008) showed that the patient-to-nurse ratios vary during and across shifts. Hours per patient day do not accurately measure the impact of admissions, discharges, and transfers on the workload of nurses. The nurse might work on a team of three nurses for 15 patients. A nurse might care for 10 patients during a shift, with the five patients present at the start of the shift being replaced by five other patients later in the shift (ibid).

2.2.6 Effectiveness of in-patient rehabilitation hospitals

Healthcare services aimed to make a protection and improvement of individuals' physical, mental, and social status and ensure of its continuity to increase welfare and happiness in the society level. As in all service organizations, service quality has an important place in healthcare organizations. So, measuring the impacts of the efforts made by enterprises for service quality and the clients' perceptions of the services provided, assessing how their perceptions differ in different dimensions of quality, and taking new measures according to the results are the key to continuous improvement (Kayral, 2014). Rehabilitation outcomes are the changes in the functioning of an individual over time that are attributed to a single measure or set of measures. Outcomes measurement include individual's impairment level, individual activity and participation outcomes (WHO, 2011b).

Communication and coordination among healthcare team are paramount in maximizing the effectiveness and efficiency of rehabilitation and underlie this entire guideline. Without

communication and coordination, isolated efforts to rehabilitate the stroke survivor are unlikely to achieve their full potential (Winstein, 2016).

2.2.6.1 Patient's characters

Socio-economic factor has an important role in IRHs patients. There has been more than 100 percent increase in incidence of stroke in low- and middle-income countries (Kamalakannan, 2017). According to gender, most of patients were male (Hillis, 2008 and Ghanem, 2008 and Radwan, 2011). According to age, most of patients were more than 45 years old (Assfa, 2009 and Hillis, 2008). Most of studies, which conducted to show marital status of IRHs patients, show that most of patients were married.

2.2.6.2 Patient's medical history

It is worth mentioning that some studies were conducted to assess medical history of IRHs patients. Assfa (2009) has found that 13.6% from the patients were bedsores patients. Another study was conducted by Nageswaran (2016) showed that pressure ulcers, medically coined as 'decubitus ulcers' have been a major threat for rehabilitation of bed-ridden patients for about a century, as these ulcers eventually leads to fatality. Similarly, Lee and Kim (2017) study was conducted to examine risk factors in stroke, found that 20.8% of patients presented with medical complications including bladder dysfunction, bowel dysfunction, sleep disturbance, pneumonia, and urinary tract infection. Similarly, Winstein (2016) has found that almost 40% to 60% of stroke patients have urinary incontinence during their acute admission for stroke, falling to 25% by hospital discharge and fecal incontinence prevalence is \approx 40% acutely but diminishes to 20% by discharge from rehabilitation. A recently study to Okuyama (2018), aimed to describe spasticity as a common problem in patients with stroke that contributes to motor dysfunction. Also, Zhao (2015) found one of the common problems in acute stroke patients was aspiration of oral or gastric contents into the larynx and lower respiratory tract.

Cognitive impairment is found in a substantial portion of stroke survivors, affecting more than one third of stroke survivors at 3 and 12 months after stroke (Winstein, 2016). Post stroke depression (PSD) is a common neuropsychiatric mood disorder believed to be under-diagnosed among stroke survivors (Rufa'I, 2018).

2.2.6.3 Hospitalization period

According to a prospective study, which aimed to monitor after acute stage of stroke patients in America, patients had a mean hospital stay of 14.78 days and patients were admitted to their rehabilitation center with a mean delay of 4 days from stroke onset (Rocco, 2007). Another study for Andrews (2015) was conducted to assess rehabilitation intensity for stroke and risk of hospital readmission, found that the majority of patients stayed from 4 weeks to 7 weeks receiving rehabilitation services (46.4%). Also, a study for traumatic spinal cord injury found that median length of stay 102 days (14 weeks), and mean therapy intensity 5.7 h/week (Truchon, 2017). Receipt of and intensity of rehabilitation therapy in the acute care of stroke is associated with a decreased risk of hospital readmission (Andrews, 2015). In addition, Musicco and et al. (2003) mentioned that patients who initiated the rehabilitative procedures early (within 7days after stroke) had better long-term outcomes than did those who initiated the rehabilitation after more than 1 month or from 15 to 30 days after the acute cerebrovascular event.

2.2.6.4 Referral access to IRHs

According to WHO (2014), the numbers of referrals to health facilities within the occupied Palestinian territory OPT has steadily increased over the past three years and 82% of all referrals in 2013 were to non-profit or private Palestinian specialty centers located within the OPT. The process of referral started from the time a doctor fills in Form No. 1 until the patient receives a decision from Referral Abroad Department (RAD). It is a simple process but a long and complicated journey for a patient from Gaza in need of medical care that is not available locally and it takes about seven to ten days (RAD, 2010). MOH provides 80% of hospital care in GGs. When a doctor works in a MOH, concludes treatment for a patient needs is unavailable in any of the MOH hospitals in Gaza, he starts the referral process by completing “Form No. 1”.The patient, or a member of the family, submits this form to RAD of the MOH. The patient first submits a doctor’s referral request to the RAD of the Palestinian MOH for a decision regarding support (ibid).

2.2.6.5 Patient follow-up after discharge from IRHs

It is worthy to be mentioned that a key informant views on continuity of care study for Grace et al., (2006) was conducted among discharged patients from cardiac rehabilitation. It was reported the complications for increasing referral of patients to useful services and

follow-up by primary care providers to ensure maintenance of functional and health-related gains are discussed. Which means that discharged referral should be done for all patients to continue their treatment.

Another study for Grace,et al., (2011), showed the main four referral strategies which consist of automatic referral right after hospital discharge, liaison referral, combination of automatic referral with liaison discussion, and usual referral or upon the discretion of physicians.

2.2.6.6 Family centered

A study was conducted by Service Improvement Unit (2011) reported that patients, parents, healthcare providers should be expert in their lives and their health underneath a patient and family centered care. Health care providers and their patients all have the same goal: the best outcomes for the patient. Patient and family centered care means health care providers work in partnership with parents/care-giver and patients to achieve this shared goal.

2.2.7 Hospital hotel services

In general, several studies that were carried out evaluation hospital hotel services in developed countries and developing agreed that it is an important issue for hospitalized patients. It was reported that it is important, to obtain the best appropriate environmental conditions within the room, and to account for the process of particle deposition at solid boundaries AL-Shami and et al. (2018).

A recent study was conducted to determine water source in low- and middle-income countries, it was found that 38% of health care facilities has lack an improved water source WHO (2018). Khader (2017) was examined handwashing basins with soap and water in Jordan's healthcare facilities, it is worth to note that, 84.2 percent had sufficient and functioning handwashing basins with soap and water, and 79.0 percent had sufficient showers.

In addition, Hillis (2008) examined many points in hospital hotel services among Al-Wafa hospital patients, the findings about ward quietness showed that 60.8% patients feel with calm and relaxing atmosphere in physiotherapy department. Also, he found that most of

the patients were uncertain about cleaning of bathroom. In addition, 82.4% of Alwafa patients were satisfied regarding to physiotherapy department. Moreover, he found that most of patients (62.7%) feel secure in Alwafa hospital during physiotherapy sessions.

Many studies have shown that staff behavior as well as the acoustical characteristics of the facility determines the levels of noise and quiet in an intensive care nursery Philbin and Gray (2002).

A study for hospital inpatients' experiences of access to food was conducted by Naithani and et al. (2008), showed that elderly patients and those with physical disabilities experienced greatest difficulty accessing food, whereas younger patients were more concerned about choice, timing and the delivery of food.

The bathroom is an essential part of any hospital patient room, yet it is associated with nurse dissatisfaction and patient falls (Fink and et al. 2010). Furthermore, air temperature for patients comfort should be between 21-5 degrees and 22 degrees C and a relative humidity of between 30% and 70%, where the air velocity was less than 0-1 m/s and the mean radiant temperature was close to air temperature for patients comfort (Smith and Rae, 1977).

A recent study for Xinhua (2018) showed that hospitals in Gaza have already been suffering from lack of medical supplies, equipment, and electricity due to the blockade Israel has been imposing on the seaside territory since 2007.

Healthcare services provide the physical structure that figures care delivery and the experience of patients, their families, and the healthcare team who care for them, eventually affecting healthcare outcomes and cost Marlone and Dellinger (2011).

A Palestinian study for Assfa (2009) was conducted among patients at Al-Wafa hospital shows that most of the patients' families are visiting them and most of the patients have daily visits from their families. The study showed that the main reasons from families' inability from visiting their patients are economic status and the location of hospital. On the other hand, Assfa (2009) found that discharged IRHs patients did not receive assistant from rehabilitation team to defend community-based program. Background evidence indicates that the continuation of therapy among community-dwelling stroke survivors improves physical function Singh (2013).

According to the study that Monro and Mulley (2004), 72% of hospital inpatients in their study needed some assistance with washing and bathing.

Follow up According to Singh (2013), background evidence indicates that the continuation of therapy among community-dwelling stroke survivors improves physical function.

2.2.8 Documentation in healthcare records

Documentation by medical practitioners must include six points: first point must be medical history, evidence of physical examination. Then it should contain diagnosis. The third point is Investigations, treatment, procedures / interventions and progress for each treatment session. A principal diagnosis must be reported for every session of admitted patient care. The third point is medical treatment plan. Then where the treatment is performed, a record of the procedure including completion of all required procedural checklists with a record of examination by a medical practitioner prior to the procedure is also required. Fifth point is a complete achievement of all patient care forms. Finally, a copy of certificates, such as Sick and Workers Compensation Certificates, provided to patients must be retained in the patient's health care record (Executive and Ministerial Services-EMS, 2012). Registering patient progression internal to team documentation is the key to effectively showing team input in the overall interdisciplinary plan of care (Darlene, 2011).

2.2.9 Governance of services

The way that management performers interact to design and implement policies within a given set of formal and informal rules that shape and are shaped by power (World Development Report-WDR, 2017). As suggested definition by Kjar (2004, p.10-11) "Governance is the capacity of government to make and implement policy, in other words, to steer society."

2.2.9.1 Monitor and evaluation (M&E)

According to health policy project (2014), M&E includes regularly collecting and using data to track evolution or change over time, permitting stakeholders to assess the effectiveness of a policy or program and track the efficient use of resources. M&E

activities cut across several areas of capability (e.g., policy monitoring, data analysis and use, and accountability systems).

2.2.9.2 Management support

The industry of healthcare is connected to healthcare facilities and patients in order to share knowledge, reduce administrative costs and improve the quality of care. Accordingly, the success of health care depends critically on the collection, analysis and seamless exchange of clinical, promoting, and utilization information or knowledge within and across the above organizational boundaries (Bose, 2003). A study for Dong (2009), defined management support by two main questions: the first one was wondering about the supportive actions that top managers do to engage in during operations, the second was wondering about the way of these actions affect operation outcomes. According to (WHO, 2011a), a good work environment includes building design improvement, workplace safety, and providing adequate equipment and resources for the work. Supportive and efficient management practices, including good management of workloads and the recognition of service.

2.2.9.3 Policy and protocol

According to Foster (2011), system failure is likely to be because of general practice. The mistakes of general practice could be a result of: the organizational culture; communication failures; ill-defined responsibilities; failure to follow protocols; equipment; resources; or low morale. Good policies and procedures play an important role in safeguarding against harm; quality, environmental, health and safety problems (ibid). Everyone makes mistakes. Unskilled and incompetent people are, at most 1% of the problem. The other 99% are good people trying to do a good job who make very simple mistakes and process make them make mistakes. The concept that bad systems, not bad people, lead to the majority of errors and injuries, has become a mantra in healthcare. However, healthcare will not become safe unless there is the will, the knowledge and the skill. Writing policies and protocols take time, and disliked by busy people focusing on providing the service (ibid).

Chapter 3

Methodology

This chapter provides details about the research methodology. It explains the study and method, the tool of data collection and analysis.

3.1 Study design

The design of this study is triangulated qualitative/quantitative, evaluative, census design. Triangulation as an approach to evaluation; is the use of a numerous methods or data which achieves a comprehensiveness that a single method could not achieve. The study utilized a methodology triangulation; carrying out questionnaires for the patients, checklist for records reviewing and qualitative data for key informant depth interviews (KII) and Focus Group Discussion (FGDs).

3.2 Study population

The study includes two types of population who were represented the quantitative and qualitative parts.

Quantitative part: It is composed of two parts: The first is patients who received the IRSs from IRHs: 263 patients at Al-Amal hospital and Al-Wafa hospital who already received the services in the last year (2017) in both hospitals. It is a census study where the researcher selected the lived patients with exception for the dead ones from the hospitals archive. While the second part involved 263 patient medical records for those patients in both hospitals that were selected.

Qualitative part: It is composed of two parts: The first part involved two FGDs, one at Al-Amal hospital, and the other at Al-Wafa hospital with the healthcare providers in the IRHs during the period of the study. They were 27 healthcare providers. The researcher took in her consideration the diversity of healthcare services, that the researcher selected carefully the healthcare providers from the different fields. While the second part involved 8 KII with key informants who managed the process in each IRH. This was interesting and enhancing our study to be more valuable.

3.3 Study setting

The study was conducted in the two main IRHs that provide IRSs in GGs. These hospitals were AL-Amal Hospital and Al-Wafa Hospital. This made our study representative and accurate.

3.4 Study period

The study consumed around 24 months in execution; it started in January 2017 and completed in December 2018. This study was initially proposed in January (2017). The research proposal has been submitted and defended in the front of the SPH assigned committee in August (2017). As its development, the research proposal described the entire process and provided information and designs of the data collection and data analysis methods and tools. Upon the approval, the researcher prepared the required tools of her study in addition to the demographic questions. The researcher consulted a group of eight experts at the arbitration stage before the finalization of the tool, of them eight have responded (Annex 2) . The arbitration stage lasted for two months including refining of tools in the light of reviewers and the academic supervisor's feedback. In December 2017, a peer was asked to propose Arabic translation of the tool. In February 2018, the tool was ready to go for data collection and the researcher trained one data collector besides her and carried out the required training prior to piloting and fieldwork. Piloting took place two weeks. Actual data collection started on 1st on March through 15th of March 2018. The researcher and data collector identified daily work hours to start at 8:00 am through 6:00 pm in order to increase the likelihood of distributing the questionnaires as many participants as possible. Initial analysis of quantitative data was done between April and May 2018. The researcher extracted findings, created descriptive tables and performed inferential statistical analysis. After finishing quantitative part, qualitative data collection was done on May 2018 in collection and analysis. The drafted report "thesis" has frequently enriched and edited by research supervisor. The final draft for defense was handed on 14th November, 2018.

3.5 Eligibility criteria

Inclusion

- Health providers in IRHs, including physiotherapists, occupational therapists, psychotherapists, speech therapists, nurses who work more than three months, and key informants from each hospital.
- Lived patients who received IRSs from both IRHs in 2017.

Exclusion

- Healthcare providers who worked in the IRHs less than three months.
- Patients who receive the outpatient service care only in both IRH, and dead patients.

3.6 Selection of the study participants

Quantitative census

Due to the limited number of patients and beneficiaries in IRHs, 263 patients were selected who had received the service in the last year in both hospitals.

Medical patients' record census

Total number of medical records is 263 from both hospitals, for patients who received the service from January 2017 until December 2017 in Al-Amal Hospital and Al-Wafa Hospital.

Qualitative part

A purposive sample of eight healthcare providers was selected, and the position title was considered in order for the researcher to select from the different services. Moreover, the researcher called on two FGDs selected them purposively by title. FGDs participants were selected in a way that ensures they present all healthcare services. In addition, eight KIIs were done with key-informants from each hospital. The idea of including this sample is to dig deeply and understand in-depth perspectives about IRHs. The qualitative component was carried out after the quantitative one in order to explore issues that emerge from the quantitative study.

3.7 Ethical and administrative matters

- The researcher had the approval from Al-Quds University-School of public health research committee for discussion and academic approval, as this research will bring benefits to GGs health care system.
- Additionally the Modified International Code of Ethics Principals (1975), known as the Declaration of Helsinki, which is adopted by the World Medical assembly were followed and an official letter of approval to conduct the research was obtained from the Helsinki Committee (annex3).
- In accordance with the Principals of the Helsinki Ethical Declaration, every participant in the evaluation received a complete explanation of the evaluation purposes, program, confidentiality, and sponsorship. Every participant in the study knew that participation was optional. Verbal consent was obtained from the healthcare providers who participated in the study. Additionally, formal permission for taking notes and tape recording of the focus groups discussions were obtained from participants. To increase the responses credibility, the researcher maintained adherence to the ethical Code Principals, through providing and maintaining anonymity and confidentiality. The researcher assumed that other ethical rights were protected through respect for people and respect for truth.
- An administration approval was obtained from the managers of both IRHs.
- Transparency was taken into consideration during both the reporting and the analysis of data with respect to confidentiality and respecting the results.

3.8 Pilot study

For quantitative part: A pilot study on 18 patients was done to explore the appropriateness of the study instruments and let the researcher train for data collection, the clarity of meanings and scales and the time taken to fill the questionnaire and for expecting response rate. As a result of this stage, few rephrasing and explanation were added to some questions.

For qualitative part: In addition, a pilot interview was done which allow for further improvement of the study validity and reliability of the study. The result of this stage; the questions were ordered and the way of asking the questions was improved to be more deeply.

3.9 Study instruments

This study utilized four instruments for data collection; interviewed structured questionnaire for discharged IRHs patients, KIIs for key-informants in IRHs, FGDs for IRHs healthcare providers and checklist for patients' medical file.

1- Quantitative data collection

Quantitative part

For the quantitative data the researcher used five instruments, see (Annex4):

- The first part of the questionnaire, the participant were asked to respond to questions related to their personal data, at that juncture questions related to the medical history, then questions related to referral to the IRHs.
- The second one is the participant's satisfaction about hospital hotel services in IRHs in GGs.
- The third one is the follow-up program after the participant discharged from the IRHs.
- The forth one is the healthcare services that the participants receive during the hospitalization period.
- The fifth one is the patient-provider interaction and patient satisfaction from the healthcare services that the patient received during the hospitalization period.
- The sixth one is the outcome.
- The seventh one is the patients' medical records. It covered the general patient's data. Moreover, the physiotherapy files, occupational therapy files, psychological therapy files, speech therapy files and nursing files. It is a checklist for completeness of the documentation of the general data, assessment form, and plan of treatment, discharged strategy.

For the quantitative data collected from the checklist of record's review. (Annex 5). It covers the documentation fullness.

Qualitative part

For the qualitative data the researcher used open-ended (semi-structured) questions, see (Annex6). The researcher within two FGDs asked those questions with health providers. In addition, eight KIIs with the key informants in each IRH. For qualitative data, the researcher used eight instruments:

- The first part is patient's hospital experience.
- The second part is target.
- The third part is management support.
- The fourth part is monitoring and evaluation.
- The fifth part is human force.
- The sixth part is general perception about IRSs in IRHs.
- The seventh part is patient-provider interface.
- The eighth part is availability of equipment and facilities.

3.10 Data entry and analysis

Quantitative part

Data entry and statistical analysis were performed by using Statistical Package of Social Science (SPSS) version 19. SPSS was used to conduct data entering, data cleaning, frequency and cross tabulation, and data analysis. Data analysis was done by the researcher with support from the supervisor. Moreover, the researcher followed the following steps:

- Questionnaire and checklist of records review were reviewed.
- Data entry was performed after over viewing of the questionnaire and checklist.
- Designing a data entry model using SPSS program version 19.
- The questionnaire questions and records review checklist were coded and entered into the computer.
- Re-entry test was performed on about 5% of the entered data then data cleaning was performed to ensure that data are entered correctly.
- Statistical analysis includes simple statistical procedures (frequency, means, and standard deviation).
- Cross tabulation was stated for specific study variables.

- Advanced statistical analysis used to explore the potential relationship among the study variables, including:
 - Independent t-test was used to assess whether the means of two groups are statistically different from each other.
 - One-way Analysis Of Variance (ANOVA) test was used to determine whether there any significant differences between the means of two or more independent groups.
 - A paired t-test was used to compare mean scores with in-dependent variable with two categories such as gender.
 - The statistical difference is regarded as significant when the P value equals or below 0.05, with confidence interval of 95%.

Qualitative part: Qualitative findings stemmed from the KIIs and the FGDs. Qualitative data from KIIs were categories and coded used open coding thematic analysis. Debriefing reports of the FGDs were done immediately after the end of each focus group. In addition, objective considerations of non-prompted intimations, group dynamics, and non-verbal cues were noted and considered. Relevant qualitative data and reflections on initial results extracted, compiled and regrouped using the open coding thematic techniques.

3.11 Scientific rigor

3.11.1 Quantitative part

3.11.1.1 Validity:

The questionnaire (English and Arabic versions) was constructed through adapting previously tested instruments in order to best serve the study objectives. Then the constructed tool was validated through eight expert reviewers who advised regarding internal content validity (Annex 2). Translation and reversed translation has been conducted. Arabic translation was vision by one relevant individual prior to piloting. The questionnaire was nicely formatted in order to insure face validity. This included appealing layout, logical sequence of questions, clarity of instructions such as skipping and professional production. The checklist of records review was validated also by peers' review and under the supervision of the supervisor. The semi-structured questions of FGD and KII were subjected to peers' review and the supervisor was consulted to ensure relevance and convenience of the tool.

