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# Assessing patient perceptions and satisfaction with the implementation of patient-centered care at King Faisal Hospital, Rwanda

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## ABSTRACT

**INTRODUCTION:** Patient-centered care (PCC) emphasizes respectful communication, shared decision-making, and responsiveness to patient needs. Evidence on PCC implementation in Rwanda remains limited. This study assessed PCC implementation at King Faisal Hospital by examining patients' awareness of their diagnosis and treatment, involvement in decisions, understanding of patient rights, and satisfaction with key care elements.

**METHODS:** A cross-sectional study was conducted from January to March 2024 among 171 patients proportionally sampled from 648 hospital admissions across departments. Data were collected using a structured 52-item questionnaire based on PCC domains, and descriptive statistics were used to summarize patient responses.

**RESULTS:** Patients reported strong diagnostic and treatment awareness (93% knew their diagnosis; 95% understood their admission reason) and high involvement in care decisions (91%). Satisfaction with end-of-life care involvement was similarly high (92%). Significant gaps emerged in cost communication, with only 41% informed about treatment costs and 40% about hospitalization costs. Nurse call responsiveness scored lowest (33%). Pain management and cleanliness showed relatively higher satisfaction levels (≥78%). The overall PCC score was 77%, below the 80% benchmark.

**CONCLUSION:** King Faisal Hospital demonstrates notable strengths in patient engagement, diagnostic communication, and end-of-life care. However, improvements are needed in cost transparency, awareness of rights, infection-control education, and staff responsiveness to enhance PCC implementation and the overall patient experience.

**Keywords:** Patient-Centered Care (PCC), Patient Satisfaction, Healthcare Quality, Patient Empowerment, End-of-Life Care, Rwanda Healthcare System; King Faisal Hospital (KFH)

## INTRODUCTION

Person-centered care (PCC) is increasingly recognized as a foundational approach in health service delivery, aiming to address each individual's unique needs and enhance access to consistent, high-quality care [1–3]. It is widely regarded as a key component of effective health systems across

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different resource settings and plays an important role in promoting equitable access to quality services and achieving Universal Health Coverage [4–6]. The World Health Organization (WHO) identifies PCC as a key strategy for improving health service delivery, with evidence linking it to increased patient satisfaction, improved clinical outcomes, and enhanced system performance [7]. PCC strengthens collaboration between patients and healthcare providers through two-way communication, shared decision-making, and compassionate care, thereby creating a more responsive and respectful healthcare delivery system [8,9].

Despite its recognized value, the implementation of PCC in many African and Middle Eastern countries remains limited. Health system gaps are driven by multiple factors, including demographic transitions, high disease burden, poverty, cultural dynamics, limited resources, weak administrative structures, and, in some contexts, political instability [10,11]. These barriers impair the responsiveness and equity of healthcare services.

Evidence from African settings highlights the importance of PCC in addressing patients' holistic needs, including physical, emotional, and social dimensions of care. Studies show that effective PCC implementation is associated with shorter hospital stays, lower readmission rates, and improved emotional well-being by reducing anxiety and depression, enhancing trust, promoting self-efficacy, and addressing healthcare disparities [10,12].

Poor-quality healthcare contributes significantly to mortality in low- and middle-income countries (LMICs), accounting for an estimated 5.7 to 8.4 million deaths annually [13]. Gaps in PCC may further contribute to challenges such as loss to follow-up, reduced medication adherence, and avoidable disease transmission. Although PCC has been introduced in African health systems, its implementation remains constrained by systemic limitations, structural barriers, and difficulties in translating policy into practice [14]. In African healthcare settings, including Rwanda, there is limited empirical data on how PCC is practiced and/or perceived [15].