3.11.1.2 Reliability

To ensure reliability, during the pilot study, test-retest was conducted with 18 patients and 18 patients file in the first stage piloting by the researcher. Data collected by the researcher and one data collector. Data collector was trained and received detailed instructions to ensure standardization and to reduce filling errors. Checking and verification the filled questionnaire have been done at the end of each data collection day, so error identification, correction and prevention were more feasible.

For qualitative data, the semi-structure questions of KII and FGD were subject to the peers' review and supervisor was consulted to ensure relevance and convenience of the tool. Minutes were taking during FGD and KII; also, digital recording took place in two FGDs and KII.

The psychometrics of the questionnaire was tested twice through the statistical analysis software (SPSS) and indicated high reliability (Cronbach's Alpha coefficient was at the actual study). Reliability of the actually collected data of each domain and total scale are presented below.

Cronbach alpha

The researcher used Cronbach alpha coefficient to find the reliability for each dimension and the total score of the scale. The results are shown in the following table:

Table (3.1): Cronbach alpha coefficient for

Dimension	Alpha coefficient
Hotel hospital services	.569
Overall physiotherapy services	.50
Overall occupational therapy services	.653
Overall psychological therapy services	.555
Overall speech therapy services	.636
Overall nursing services	.577
All scales	.847

3.11.2 Qualitative part

The following was done to assure the trustworthiness of the qualitative part in this study . First, a peer check was done through health experts to revise the FGDs and KIIs questions to assure that they cover all the required dimensions.

3.12 Response rate

The 263 questionnaire were distributed and 263 were returned. Therefore, the response rate was 100%.

3.13 Limitation of the study

- 1- Frequent power shortage and limited access to international publications
- 2- The number of health providers working in IRH is low.
- 3- The number of admitted patients in IRH is low.
- 4- Lack of resources and materials about the study of concern.
- 5- Personal interview questionnaire was expensive and time consuming.

Chapter 4

Results & Discussion

4.1 Introduction

This chapter shows the results of the analysis of the data and the interpretation of these results. Descriptive analysis represents general description of the respondents and the services they received. Inferential analysis explores the differences wherever possible. In addition, qualitative data are used to support, argue with, or complement the quantitative data.

4.2 Descriptive statistics

4.2.1 Personal characters

Table (4.1): Distribution of participants by personal characters (N= 263)

Variables		Frequency	%
Governorate	North	33	13
	Gaza	100	38
	Deir Al Balah	40	15
	Khanyounis	51	19
	Rafah	39	15
Gender	Female	94	35.7%
	Male	169	64.3%
Age	Up to 30	87	33.1
	31 -55	85	32.3
	56 – 90	91	34.6
	Mean	42.62 years	
	Median	46 years	
Marital status before getting ill	Child	43	16
	Single	43	16
	Married	153	58
	Widow	13	6
	Separated	11	4
Current marital status	Child	43	16.3
	Single	43	16.3
	Married	138	52.5
	Widow	27	10.3
	Separated	12	4.6
Education level	Up to primary	52	31.9
	Preparatory	75	28.5
	Secondary	52	19.8
	University	52	19.8
Current income in NIS	1 to 1000	67	36.8
	1001 to 1800	68	37.4
	More than 1800	47	25.8
	Mean	1481NIS	
	Median	1200 NIS	
	Missing income data	81	30.8

Table 4.1 shows that more than 33% of respondents were from Gaza governorate (38%), followed by Khanyounis governorate (19%) then Deir Al Balah governorate, Rafah and North governorates. This distribution was somewhat congruent with the population density in Gaza PCBS (2015). Two thirds of the patients were males (64.3%) which was congruent with other studies that showed that more males are exposed to illnesses and injuries and thus in need for rehabilitation services more than females or maybe because of female stigma and some families didn't care about female as much as male. Also (Hillis 2008; Radwan 2011; Ghanem 2008) reported the same results.

Regarding age, the researcher noted that more than one third of participants were older than 56 years (34.6%). The mean age for participants was 42.62 years. Our study finding was reported the same result as Assfa (2009) and Hillis (2008). It was noticed that rehabilitation services are more and more needed for patients at younger age groups. This was of great public health significance because if they didn't receive rehabilitation services, they might carry the potential for greater lifetime burden of disability.

Regarding marital status, more than half of participants were married (58.2%). Our study findings were constant with Assfa (2009) and Hillis (2008) where both studies reported the same. This percentage slightly differs after getting ill or injured, as the proportion reduced slightly to (52.5%). This might reflect strong social ties among people living in GG; however, psychosocial support is highly needed in such a critical period especially those who lost their partners. In addition, regarding education, the results revealed that almost one third of participants were holding up to primary phase (31.9%) then (28.5%) had finished preparatory phase then (19.8%) had completed secondary and university for each. According to (Assfa, 2009), the majority of participant clients reported low education. This explains the difficulty to understand rehabilitation process.

With regard to the income of participants, the median income was 1200 NIS, 37.4% earned from 1001 to 1800 shekels). Also (Kamalakaran, 2017), Hillis (2008) and Assfa (2009) reported the same results. This reflects the bad economy status of GGs population.

4.2.2 Medical history

Table (4.2): Distribution of participants by medical history (N=263)

Variables		Frequency	%
Reasons of admission to IRHs	Disorder	165	62
	Accident	91	35
	Others	7	3
Waiting time in days to obtain the referral form	0 to 10	90	34.2
	11 to 20	107	40.7
	More than 20	66	25.1
	Mean	19.22	
	Median	14	
Main health problems at the moment clients arrived to IRH	Bed sores	102	39
	Bladder and bowel dysfunction	82	31
	Joint contracture	52	20
	Respiratory disorder	27	10
Current main health problems after clients received treatment in IRH	Bladder and bowel dysfunction	58	36
	Joint contracture	41	25
	Bed sores	33	22
	Respiratory disorder	28	17
Hospitalization period in the IRH (weeks)	1 to 3	69	26.2
	4 to 7	122	46.4
	More than 7	72	27.4
	Mean	6.52 weeks	
	Median	5 weeks	

The table 4.2 shows that highest category (62%) of participants were admitted to IRHs because of having a medical disorder including Cerebrovascular Accident CVA, neurological disorder, orthopedic disorder, congenital disorder and cancer. That was followed by 35% due to accidents such as war injury, road traffic accident, falling down and violence. These study findings were congruent with Assfa (2009) which stated the same. This means that IRHs in GGs deal with large variety of rehabilitation cases. Most of key informants supported our result and mentioned that the most patients who benefits from IRHs in GG are active and conscious patients who were suffering from head injury and neurological disorders. One senior key informant said, "*We receive head injury, Spinal Cord Injury SCI, Road Traffic Accident RTA, neurological disorders, CVA and recently most of cases were presented with gunshot as a result of participating in the March of Return. On the other hand, outpatients are less benefited from our services*", "*The services*

include all ages, but SCI and gunshot injuries are the most prominent among patients while patients who suffer from medical disorders are less prominent" other senior manager stated.

Moreover, almost one third of participants waited from 0 to 10 days to obtain "Form No. 1" from the health provider (34.2%) (Mean was (19.22) days). These study findings were inconsistent with Rocco (2007) and Massico (2003) who reported similar time interval. According to El-Sharif (2015), the majority of patients waited from 0 to 12 months' time since the diagnosis of the disease until approaching the RAD. This means that patient needs almost two weeks to have a ready Form No. 1. Recovery after stroke is greatly influenced by early intervention.

Regarding to health problems of participants when they arrived to IRH, the highest percentage (39%) had suffered from bedsores followed by 31% who suffered from bladder, bowel dysfunction then 20% had suffered from joint contracture, and finally 10% had suffered from respiratory disorders. There was improvement in patients' conditions; they suffered less after receiving services from the rehabilitation centers. Our study was constant with Bo-Ram Kim (2017), Winstein (2016), Okuyama (2018) and Zhao (2015) who reported the same main health problems of patients in IRHs.

Finally regarding to hospitalization period in the rehabilitation center, the highest percentage of participants (46.4%) stayed from 4 weeks to 7 weeks. This study finding was consistent with Truchon (2017) who reported the same while Rocco (2007) reported shorter time. This means that patient whom need rehabilitation require long hospitalization period to decrease the complication associated with the main cause of being admitted to the IRHS.

4.2.3 Hospitalization experience

4.2.3.1 Referral process

Table (4.3): Distribution of participants by referral process

	Variables	Frequency	%
Referred by a health provider	Yes	250	95.1
	No	13	4.9
Place of referral	Governmental	215	81.7
	Private	44	16.7
	International NGO	2	0.8
	Local NGO	2	0.8
Experiencing problems during referral process	No	201	76.4
	Yes	62	23.6
Type of problems during referral process	No space at IRH	17	27
	Delay in getting appointment at IRH	12	19
	Difficulty in convincing doctor to fill in Form No.1	11	18
	Co-ordination	10	16
	Getting financial coverage	7	11
	Lengthily procedure	5	9
Waiting time in days till the patient received a decision from RAD	Up to 2	67	25.5
	3 to 7	125	47.5
	More than 7	71	27
	Mean	7.31	
RAD	Median	4	
Using personal connections to get referral	Yes	67	25.5
	No	196	74.5
Number of visits to (RAD)	Visits		
	up to 2	105	39.9
	3 to 7	117	44.5
	More than 7	41	15.6
	Mean	4.44	
	Median	3	
Number of calls to (RAD)	Calls		
	Up to 2	179	68.1
	3 to 7	40	15.2
	More than 7	44	16.7
	Mean	3.18	
Perceptions about fairness of the referral process	Fair	174	66.2
	Just OK	69	26.2
	Unfair	20	7.6
Completed plan of treatment in IRH	No	172	65.4
	Yes	87	33.1
	Don't know	4	1.5

The table 4.3 shows that health care provider referred 95% of patients while others are self-referred. Our study result in steadily with RAD (2010) and IRH roles which reported that there must be a referral from filled by a health care provider; the remaining 5% didn't know that there was a referral form or because they are self-referred. Most of key informants supported our result and mentioned that patients thought that the IRHs were nursing centers for elderly people while the healthcare providers thought that IRHs were places for providing only nursing and physiotherapy. One therapist at Al-Amal FGD said, *"Unfortunately, many doctors think that IRHs are providing only nursing and physiotherapy."* One senior key informant said, *"Generally, people and health providers from other fields don't really know the exact meaning of rehabilitation, they think its only nursing home."* One therapist at Al-Wafa FGD stated, *"Some patients' families think that Al-Wafa Hospital is an old people center care"*. This means there was a real need for increasing general awareness about the exact mean of rehabilitation concept between GGs society as general.

Regarding to the referral site, 81.7% governmental hospital was the highest percentage, which was congruent with the WHO (2014) and Assfa (2009) who reported the same main referral site. This could be attributed to low income of participants in study and therefore they rely on MOH to cover their hospitalization fees.

Regarding to problem that participants faced during referral process, the highest percentage (76.4%) did not face any problem. This study results were consistent with RAD (2010) which reported that it's a long complicated process. Regarding to the main problem that participants faced during referral process, the highest percentage (27.4%) of participants suffered from that the IRH had no bed for them.

Regarding to the number of waiting days till the patient received a decision from RAD after doctor fill in Form No. 1, the highest percentage (47.5%) of participants waited from 3 to 7 days (mean was 7.31 days). Our study finding was congruent with RAD, 2010 that reported the same number of waited days. In addition, it was constant with El-Sharif (2015) who reported that 35% of patients get the answer of referral request. Regarding to personal connections used to get the referral ready; the highest percentage (74.5%) of participants did not contact anyone. In addition, regarding number of visits, the highest

percentage (44.5%) visited RAD from three to seven times (mean of visits was 4.44 times). Moreover, regarding number of calls, the highest percentage (68.1%) of participants called RAD from zero to two calls (mean of calls was 3.18). This study was inconsistent with (El-Sharif, 2015) who finds that the majority of patients had to visit RAD from 1 to 5 times and did not use phone calls as a way to follow the request.

Moreover, regarding judgment of the referral process, the highest percentage of participants (66.2%) said that it was fair. However, regarding to completeness plan of treatment in IRH, the highest percentage (65.4%) had not completed their plan of treatment after discharged from IRHs. The period of referral on the hospital was emphasized by the qualitative study of key informant interviews and FGD at Al-Wafa hospital. One key informant said, *"MOH referral sometimes causes patients to be discharged before completing their plan of treatment."* *"We always complain from the short period of MOH referral to the rehabilitation patient, the patient discharged after two weeks or maximum one month without completing his plan of treatment"*, one therapist of Al-Wafa FGD echoed. This indicates there was an important need of IRHs to follow-up their patient after discharging them also there was a need to make a referral for the discharged patients for specialized centers to continue their plan of treatment as needed and the urgent need to increase the referral period of rehabilitation patients at Al-Wafa hospital.

Referral

The results of our qualitative study of both key informants interviews and FGD supported the previous mentioned result, emphasized on duration of hospitalization that is from 2 weeks to 4 weeks. One of the senior managers from Al-Wafa hospital said, *"The duration of MOH referral of rehabilitation cases is only two weeks, it leads to inability to complete the plan of treatment. Everyone needs referral should have governmental insurance otherwise he will pay out of pocket"*, *"One of the week points is the referral hospitalization period for the rehabilitation patients at Al-wafa hospital which varies from 2 weeks to one month, which is not enough to complete the plan of treatment"* one of the members of the FGD echoed. Another one stressfully said, *"MOH says that patient can continue the plan of treatment at their home."* On another hand, at Al-Amal hospital there was only the patients who need rehabilitation, one manager at Al-Amal hospital stated proudly *"we try*

to reach the best outcome in a short period of hospitalization," "We evaluate the patients' case before we accept him/her as a rehabilitated patient" another senior manager at Al-Amal hospital mentioned. Therefore, we recommended the managers at Al-Wafa hospital to focus on the rehabilitation patients more than the patients who need only dressing for long periods, because they need to be merged in the community, and send them back to their work and school.

To sum up, the study findings showed that there was a weak communication between RAD and IRHs in GGs. The researcher recommended making better system for communication between RAD and IRHs with clear process for each the patients and healthcare providers.

4.2.3.2 Approach of care

Table (4.4): Distribution of participants according to personal care during hospitalization period

Variable		N	%
There was someone stayed with the patient during hospitalization period	No	142	54
	Yes	121	46
Reasons for staying with the patient during hospitalization	Can't do my ADL	54	44.6
	My family insist to be with me	50	41.3
	Hospital instructions	16	12.3
	I need someone to help me	1	1.8
Having daily shower	Yes	219	83.3
	No	44	16.7
The person who was responsible about daily shower	Nurse only	159	72.6
	Family only	50	22.8
	Both	10	4.6

The table 4.4 shows that the highest percentage (54%) of participants had stayed unaccompanied during hospitalization. Our study findings were congruent with Assfa (2009) who reported that most of families visited their patients daily. Results were consistent with the result of the qualitative study in which key informants and FGD members interpreted the same explanation that patients should stay alone at hospital, one member of FGD stated, "The roles of IRHs do not allow anyone to stay with patients." This result indicates that almost half of IRHs patients hospitalized alone. Because there was a

qualified team, all the day and night that family can trust them in keeping their relatives with them. In addition, nurses do everything alone without any need to the patients' family which consistence with one key informant who said proudly, "*Nurses do everything alone without any need to the patients' family.*"

Concerning the main reason of not being hospitalized alone, the highest percentage (44.6%) of participants report that they couldn't do their active daily living then 41.3% the family insists to be with them. These study findings were incongruent with Assfa (2009) who reported that the main reason from preventing families from visiting their patients due to economic status and the location of hospital. The results indicated that patients' inability of doing active daily living is the main reason that makes family hospitalized with their relatives during hospitalization in IRHs. Regarding to the daily shower most of participants had daily shower (83.3%), mostly arranged/done by nurses (72.6%), 22.8% reported that the family did it. Our study findings were congruent with Monro and Mulley (2004) who reported the same. This study results indicated that the daily shower is the nurse responsibility in IRHs in GGs.

Family centered approach to care:

The qualitative study of key informants interviews and FGD agreed that family centered therapy is important and need to be empowered more. One of the key informants said loudly, "*We meet the family to know their expectation, tell them what are the medical status and expected outcome and give them home program and advices.*" Another one commented, "*Some families are not convinced about speech therapy because they think it will be better due to physiotherapy only*", also one of the FGD members stated proudly "*We train family from the moment we integrate their patient to our hospital. Tell them what the expected outcome of their patient is. Because sharing patient and family increases their confident about received services.*" Moreover, more of that key informant said, "*One of the negative points is from patient and his family due to interfaces the psychosocial intervention.*" One of the FGD members said, "*It's very important to focus on family centered. Family should know the expected outcome to patient's case. We did it the moment we integrate the patient to our IRH. To reach the independency as possible as we can*" the researcher argued that there is no family training sheet in the patients' files and that reflect the relationship between the provider and the patient. Additionally, the researcher interpreted that the patient's family is the responsible about patients' case when they

discharge from hospital. One of the key informants stated, *"There is weekly home visit of the hospitalized patients to their homes."* The literature review showed that the family centered therapy is one of the most important goals in rehabilitation.

To settle, the study results show that there was gap in family centered therapy. The researcher recommends making a better new system in IRHs.

4.2.3.3 Follow-up schedule for the participants who discharged from IRHs

Table (4.5): Distribution of participants' responses about follow up after discharge

Variables		Frequency	%
Referred to other community resources after being discharged from IRHs	No	200	76.1
	Yes	63	23.9
Place of referral to community resources	Home visits associations	22	34.4
	Private clinic	21	32.8
	NGO	15	23.4
	Others	5	7.8
	MOH clinic	1	1.6
Receiving services from other providers	No	245	93.2
	Yes	18	6.8
Patients are familiar with long-term plan for their case	Yes	220	83.7
	No	43	16.3
Adapted house to suit patients' needs	Yes	202	76.8
	No	61	23.2

Table 4.5 shows that 76% of participants were not referred to other community resources when they discharged from the IRHS. This study finding was congruent with Assfa (2009) who reported the similar, Singh (2013) who indicated the important role of continuation of therapy among community. The study results indicated that IRHs did not make referral of the discharged patients, despite the importance of this process for the patients to make it easy for them returning to active daily living and easy communicate with the their surrounded environment at home or/and at work. This indicates poor follow-up and stopping of rehabilitation role after patient discharged from IRH, despite the importance role of it in improving daily function, as it is a long-term plan of treatment.

Concerning patients who received services from other providers, the highest percentage (93.2%) of the participants did not receive any. This indicated that most of the patients dependent all the time. Concerning patients who were familiar with long-term plan for their case, the highest percentage (83.7%) of the participants were familiar. These study findings were congruent with Assfa (2009) who reported that most of patients wanted to continue their plan of treatment. This indicated the importance role of community services to improve needs of patients. Regarding conducting house adaptation to suit patients' needs, the highest percentage (76.8%) of participants adapted their homes to suit their needs and cases. Our study findings were incongruent with Assfa (2009) who reported that most of patients didn't have adapted homes. One key informant reported, *"We have lack of communication after discharging the patient from our hospital. Patient needs to be merged at their homes, works and school; they need to continue their long term rehabilitation plan of treatment."* Researcher concluded that this result indicates that there is no follow-up after discharging from IRHs, which is an important process in the long-term plan of treatment of the rehabilitation patients. She recommends creation a new system with a clear process for follow-up.

4.2.4 Hospital hotel services:

Table (4.6): Distribution of participant's responses about hospital hotel services

	SA		A		U		DA		SDA		M	%
	No.	%	No.	%	No.	%	No.	%	No.	%		
Room-bedding clean	7	2.7	243	92.4	11	4.2	1	0.4	1	0.4	3.97	79.4
Access to drinking water	5	1.9	238	90.5	13	4.9	5	1.9	2	0.8	3.91	78.2
Access to hot water for shower	7	2.7	233	88.6	14	5.3	8	3	1	0.4	3.90	78
Quiet ward	6	2.3	232	88.2	20	7.6	3	1.1	2	0.8	3.90	78
Entertainment in the room	6	2.3	227	86.3	21	8	6	2.3	3	1.1	3.86	77.2
Suitable meal	4	1.5	206	78.3	41	15.6	11	4.2	1	0.4	3.76	75.2
Bathroom cleanliness	4	1.5	191	72.6	57	21.7	7	2.7	4	1.5	3.70	74
Room temperature	6	2.3	181	68.8	48	18.3	22	8.4	6	2.3	3.60	72
Available medicine	4	1.5	138	52.5	29	11	64	24.3	28	10.6	3.10	62
Furniture convenient	0	0	135	51.3	43	16.3	55	20.9	30	11.4	3.08	61.6
Security hospitalization	3	1.1	108	41.1	51	19.4	51	19.4	50	19	2.86	57.2
Overall in hospital hotel services											3.60	72
Strongly agree (SA), Agree (A), Uncertain (U), Disagree (DA), Strongly disagree (SDA), Mean (M)												

The table 4.6 shows that the majority of participants were satisfied with hospital hotel services related variables. The overall mean of satisfaction was (3.6) and overall percentage was 72 %.

Satisfaction about cleanness of room-bedding showed that most of participants (95.1%) were agreed or strongly agreed that the beddings are clean (Mean was 3.97 and mean percentage was 79.4%). This study finding was congruent with Hillis (2008) and AL-Shami (2018) who reported the same. One of key informants commented, "*The hospital is clean in comparison to other hospitals.*"

Also, access to drinking water showed that most of participants were agreed and strongly agreed (92.4%) (Mean was 3.91 and mean percentage was 78.2%. It indicates good results of access to drinking water compared with WHO (2018) results that reported lesser percentage than our results.

The researcher also noticed that 91.3% were satisfied with access to hot water for shower (mean was 3.9 and percentage mean was 78%). Our study findings were congruent with Khader (2017) who reported the same, which indicated that IRHs are having good hot shower supply.

Regarding quiet ward, most of participants were agreed and strongly agreed (90.5%) (Mean was 3.9 and percentage mean was 87%). The study results were congruent with Hillis (2008) and Philbin (2002) which showed similar findings. This result indicated a quiet ward of the IRHs in GG.

Regarding to entertainment in the room, most of participants agreed and strongly agreed (88.6%) (Mean was 3.86 and percentage mean was 77.2%) that indicated good entertaining in IRHs for hospitalized patients.

The researcher also noticed that the highest percentage of participants (79.8%) were satisfied about the meal (Mean was 3.76 and percentage mean was 75.2). Our study results were congruent with Naithani (2008) which reported the same results. This means there is a good suitable meal in the IRHs that patients are satisfied about it.

Regarding to bathroom cleanliness most of participants agreed and strongly agreed about its cleaning (74.1%) (Mean was 3.7 and percentage mean was 74%). Our study results were incongruent with Hillis (2008) which reported the opposite results. This indicates that there is improvement in bathroom cleanliness in IRHs in GGs.

Regarding to the suitability of room temperature most of participant had agreed and strongly agreed that there was a suitable room temperature 71.1%) (Mean was 3.60 and percentage mean was 72%). These study findings were congruent with Smith & Rae (1977) which reported the standard room temperature degree. This reflects good room temperature in IRHs in GGs.

Regarding to the availability of medicine in the rehabilitation center, the researcher noticed that most of participants had agreed (54.3%) which indicated that the other half needs to buy some kind of medicine from outside the IRHs (Mean was 3.10 and percentage mean was 62%). Our study findings were congruent with Xinhua (2018) who reported the same results. This reflects the dire shortage of drugs and medical equipment in GGs.

In addition, results showed that furniture convenient most of participants, the researcher found that most of the patients had agreed (51.3%) (Mean was 3.08 and percentage mean was 61.6%). According to Marlone and Dellinger (2011), this study results indicated that IRHs need more furniture that is comfortable for the patients, which affects their outcome.

Unfortunately, 52.8% of participants were not satisfied about the degree of security in hospital while 42.2% were satisfied (Mean was 2.86 and percentage mean was 57.2%) they said that they could not keep any money or mobiles with them especially when they are hospitalized alone. These study findings are congruent with Hillis (2008) who reported the same results about security. One of key informants mentioned, "*Hospitalization is safe; it's so rare to face a problem in safety.*" This indicates that the health status and may be the age of patients plays a role in feeling secure during receiving rehabilitation services in IRHs.

One of the key informants commented "*We need a specialized team and financial support for the hospital hotel services at Al-Wafa hospital, also we need a special place and well known goals*". Regular monitoring and evaluation for this department according to the main goals of the IRHs in GGs will improve hospital hotel services in IRHs, one of the

FGD members spoke insistently *"There is no suitable food for every patient. There is no entertainment for the patients. The painting color of patients' room is not suitable."* Still we need the discussion to be with patients, and take their notes to the action stage.

Availability of equipment and facilities:

During FGD and key informants interviews there was a large debate about that, in which some of them agreed that there is a problem, while the other named it, a shortage in equipment and facilities is one the weak points in the IRHs in GGs. *"The shortage of equipment is one of the weakness points. Recently we have some physiotherapy equipment. Next plan is expansion of rehabilitation hospital and providing occupational therapy equipment,"* one of the senior medical officer reported. The other commented, *"We need a special room for psychosocial therapy, now we can't protect our patients' privacy. The psychosocial department has no independency."* Another senior manager said, *"We don't have a special office for speech therapy and there is no speech therapy equipment, I used to work manually."* Also during the FGD, we have the same debate, one of the staff member said *"In physiotherapy we could save time and effort if there is no a shortage of some main equipment such as gait training, hydrotherapy. Mentioning that, previously before attaching Al-Wafa hospital by Israeli army, this equipment was available."* Other one of FGD also said, *"We only have fitness equipment not therapeutic type. This affects the therapist health status due to the un-comfortable positions during the session. We have a pediatric department with suitable beds, but there is no therapeutic pediatric equipment, which makes child not motivated to our session. The floor also is not safe for therapy."* Finally, we should feel the speech of one the FGD members, when she said, *"The availability of such equipment saves time and effort. Now the therapists do uncomfortable positions to give the suitable session for the patient, which cause health problems to the therapist."* The researcher founds that there is huge shortage of equipment and facilities in IRHs in GGs and recommended the managers to make such equipment available to safe effort and time of the staff and have better outcome of the patients.

Space:

Most of the key informants during the qualitative study complained from the space of IRHs; one of the key informants mentioned, *"We don't have a special space for the speech therapy."* Another one commented, *"There is no special place for psychosocial therapy."*

In addition, one of the senior medical officers said in distress, "*The space is one of the weak points.*" Each recommended having a special room for each speech therapy and psychosocial therapy at both hospitals. "*The general environment is not suitable for rehabilitation patients*" One member of the FGD echoed. Another member of FGD commented, "*The space is narrow which causes difficulties in transporting in the hospital.*" On the other hand, one of key informants mentioned, "*The place suits all services that provided at IRHs and helps from 30 to 40 patients.*"

To sum up, the study results show that hospital hotel services needs to be improved. So, the researcher recommended the management of IRHs to increase focusing on the

4.2.5 Receiving specialized rehabilitation services during hospitalization:

4.2.5.1 Physiotherapy:

Table (4.7): Distribution of participants' responses about physiotherapy care

Variables		Frequency			
		Yes		No	
		No	%	No	%
Number of participants who received physiotherapy service		258	98.1	5	1.9
Services received					
Manual therapy		241	93.4	17	6.6
Mechanical therapy		207	80.2	51	19.8
Hydrotherapy		203	78.7	55	21.3
Electrotherapy		185	71.7	73	28.3
Quality of care					
Sessions done daily		242	93.8	16	6.2
Standards of care were excellent		242	93.8	16	6.2
Sessions were done on time		241	93.4	17	6.6
Providers spent enough time with you		236	91.5	22	8.5
No. of sessions (each day)	1	92	35.7		
	2	117	45.3		
	3	49	19		
	Mean	1.83			
Time of sessions (in minutes)	5 to 20	110	42.6		
	21 to 35	92	35.7		
	36 to 45	56	21.7		
	Mean	33.33			

The highest percentage (93.4%) of participants received manual therapy that includes exercise, massage therapy, manipulation techniques ...etc. Then 80.2% of participants received mechanical therapy that includes using treadmill, bicycle, and other machines then 71.7% of participants received electrotherapy like TENS that used for pain management, finally 78.7% of participants received hydrotherapy such as hot back and ice back. Our study findings were congruent with Assfa (2009), Elsodany (2017) and Foundation (2010) as discussed lately in the literature. This result indicated that there is good use of manual therapy, mechanical therapy, electrotherapy and hydrotherapy.

Concerning interaction during providing service, the highest percentage (93.8%) of participants received excellent standards of physiotherapy care and daily sessions. About the daily physiotherapy sessions, 93.4% of participants received a daily session. Moreover, 91.5% of participants said that physiotherapy spends enough time with them. Our study findings were congruent with Assfa (2009) and Partridge (2001) who reported the same results.

The researcher concludes that participant agreed that the sessions were done on time with enough time despite that internationally the session time should be standard, as we will discuss later. Regarding number and time of physiotherapy sessions, the table shows that the highest percentage (45.3%) of participants received two sessions per day (Mean was 1.83). These findings were congruent with Assfa (2009) in receiving two sessions per day, also constant with Wittwer (2000) in the importance of recording the treatment time. One of the key informants commented proudly, *"We are unique at Al-Amal hospital in providing 3 physiotherapy sessions to our patients"* which explains why some patients reported that they received three sessions daily.

Concerning time of physiotherapy session, the highest percentage (42.6%) of participants received from 5 to 20 minutes per session (Mean was 33.33 minutes per session). Our study finding was inconsistent with Association (2012), Foundation (2010) and (Foley et al., 2012) who reported more session time. The average of standard session time is 46.7 minutes per session according to literature review.

4.2.5.2 Occupational therapy:

Table (4.8): Distribution of participants' responses about occupational therapy

Variables	Frequency			
	Yes		No	
	No	%	No	%
Number of patients who received occupational therapy service	185	70.3	78	29.7
Type of services received				
Training on ADL and on functional activities	175	94.6	10	5.4
Investigation	172	93	13	7
Training on assistive device	167	90.3	18	9.7
Recommendations suits patients' needs	155	83.8	30	16.2
Quality of care				
Sessions done daily	175	94.5	10	5.5
Standards of care were excellent	173	93.4	12	6.6
Spend enough time with patient	170	91.7	15	8.3
Sessions were done on time	169	91.3	18	9.9
No. of sessions (each day)	1	165	89	
	2	20	11	
	Mean	1.11		
Time of sessions (in minutes)	5 to 20	156	84.3	
	21 to 35	20	11	
	36 to 45	4	2.2	
	More than 46	5	2.7	
	Mean	17.8		

Table 4.8 shows that 70.3% of patients received occupational therapy during their hospitalization period in IRHs. Our study results were constant with Assfa (2009), who reported a higher percentage.

Regarding to type of occupational therapy services provided to patients, the highest percentage (94.6%) of participants received training on active daily living and functional activities such as bed mobility, balance, and transfer. The majority (93%) of participants received investigations. Our study results were consistent with Olsson and Lundborg (2015) in receiving the needed investigation. Then 90.3% of participants received training on assistive device, our study results were incongruent with Assfa (2009) who reported less percentage. At that point (83.8%) of participants received recommendations suits patient's

needs, this study result was constant with Assfa (2009) who reported a little less percentage.

Concerning interaction during providing service, the highest percentage of participants (94.5%) received daily sessions and 93.4% of them said that the standards were excellent. The highest percentage (91.7%) of participants reported that occupational therapist spends enough time with them. In addition, most of participants (90.1%) received sessions on time. Regarding number of occupational therapy sessions, the highest percentage (89%) of patients received one session per a day (Mean was 1.11). with regard to time of occupational therapy session, the highest percentage (84.3%) of participants received sessions from 5 to 20 minutes (Mean was 17.8 minutes per session). Out study finding is inconsistent with Foley (2012) and (Foundation, 2010) who both reported an hour per day session. The standard average of time of session in times according to literature review is 60 minutes per each session.

4.2.5.3 Psychosocial therapy:

Table (4.9): Distribution of participants' responses about psychosocial therapy

Variables		Frequency			
		Yes		No	
		No	%	No	%
Number of participants who received psychosocial therapy service		141	53.6	122	46.4
Services received					
Supportive sessions		96	68	45	32
Post traumatic complication		93	66	48	34
Controlling anxiety		91	64.5	50	35.5
Managing depression		90	64	51	36
Quality of care					
Standards of care were excellent		127	90	14	10
Spend enough time with patient		125	88.6	16	11.3
Sessions were done on time		119	84.3	22	15.6
Sessions done daily		117	83	24	17
No. of sessions (each day)	1	126	89.3		
	2	15	10.7		
	Mean	1.08			
Time of sessions (in minutes)	5 to 20	125	88.6		
	21 to 45	9	6.3		
	More than 46	7	5		
	Mean	13.89			

The table above (4.9) shows that 53.6% of participants received psychosocial therapy. According to Assfa (2009), most IRHs patients received this therapy. The highest percentage (68%) of participants received supportive sessions, then results show that 66% of participants received support for controlling post-traumatic complications. Regarding controlling anxiety, the highest percentage (64.5%) of participants received anxiety control care. Our study results were congruent with international standards plan of treatment as mentioned before in literature for (Gillham, 2011), (Pérez et al., 2017), Hackett (2005) and (Langhorne, 2000) as they all reported the same results.

Regarding interactions during providing service, the highest percentage (90%) of participants received a high standard session. Responses about the statement psychologist spent enough time with patient showed that most of participants (88.6%) were agreed. The majority of participants agreed that the sessions were done daily and on time.

The highest percentage (89.3%) of participants received one session per a day (Mean was 1.08). One of the key informants commented, "*The quality of these sessions is the most important thing.*" About timing of sessions, the highest percentage (88.6%) of participants received was from 5 to 20 minutes (Mean was 13.89 minutes per session). Our study results were incongruent with Braun (2006) in the need of multiple sessions per day to three times a week. The results indicated that the psychologists need to work more standardized.

4.2.5.4 Speech therapy:

Table (4.10): Distribution of participants' responses about speech therapy

Variables	Frequency			
	Yes		No	
	No	%	No	%
Number of participants who received speech therapy service	108	41.1	155	58.9
Services received				
Expressive language	98	90.7	10	9.3
Swallowing and dysphagia	93	86.1	15	13.9
Receptive language	90	83.3	18	16.7
Quality of care				
Spend enough time with patient	95	87.7	13	12.3
Standards of care were excellent	94	87	14	13
Sessions done daily	87	80.5	19	17.5
Sessions were done on time	84	77.8	22	20.2
No. of sessions (each day)	1	96	90.6	
	2	10	9.4	
	Mean	1.09		
Time of sessions (in minutes)	5 to 20	86	80	
	21 to 35	20	18.2	
	36 to 45	2	1.8	
	Mean	14.86		

The table (4.10) shows that 41.1% of participants received speech therapy during hospitalization. Regarding speech therapy received services, the highest percentage (90.7%) of participants received expressive language therapy. Then 86.1% of participants received techniques to manage swallowing and dysphagia, finally 83.3% of participants received managing on receptive language. The great shortage of speech therapy equipment in both IRHs was emphasized by the qualitative study of key informant interviews and FGD. One key informant said, *"We don't have any speech therapy equipment for us and there is no special room for ST."* One therapist in the FGD stated, *"There is no special place for the speech therapy to do the session for the patient, also no equipment to work with them."* The researcher attributed this differences between the quantitative and qualitative results to that patients didn't know how should they receive the service while healthcare provider know the needed way of treatment.

Regarding interaction during providing service, the highest percentage (87.7%) of participants reported that therapists spend enough time with them. About speech therapy standards of care, the highest percentage (87%) of participants reported that they were excellent. The highest percentage (80.5%) of participants reported that they did receive daily session. Our study finding was inconsistent with Bhogal (2003) in performing intense therapy over a short amount of time.

In addition, 77.8% of participants said that sessions were done on time. Concerning speech therapy number and time of sessions, the highest percentage 90.6% of participants received one session per a day (Mean was 1.09), and 80% reported that the session duration was 5 to 20 minutes (Mean was 14.86 minutes per session). Our findings are inconsistent with Karges and Smallfield (2009) who reported that patients need 30 minutes per session, 1.5 times per day. However, it was constant with Foley (2012) who reported 13 min from speech-language pathologists per day. The standard time per session according to literature review is 14.2 minutes.

4.2.5.5 Nursing care:

Table (4.11): Distribution of participants' responses about nursing care

Variables		Frequency			
		Yes		No	
		No	%	No	%
Number of participants who received nursing service		249	94.7	14	5.3
Type of services received					
Medicine		236	94.8	13	5.2
Active daily living		234	94	15	6
Psychological support		232	93.2	17	6.8
Feeding patient		238	90.5	11	4.4
Interaction during providing service					
Spend enough time with patient		231	92.8	18	7.2
Sessions done daily		231	92.8	18	7.2
Sessions were done on time		231	92.8	18	7.2
Standards of care were excellent		229	92	20	8
No. of sessions (each day)	1 to 3	112	45		
	4 to 5	119	47.8		
	More than 5	18	7.2		
	Mean	3.73			
Time of sessions (in minutes)	5 to 20	241	96.8		
	21 to 45	7	2.8		
	More than 46	1	0.4		
	Mean	10.17			

The table above (4.11) shows that 94.7% of participants received nursing care during hospitalization, 94.8% of participants reported receiving medicine on time. About active or activities of daily living services, the highest percentage (94%) reported that they had it. Concerning psychosocial support, the highest percentage (93.2%) of participants reported that they had. Also about feeding patients according to case, the highest percentage (90.5%) of participants reported that they had. Our study results were congruent with Assfa (2009) who reported the same results.

About interaction during providing service, the highest percentage (92.8%) of participants received daily on time sessions and nurse spend enough time with them. The standards of nursing care were regarded as excellent as reported by most of the participants (92%).

Concerning the number and time of nursing sessions, the highest percentage (47.8%) participants received 4-5 sessions per a day (Mean was 3.73), also about time of session, the highest percentage (96.8%) of patients received care from 5 to 20 minutes (Mean was

10.17 minutes per session). This finding was consistent with the result of qualitative study in which key informants provided the same results that nursing is offering all day service to the patients, one of key informants stated, "*We are unique in providing 24/7 nursing service to our patients*".

To sum up, the study results show that there was no specific protocol for each healthcare service in IRHs to be followed by healthcare providers. The researcher implicated the quickly starting in implementing a specific protocol for each service in IRHs.

4.2.6 Patient-provider interface and interaction:

4.2.6.1 Patient-providers interface-physiotherapy

Table (4.12): Distribution of responses about patient-providers interface-physiotherapy

Variable		SA	A	U	DA	SDA	M	%
Making patient feels at ease friendly with you "warming-up before starting the session"	No	13	226	8	10	1	3.93	78.6
	%	5	87.6	3.1	3.9	0.4		
Explaining things clearly	No	21	201	11	16	9	3.9	78
	%	8.1	77.9	4.3	6.2	3.5		
Really listening in privacy	No	13	216	14	13	2	3.87	77.4
	%	5	83.7	5.4	5	0.8		
Being interested in the patient as a whole person during the session	No	12	214	13	16	3	3.84	76.8
	%	4.7	82.9	5	6.2	1.2		
Patient was satisfied with the physiotherapy services	No	4	197	26	20	9	3.65	73
	%	1.6	76.4	10.9	7.8	3.60		
Rehabilitation physiotherapy services meets the patient's expectations	No	1	192	31	23	11	3.58	71.6
	%	0.4	74.4	12	8.9	4.3		
Hospital staff favored some patients over others	No	6	58	15	88	91	2.22	44.4
	%	2.3	22.5	5.8	34.1	35.3		
Overall							3.57	71.4
Strongly agree (SA), Agree (A), Uncertain (U), Disagree (DA), Strongly disagree (SDA), Mean (M)								

The table above (4.12) shows that the majority of participants were satisfied with physiotherapy services they received. The overall mean of satisfaction was (3.57 out of 5) and overall percentage was 71.4%, 92.6% of patients were satisfied about making patients feel at ease and being friendly in warming-up of the session (Mean was 3.93 and percentage mean was 78.6%). One key informant commented, *"There is a mutual respect between patient and provider."* About listening in privacy, 88.7% of participants were satisfied about that (Mean was 3.87 and percentage mean was 77.4%). One of the key informants commented, *"There is privacy in physiotherapy treatment for all patients."* Also 87.6% of participants were satisfied about physiotherapy being interested in the patient as a whole person not only as a case (Mean was 3.84 and percentage mean was 76.8%). In addition, 86% of participants were satisfied about explaining things clearly (Mean was 3.9 and percentage mean was 78%). Similarly 78% of participants were

satisfied about physiotherapy services (Mean was 3.65 and percentage mean was 73%). Overall, 74.8% of participants were satisfied about physiotherapy services (Mean was 3.58 and percentage mean was 71.6%). Our study findings were congruent with Hillis (2008) and Assfa (2009) who reported similar satisfaction and results for perception.

To sum up, our study showed that there was a good patient provider interface in physiotherapy service.