For example, in Ethiopia, healthcare delivery remains largely biomedical, with minimal integration of the bio-psychosocial model. A 2015 national report indicated that 71% of healthcare providers reported failing to provide compassionate and respectful care [16]. This reflects broader regional challenges in integrating PCC into health systems across sub-Saharan Africa [17]. In Rwanda, although hospitals such as King Faisal Hospital have made efforts to align care delivery with PCC principles, evidence on patient experience remains limited; however, a national study on antenatal care reported suboptimal person-centered care, with 30% of women leaving visits with unanswered questions and about one-quarter experiencing disrespect [18].

This study aimed to fill the gap by assessing the implementation of PCC at King Faisal Hospital through patient-reported measures. The study addressed key aspects of care, including patients' awareness of their diagnosis, treatment options, and rights, as well as their satisfaction with involvement in decision-making, end-of-life care, and follow-up support. Specifically, it examined the level of patient awareness regarding their medical condition, the sufficiency of information provided about treatment and costs, their understanding of patient rights, and satisfaction with care, particularly concerning end-of-life decisions and anxiety management. The findings generated empirical evidence on the effectiveness of PCC at King Faisal Hospital and contributed to improvements in healthcare practice and policy in Rwanda and similar settings, particularly in strengthening timely care and patient engagement in care planning processes.

## METHODS

### Study Design

This cross-sectional study evaluated the implementation of patient-centered care (PCC) at King Faisal Hospital, Rwanda, using a quantitative approach based on patient-reported measures.

### Study Setting

Data were collected across multiple departments at King Faisal Hospital, including Obstetrics and Gynecology, Internal Medicine, Surgery, Pediatrics, and Accident and Emergency, to capture a diverse range of patient experiences.

### Study Period and Data Collection

Data were collected from January to March 2024 using structured questionnaires. Two trained enumerators administered the surveys, ensuring accuracy and addressing participants' concerns with cultural sensitivity. All data were collected confidentially, and participants' privacy was

protected throughout the process.

**Sampling and Population**

The study population included adult inpatients and outpatients at King Faisal Hospital. A total of 648 patients were admitted.

During the study period, it served as the sampling frame. From this, 171 participants were randomly selected using a finite population formula with a 95% confidence level and a 5% margin of error. The sample was proportionally distributed across departments to ensure representative input. Only individuals meeting the inclusion criteria were enrolled.

The sample size was calculated using the following formula:manuscript is the finite population sample size formula:

$$n=N\times((Z^2\ p(1-p))/e^2\ )/((N-1)+(Z^2\ p(1-p))/e^2\ )$$

Where:

N = 648 (population size based on hospital records)

Z = 1.96 (Z-score for a 95% confidence level)

p = 0.5 (assumed response distribution for maximum variability)

e = 0.05 (margin of error)

Substituting these values:

$$n=(648(1.96)^2(0.5)(0.5))/((0.05)^2(648-1)+(1.96)^2(0.5)(0.5)/0.025)$$

n=171

**Inclusion Criteria**

Participants were eligible if they were aged 18 years or older, provided informed consent, and were able to complete the questionnaire independently or with minimal assistance.

**Data Collection Tool**

Data were collected using a structured 52-item questionnaire adapted from validated PCC frameworks, including the WHO People-Centred Care Framework [19], and the Patient-Centered Care Improvement Guide (Institute for Patient- and Family-Centered Care, 2017). The tool was organized around key PCC elements, including diagnosis and treatment information, involvement in care decisions, pain management, informed consent, patient rights, end-of-life care involvement, facility and equipment experience, and infection control and follow-up education.

Most questions were closed-ended (Yes/No or categorical), allowing results to be summarized as frequencies and corresponding percentages for each PCC domain. Higher percentages reflected stronger PCC implementation or greater patient satisfaction. The questionnaire underwent expert review for content validity and was pilot tested to ensure clarity and cultural relevance. The full instrument is provided in Appendix 1.