4.2.6.2 Patient-providers interface-occupational therapy:

Table (4.13): Distribution of responses about patient-providers interface-occupational therapy

Variable		SA	A	U	DA	SDA	M	%
Making patient feels at ease friendly with you "warming-up before starting the session"	No	1	166	6	11	1	3.84	76.8
	%	1.1	89.7	3.2	5.9	0.5		
Really listening in privacy	No	2	164	7	11	1	3.84	76.8
	%	1.1	88.6	3.8	5.9	0.5		
Explaining things clearly	No	2	163	7	12	1	3.83	76.6
	%	1.1	88.1	3.8	6.5	0.5		
Being interested in the patient as a whole person during the session	No	1	157	7	20	0	3.75	75
	%	0.5	84.9	3.8	10.8	0		
Patient was satisfied with the occupational therapy services	No	0	138	20	20	7	3.56	71.2
	%	0	74.6	10.8	10.8	3.8		
Rehabilitation occupational therapy services meets the patient's expectations	No	0	129	27	23	6	3.51	70.2
	%	0	69.7	14.6	12.4	3.2		
Hospital staff favored some patients over others	No	2	44	7	83	49	2.28	45.6
	%	1.1	23.8	3.8	44.9	26.5		
Overall							3.51	70.3
Strongly agree (SA), Agree (A), Uncertain (U), Disagree (DA), Strongly disagree (SDA), Mean (M)								

Table (4.13) shows that the majority of participants were satisfied with occupational therapy related factor. The overall mean of satisfaction was (3.51) and overall percentage was (70.3%). One member of FGD commented, "There is respect between patient and healthcare provider." The table showed that most of participants were satisfied (90.8%) about making patients feel at ease and being friendly in warming-up (Mean was 3.84 and percentage mean was 76.8%).The researcher also proved out that more than three quarters of participants (89.7%) were satisfied about really listening in privacy (Mean was 3.84 and

percentage mean was 76.8%). Most of participants (89.2%) were satisfied explaining things clearly (Mean was 3.83 and percentage mean was 76.6%). Our study results were constant with Assfa (2009) who reported the same results. Also were constant with Richardson (2009) in the importance of communication.

In addition, most of patients (85.4%) were satisfied being interested in-patient as a whole person (Mean was 3.75 and percentage mean was 75%). This indicated good relationship between the occupational therapists and patients. Most of participants (74.6%) were satisfied about occupational therapy services in IRHs (Mean was 3.56 and percentage mean was 71.2%). Moreover, most of participants (69.7%) were satisfied about the expectation of occupational therapy in this IRHS (Mean was 3.51 and percentage mean was 70.2%). The research also reveals that most of patients (71.4%) were not agreed that occupational therapy favored some patients over others (Mean was 2.28 and percentage mean was 45.6%). Our study findings were congruent with Eyssen (2011) and Wressle and et al. (1999) who reported the importance role in co-operation between occupational therapist and patient.

To sum up, our study showed that there was a good patient provider interface in occupational therapy service.

4.2.6.3 Patient-providers interface- Psychosocial:

Table (4.14): Distribution of responses about patient-providers interface-psychosocial

Variable		SA	A	U	DA	SDA	M	M %
Making patient feels at ease friendly with you "warming-up before starting the session"	No	1	117	8	8	1	3.81	76.2
	%	0.7	86.7	5.9	5.9	0.7		
Really listening in privacy	No	1	113	12	8	1	3.78	75.6
	%	0.7	83.7	8.9	5.9	0.7		
Being interested in the patient as a whole person during the session	No	1	107	11	15	1	3.68	73.6
	%	0.7	79.3	8.1	11.1	0.7		
Explaining things clearly	No	3	101	14	14	3	3.64	72.8
	%	2.2	74.8	10.4	10.4	2.2		
Rehabilitation psychosocial services meets the patient's expectations	No	1	86	33	14	1	3.53	70.6
	%	0.7	63.7	24.4	10.4	0.7		
Patient was satisfied with the psychosocial services	No	1	91	23	14	6	3.5	70
	%	0.7	67.4	17	10.4	4.4		
Hospital staff favored some patients over others	No	2	32	17	46	38	2.36	47.2
	%	1.5	23.7	12.6	34.1	28.1		
Overall							3.47	69.4
Strongly agree (SA), Agree (A), Uncertain (U), Disagree (DA), Strongly disagree (SDA), Mean (M)								

Table 4.14 shows that the majority of participants were satisfied with psychosocial therapy related services factor. The overall mean of satisfaction was (3.47) and overall percentage was (69.4%). Our study results were constant with Assfa (2009) who reported the same. One therapist in FGD reported, *"No one can deny the importance of psychosocial in IRH because patient becomes depressed during rehabilitation period. We as physiotherapists do support to the patient but rehabilitation works as a team not only one person who do others job. Psychosocial status affects physical status and sometimes more important than it"*.

Most of participants (87.4%) were satisfied about making patients feel at ease and being friendly with them (Mean was 3.81 and percentage mean was 76.2%). Our study findings were inconstant with Assfa (2009) who reported less percentage.

Most of participants (84.4%) were satisfied about really listening in privacy (Mean was 3.78 and percentage mean was 75.6%). Our study results were constant with Assfa (2009) who reported almost the same results. One member of FGD commented, *"Speech therapy and psychosocial therapy have not a special room for each one. This causes weak of privacy of the patients."*

Moreover, 80% of patients were satisfied about being interested in the patient as a whole person (Mean was 3.68 and percentage mean was 73.6%). In addition, most of participants (77%) were satisfied about explaining things clearly (Mean was 3.83 and percentage mean was 76.6%). Our study results were not constant with Assfa (2009) who reported less percentage.

Most of participants (68.1%) were satisfied with psychosocial therapy in IRHs (Mean was 3.5 and percentage mean was 70%). In addition, 64.4% of participants were satisfied about the expectation of psychosocial therapy in IRHs (Mean was 3.51 and percentage mean was 70.2%). In addition, most of patients (62.2%) were not in agreement that psychosocial therapists favored some patients over others (Mean was 2.36 and percentage mean was 47.2%).

To sum up, our study showed that there was a moderate patient provider interface in psychosocial therapy service.

4.2.6.4 Patient-providers interface-speech therapy:

Table (4.15): Distribution of responses about patient-providers interface-speech therapy

Variable		SA	A	U	DA	SDA	M	%
Making patient feels at ease friendly with you "warming-up before starting the session"	No	0	93	8	8	0	3.78	75.6
	%	0	85.3	7.3	7.3	0		
Really listening in privacy	No	0	87	7	15	0	3.66	73.2
	%	0	79.8	6.4	13.8	0		
Explaining things clearly	No	2	80	10	16	1	3.61	72.2
	%	1.8	73.4	9.2	14.7	0.9		
Being interested in the patient as a whole person during the session	No	0	78	11	20	0	3.53	70.6
	%	0	71.6	10.1	18.3	0		
Rehabilitation speech therapy services meets the patient's expectations	No	0	72	20	15	2	3.49	69.8
	%	0	66.6	18.5	13.8	1.8		
Patient was satisfied with the speech therapy services	No	0	75	18	10	6	3.49	69.8
	%	0	69.4	16.6	9.2	5.5		
Hospital staff favored some patients over others	No	1	22	15	47	24	2.35	47
	%	0.4	20.2	13.8	43.1	22		
Overall							3.41	68.2
Strongly agree (SA), Agree (A), Uncertain (U), Disagree (DA), Strongly disagree (SDA), Mean (M)								

Table 4.15 shows that the majority of participants were satisfied with speech therapy related factor. The overall mean of satisfaction was (3.41) and overall percentage was (68.2%). Most of participants (85.3%) were satisfied about making patients feel at ease and being friendly with them (Mean was 3.78 and percentage mean was 75.6%). Though, more than two thirds of participants (79.8%) were satisfied about listening in privacy (Mean was 3.66 and percentage mean was 73.2%). One member of the FGD mentioned, "*There is no private room for patients. A coma patient can't have quiet time.*" In addition, more than two thirds of participants (75.2%) about explaining things clearly were satisfied (Mean was 3.61 and percentage mean was 72.2%). In addition, more than two thirds of patients (71.6%) were satisfied about being interested in-patient as a whole person (Mean was 3.53 and percentage mean was 70.6%). More than two thirds of participants (69.4%) were satisfied about speech therapy in IRHs (Mean was 3.49 and percentage mean was 69.8%). In addition, more than two thirds of participants (66.6%) were satisfied about expectation

of speech therapy in (Mean was 3.49 and percentage mean was 69.8%). Also (65.1%) of patients were not agreed about that speech therapy favored some patients over others (Mean was 2.35 and percentage mean was 47%). The study findings are congruent with Assfa (2009).

To sum up, our study showed that there was a moderate patient provider interface in speech therapy service.

4.2.6.5 Patient-providers interface-nursing:

Table (4.16): Distribution of responses about patient-providers interface- nursing

Variable		SA	A	U	DA	SDA	M	%
Making patient feels at ease friendly with you "warming-up before starting the session"	No	3	226	12	7	1	3.9	78
	%	1.2	90.8	4.8	2.8	0.4		
Really listening in privacy	No	5	218	15	10	1	3.87	77.4
	%	2	87.6	6	4	0.4		
Explaining things clearly	No	3	213	17	13	3	3.8	76
	%	1.2	85.5	6.8	5.2	1.2		
Being interested in the patient as a whole person during the session	No	5	209	13	20	2	3.78	75.6
	%	2	83.9	5.2	8	0.8		
Patient was satisfied with the nursing services	No	2	195	30	13	9	3.67	73.4
	%	0.8	78.3	12	5.2	3.6		
Rehabilitation nursing services meets the patient's expectations	No	1	182	36	20	10	3.58	71.6
	%	0.4	73.1	14.5	8	4		
Hospital staff favored some patients over others	No	4	57	20	101	67	2.32	46.4
	%	1.6	2.9	8	40.6	26.9		
Overall							3.56	71.2
Strongly agree (SA), Agree (A), Uncertain (U), Disagree (DA), Strongly disagree (SDA), Mean (M)								

Table 4.16 shows that the majority of participants were satisfied with nursing related factor. The overall mean of satisfaction was (3.56) and overall percentage was (71.2%). Most of participants (92%) were satisfied about making patients feel at ease and being friendly with them (Mean was 3.9 and percentage mean was 78%). Also 89.6% of participants were satisfied that nurses really listen in privacy (Mean was 3.87 and percentage mean was 77.4%). In addition, (86.7%) of respondents were satisfied about explaining things clearly (Mean was 3.8 and percentage mean was 76%). Also, (85.9%) were satisfied about that nurses being interested in patient as a whole person according to

his/her case (Mean was 3.78 and percentage mean was 75.6%). (79.1%) of participants were satisfied about nursing in IRHs (Mean was 3.67 and percentage mean was 73.4%). In addition, 73.5% of participants were satisfied as nursing care met their expectations (Mean was 3.58 and percentage mean was 71.6%). The researcher also noticed that 67.5% of patients didn't agree that nurses favored some patients over others (Mean was 2.32 and percentage mean was 46.4%). Our study findings were congruent with Assfa (2009) who reported almost the same results.

Generally, in our qualitative study with key informants and FGD, some of them surprised from that result while the other had expected it, but all of them emphasized on the gap related to miss understanding of the rehabilitation concept in GGs society at all mentioning patients and other healthcare providers. One of the key informants wasn't surprised and said *"Most cases are global aphasia which difficult to be improved. The patients don't know what is speech therapy. Also, speech therapy needs long time to gain positive outcome and needs special suitable place."* One therapist of FGD said, *"Physiotherapists and nurses spend more contact time with patients. The main purpose of the patient from integration to rehabilitation hospital is walking, so he couldn't see the other services."* Additionally another therapist on FGD expected our results and supported it, he commented, *"The referral doctor tells the patients this referral for physiotherapy, which means there is miss-understanding of the main meaning of the rehabilitation."* Another therapist reported, *"Family didn't really know the exact meaning of IRH."* Also, one therapist echoed, *"Culturally known to people that rehabilitation means only physiotherapy while speech therapy and psychosocial are not clear for patients because these are new services"*. They recommended doing general awareness through radio and internet to GGs society about the rehabilitation concept.

To summarize, the study results showed that patient-provider interface, patient satisfaction and expectation of psychosocial therapy and speech therapy needs to be improved. The researcher recommended that there is a need for general awareness through media about the exact meaning of rehabilitation. Also, suggested to do training for healthcare providers especially psychosocial and speech therapists for the way of dealing and communicating with patients.

To sum up, our study showed that there was a good patient provider interface in nursing care service.

4.2.7 General perceptions about the quality of care:

Table (4.17): Distribution of responses about the quality of care in general at IRHs

Variables	Good		Moderate		Bad		Mean	%
	N	%	N	%	N	%		
Describing the hospital culture as all	225	85.6	34	12.9	4	1.5	2.84	94.67
Judging healthcare provider involving other healthcare providers and caregivers in patients care when needed	178	67.7	82	31.2	3	1.1	2.67	89.00
Judging medical staff teaching patient about improving their health	173	65.8	87	33.1	3	1.1	2.65	88.33
Judging hospital's appearance	233	88.6	36	9.9	4	1.5	2.87	95.67
Overall							2.76	92.00

The table 4.17 shows that the majority of participants were satisfied with the hospitals. The overall mean of general satisfaction was (2.76) with overall percentage of 92%. Results show that patients perceptions about the hospital culture, as a whole was positive (94.6%). One key informant stated, "*Despite the siege on GGs and the limited sources for the IRHs, we provide a very good rehabilitation service.*"

In addition, the study results showed participants positively judged the involvement of other healthcare provider and caregivers (89%). Our study results were inconstant with Assfa (2009) who reported much less percentage. One key informant stated, "*One of the strength points in our IRH is that we have well-trained strong team, with long period of experience in rehabilitation services.*"

Moreover, results show that patient's judgement of the medical staff in teaching patients about improving their health, as all was positive (88.3%). One key informant said proudly, "*Very good staff experience in rehabilitation, bachelor to master degrees staff with specially training.*" Also, one therapist echoed, "*We have strong, well-trained healthcare providers*" which emphasized our quantitative results. In addition, results show that patients judging hospital's appearance was excellent (95.6%). The general satisfaction of

the IRHs reflects high percentage of patient trust and confidence in the IRHs in GGs. According to Shan et al. (2016), at the core of high levels of patient dissatisfaction with hospital care is the lack of trust.

The key informant qualitative data showed that there is a patient satisfaction in Al-Amal hospital. One manager said proudly, "*Almost all patients refused to be discharged; they ask us to expand their rehabilitation period, which shows their satisfaction. We send patient at home once every week as a home visit to make them merged with their family.*" Another senior manager stated, "*Good relationship between healthcare provider and patient provides high quality service. It is also clear to us when the patient do comparison between our services with other hospital services they received.*" "*Patients family already knows the case of their patient. Seeing the improvement in the case is the satisfaction*" one manager stated. Another senior manager reported, "*There is patient satisfaction; we feel it without measuring it.*" "*Satisfaction is not easy to get in general due to different backgrounds of patients. We noticed the satisfaction after discharging the patients when they come back to thank the team with simple gifts*", another key informant stated. The researcher showed that there is patient satisfaction from the number of simple gifts the IRH received from the discharged patients to thank staff for their efforts for having expected level of outcome.

In summary, the researcher discovers that there is good general satisfaction and positive perceptions about IRHs in GGs. Despite this, to improve satisfaction about IRHs, the researcher recommends that healthcare providers need to invest more in teaching patients about how to improve their health and they need to involve other healthcare providers in plan of treatment.

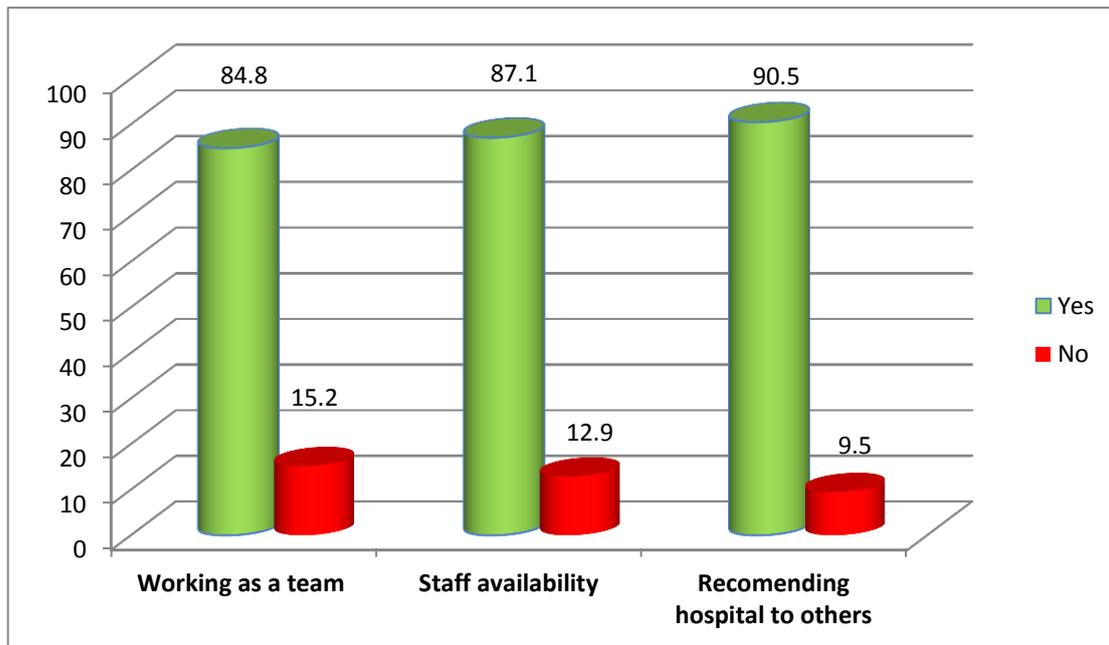


Figure (4.1): Distribution of responses about some quality of care related variables

Figure (4.1) shows general quality of care. The researcher asked participants about general quality of care of IRH, 90.5% of participants would recommend the IRH to other patient who may need it. One therapist in FGD said, *"The degree of satisfaction among patients motivates us to work and give more effort to our patients."* Our study results constant with Hillis (2008) who reported more percentage.

In addition, more than three quarters of participants (87.1%) agreed that hospital staff availability around the patients when they need them. Results show that health care providers working together as a team showed that most of participants were agree (84.8%). Our study findings were congruent with (Winstein, 2016) who recommended with communication and co-ordination to achieve full potential. The key informants and FGD members commented on our results saying that they have a weekly evaluation for each patient according to all services s/he receives at Al-Amal hospital it's done in a weekly meeting while at Al-Wafa hospital it's done in a weekly round. One of the key informants said, *"Teamwork is one of the strength points in our IRH."* Another key informant mentioned, *"We have multi-disciplinary team with weekly meeting to discuss cases together."* In addition, one member of FGD stated, *"Teamwork is one of the strength points."* This indicates that loyalty and patients satisfaction reflected in patients attitude that will make them come again to the same IRH to have the same services if it needed to patient or to relatives.

This study reveals that there was good general quality of care in IRHs. To improve general quality of care in IRHs, the researcher implicates that healthcare provider should work together as a team and they should be available around the patients.

4.2.8 Treatment outcome results:

Table (4.18): Distribution of participants' responses about the treatment outcome

Variables		Before		After	
		N	%	N	%
Mobility	Confined to bed	170	64.6	40	15.2
	Some problems in manipulation	91	34.6	91	34.6
	Normal manipulation	2	.8	132	50.2
Mean score		0.3612		1.3498	
Self-care	Unable to do it	149	56.7	41	15.6
	Some problem with self-care	112	42.6	90	34.2
	No problem with self-care	2	.8	132	50.2
Mean		0.4411		1.3460	
Usual activities	Unable to perform it	171	65.0	41	15.6
	Some problems	90	34.2	92	35.0
	Normal performing activities	2	.8	130	49.4
Mean		0.3574		1.3384	
Pain / discomfort	Extreme pain or discomfort	124	47.1	24	9.1
	Moderate pain or discomfort	128	48.7	94	35.7
	Normal, No pain or discomfort	11	4.2	145	55.1
Mean		0.5703		1.4601	
Anxiety / depression	Extremely anxious or depressed	116	44.1	33	12.5
	Moderately anxious or depressed	122	46.4	78	29.7
	Normal, Not anxious or depressed	25	9.5	152	57.8
Mean		0.6540		1.4525	
General mean		0.4768		1.2297	

The domain consists of 5 items that reflect the main important outcome results. To calculate the mean of each item, the researcher give 0 to the minimum or low performance, 1 to the moderate level and 2 to the normal one. Table 4.18 shows outcome of care among the participants pre-admission and post-discharge from the IRHs. Regarding mobility, 62% of respondents were confined to bed pre-admission to IRHs, which decreased to 15% post-discharge and this indicates the positive mobility outcome measures of services provided at IRHs in GGs. Concerning self-care, 56.3% of respondents were unable to do it, which decreased to 15.2% post- discharge. In regard to perform activities, 63.5% of participants were unable to perform them, which decreased to 34.6% post- discharge. About extreme pain, 47.5% of participants suffered from extreme pain, which decreased to 9.1% post-discharge. Regarding extreme anxiety and depression, 46.4% participants suffered from extreme anxiety and depression which decreased to (13.3%) post- discharge. Our results findings were congruent with (Winstein, 2016) and (Rufa'I, 2018) who both reported depression and cognitive disorders are common problems in after stroke. To sum up, this percentage reflects improvement in health status outcome.

4.2.9 Records review:

According to EMS (2012), the documentation by medical practitioners must be complete and accurate. In this part of the study, the researcher tried to describe the fullness in documentation during the year 2017. As shown in Table 4.19, the researcher divided documentation status into complete, partial, and not documented. The researcher revised 263 files in IRHs in GGs with equal number of files from each.