**Data Analysis**

Quantitative data were analyzed using SPSS version 25. Descriptive statistics summarized participant characteristics and PCC indicators. In addition, exploratory inferential analyses (chi-square tests and t-tests) were conducted to examine potential associations between patient satisfaction and selected demographic variables. Results were interpreted cautiously, given the study's quality-improvement orientation.

**Ethical Considerations**

Ethical approval was obtained from the King Faisal Hospital Institutional Review Board (KFH/2023/125/IRB). All participants received detailed study information and provided voluntary informed consent. Personal data were anonymized to ensure confidentiality and privacy.

Data Privacy and Storage

All data were used solely for research purposes, and no identifiable personal information was retained or disclosed. In line with data protection regulations, anonymized datasets were stored in password-protected systems and will be securely maintained for a minimum of five years, after which they will be permanently and safely destroyed.

**RESULTS**

A total of 171 patients participated in the study, representing multiple clinical departments at King Faisal Hospital, including Obstetrics and Gynecology, Internal Medicine, Surgery, Pediatrics, and Accident and Emergency. Overall, patient perceptions of Patient-Centered Care (PCC) were favorable, with an aggregate hospital PCC score of 77%, although this remained slightly below the institutional benchmark of 80%. Among the seven service domains assessed, only pain management and end-of-life care achieved scores exceeding the benchmark, while the remaining domains demonstrated varying degrees of performance requiring improvement (Figure 1).

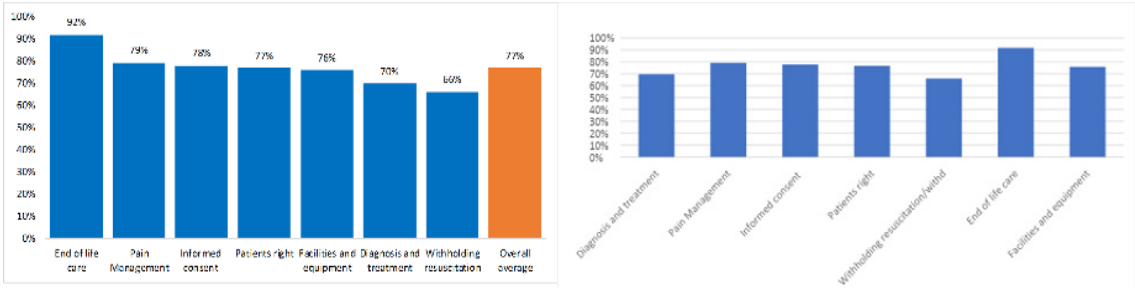


**Figure 1: Overall hospital score for each service element (Left) and Average proportion per Services (Right)**

**Table 1: Diagnosis and Treatment at the Hospital Level**

| No. | Indicators | | Score (%) |
|---|---|---|---|
| 1 | When admitted, did you receive any or sufficient information about your proposed treatment? | 168 | 91% |
| 2 | When admitted, did you receive any or sufficient information about your proposed treatment expected outcome? | 168 | 88% |
| 3 | Do you know your diagnosis? | 171 | 93% |
| 4 | Do you know the reason for your admission? | 165 | 95% |
| 5 | Did you receive sufficient health education appropriate to your condition? | 166 | 83% |
| 6 | Do you understand what this diagnosis is, and how your condition will be managed? | 164 | 92% |
| 7 | Did you participate in the decisions regarding your priority needs to be met? | 164 | 91% |
| 8 | Were you involved in the marking process of your surgical site (where applicable)? | 93 | 68% |
| 9 | Have you been told about the correct use of medication/medicine and the food interaction? | 119 | 82% |
| 10 | Have you been told about the correct use of medical equipment (where applicable)? | 114 | 86% |
| 11 | Did you receive any or sufficient information about the expected costs of your treatment? | 168 | 41% |
| 12 | Did you receive any or sufficient information about the expected costs of your hospitalization? | 155 | 40% |
| 13 | Have you been educated on Infection Control practices relevant to your condition? | 158 | 63% |
| 14 | Have you been informed about immunizations appropriate to your age? | 25 | 30% |
| 15 | Have you been informed about immunizations appropriate to your disease group? | 19 | 39% |
| 16 | Are you satisfied with the availability of food? | 120 | 66% |
| 17 | Are you satisfied with the mealtimes? | 120 | 76% |
| 18 | Do staff respect your food preferences? | 120 | 63% |
| 19 | When your food preferences are not available, are substitutions made available? | 117 | 49% |
| 20 | Family: Have you been informed about what type of food the patient should not eat? | 118 | 56% |
| | **Average score** | | **70%** |