Table (4.19): Distribution of general data records completeness

Variables	Completely documented		Partial documented		Not documented	
	N	%	N	%	N	%
General data						
Personal information	263	100	-	-	-	-
Past history	263	100	-	-	-	-
Present history	263	100	-	-	-	-
Diagnosis	263	100	-	-	-	-
Total percentage	100		-		-	

The researcher found that the overall completely documentation of IRHs in GGs was 86.3%. According to Alkhaldi (2017), the overall quality of healthcare documentation at UNRWA health centers has elicited score of 77%.

For more facts, in relation to general data, which consisted of personal information, past history, present history, and diagnosis, table 4.19 showed that 100% of files were full documented.

Table (4.20): Distribution of physiotherapy records completeness

Variables/ Physiotherapy	Completely documented		Partial documented		Not documented	
	N	%	N	%	N	%
Musclo-skeletal investigation	184	69.5	2	0.7	77	29.8
Sensation test	171	65	2	0.7	90	34.3
Plan of treatment						
Aim of treatment	191	72.6	2	0.7	70	26.7
Treatment plan	190	72.2	2	0.7	72	27.3
Follow up sheet	186	70.7	8	3	69	26.3
Family training sheet	0	0	0	0	0	0
Discharge strategy						
General data	201	76.4	20	7.6	42	16
Investigation and operation done	157	59.6	26	10	80	30.4
Final diagnosis	188	71.4	20	7.6	45	17
Recommendation	204	77.6	20	7.6	39	14.8
Cause of discharge	207	78.7	14	5.3	42	16
Signature	210	80	0	0	53	20
Referral form	0	0	0	0	0	0
Total percentage	72.5		4		23.5	

Table 4.20 shows that about 72.5% of physiotherapy files were full documented. Also, 69.5% of files were full documented related to musclo-skeletal investigation while 65% of files were full documented related to sensation test. In addition, the plan of treatment section, which consisted of aim of treatment, treatment plan, follow-up sheet the full documentation get hold of 72.6% , 72.2%, and 70.7% consequently. As stated by discharge section, which consisted of signature, cause of discharge, recommendation, general data, final diagnosis, and investigation & operation done, the fullness touched 80%, 78.7%, 77.6%, 76.4%, 71.4%, and 59.6% consequently. Unfortunately, there was no family training sheet. While referral form were not founded.

Table (4.21): Distribution of occupational therapy records completeness

Variables	Completely documented		Partial documented		Not documented	
	N	%	N	%	N	%
Occupational therapy						
Musculo-skeletal test	218	83	8	3	37	14
Functional activities	217	82.5	8	3	38	14.4
Active daily living	215	82	8	3	40	15.2
Cognitive activities	215	82	8	3	40	15.2
Evaluate assistive device	213	81	5	2	45	17
Plan of treatment						
Aim of treatment	220	83.6	11	4	32	12
Treatment plan	220	83.6	11	4	32	12
Follow up sheet	220	83.6	11	4	32	12
Family training sheet	0		0		0	
Discharge strategy						
General data	220	83.6	11	4	32	12
Referral form	0		0		0	
Investigation and operation done	191	72.6	17	6.4	55	21
Final diagnosis	197	75	11	4	55	21
Recommendation	214	81	11	4	38	14.4
Cause of discharge	214	81	11	4	38	14.4
Signature	205	78	2	0.7	56	21.3
Total percentage	80.8		3.8		15.4	

Table 4.21 shows that about 80.11% of occupational therapy files were full documented. File completeness reached to 83%, 82.5%, 82%, 82%, 81% consequently in related to musculo-skeletal test, functional activities, active daily living, cognitive activities and evaluate assistive device. Moreover, table shows 83.6% full documentation of plan of treatment section, which consisted from aim of treatment, treatment plan and follow-up sheet. As stated by discharge section, which consisted from discharge strategy, general data, recommendation, cause of discharge, signature, final diagnosis, and investigation & operation done, according to table the full documentation reached to 83.6%, 81%, 81%, 78%, 75% and 72.6% consequently. There were no family training sheet and referral form to be documented. According to Richardson 2009, understanding complex connections

between the person and the environment and how these are influenced by impairments that restrict performance.

Table (4.22): Distribution of nursing records completeness

Variables	Completely documented		Partial documented		Not documented	
	N	%	N	%	N	%
Nursing						
Active daily living	263	100	-	-	-	-
Medicine in time	263	100	-	-	-	-
Psychological support	263	100	-	-	-	-
Feeding patient according to case	263	100	-	-	-	-
Plan of treatment						
Aim of treatment	263	100	-	-	-	-
Treatment plan	263	100	-	-	-	-
Follow up sheet	263	100	-	-	-	-
Family training sheet	0	0	-	-	-	-
Discharge strategy						
General data	259	98.5	3	1.1	1	0.4
Referral form	0	-	-	-	-	-
Investigation and operation done	258	98	4	1.6	1	0.4
Final diagnosis	263	100	-	-	-	-
Recommendation	263	100	-	-	-	-
Cause of discharge	263	100	-	-	-	-
Signature	240	91.3	2	0.7	21	8
Total percentage	92		1.3		6.7	
Overall	86.3		2.3		11.4	

Table 4.22 shows nursing records review. The table shows that there was full completeness of 92% of documentation in the nursing sheets. Only discharge strategy has some files which are not documented in general data, investigation & operation done and signature. In addition, the researcher noticed that there was no family training sheet and referral form in the nursing files.

The researcher noted that there was no sheets for psychosocial therapy in the patient record archive in both hospitals of IRHs in Al-Amal and Al-Wafa. One senior manager of psychosocial at Al-Wafa hospital mentioned; *"We have started archiving psychosocial files this May, 2018 in the psychosocial office."*

In relation to speech therapy files, about 17 files out of 108 patients who received this service were found in the archive. The completeness of documentation of these files was (100%). There was no family training sheet and referral form for speech therapy. The researcher found these files at Al-Amal hospital. There were no files of speech therapy in archive of Al-Wafa hospital.

Both focus group and key informants interviews results agreed and supported our results that there is a weekly follow-up for all services. One key informant said, *"One of our strength points is the weekly follow-up for every patient. There is a big co-operation between the staff, its teamwork."*

The qualitative study of FGD agreed that information system is new and need to be empowered more; one of the FGD members stated proudly *"We have a computerized database system; every healthcare provider can see every service that patient receives but techniques are not involved in this database."* Moreover, more of that one FGD member said, *"Everyday there is follow-up on this database, type of service, time of sessions and what the type of service that patient receives."* One of the FGD members said, *"We have weekly meeting to share information."*, *"We started computerized database for preparing discharge reports for each patient."* Another member of FGD echoed. The researcher argued that there are no files in the both hospitals archive for speech therapy and psychosocial therapy, which reflects that there is evaluation and monitoring for these services and no written fixed information about patients to follow-up the patients case. Additionally, the researcher interpreted that all healthcare providers need to know what kind of therapy that the patient receive to work in team spirit. One of the senior medical officers stated, *"I started archiving psychosocial therapy patients' files this June in my office to keep patients privacy."* *"Speech therapy is new (2 years old) not all patients need it."* One member of the FGD commented. The results of the FGD there was a promise to start working more in files and documentation of each rehabilitation service.

This study recommends IRHs to do a training focus-group in filing documentation for all services, prepare a written booklet to show how to use the documentation, make a better system in IRHs for documentation and prepare monitor and evaluation system for the all staff.

4.2.10 Governance of services

4.2.10.1 Policy and protocol

From the qualitative study, the researcher reported that there is no rehabilitation protocol on both Al-Amal and Al-wafa hospitals for all the services, they used global protocols, while some of them used global scales to evaluate the independency level of the patient. One of the senior medical reported, *"We try to have our own protocol to treat patients case by case starting from assessment, follow-up and plan of treatment and for the specific cases. We use international protocol but we should have our own written protocol"* , also one of the senior medical commented *" speech therapy is a new service two years old that does not has its own protocol"* from the qualitative study the researcher interpreted that every service has its way to perform the service without a written specific protocol. Management has the biggest role; it should be aware that the written specific protocol is the best way to evaluate healthcare providers' activity and the patient's case. Also should create a protocol for each service they provide to the rehabilitated patient. Additionally, the policy and protocol help to manage the work in both IRHs. It can recommend HR to develop written protocol and policy. One of the senior medical officers stated, *"There is good policy that works with global rehabilitation hospitals, but the psychosocial protocol is still under process and not ready yet."* One of the senior managers said, *"We use global protocols with some adaptation to suits our Palestinian culture in Gaza and we work according to the RCS roles."* One of the FGD members said, *"I don't know what are you talking about, but everyone in the team has studied rehabilitation at the university, and all of us know what each patient's need."* One senior manager stated, *" we use global protocols with some adaptation to suits our Palestinian culture in Gaza and we work according to the RCS roles,"* another senior nursing manager at Al-Wafa mentioned that they already have a nursing protocol at Al-Wafa hospital. One member Al-Wafer FGD said, *"We use global scales to determine independency. Nursing has a ready protocol for Al-Wafa hospital but protocol of physiotherapy and occupational therapy still under process. speech therapy has not protocol yet."* One manager said, *"We work on global protocols*

with improving weak points on them through team work to make these protocol adapted to Palestinian Gazan patient", "Rehabilitation policy differs from other medical services. We follow global and national rehabilitation hospitals. We already visited some of these hospitals," another senior manager stated. Finally, the researcher concluded that there are no specific protocols for IRHs.

4.2.10.2 Target

Most of key informants support our result and mentioned that the most patients benefits from IRHs in GG are active and conscious patients who are suffering from head injury and neurological disorders one senior key informant said "*we receive head injury, SCI, RTA, neurological disorders, CVA and recently most of cases were gunshot due to the March of Return. In the other hand outpatients are less benefit.*", "*the services include all ages, but SCI and gunshot injuries are the most benefit while patients who suffer from internal disorders are the least benefit*" other senior manager stated. Another manager mentioned, "*The most benefit patients from IRH are the conscious active patients who can reach high score in independency.*"

4.2.10.3 Management support

The qualitative study of key informant interviews and FGD emphasized on the important effect of management support on healthcare provider's satisfaction, one of FGD members said, "*We have management support, and they send us for training. They share us in decision-making but we need job security,*" and other one said, "*We need job security to increase our commitment to the IRHs*" they agreed that job security is an important thing for all healthcare providers in IRHs. Another one of the FGD members said sadly, "*We only have our support from the patients when they thank us for what we do for them.*" Additionally all of the key informants agreed that they provide the desirable management support for all the team. One manager said, "*I share the moment of success with the staff all the time and motivate them to have more success stories*"; also one of the senior medical officer reported, "*We do continuous encouraging. We have big interest from our management to do fixed contracts for our staff to give them the job security to be more affiliation to our IRH.*" "*There is a good support from our management but the financial status is difficult, but we need salaries.*" Another senior manager mentioned. Senior managers said that there is always moral support from management and we share them our

success stories all the time. Another senior manager stated, " *The most important thing that we do for our staff is the continuous support we provide all the time.*", "*It is a new program with only one person. I hope we could increase speech therapy staff to provide a suitable service to whom that needs it*" one senior manager said. The researcher finds that there is not well contact between staff and managers. She finds there is some kind of fear from their managers that prevents them to tell them their needs and support. In addition, maybe they have moral support but it appears that it's not enough for the staff because job security and salaries are both important.

4.2.10.4 Monitoring and evaluation

In summary, from the quantitative and qualitative results, the researcher found that the managers monitor and evaluate the staff by not written way. Moreover, this could be a good recommendation for writing a known procedure for both the manager and staff for the way of monitoring and evaluation. Also, we need to create environment that encourages the good job between the staff to motivate them to give their best, the researcher also recommends HR to understand the main needs of the staff. One member of FGD stated irritably, "*We have camera everywhere and we have criticisms for the team,*" "*We don't know how we are monitored and evaluated, ask our managers how they do that*" another member of FGD echoed. Another member of FGD said, "*We have daily attendance; services are computerized followed by the head of department and health manager of the IRH.*" One senior manager mentioned that they use the outcome measures when they the patient, during follow-up and when they discharging him, he gives an example, FIM. In addition, he mentioned that they do weekly evaluation of the staff according to outcome that is expected from the patient. In addition, he said that they have a written timetable; every specialist should register the time of starting and finishing every session. Another senior manager said, "*The head of department monitors nurses work, the indicator is the outcome of the patient.*" "*Every service has its stages starting from the assessment, follow-up, and plan of treatment then show the outcome. We do weekly meeting with all medical team, listening to them and monitoring their work*" one senior manager stated. One manager emphasized that, "*All the services have a care plan. There is weekly evaluation to monitor progress. Because rehabilitation is not a surgery, it needs more time to touch the progress.*" All managers emphasized the same way of monitoring and evaluation. Finally, it is important to have a written known way for monitor and evaluation in IRHs in GGs.

4.2.10.5 Health force

The qualitative study of key informants interviews and FGD agreed that human force is the most important part in IRH and they emphasized it is good and need to be empowered more; one of the senior managers said loudly *"rehabilitation services need special trained medical care providers with clear plan of treatment. According to the skills of the healthcare providers, every one of the staff should be able to deal with the patients."* Another one commented, *"We need training to refresh staff's information and know the new techniques in rehabilitation."* Also one of the FGD members stated proudly, *"We have 21 nurses, 9 physiotherapists, 4 occupational therapists, 1 psychosocial therapist, 1 speech therapist, and 5 doctors. It's enough according to internal statistics we did before. We need to continue the program of continues education, consultation group meeting to evaluate the patient, we need more attendance and participation in conferences and to communicate with global and national rehabilitation hospitals."*

Table (4.23): Distribution of staff and number of patients at the concerned hospitals

Variables	Al-Amal hospital			Al-Wafa hospital		
	No. of Staff	No. of patients	Patient per staff %	No. of Staff	No. of patients	Patient per staff %
Physiotherapy	9	29	3.2	10	40	4
Occupational therapy	4	29	7.2	6	12	2
Psychosocial therapy	1	15	15	5	35	7
Speech therapy	1	9	9	1	13	13
Nurses	21	29	1.3	25	40	1.6

According to qualitative data, the numbers of patients per staff, one senior manager said, *"We need to continue our communication with global rehabilitation hospitals. We already visited Sona hospital." We do video conference with them. We once play a part on a conference, but we could not do it again due to the siege. "* In another hand, one of the FGD members said, *"The number of nurses is not suitable to patient number."* One of the senior medical officers stated, *"We should have more staff in speech therapy especially female speech therapist according to our culture."* Another senior medical officer mentioned, *"We don't have enough staff in psychosocial department; we need to train more female and male staff in psychosocial."* The researcher commented that there is a

cultural need for both speech and psychosocial therapy as female and male existence in both services.

The number of working hours per shift in IRHs in GGs is 6 hours, minus half hour preparing material in the morning and half hour break, the remaining working hours is 5 hours.

For physiotherapy, number of staff per sessions: According the literature, the average minute time during session is 46.7 minutes, which means one physiotherapy should do 6.4 sessions per day and treats almost 6 patients. According to the table 4.20, At Al-amal hospital one physiotherapy did 3.2 sessions per day while at Al-Wafa did 4 sessions. This means that there is a gap of almost 2 sessions for each physiotherapist.

For occupational therapy, according the literature, the average minutes during session is 60 minutes, which means one occupational therapist should do 5 sessions per day and treats 5 patients. According to the table 4.20, at Al-amal hospital one occupational therapist do sessions for almost 7 patients per day, while at Al-Wafa each occupational therapist do 2 sessions per day almost 2 patients. This means that occupational therapists at Al-Amal hospital are over loaded while at Al-wafa are less loaded.

For speech therapy, according to the literature review the standard average time of sessions is 21.5 minutes, which means that each speech therapist should do 14.2 sessions per day. According to table 4.20, At Al-amal hospital each speech therapist treated 9 patients, while at Al-Wafa hospital each one treated 13 patients per day. Our study findings are in consist with qualitative findings in needing more staff. However, the researcher has to mention that speech therapy at Al-Wafa hospital is not daily.

According to literature review, standard average for each nurse is treating 10 patients per shift. According to table 4.20, at Al-Amal hospital the general average number of patients was 1.3 per nurse, while at Al-Wafa hospital was 1.6 per nurse. When 4 nurses worked each shift, this means almost 8 patients. The researcher commented that the number of nurses is suitable at both hospitals.

According to psychosocial therapy, the standard time of session is defined according to the needs of the patients. That means that the number is ranging from time to time in psychosocial therapy.

4.3 Inferential analysis:

This section explores important variations in relation to the study domains.

4.3.1 Differences in satisfaction about hospital hotel services in reference to patient characters

Table (4.24): Differences in satisfaction about hospital hotel services in reference to patient characters

Independent variables		N	Mean	SD	Factor	Value	Sig.
Governorate	North Gaza	33	2.4738	.26675	F	2.96	.020
	Gaza	100	2.3500	.32287			
	Middle Gaza	40	2.3227	.48932			
	Khan younis	51	2.5027	.25412			
	Rafah	39	2.3846	.17876			
Gender	Female	94	2.3288	.23514	t	2.84	.001
	Male	169	2.4336	.36010			
Age	1 to 30	87	2.5005	.41333	F	7.28	.001
	31 to 55	85	2.3615	.28054			
	56 to 90	91	2.3287	.23148			
Marital status	Child	43	2.4397	.35539	F	3.83	.005
	Single	43	2.5518	.45211			
	Married	138	2.3505	.26052			
	Widow	27	2.3300	.30377			
	Separated	12	2.3561	.20312			
Income	1 to 1000	67	2.4464	.32499	F	1.59	.206
	1001 to 1800	68	2.3610	.26746			
	More than 1800	47	2.3714	.29781			
Hospitalization period (in weeks)	1 to 3	69	2.4361	.39919	F	3.34	.037
	4 to 7	122	2.4225	.33221			
	More than 7	72	2.3131	.19533			

Regarding the satisfaction about hospital hotel services across governorates, table reveals that Khanyounis elicited the highest mean score while middle area elicited the lowest. There are statistically significant differences in the hospital hotel services in relation to governorates (P value = 0.020). Annex (7)Least Significant Difference LSD post hoc test shows that patients who live in Khanyounis reported a high level of satisfaction about hospital hotel services (mean = 2.502), compared with those who live in Middle Area perceived a less degree of satisfaction (mean = 2.322). The researcher attributed the results to the existence of Al-Amal hospital in Khanyounis, most of Khanyounis patients who need IRHs; go to Al-Amal hospital. The same for Middle Area, as the most of patients receive their IRSs from Al-Wafa hospital, which was destroyed in the last war by the Israeli airplanes. This study recommends that Al-Wafa hospital to improve hospital hotel services because it is an important part in IRHs generally.

As a clearly evident in Table, the prevalence of satisfaction about hospital hotel services among male participants (mean= 2.43) compared to female participants (mean= 2.32). Regarding gender, t-test pointed out statically significant variances among males and females in the overall satisfaction about the hospital hotel services (P value = .001). This finding is consistent with the study of influence of gender on patient satisfaction. Women expressed significantly less satisfaction compared to men (Woods and Heidari, 2003). The researcher explains this by females used to work at home more than males that made her more experience in these services. Our study vouches for taking care about female overview for hospital hotel services in IRHs.

Moreover, age group (0 to 30) years old reported the highest prevalence of the overall hospital hotel services satisfaction (mean = 2.50) while the age group (56 to 90) years old reported the lowest level of satisfaction (mean = 2.32). Table shows that relationship between hospital hotel services and age (regrouped intervals of age) was statistically significant with (P value= 0.001) when ANOVA test was applied to explore the difference in hospital hotel services satisfaction between regrouped intervals of age. This is opposes the studies that said, satisfaction exhibits a complex relationship with age, with scores increasing until age 65 to 80 and then declining (Jaipaul and Rosenthal, 2003). Dissatisfaction increased markedly with age, the researcher attributed this to the psychosocial health, pain, and feeling of patronized or ignored by healthcare providers. In addition, the old age group was the majority of the IRHS patients in this study.

Annex (8) of post hoc LSD for age grouped show that there is significant difference between age group (0-30) years from other groups, with group (31- 55) (P value = .004) and with group (56 – 90) (P value = .000). While there is no significant difference between age group (31 – 55) and (56 – 90) (P value = .493). This means that the study from age group (31 – 90) is consistent with what has been concluded in Jaipaul and Rosenthal (2003) study as aforementioned. The researcher attributed this into that the group (0-30) most of the participants families helped them to fill in the questionnaire which does not reflect the clear point of view of the hospitalized patient due to their age most of the time. Most family members were highly satisfied with the care provided to them and their critically ill relative in the intensive care unit (Heyland, et al., 2002). The study applauds increasing the satisfaction of hospital hotel services for the age groups over 30s by considering their needs and capabilities.

Table reveals that single participants reported the highest mean of hospital hotel satisfaction (mean = 2.55), while widow participants reported the lowest level of satisfaction was for (mean = 2.33). It shows that the relationship between hospital hotel services and marital status was statically significant (p value = .005) as indicated by ANOVA test.

According to post hoc LSD Annex (9)there was significant differences between single and married patients (P value= .000). Also, there was significant difference between single patients and widow patients (P value = .005). This means single patients were more satisfied than married and widow patients about hospital hotel services. Findings are consistent with Ahmed (2017) that single patients perceive tangibles, reliability, empathy, and loyalty higher compared to married patients. The researcher attributed this to that married patients has many persons to take care about them while being hospitalized which means that they have alternative service source that they can compare with. While when asking widow patients (who get widow after being discharged and before) this makes them having some kind of services from their partners that they can compare with. Our study endorses improving hospital hotel services for married and widow patients to increase their satisfaction about it.