**Table 2: Pain Management, Informed Consent, Patient Rights, Family Involvement in Patient Care**

| | Indicators | Respondents (N) | Score (%) |
|---|---|---|---|
| | **Pain Management** | | |
| 1 | Did you receive any information on how to manage your pain? | 134 | 80% |
| 2 | Do you feel that your pain is managed adequately? | 132 | 78% |
| | **Informed consent** | | |
| 1 | Did you have to sign any consent form on admission? | 148 | 81% |
| 2 | Did you have to sign consent for any procedure or surgical operation? | 113 | 75% |
| 3 | Did you receive adequate information about your condition and the proposed procedure/operation? | 120 | 73% |
| 4 | Do you know the name of your health care team and or team leader? | 160 | 83% |
| | **Patient Rights** | | |
| 1 | Were you given any information about your rights as a patient, either verbally or written? | 167 | 55% |
| 2 | Were you given the information above in a language that you could easily understand? | 163 | 55% |
| 3 | Have you been informed of your right to refuse or discontinue treatment? | 164 | 57% |
| 4 | And about the consequences of such decisions? | 163 | 57% |
| 5 | Do you feel the staff respect your right to refuse or discontinue treatment? | 164 | 71% |
| 6 | Do you feel that staff respect and make provision for your specific values and beliefs? | 163 | 93% |
| 7 | Are you aware that you can complain and has the process been explained to you? | 163 | 67% |
| 8 | Do you know whom to complain to? | 164 | 52% |
| 9 | Do you know what you are allowed to complain about? | 164 | 63% |
| 10 | Do you feel that your privacy has been respected during consultations/examinations/ procedures? | 164 | 93% |
| 11 | And when you provided personal information? | 164 | 96% |
| 12 | Did you receive any information on the hospital's policy to take care of your personal items/possessions? | 151 | 75% |
| 13 | Do you feel these are being kept safely? | 149 | 93% |
| 14 | Do you feel safe in the hospital? | 164 | 96% |
| 15 | Do you feel the safety measures to protect you and other patients are adequate? | 164 | 94% |
| 16 | Patient/Family: Are you satisfied with the way in which your religious concerns have been taken into account? | 160 | 91% |
| 17 | Patient/Family: Are you satisfied with the way in which your cultural concerns have been taken into account? | 162 | 94% |
| | **Average score** | | 77% |
| | **Withholding resuscitation/withdrawal of life support** | | |
| 18 | Have you/the family been in discussion with the hospital staff about your decision regarding the withholding of resuscitative services and has this been honoured? | 7 | 57% |
| 19 | Have you/the family been in discussion with the hospital staff about your decisions regarding the withdrawing life-sustaining treatments, and have these been honoured? | 12 | 75% |
| | **End-of-life care** | | |
| 20 | Patient/Family/Carer: Are you satisfied with the extent to which you have been involved in care decisions? | 12 | 92% |

**Table 3: Facilities and Equipment**

| No | Indicators | Respondents (N) | Score (%) |
|---|---|---|---|
| 1 | Do you feel that personnel respond timeously when you use the nurse call system? | 171 | 33% |
| 2 | Are the bathroom facilities clean? | 122 | 80% |
| 3 | Are the toilet facilities clean? | 161 | 80% |
| 4 | Are utensils used to serve and administer medication clean? | 132 | 94% |
| 5 | Is the equipment used during your care clean and in good order | 133 | 91% |
| **Average score** | | | **77%** |