With regard to hospitalization period (in weeks) and its relationship with satisfaction of hospital hotel services as shown in Annex (10) LSD post hoc test shows that (1- 3) weeks hospitalized patients reported a high level of hospital hotel services satisfaction compared

with those who have been hospitalized more than 7 weeks (mean = 2.31). The results show that there is statistically significant relationship between them (P value= .037) according to ANOVA test. These results indicated that the hospitalization period is negatively affecting the patients' satisfaction about hospital hotel services. It was consistent with the study of Lapa& Souza (2011), which found that there was a negative perception of hospitalization. The researcher attributed this result to loss of autonomy; to being restricted to the hospital environment; to being distant from family and friends; and to pain related to invasive procedures and/or to the pathology itself. The other variables in Table were statistically not significant. This study implicates that IRHs should add more efforts for long hospitalized patients to increase their satisfaction about hospital hotel services.

4.3.2 Differences in patient-provider interaction and patient's satisfaction, in reference to variables related to the quality of the specialized services

Table (4.25): Differences in patient-provider interaction and patient's satisfaction, in reference to variables related to the quality of the specialized services

Therapist spends enough time with the patient							
Independent variables		N	Mean	SD	Factor	Value	Sig.
Physiotherapy	No	22	2.3935	.34464	t	-3.76	.000
	Yes	236	3.0909	.86341			
Occupational therapy	No	13	2.4860	.35146	t	-2.24	.001
	Yes	117	2.8901	.63394			
Psychological therapy	No	13	2.4860	.35146	t	-2.26	.003
	Yes	117	2.8901	.63394			
Speech therapy	No	12	2.5264	.41874	t	-3.34	.422
	Yes	92	2.9643	.49158			
Nursing	No	18	2.3995	.30862	t	-3.001	.000
	Yes	231	2.9603	.78828			
Sessions were done daily							
Independent variables		N	Mean	SD	Factor	Value	Sig.
Physiotherapy	No	16	2.4215	.42464	t	-3.15	.007
	Yes	242	2.9286	.63460			
Occupational therapy	No	10	2.4718	.40734	t	-1.43	.011
	Yes	172	2.7714	.65361			
Psychological therapy	No	21	2.4351	.31128	t	-5.004	.018
	Yes	109	3.0000	.49898			
Speech therapy	No	18	2.5017	.39123	t	-3.28	.036
	Yes	86	2.9365	.53277			
Nursing	No	18	2.4037	.31972	t	-2.87	.000
	Yes	230	2.9206	.75787			
Standards of care were excellent							
Independent variables		N	Mean	SD	Factor	Value	Sig.
Physiotherapy	No	16	2.4085	.40314	t	-4.30	.001
	Yes	242	3.1250	.65751			
Occupational therapy	No	12	2.4622	.38923	t	-1.87	.001
	Yes	170	2.8571	.72075			
Psychological therapy	No	11	2.4682	.35038	t	-6.11	.344
	Yes	119	3.1558	.42597			
Speech therapy	No	14	2.5413	.42803	t	-2.092	.151
	Yes	90	2.8061	.51844			
Nursing	No	20	2.3974	.30702	t	-3.094	.000
	Yes	229	2.9286	.76230			
Sessions were done on time							
Independent variables		N	Mean	SD	Factor	Value	Sig.
Physiotherapy	No	17	2.4197	.41712	t	-2.98	.000
	Yes	241	2.9244	.68720			
Occupational therapy	No	18	2.4634	.40036	t	-1.76	.033
	Yes	164	2.7143	.59003			
Psychological therapy	No	19	2.4286	.29340	t	-5.77	.034
	Yes	111	3.0977	.49039			
Speech therapy	No	21	2.4991	.39369	t	-3.161	.028
	Yes	83	2.8844	.52220			
Nursing	No	18	2.4032	.32354	t	-2.899	.000
	Yes	231	2.9127	.74010			

The table unveiled that therapist of physiotherapy, occupational therapy, psychosocial therapy and nursing who spends enough time with patient provoked the highest level of patient's satisfaction (mean= 3.09, 2.89, 2.89, 2.98 respectively) equated with the results of therapists who didn't spend enough time with patients. Results from table show that there are statistically significant differences in the physiotherapy, occupational therapy, psychosocial and nursing services patient-provider interaction and patient's satisfaction related to the variable "sessions were done daily" of quality of care (P value = .000, .001, .003 and .000 in rank) according to independent t test. The study finding is unswerving with Hush et al. (2012), Richardson (2009), Priebe (2011), and Kourkouta and Papathanasiou (2014). Conclusion; there is positively affect from quality of care variable "therapist spend enough time with the patient" on the patient-provider interaction and patient's satisfaction. One senior key informant said, *"Although there is a simple source for the IRHs in GGs, we succeeded to provide the highest quality of care."* The table showed that there was no statically significant differences in speech therapy patient-provider interaction and patient's satisfaction related to the variable "therapist spends enough time with the patient" of quality of care (P value = .42) according to independent t test.

The table uncovered that patients who received daily sessions of physiotherapy, occupational therapy, psychosocial , speech therapy and nursing services reported high level of satisfaction (mean= 2.92, 2.77, 2.77, .036 and .000 in that order) associated with patients who didn't. Results from table show that there are statistically significant differences in the physiotherapy, occupational therapy, psychosocial , speech therapy and nursing services patient-provider interaction and patient satisfaction related to the variable "sessions were done daily" of quality of care (P value = .007,.011, .018, .036, .000 in turn) according to independent t test. Our study finding is consistent with Foley (2012), according to Braun (2006), frequencies ranged from multiple sessions per day to 3 times a week and as mentioned before according to Bhogal (2003), intense therapy over a short amount of time can improve outcomes of speech and language therapy for stroke patients with aphasia. Conclusion; there is positively affect from quality of care variable communication process "therapist spend enough time with the patient" on the patient-provider interaction, patient satisfaction and patient expectation.

The table exposed that patients who received physiotherapy, occupational therapy and nursing services sessions with excellent standards of care reported a higher level of patient-

provider interaction and patient satisfaction (mean = 3.12, 2.85, 2.92 in sequence) in related to patient who didn't receive sessions with excellent standards of care. The table showed that there were statistically significant differences in patient-provider interaction and patient satisfaction in reference to the quality of care that "standards of care were excellent" of physiotherapy (P value= .001, .001, .000 correspondingly) using independent t-test. As mentioned before in literature, according to Tabish (2009), standards of health profoundly influence economic performance and quality of life. There was no statistically significant difference for the other services psychosocial and speech therapy. To conclude, there is a positive effect from using excellent standards on patient-provider interaction and patient satisfaction during the sessions of the physiotherapy, occupational therapy and nursing services in the rehabilitation management in IRHs with the hospitalized patients. While there was no effect of speech therapy and psychosocial in using such equipment with high standards with the hospitalized in patient-provider interaction and patient satisfaction.

The table uncovered that patients who received physiotherapy, occupational therapy, psychosocial , speech therapy and nursing services sessions on time reported high level of patient-provider interaction and patient satisfaction (mean = 2.92, 2.46, 3.09, 2.88, 2.91 one-to-one) compared to those who did not. The results showed that there is statistically significant difference in physiotherapy, occupational therapy, psychosocial, speech therapy and nursing services patient-provider interaction and patient satisfaction related to the variable "session of physiotherapy, occupational therapy, psychosocial, speech therapy and nursing services were done on time" of quality of care (P value =.000, .033, .034, .028, .000 in that order) according to independent t test. This study result indicates that there is a positive effect from the regular sessions of physiotherapy, occupational therapy, psychosocial, speech therapy, and nursing services on patient-provider interaction, patient satisfaction and patient expectation.

However, to ensure better patient-provider interface, the researcher recommended the following points; physiotherapy, occupational therapy, psychosocial therapists and nurses should spend enough time with the patient. Patients should receive daily sessions for all services. Improve standards of care of physiotherapy, occupational therapy, and nursing services sessions. Patients should receive regular on time sessions of physiotherapy, occupational therapy, psychosocial, speech therapy, and nursing services.

4.3.3 Differences in outcome parameters before and after receiving treatment at rehabilitation hospitals

Table (4.26): Differences in outcome parameters before and after receiving treatment at rehabilitation hospitals

Independent variables		N	Mean	SD	Factor	Value	Sig.
Mobility	Before	263	.3612	.49688	t	-24.203	.001
	After	263	1.3498	.73052			
Self-care	Before	263	.4411	.51258	t	-23.224	.001
	After	263	1.3460	.73493			
Activity	Before	263	.3574	.49580	t	-24.023	.001
	After	263	1.3384	.73329			
Pain	Before	263	.5703	.57442	t	-20.344	.001
	After	263	1.4601	.65769			
Less Depressed	Before	263	.6540	.64652	t	-15.875	.001
	After	263	1.4525	.70753			
Total outcome	Before	263	.4768	.38128	t	-28.508	.001
	After	263	1.2297	.52585			

Paired t-test was used to compare the difference in outcome after receiving treatment with regard to outcome before receiving treatment. The table exhibited that the after treatment outcome results in mobility, self-care, activity, pain and feeling less depressed of the patient elicited a higher level (mean= 1.349, 1.346, 1.338, 1.460, 1.452 respectively) compared with the results of before treatment outcome results and the differences were statistically significant find differences in overall outcome in mobility, self-care, activity, pain and feeling depressed of the patient between outcome before receiving the IRSs and after receiving the IRSs in the IRHs, the researcher used paired t-test as illustrated in the table and found that there are strong statistically significant differences in the overall before treatment outcome mobility, self-care, activity, pain and feeling depressed related to after treatment outcome (P value= .000 for all). According to Musicco (2003), recovery after stroke is greatly influenced by the clinical and demographic characteristics of the patients and that early rehabilitation intervention may have a relevant role. According to Denti and et al. (2008), rehabilitation can be effective in elderly stroke patients, in improving function as well as in favorably affecting discharge destination. From the above the researcher interpreted that patients receive good IRSs that makes them getting better. It

is clear that the outcomes were positive as there was improvement as a result of receiving the care at IRHs.

4.3.4 Differences in treatment outcome results in reference to type of services

Table (4.27): Differences in treatment outcome results in reference to type of services

Independent variables		N	Mean	SD	Factor	Value	Sig.
Physiotherapy	No	5	1.0800	.72938	t	-.642-	.137
	Yes	258	1.2326	.52266			
Occupational therapy	No	78	1.2205	.49892	t	-.405-	.010
	Yes	185	1.2513	.58770			
Psychological therapy	No	122	1.1820	.55626	t	-1.370-	.157
	Yes	141	1.2709	.49635			
Speech therapy	No	155	1.2271	.54705	t	-.094-	.146
	Yes	108	1.2333	.49634			
Nursing	No	14	1.1429	.57340	t	-.634-	.869
	Yes	249	1.2345	.52388			

Table shows that occupational therapy service reported the highest level in the after-treatment outcome results (mean = 1.25) compared to patients who didn't receive the service. The results showed that there is a statically difference between the after-treatment outcome results related to occupational therapy service (P value = .010) according to independent t-test. The study signposts that there is appositve effect from receiving the occupational therapy service on the after-treatment outcome results. Other services are not statistically significant.

This study recommends that patients should receive occupational therapy to improve the results of after treatment outcome for the patients who received services from IRHs.

4.3.5 Differences in after treatment outcome results in reference to quality of services

Table (4.28): Differences in after treatment outcome results in reference to quality of services

Sessions were done daily							
Independent variables		N	Mean	SD	Factor	Value	Sig.
Physiotherapy	No	16	.8125	.41613	t	-4.100-	.016
	Yes	242	1.2603	.51773			
Standards of care were excellent							
Physiotherapy	No	16	.8500	.37594	t	-4.087-	.001
	Yes	242	1.2579	.52169			
Psychological therapy	No	12	1.0167	.65759	t	-1.460-	.012
	Yes	119	1.3008	.47147			
Sessions were done on time							
Physiotherapy	No	17	.8824	.38768	t	-3.754-	.004
	Yes	241	1.2573	.52269			
Occupational therapy	No	18	1.0000	.33607	t	-2.818-	.002
	Yes	164	1.2500	.51116			
Nursing	No	18	.8333	.46653	t	-3.758-	.035
	Yes	231	1.2658	.51600			

Table confirms that daily sessions for physiotherapy reported the highest level in the after-treatment outcome results (mean = 1.26) compared to patients who didn't receive. The results showed that there is a statically difference between the after-treatment outcome results related to daily physiotherapy sessions (P value = .016) according to independent t-test. The study indicates that there is appositive effect from receiving daily physiotherapy sessions on the after-treatment outcome results. Other services are not statistically significant.

Table approves that excellent standards for physiotherapy and psychosocial therapy reported the highest level in the after-treatment outcome results (mean = 1.25, 1.30) compared to patients who didn't receive. The results exposed that there is a statically difference between the after-treatment outcome results related to excellent standards for physiotherapy and psychosocial therapy (P value = .016) according to independent t-test. The study shows that there is appositive effect from excellent standards for physiotherapy

and psychosocial therapy sessions on the after-treatment outcome results. Other services are not statistically significant.

Table supports that patients who receive on time sessions of physiotherapy, occupational therapy and nursing services reported the highest level in the after-treatment outcome results (mean = 1.257, 1.250, 1.26 respectively) compared to patients who didn't receive. The results exposes that there is a statically difference between the after-treatment outcome results related to on time sessions of physiotherapy, occupational therapy and nursing services (P value = .004, .002, .035 in that order) according to independent t-test. The study indicated that there is appositve effect from receiving on time sessions of physiotherapy, occupational therapy and nursing services on the after-treatment outcome results. Other services are not statistically significant.

To improve the after-treatment results of outcome for hospitalized patients in IRHs, researcher recommends that patients should receive daily physiotherapy sessions, improve standards for physiotherapy and psychosocial therapy sessions and patients should receive on time sessions of physiotherapy, occupational therapy, and nursing services.

Chapter 5

Conclusion and recommendation

5.1 Conclusion

This study is carried out for evaluating the services In-patient Rehabilitation Hospitals in Gaza Governorates. In addition, the study suggests that demographic aspects such as governorate, gender, age, marital status and hospitalization period affect the patients' satisfaction about hotel hospital services in different directions. It is noteworthy to report that there were no different according to income in relation to hotel hospital services patients' satisfaction. However, the results indicate that patients who lived in Khanyounis governorate perceived higher level of hotel hospital patients' satisfaction. Also, the results indicate that male perceived higher satisfaction than female in hotel hospital services. Moreover, these results showed that patients from age 1-30 years old perceived higher satisfaction of hotel hospital services. Additionally, it is interesting to report that results suggest that patients who have been hospitalized from 1-3 weeks perceived higher satisfaction of hotel hospital services.

Main results indicate that the patient-provider interaction, patient satisfaction and patient expectation elicited relationship with quality of care. The study results indicate that the physiotherapist who spends enough time with the patient during the session, perceived high rate in patient-provider interaction, patient satisfaction and patient expectation. While it is worthy that occupational therapists who spend enough time with the patients during the session perceived higher rate of patient-provider interaction, patient satisfaction and patient expectation. Results suggest that psychosocial therapist who spends enough with the patient's perceived high rate of patient-provider interaction, patient satisfaction and patient expectation. To gain the required objective from speech therapy, there is a need to empower it through training courses and initiatives on communication between patient and therapist. In addition, results show that nurses who spend enough time with the patients' perceived high rate of patient-provider interaction, patient satisfaction and patient expectation. Results conclude that the majority of therapists spend enough time with patients perceived higher rate patient-provider interaction, patient satisfaction and patient expectation and this indicates of good communication process.

And analyzing the quality of care that session were done daily, showed that patient who received daily sessions elicited the highest level of patient-provider interaction, patient satisfaction and patient expectation. This result indicates that the daily session of physiotherapy affects positively this scale. Furthermore, result indicates that the daily session of occupational therapy affects positively this scale. In addition, result indicates that the daily session of psychosocial therapy affects positively this scale. In addition, result indicates that the daily session of speech therapy affects positively this scale. Additionally, result indicates that the daily session of nursing affects positively this scale. This study results indicate that patients in IRHs need intensive therapy sessions in all services.

The result also suggest that quality of care "excellent standards of care" regarding to manual therapy, mechanical therapy and warming-up techniques perceived higher level of patient-provider interaction, patient satisfaction and patient expectation. This result indicates that the excellent standards of care of physiotherapy affect positively this scale. Furthermore, result indicates that the excellent standards of care of occupational therapy affect positively this scale. Additionally, result indicates that the excellent standards of care of occupational therapy affect positively this scale. Also, result indicates that the excellent standards of care of occupational therapy affect positively this scale. While the study results show that, there is no different change to the quality of care "excellent standard of care" on the psychosocial therapy and occupational therapy patient-provider interaction, patient satisfaction and patient expectation. This is important since high standards in the patient-provider interaction, patient satisfaction and patient expectation correlated to the excellent standards of equipment and health staff. However, it is noteworthy that psychosocial therapy and speech therapy need a special attention from IRHs in GGs to be more empowered.

To improve the post-discharge results of outcome for hospitalized patients in IRHs, researcher recommends that patients should receive daily physiotherapy sessions, improve standards for physiotherapy and psychosocial therapy sessions and patients should receive on time sessions of physiotherapy, occupational therapy, and nursing services. Patient should receive occupational therapy during his hospitalization in IRHs. In addition, daily physiotherapy sessions, improve standards for physiotherapy and psychosocial therapy sessions and on time sessions of physiotherapy, occupational therapy, and nursing services

Finally, the study concluded that there is strong difference between pre-outcome mobility, self-care, activity, pain and feeling depressed related to post-outcome results of the patients of IRHs and post outcome results. It is now revealed that post outcome is higher than pre outcome measures.

5.2 Recommendations:

Based on the study analysis, findings, and conclusions, the researcher proposes the following recommendations: The study provided important findings that worth to be studied carefully and responded by the management of IRHs. The researcher strongly recommends that the uptake of the study be considered in the future important improvement initiatives.

1. Management at IRHs could reinforce and support the hotel hospital services through paying more attention to this important concept and introducing it as part of the center culture including bring findings from the study security of patients during hospitalization and availability of the medicine.
2. The communication between RAD and IRHs in GGs needs to be strengthened through making better system with clear processes for both the patients and the healthcare providers also.
3. Overall patient-provider interaction scored high. Measures to reinforce that are important including counseling, listening to client and getting feedback.
4. It is essential to focus on follow-up after discharging from IRHs, which is an important process in the long-term plan of treatment of the rehabilitation patients.
5. It is important to establish protocols for the rehabilitation services as this enhances standardizations of services in IRHs.
6. The results of patients' satisfaction with speech therapy and psychosocial therapy was low; therefore urgent measures need to be exerted to address those services. Reasons behind low satisfaction need to be carefully studied and addressed.
7. Medical patients' files at IRHs scored low documentation in certain parts of the file; therefore, they required greater attention by management to develop and support them; it is important to work more on their fullness, through training and mentoring.
8. It is important to create a better new system on the discharged strategy and family centered therapy.
9. Human force needs enforcement in the quality of session.

10. Patient should receive occupational therapy during his hospitalization in IRHs. In addition, daily physiotherapy sessions, improve standards for physiotherapy and psychosocial therapy sessions and on time sessions of physiotherapy, occupational therapy, and nursing services.

5.3 Recommendation for further research:

1. Conduct similar study at the outpatient services in rehabilitation centers in Gaza Governorates.
2. Conducting in-depth study on patient-provider interaction, patient satisfaction and patient expectation of both psychosocial therapy and speech therapy.
3. Study the effect of the quality of care on the outcome results of patients of IRHs.
4. Conduct a study to identify the effect of discharge strategy and follow-up system on the post-outcome of the discharged patients from IRHs.

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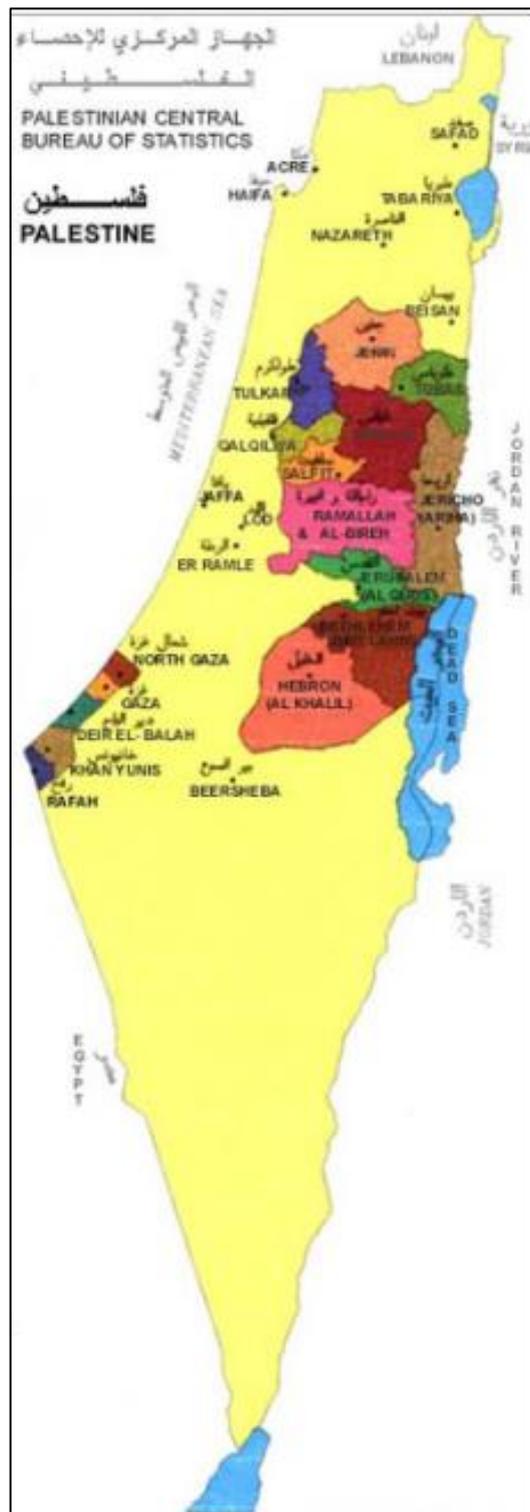
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Annexes

Annex (1): Map of Palestine.



Annex (2): List of arbitrators

	Name
1	Dr. Yehia Abed
2	Dr. Khamis Essi
3	Dr. Wael Mikki
4	Dr. Fadel Masoud
5	Dr. Soad Ghaben
6	Dr. Mohammed Abo Maghaseib
7	Dr. Mousa Abo Mostafa
8	Dr. Fatma Karsou'

Annex (3): An official letter of approval from the Helsinki Committee in the Gaza Governorates:

**المجلس الفلسطيني للبحوث الصحي**
Palestinian Health Research Council

تعزيز النظام الصحي الفلسطيني من خلال مأسسة استخدام المعلومات البحثية في صنع القرار
Developing the Palestinian health system through institutionalizing the use of information in decision making

Helsinki Committee
For Ethical Approval

Date: 05/02/2018 **Number: PHRC/HC/332/18**

Name: MABADEE H. ALFARRA **الاسم:**

We would like to inform you that the committee had discussed the proposal of your study about: **نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:**

Evaluation of In-patient Rehabilitation Services in Gaza Governorates.

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/332/18 in its meeting on 05/02/2018 **و قد قررت الموافقة على البحث المذكور عاليه بالرقم والتاريخ المذكوران عاليه**

Signature

Member


Member


Chairman


Genral Conditions:-

1. Valid for 2 years from the date of approval.
2. It is necessary to notify the committee of any change in the approved study protocol.
3. The committee appreciates receiving a copy of your final research when completed.

Specific Conditions:-



E-Mail: pal.phrc@gmail.com
Gaza - Palestine غزة - فلسطين
شارع النصر - مفترق العيون

Annex (4): The study quantitative instrument – English Study questionnaire

طلب الموافقة علي المشاركة في عينة البحث

الاخوات و الاخوة الاعزاء:

انا الباحثة / مبادئ حمدان الفراء، طالبة ماجستير في جامعة القدس و اقوم بعمل دراسة بعنوان "تقييم خدمات مراكز التأهيل الداخلي في محافظات غزة" كمتطلب للحصول على درجة الماجستير حيث اقوم بجمع البيانات لهذه الدراسة التي تركز على تقييم خدمات التأهيل الداخلي في مراكز محافظات غزة، و تتناول الدراسة عدة محاور تهدف لمعرفة جودة هذه الخدمات و معرفة مدى رضاك كمستفيد عنها والنتائج التي حصلت عليها بعد تلقك الخدمة. و قد تم اختيارك من سجلات مراكز التأهيل الداخلي التي عولجت فيها حيث ينطبق عليك معايير الدراسة و الغرض من هذه الزيارة هو جمع المعلومات التي تساعدني كباحثة على فهم طبيعة خدمات مراكز التأهيل الداخلي و كيفية تقديمها و برار نقاط القوة و الضعف في الخدمات المقدمة من وجهة نظرك. و على الرغم من ان المشاركة في هذه الدراسة طوعية يمكنك عدم الاجابة على بعض او جميع الاسئلة، الا انني سأقدر كثيرا مشاركتك حيث ان ردودك مهمة بالنسبة لنا.

المشاركة في هذه الدراسة ينطوي على ملء الاستبيان الذي سيتطلب حوال 25 دقيقة من وقتك. مهما كانت المعلومات التي ستقدمها سيتم الاحتفاظ بها بسرية تامة وسوف يطلع عليها فريق البحث فقط، حيث لن يتم مشاركتها مع أي جهات اخرى.

يبقى ان اوضح ان مشاركتك في تعبئة هذا الاستبيان لن ينتج عنها أي مقابل مالي و ان المعلومات التي تم الحصول عليها عنك و عن اسرتك في هذه الدراسة لن تؤثر على أي خدمات او أي دعم تتلقاه من قبل أي جهة.

غير موافق	موافق	هل أنت موافق على المشاركة؟

شاكرين تعاونكم

الباحثة/ مبادئ الفراء

Beneficiaries interviewed questionnaire:

Serial number: _____

1- Personal characters:

1 | Governorate :										
North			Gaza			Middle		Khanyounis		Rafah
Personal characteristics:										
2 | Gender		Male			Female					
3 | Age		..... years							
4 | Social status before becoming ill (the most recent illness which required admission to inpatient rehabilitation hospital)										
Child		Single		Married		Widow		Divorced		Separated
5 | Current social status										
Child		Single		Married		Widow		Divorced		Separated
6 | Type of work at the time of becoming ill:										
7 | Type of work after becoming ill:										
8 | Level of education:										
Illiterate		Can read and write		Elementary		Preparatory		Secondary		Diploma
								Bachelor		Post graduate/ higher education
9 | Family monthly income (total average): INS										
Medical situation :										
10 | The duration of hospitalization at RH (In weeks): weeks										
11 | The reason of admitted in the rehabilitation hospital										
Accident or Injury:			Disease			Others				
War injury		Falling down	RTA	Violence injury		CVA	Congenital disease	Orthopedic disease	Neurological disease	Cancer
12 | Diagnosis as in the medical file :										
13 | After how many days did you start receiving the in-patient rehabilitation services after becoming ill?								..... days	
14 | At the time of referral, what were your the main health problems:										
Breathing diseases		Pressure ulcers		contractures		Bowel and bladder dysfunction		coma		Others
15 | Which of these problems still exist?										
Breathing disease	Bed sores		Contractures		Bowel and bladder dysfunction		Decrease cognition		Others	
16			Have you been referred to this hospital by a health provider?		Yes				No, self-referral	
17 | From where you have been referred?										
Governmental			International NGO			Local NGO			Private	
18 | Did you face any problems/ challenges when you have been referred?								Yes		No
If yes, choose from the following list which one you faced?										
No space at the rehabilitation hospital		Delay in getting a an appointment at the rehabilitation hospital			Co-ordination between the referring and the referral organizations			Difficulty in convincing the treating doctor to issue the referral		
Getting Financial coverage		Lengthily procedures		Unstable patients case			Others , Specify			
19 | How many days have you waited from the movement of taking the decision to refer you till your arrival to the RH					.....				
20 | Did you approach or used any personal connections to be referred?				Yes				No		
21 | How many times did you visit or call the referral abroad department				Visits:						
				Calls:						
22 | How do you judge the referral process?			Fair			Just OK		Unfair		
23 | Has your plan of treatment been completed?			Yes			No		DK		

2- Hospital hotel services:

Key :

1 = Strongly agree (SA)	2= Agree (A)	3= Uncertain (U)	3= Dis-agree (DA)	4= Strongly Dis-agree (SDA)
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Hotel services during hospitalization				Score
24	The room and bedding were clean			
25	The ward was quiet			
26	The meals provided was suitable and delicious. The meals with regard to appearance was nice			
27	Good cleanliness of bathrooms			
28	I felt concerns about security while I was hospitalized			
29	Suitable room temperature			
30	All the medicines for my treatment are available in the hospital.			
31	Access to recreational activities like TV			
32	Furniture was convenient			
33	Access to drinking water			
34	Access to hot water for shower			
35	Is there any of your family a stayed as a companion with you during hospitalized?	Yes	No	
	If Yes, specify			
36	Why you have been accompanied by someone			
	The hospital asked me to	I can't do my ADL	My family insist to be with me	I need someone to help me
				Others
37	Did you have daily shower during hospitalized?	Yes	No	
	If Yes, specify the one who did it for you			

3- The hospital gave you a schedule for Follow up:

38	Have you been referred to other community resources			Yes	No
	If yes, Where you have been referred?				
	Home	NGO's	MOH clinic	Private clinic	Others
39	Are you now receiving services from any providers			Yes	No
40	What are services after discharge you still need and take?				
	PT	OT	PSY	ST	Nursing
41	Are you familiar with the long term plan for your case			Yes	No
42	Is your house adapted to suit your needs?			Yes	No

4- Services received:

Please choose the service that you received during your hospitalization at the IRH:

43	What type of rehabilitation services did you received?											
	Physiotherapy		Occupational therapy		Psychological therapy		Speech therapy		Nursing		All of them	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No		
Physiotherapy services received:												
44	Manual techniques, such as exercises and massage..... etc.										Yes	No
45	Mechanical techniques such as treadmill, bicycle etc.										Yes	No
46	Electrical therapy such as electrical stimulation, ultrasound ... etc.											
47	Hydro therapy such as hot pack and ice therapy.										Yes	No
Occupational therapy services provided you:												
48	Training on functional activities such as bed mobility, balance and transfer.										Yes	No
49	Training on your active Daily Living such as eating, wearing your clothes, grooming etc.										Yes	No
50	Teaching on using suitable active devices (wheel chair, crutches, orthosis, spinal orthosis, neck orthosis.... etc.)										Yes	No
51	Recommendations for adaptive equipment or modifications to the environment (at home, at work, in the hospital) to maximize your safety and ability to succeed.										Yes	No
Psychological therapist services provided:												
52	Talking with you and your family and careers e.g. cognitive behavior therapy (supportive sessions)										Yes	No
53	Guided you on controlling fair.										Yes	No
54	Reducing the post traumatic disease complications.										Yes	No
55	Helped you in managing depression.										Yes	No
Speech therapy provided:												
56											Yes	No
57	Speech and Voice Clarity										Yes	No
58											Yes	No
Nursing provided:												
59	Active daily living such as feeding, bathing.... According to your case										Yes	No
60	Medicine in time										Yes	No
61	family										Yes	No
62	Feeding patient according to his case										Yes	No
Quality of care:												
			PT		OT		PSY		ST		Nursing	
63	Do you feel the health provider has spent enough time with you?		Y	N	Y	N	Y	N	Y	N	Y	N
64	Are the sessions done regularly?		Y	N	Y	N	Y	N	Y	N	Y	N
65	The standards of care were excellent		Y	N	Y	N	Y	N	Y	N	Y	N
66	Sessions were done on time		Y	N	Y	N	Y	N	Y	N	Y	N
67	The number of session per day		.....		.....		.....		.....		.....
68	Average time of session		.....		.....		.....		.....		.....
69	Health care providers work together as a team										Y	N
70	Hospital staff were available around the patient if he needs them										Y	N
71	Would you recommend this hospital to other patient who needs it?										Y	N

5- Please give comments on your own point of view on the following: * patient-provider interfaces,* satisfaction of patients and *meeting expectations:

Key:

1= Strongly Dissatisfied (SD)	2= Dis-Satisfied (DS)	3= Uncertain (U)	4= Satisfied (S)	5= Strongly Satisfied (SS)
--------------------------------------	------------------------------	-------------------------	-------------------------	-----------------------------------

		PT	OT	PSY	ST	Nursing
72	Making you feel at ease... (being friendly and warm towards you, treating you with respect; not cold or abrupt)					
73	Really listening (paying close attention to what you were saying; not looking at the notes or computer as you were talking)					
74	Fully understanding your concerns (communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)					
75	Helping you to take control (exploring with you what you can do to improve your health yourself; encouraging rather than "lecturing" you)					
76	Hospital staff favored some patients over others					
77	The rehabilitation services meets my expectations					
78	Overall, I was satisfied with this hospital services.					
79	How would you rate the way the medical staff teaching you about improving your health?	Good	Moderate	Bad		
80	How would you rate the way your healthcare provider involves other healthcare providers and caregivers in your care when needed?	Good	Moderate	Bad		
81	How would you describe the hospital culture as all?	Good	Moderate	Bad		
82	How do you see our hospital's appearance?	Good	Moderate	Bad		

6- Outcome:

By placing a tick in one box in each group below, please indicate which statements best describe your own health state		Before	After
83	<u>Mobility</u>		
	1 I have no problems in ambulation		
	2 I have some problems in ambulation		
	3 I am confined to bed		
84	<u>Self-Care</u>		
	1 I have no problems with self-care		
	2 I have some problems washing or dressing myself		
	3 I am unable to wash or dress myself		
85	<u>Usual Activities</u> (e.g. work, study, housework, family or leisure activities)		
	1 I have no problems with performing my usual activities		
	2 I have some problems with performing my usual activities		
	3 I am unable to perform my usual activities		
86	<u>Pain/Discomfort</u>		
	1 I have no pain or discomfort		
	2 I have moderate pain or discomfort		
	3 I have extreme pain or discomfort		
87	<u>Anxiety/Depression</u>		
	1 I am not anxious or depressed		
	2 I am moderately anxious or depressed		
	3 I am extremely anxious or depressed		

The study quantitative instrument – Arabic

استبيان للمستفيدين:

الرقم التسلسلي:.....

1- المعلومات الشخصية:

المحافظة:		1	
شمال غزة	غزة	دير البلح	خان يونس
رفح			
الجنس:		2	
ذكر	انثى		
العمر (بالسنوات)		3	
.....			
4 الحالة الاجتماعية قبل المرض المسبب لدخول قسم التاهيل الداخلي			
طفل	اعزب	متزوج	ارمل
مطلق			
الحالة الاجتماعية الحالية:		5	
طفل	اعزب	متزوج	ارمل
مطلق			
6 طبيعة العمل قبل المرض المسبب لدخول قسم التاهيل الداخلي		.....
7 طبيعة العمل بعد المرض المسبب لدخول قسم التاهيل الداخلي		.....
8 مستوى التعليم:			
أمي	يستطيع القراءة والكتابة	ابتدائي	اعدادي
		ثانوي	دبلوم
تعليم عالي	بكالوريوس		
9 متوسط دخل الاسرة الشهري بالشيكل :		.....
10 مدة البيات في قسم التاهيل الداخلي (بالاسابيع)		.....
التاريخ الطبي:			
11 سبب دخول قسم التاهيل الداخلي			
اصابة او حادث		مرض	
اصابة	سقوط من علو	سرخان	مرض اعصاب
حادث طرق	جذبة	مرض عظام	مرض وراثي
عنف			
12 التشخيص كما ذكر في الملف الطبي		.....
13 بعد كم يوم من الاصابة بدأت العلاج في التاهيل؟		.....
14 في وقت دخول القسم، ما هي اهم المشاكل الصحية التي واجهتك؟			
مشاكل في الجهاز التنفسي	تقرحات سرير	شد في المفاصل	مشاكل في الاخراج
غير ذلك	.....	.....	.....
15 ما المشاكل الصحية التي ما زالت مصاحبة لك ؟			
مشاكل في الجهاز التنفسي	تقرحات سرير	شد في المفاصل	مشاكل في الاخراج
غير ذلك	.....	.....	.....
16 هل تم تحويلك للمستشفى عن طريق الطبيب المختص؟		نعم	
لا، داخليا	اذهب لسؤال	16	
17 من اين تمت التغطية المالية للتحويل؟			
الحكومة	منظمة دولية غير حكومية	منظمة محلية غير حكومية	خاص
18 هل واجهتك اي مشاكل او تحديات عندما تم تحويلك؟			
لا	نعم	لو نعم، اختر طبيعة المشكلة من القائمة الاتية:	
لا يوجد متسع في مركز التاهيل	تاخير في الحصول على موعد في مركز التاهيل	مشاكل في التنسيق بين مركز التاهيل و قسم التحويلات	صعوبة اقناع الطبيب المعالج في توقيع نموذج رقم 1
الحصول على تغطية مالية		اجراءات قانونية	
19 كم يوم انتظرت ليتم قرار التحويل؟		.....

20	هل استعنت بمعارف شخصية لاتمام التحويلة؟	لا	لا	لا	لا
21	كم مرة قمت بزيارة العلاج بالخارج؟ او في حالة الاتصال كم مرة اتصلت؟	عدد الزيارات:	عدد الاتصالات:	لا	لا
22	ماهو تقييمك لعملية التحويل؟	عادية	عادية فقط	غير عادلة	لا اعرف
23	هل انتهت خطتك العلاجية؟	لا	لا	لا اعرف	لا اعرف

2- خدمات المستشفى الفندقية:

1= اوافق بشدة	2= اوافق	3= محايد	4= لا اوافق	5= لا اوافق بشدة
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الدرجة		خدمات الفندقة خلال المبيت في المستشفى:			
24	الغرفة كانت نظيفة، و السرير ايضا.				
25	الممر كان هادئا.				
26	وجبات الطعام المقدمة كانت مناسبة و لذيذة، و مقدمة بطريقة جيدة.				
27	الحمام كان نظيفا.				
28	شعرت بقلق بخصوص الامن.				
29	درجة حرارة الغرفة كانت مناسبة.				
30	جميع الادوية اللازمة كانت متوفرة.				
31	سهولة الوصول للانشطة الترفيهية كالتلفاز مثلا.				
32	الاثاث كان مريحا.				
33	سهولة الوصول على مياة للشرب.				
34	سهولة الوصول لمياة ساخنة للاستحمام.				
35	هل كان هناك مرافق من اقاربك يرافقك خلال فترة مبيتك بالمستشفى؟	لا	لا	لا	لا
لو نعم، حدد طبيعة الشخص لك					
36	لماذا تمت مرافقتك خلال فترة المبيت؟				
حسب تعليمات المستشفى		لا استطيع القيام بالأنشطة اليومية	اصرار عائلتي على ان تكون معي	غير ذلك	
37	هل كنت تستحم يوميا؟	لا	لا	لا	لا
لو نعم، حدد من كان يقوم بمساعدتك فيه؟					

3- المستشفى زودك بجدول لمتابعة ما بعد الخروج:

38	هل تم تحويلك لخدمات في منظمات مجتمعية؟	لا	لا	لا	لا	
لو نعم، اين تم تحويلك؟						
المنزل		منظمات غير حكومية	عيادة حكومة	عيادة الوكالة	عيادة خاصة	غير ذلك
39	هل يتم تقديم خدمات الان من ممولين اخرين؟	لا	لا	لا	لا	
40	ما الخدمات التي تقدم لك بعد خروجك من المستشفى؟					
علاج طبيعي		علاج وظيفي	علاج نفسي	علاج النطق	تمريض	
41	هل تعرف الخطة العلاجية طويلة المدى لحالتك؟	لا	لا	لا	لا	
42	هل منزلك تم تكييفه لاحتياجاتك الصحية الحالية؟	لا	لا	لا	لا	

4- من فضلك اختار الخدمة التي تلقيتها خلال مبيتك بالمستشفى:

43	اختر طبيعة الخدمة التي تلقيتها خلال تاهيلك:				
علاج طبيعي		علاج وظيفي	علاج نفسي	علاج النطق	تمريض
Annex خطأ! الإشارة المرجعية غير معروفة.		لا	لا	لا	لا
خدمات العلاج الطبيعي التي تلقيتها:					

44	تقنيات يدوية : كالماساج، و التمارين الخ	نعم	لا
45	تقنيات بالاجهزة مثل جهاز المشي، البسكليت الخ	نعم	لا
46	علاج كهربائي مثل التحفيز الكهربائي او الالتراساوند الخ	نعم	لا
47	علاج مائي مثل الكمادات الساخنة او الباردة	نعم	لا
خدمات العلاج الوظيفي التي تلقيتها:			
48	تدريب على الوظائف اليومية مثل الحركة عالسريير، التوازن، و التنقل	نعم	لا
49	تدريب على الانشطة اليومية مثل الاكل و لبس ملابسك الخ	نعم	لا
50	تعليمك على استخدام الاجهزة المساعدة مثل الكرسي المتحرك او العكازات الخ.....	نعم	لا
51	نصائح لجعل البيت و العمل و المستشفى ملائمة لحالتك الصحية	نعم	لا
خدمات العلاج النفسي التي تلقيتها:			
52	التحدث معك و مع اهلك من خلال جلسات سلوك التعامل.	نعم	لا
53	تعليمك التحكم في الخوف	نعم	لا
54	تخفيف مضاعفات ما بعد الصدمة	نعم	لا
55	مساعدتك في السيطرة على الاكتئاب	نعم	لا
خدمات علاج النطق التي تلقيتها:			
56	تقييم و معالجة صعوبة السمع	نعم	لا
57	وضوح الصوت و الكلام	نعم	لا
58	تدريب على البلع و صعوبة الكلام	نعم	لا
خدمات التمريض التي تلقيتها:			
59	الانشطة اليومية مثل الاكل، التنظيف ... الخ	نعم	لا
60	الدواء في مواعيد	نعم	لا
61	الدعم النفسي	نعم	لا
62	اطعام المريض حسب حالته	نعم	لا
جودة الخدمة:			
(من سؤال 63 ل سؤال 66 : الاجابة ب نعم او لا)			
63	هل استغرق معك الاخصائي الوقت المناسب؟	ع ط	ع و
64	هل الجلسات تمت بانتظام؟	ع نفسي	ع نطق
65	هل الجلسات كانت جيدة؟	تمريض	
66	الجلسات كانت تتم في مواعيدها المحددة		
67	عدد الجلسات في اليوم		
68	مدة الجلسة		
69	الاخصائيين كانوا يعملون ك فريق	نعم	لا
70	الاخصائيين كانوا متوفرين عند احتياج المريض	نعم	لا
71	هل سوف تنصح مريض يلزمه تاهيل بهذه المستشفى؟	نعم	لا

5- من فضلك، زدونا بوجهة رأيك بالنقاط التالية: علاقة الاخصائي بالمريض، مدى رضى المريض عن الخدمة، و مدى الاستجابة لتوقعات المريض:

1= اوافق بشدة	2= اوافق	3= محايد	4= لا اوافق	5= لا اوافق بشدة
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72	التعامل معك بود و احترام	ع ط	ع و	ع نفسي	ع نطق	تمريض
73	مستمع جيد و بعناية لما تقوله					
74	يهتم بك يسالك تفاصيل حياتك و حالتك و لست مجرد رقم					
75	يشرح لك الامور بوضوح					

76	طاقم المستشفى كان يميز مريض عن مريض				
77	خدمات التأهيل استجابت لتوقعاتي				
78	كنت راض عن خدمات المستشفى				
79	كيف تقيم طريقة تعليم الطاقم كله لك لتحسين صحتك؟	جيد	متوسط	سيء	
80	كيف تقيم ان يشارك الاخصائي زميلا له في علاجك؟	جيد	متوسط	سيء	
81	كيف تصف بيئة المستشفى بصفة عامة؟	جيد	متوسط	سيء	
82	كيف ترى الشكل الخارجي العام للمستشفى؟	جيد	متوسط	سيء	

6- النتائج

عن طريق وضع اشارة، من فضلك اختار العبارة التي تمثل حالتك الصحية:	قبل	بعد
83		
الحركة:		
1- لا يوجد لدى مشاكل بالحركة		
2- لدى بعض المشاكل بالحركة		
3- انا ملزم الفراش		
84		
العناية الشخصية:		
1- لا يوجد لدى مشاكل في القيام بالعناية بنفسى		
2- لدى بعض المشاكل في القيام بالعناية بنفسى		
3- لا استطيع القيام بغسل يدي او لبس ملابسى		
85		
الانشطة اليومية الاعتيادية (الشغل ، الدراسة ، شغل البيت ،)		
1- لا يوجد لدى مشاكل في القيام بالانشطة		
2- لدى بعض المشاكل في القيام بالانشطة		
3- لا استطيع القيام ب اي نشاط		
86		
الالم/عدم الراحة:		
1- لا يوجد عندي الم		
2- يوجد الم متوسط		
3- لدى الم شديد		
87		
القلق/الاكتئاب:		
1- انا لست قلق ولا مكتئب		
2- انا قلق بدرجة متوسطة		
3- انا قلق جدا		

Annex (5): Records review checklist

Variables	Completely documented		Partial documented		Not documented	
	N	%	N	%	N	%
General data						
Personal information						
Past history						
Present history						
Diagnosis						
Total percentage						
Physiotherapy						
Musculo-skeletal investigation						
Sensation test						
Plan of treatment						
Aim of treatment						
Treatment plan						
Follow up sheet						
Family training sheet						
Discharge strategy						
General data						
Investigation and operation done						
Final diagnosis						
Recommendation						
Cause of discharge						
Signature						
Referral form						
Total percentage						
Occupational therapy						
Musculo-skeletal test						
Functional activities						
Active daily living						
Cognitive activities						
Evaluate assistive device						
Plan of treatment						
Aim of treatment						
Treatment plan						
Follow up sheet						
Family training sheet						
Discharge strategy						
General data						
Referral form						
Investigation and operation done						
Final diagnosis						
Recommendation						
Cause of discharge						
Signature						
Total percentage						
Nursing						
Active daily living						
Medicine in time						
Psychological support						
Feeding patient according to case						

Plan of treatment						
Aim of treatment						
Treatment plan						
Follow up sheet						
Family training sheet						
Discharge strategy						
General data						
Referral form						
Investigation and operation done						
Final diagnosis						
Recommendation						
Cause of discharge						
Signature						
Total percentage						
Overall						

Annex (6): In-depth interview and focus group questions (English and Arabic version In depth interview and FGD questions- English

Focus group:

- 1- How do you see the IRSs, what do you think about the services?
- 2- How you perceive the quality of services? What works well and what doesn't work well?
3. What are the strength and weaknesses in the rehabilitation services?
- 4- Tell me about the protocols for IRH, are they national, who prepared them, do you use them? If yes, how, if no why you don't use them
- 5- How can we improve documentation in PSY and ST in IRHs? How is the information system works in IRHs? How does the staff share data within IRHs?
- 6- Thinking about patient- and family-centered care and its relation to enhance outcome. How important you see it? How interactions with clients and families can be better?
- 7- How supported and encouraged you are by your management, what management should do to support you and rehabilitation services.
- 8-What kind of equipment are needed but are not available? how it affects your work?
- 9- Thinking about program monitoring and evaluation, how that is being done does at your in work in IRHs?
- 10- Quantitative findings showed that overall PT & nursing patient-provider interaction, patient's satisfaction and patient's expectation were the highest. How can you explain that and to what extent the concept of patient-provider interaction, patient's satisfaction and patient's expectation is important in IRHs work environment and consequences of patient-provider interactions, patient's satisfaction and patient's expectations in IRHs like AL-Wwafa and Al-aAmal hospitals?
- 11- Quantitative findings showed that overall Speech therapy patient-provider interaction, patient's satisfaction and patient's expectation were the lowest. How can you explain that?
- 12- If we need to improve the rehabilitation services, what should be done?

KII 8:

- 1- How you perceive rehabilitation services, how important it is in relation to other services? probe for space, cleanliness, human resources, respect, privacy, all quality related aspects, safety. Why do you think it is important?
- 2- Tell me about the strength of rehabilitation services as you see it
- 3- Tell me about the weakness of rehabilitation services as you perceive it
- 4- How do you describe the availability of adequate policies and protocols for Rehabilitation services, how it is being used, what can be done in this regard
5. Thinking about targeting and barrier of access –who is denied, why denied, what can be done to improve access ? Who is more benefited from the services and who is less benefited? What can be done to benefit all those who need the services?
- 6- How supporting and encouraging the management to the healthcare providers?
- 7- Thinking about the program monitoring and evaluation, how does it work in IRHs? Which performance indicators, you use, give examples?
- 8- To what extent the human resources needed for delivery of rehabilitation services are available? Shortages in certain specialties? What are the training needs for IRH?
- 9- In your opinion, how can we enhance satisfaction about IRHs?
- 10-How satisfied are you about the outcomes of the RS? Who benefits more, who didn't benefit
- 11- How we can improve the Rehab services (what should we do, human resources, space, hotel services, interaction, respect, approach of care, access)

In depth interview and FGD schedule- Arabic 9

أسئلة مجموعات النقاش:

- 1- كيف ترى خدمات التأهيل؟ ما هو رأيك فيها؟
- 2- كيف تقيم جودة الخدمات؟ ما الذي يعمل جيدا و ما الذي لا يعمل جيدا؟
- 3- ما نقاط قوة و ضعف خدمات التأهيل؟
- 4- اخبرني عن بروتوكولات خدمات التأهيل. هل هي محلية؟ من قام بإعدادها؟ هل تستخدمها؟ لو نعم، كيف . لو لا، لماذا لا؟
- 5- كيف نستطيع تطوير توثيق الملفات في العلاج النفسي و النطق في مستشفيات خدمات التأهيل؟ كيف يعمل نظام المعلومات داخل المستشفيات؟
- 6- بالتفكير في خدمة التركيز على الاهل والمريض وعلاقتها في زيادة المخرجات والنتائج . مامدى اهميتها؟ كيف يمكن ان يكون التفاعل بين الطاقم والعائلات افضل؟
- 7- مامدد عمكو تشجيعكم قبل ادارتكم؟ ماذا ينبغي علينا الادارة فعله لمد عمكو تشجيعك؟
- 8- ما نوع الأجهزة اللازمة وغير الموجودة؟ كيف تؤثر على العمل؟
- 9- بالتفكير في المراقبة و المتابعة. كيف تعمل في شغلك؟
- 10- ماذا يلزمنا لتطوير خدمات التأهيل؟
- 11- النتائج الرقمية اوضحت ان اعلى نسبة رضا بين المرضى كانت على خدمات العلاج الطبيعي و التمرريض . كيف تفسر هذا؟ و ما مدى اهميته و تبعاته في بيئة العمل؟
- 12- النتائج الرقمية اظهرت ان اقل نسبة رضا بين المرضى كانت على خدمات العلاج النفسي و النطق . كيف تفسر ذلك؟

اسئلة المقابلات الشخصية:

- 1- كيف تقيم خدمات التأهيل؟
- 2- اخبرني عن نقاط قوة خدمات التأهيل من وجهة نظرك.
- 3- اخبرني عن نقاط ضعف خدمات التأهيل من وجهة نظرك.
- 4- كيف تصف السياسات و البروتوكولات المتاحة لخدمات التأهيل؟ كيف يتم استخدامها؟ ماذا نستطيع ان نعمل في هذا المجال؟
- 5- من هو المستفيد الاكثر من خدمات التأهيل؟ و من هو الاقل استفادة؟ ماذا نستطيع ان نعمل لافادة جميع الذين يحتاجون الخدمات؟
- 6- مامدى دعم وتشجيع الادارة للطاقم الطبي؟
- 7- بالتفكير في مراقبة و تقييم البرنامج. كيف تعمل في مستشفيات التأهيل؟ مانوع المؤشر المستخدم مع مثال.
- 8- لأى مدى الموارد البشرية لازمة لتقديم الخدمات؟ ما التدريبات اللازمة لمستشفيات التأهيل؟
- 9- من وجهة نظرك، كيف لنا ان نحفز ارضا عن مستشفيات التأهيل؟
- 10 – كيف نستطيع تطوير خدمات التأهيل؟

Annex (7) Differences in hospital hotel services in relation to governorates

Multiple Comparisons						
hotel_serLSD						
(I) personal characters governorate	(J) personal characters governorate	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
north	Gaza	.12383	.06419	.055	-.0026	.2502
	Middle area	.15110*	.07520	.046	.0030	.2992
	Khanyounis	-.02884	.07144	.687	-.1695	.1118
	Rafah	.08921	.07563	.239	-.0597	.2381
Gaza	north	-.12383	.06419	.055	-.2502	.0026
	Middle area	.02727	.05982	.649	-.0905	.1451
	Khanyounis	-.15267*	.05502	.006	-.2610	-.0443
	Rafah	-.03462	.06037	.567	-.1535	.0843
Middle area	north	-.15110*	.07520	.046	-.2992	-.0030
	Gaza	-.02727	.05982	.649	-.1451	.0905
	Khanyounis	-.17995*	.06753	.008	-.3129	-.0470
	Rafah	-.06189	.07196	.391	-.2036	.0798
Khanyounis	north	.02884	.07144	.687	-.1118	.1695
	Gaza	.15267*	.05502	.006	.0443	.2610
	Middle area	.17995*	.06753	.008	.0470	.3129
	Rafah	.11806	.06802	.084	-.0159	.2520
Rafah	north	-.08921	.07563	.239	-.2381	.0597
	Gaza	.03462	.06037	.567	-.0843	.1535
	Middle area	.06189	.07196	.391	-.0798	.2036
	Khanyounis	-.11806	.06802	.084	-.2520	.0159

*. The mean difference is significant at the 0.05 level.

Annex (8): Differences in hospital hotel services satisfaction in relation to age

According to post hoc LSD:

Age I	Age J	Mean difference (I – J)	Sig.
0 – 30	31 – 55	.139	.004
	56 – 90	.171	.000
31 – 55	56 – 90	.032	.493

Annex (9): Differences in hospital hotel services satisfaction in relation to marital status.

According to post hoc LSD:

Marital status I	Marital status J	Mean differences I-J	Sig.
child	Single	-.011	.103
	Married	.089	.109
	Widow	.109	.161
	Separated	.083	.421
Single	Married	.201	.000
	Widow	.221	.005
	Separated	.195	.060
Married	Widow	.020	.759
	Separated	-.005	.953
Separated	Widow	-.026	.813

Annex (10): Differences in hospital hotel services in relation to hospitalization period

Multiple Comparisons						
hotel_serLSD						
(I) durationofhospinew	(J) durationofhospinew	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
1.00	2.00	.01360	.04845	.779	-.0818	.1090
	3.00	.12297*	.05419	.024	.0163	.2297
2.00	1.00	-.01360	.04845	.779	-.1090	.0818
	3.00	.10937*	.04780	.023	.0152	.2035
3.00	1.00	-.12297*	.05419	.024	-.2297	-.0163
	2.00	-.10937*	.04780	.023	-.2035	-.0152

*. The mean difference is significant at the 0.05 level.

دراسة/ تقييم خدمات مراكز التأهيل الداخلي في محافظات غزة

مبادئ حمدان الفراء

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ملخص الدراسة

لقد أدى الاحتياج المتزايد لمراكز التأهيل الداخلي في محافظات غزة إلى ازدياد الحاجة إلى تقييم الخدمات المتنوعة التي تقدمها هذه المراكز، حيث انه لا يوجد إلا مركزين يغطيان هذا الاحتياج المتزايد، و أصبحت الحاجة ملحة إلى تقييم شامل لهذه الخدمات، فهم بحاجة إلى دراسة مدى رضا المرضى عن هذه الخدمات و تقييم احتياجاتهم لكل خدمة منها، ولضمان استمرار هذه الخدمات اصبح لزاما عمليا المحافظة على العوامل التي تسهل تلك الخدمات الصحية و الفندقية و منها رضا المرضى الذي يعد أساساً لكل التفاعلات و العلاقات الاجتماعية داخل المراكز و عنصرا مهما في بنائها و تأثيرها الإيجابي المباشر في سلوك العاملين، وصولا لتحقيق الأهداف التي تسعى إليها، ولان حاجة هذه المراكز الداخلية إلى التميز يدعوا بمختلف مجالاتها إلى إظهار عناية فائقة لطبيعة الجهود المبذولة لإنجاز الأعمال و ذلك بالتركيز على ما ينجزه العنصر البشري، لذلك اصبح من الضروري دراسة تقييم للخدمات المقدمة من قبل هذه المراكز و دراسة العلاقة المتبادلة بين المريض و الطاقم الطبي و اللوجستي و دورها في نمو المراكز و تطورها المستمر. فهي بمثابة الجسر بين المريض و الطاقم الطبي و اللوجستي من اجل تحقيق أهداف المؤسسة.

هدفت هذه الدراسة إلى تقييم خدمات مراكز التأهيل الداخلية في محافظات غزة.

و كان من أهداف هذه الدراسة تقييم مدى كفاءة خدمات مراكز التأهيل الداخلية التي تقدم للمرضى في محافظات غزة بالإضافة إلى قياس مدى رضا المرضى عن هذه الخدمات، كما هدفت إلى التعرف على نقاط قوة و ضعف هذه الخدمات، إضافة إلى وضع مجموعة من التوصيات والاقتراحات اللازمة لتعزيز و تطوير هذه الخدمات.

وقد أجريت هذه الدراسة بطريقة التثبيت الكمي و الكيفي. في الجزء الأول الكمي شارك 263 مريض اخذوا خدمات المراكز التأهيل الداخلية على مستوى محافظات غزة ممن تنطبق عليهم شروط الدراسة من خلال تعبئة الاستبيانات بطريقة المقابلة الشخصية و قد وصلت نسبة المشاركة إلى 100%، و استخدم الباحث طريقة مراجعة ملفات 263 مريضا.

بينما تكون الجزء الثاني وهو النوعي من قيام الباحث بأجراء مقابلات مع أصحاب القرار في كلا المركزين بالإضافة إلى إجراء حلقتي نقاش معمقة مع مجموعتين من الطاقم الطبي من داخل المراكز .

بينت النتائج مستوى عال من الرضا لكل من الخدمات الفندقية، و خدمات العلاج الطبيعي و العلاج الوظيفي و العلاج النفسي و علاج النطق و التمريض حيث كانت النسب المئوية كالتالي 72%، 71.2%، 70.2%، 69.4%، 68.2%، 71.2%.

كما حقق الرضا العالم على خدمات مراكز التأهيل الداخلية في محافظات غزة اعلى مستوى بنسبة 92%.

كما اظهرت نتائج مراجعة الملفات الطبية للمرضى على تفاوت اكتمال الملفات العامة و ملفات العلاج الطبيعي و ملفات العلاج وظيفي و ملفات التمريض حيث كانت النسب المئوية على التوالي 100%، 72.5% ، 80.8%، 86.3% ، كذلك اظهرت النتائج عدم وجود ملفات للعلاج النفسي و علاج النطق في أرشيف كلا من المركزين.

اضافة الى ذلك اظهرت النتائج وجود فروقات ذات دلالة إحصائية في العلاقة بين الأخصائي و المريض و درج رضا المريض و توقعاته من العلاج بالمركز لصالح الاستغراق الأخصائي الوقت المناسب خلال الجلسة مع المريض، و في كون الجلسات تتم يوميا، و ان تكون العناية المقدمة بمعايير ممتازة و جلسات منتظمة في وقت محدد.

كذلك لم تكن هناك فروقات ذات دلالة إحصائية بالنسبة للرضا العام على خدمات العلاج النفسي و الرضا العام على خدمات علاج النطق و الرضا العام على خدمات التمريض.

بالإضافة الى ذلك اظهرت النتائج وجود علاقة ارتباطية ذات دلالة إحصائية بين النتائج قبل و بعد التأهيل في الحركة، العناية الشخصية، القيام بالنشاطات اليومية، الألم و القلق لصالح نتائج ما بعد الخروج من المراكز، مما يشير الى تحسن الوضع بصفة عامة في حالة المريض.

خلصت الدراسة الى وجود مستوى عال من العلاقة التبادلية بين الأخصائي و المريض و كذلك مستوى عال من التحسن في الوضع الصحي للمريض بعد خروجه من المركز، وان هناك مجال لتحسين و تطوير هذه الخدمات المقدمة للمريض و العمل المستمر على دعمها خصوصا بين الأخصائيين و ذلك لخلق بيئة مناسبة تشجع على بناء علاقة قوية بين المريض و الاخصائي لما يترتب عليه من مستوى عال من الخدمات و الرضا العام عليها.

و قد خرجت هذه الدراسة ببعض من التوصيات الهامة من بينها:

- هناك الحاجة لإبداء المزيد من الاهتمام بالعلاقة التبادلية بين المريض و الأخصائي على جميع المستويات من خلال تحسين و دعم الخدمات المقدمة للمريض.

- لكفاءة جودة الخدمة دور فعال في تحسين العلاقة التبادلية بين المريض و الأخصائي من خلال خلق بيئة علاجية مريحة بما يكفل رضا المريض.

- على الرغم من ان النتائج قبل و بعد العلاج في مراكز التأهيل الداخلي حققت درجات عالية بين المرضى في محافظات غزة، الا انها بحاجة الى المزيد من التعزيز من خلال الحرص على تدريب الطاقم الصحي و تشجيع الإدارة للأخصائي عن طريق التفويض و التمكين و المشاركة الفعلية في تكوين خطة مناسبة و بيئة مريحة للمريض.

- نتائج رضا المرضى بالنسبة للخدمات المقدمة للعلاج النفسي و علاج النطق ليست مرضية، و عليه هناك حاجة ضرورية لبذل المزيد من التدابير العاجلة لمعالجة هذه القضايا و إجراء المزيد من الدراسات النوعية على وجه الخصوص لمعرفة الأسباب التي تكمن وراء ذلك و الوقوف على التباينات في توقعات المرضى فيما يتعلق بالعلاقة بين الأخصائي و المريض و جودة الخدمة المقدمة للمريض و الرضا العام و العمل على الحد من نقاط الضعف.

- نتائج الدراسة بما يتعلق بالملفات في مراكز التأهيل الداخلي في محافظات غزة تطلب اهتماما اكبر من قبل الأخصائيين.

- بما يتعلق بجودة الخدمات و التواصل بين الأخصائي و المريض بشكل عام يتطلب اهتماما من قبل الإدارة لدعم و تطوير الأخصائيين من اجل الارتقاء بالمستوى العلمي و العملي لهم من خلال زيادة المشاركة في برامج التدريب و التواصل و زيادة جودة الخدمة و خصوصا بعد زيادة الطلب على الخدمة المقدمة من مراكز التأهيل الداخلي في محافظات غزة.