### Diagnosis and Treatment

Patients reported high levels of awareness and engagement regarding their care. Most respondents knew their diagnosis (93%) and reason for admission (95%), while 92% reported understanding their condition and its management. Participation in decisions regarding priority care needs was also high (91%). Adequate information regarding proposed treatment was reported by 91% of participants, and 88% received information regarding expected treatment outcomes. However, substantial gaps were observed in communication regarding treatment costs, with only 41% receiving information about treatment costs and 40% about hospitalization costs. Education regarding infection prevention and control was reported by 63% of respondents, while information on age-appropriate and disease-specific immunization was reported by only 30% and 39%, respectively. Satisfaction with food-related services ranged from 49% to 76%, resulting in an overall domain score of 70% (Table 1).

### Pain Management, Informed Consent, and Patient Rights

Pain management indicators showed relatively strong performance, with 80% of respondents receiving information on pain management and 78% reporting adequate pain control. Regarding informed consent, 81% signed consent forms upon

**Table 4: Distribution of diagnosis and treatment, Pain management, and Informed consent per unit**

| | Average score | | |
|---|---|---|---|
| **Unit** | **Diagnosis and treatment** | **Pain management** | **Informed consent** |
| ICU | 100% | - | - |
| Physiotherapy | 90% | 56% | 100% |
| Cardiac ICU | 89% | 92% | 97% |
| Urusaro | 78% | 100% | 66% |
| Surgical ward | 77% | 82% | 96% |
| Medical ward | 77% | 83% | 87% |
| Renal unit | 76% | 50% | 100% |
| Pavilion | 74% | 69% | 88% |
| A&E department | 72% | - | - |
| Maternity | 72% | 90% | 95% |
| Overall OPD | 66% | 71% | 29% |
| Pediatric ward | 65% | 92% | 57% |
| HDU | 63% | 75% | 100% |
| NICU | 53% | 0% | 83% |

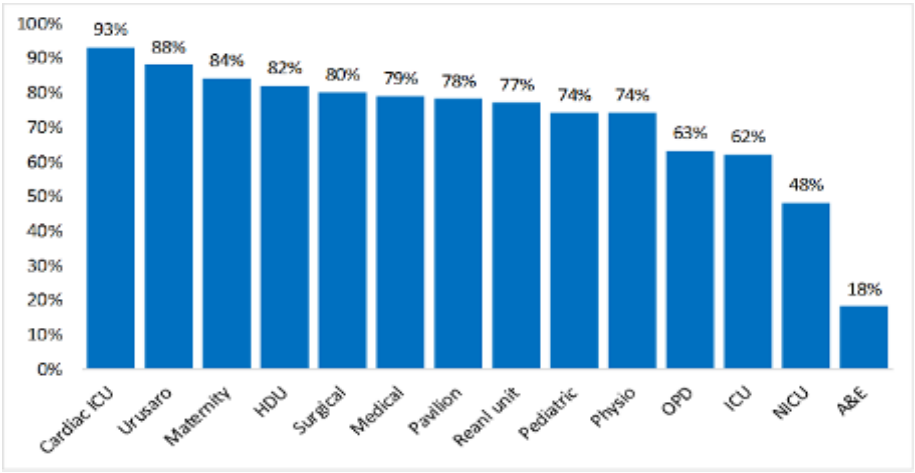


**Figure 2: Overall score per ward or unit**

**Table 5: Distribution of Facilities and equipment, Education on infection control, and Perception of hospital safety per unit**

| | Average score | | |
|---|---|---|---|
| **Unit** | **Facilities and equipment** | **Education on infection control** | **Perception of hospital safety** |
| Urusaro | 100% | 40% | 100% |
| Cardiac ICU | 98% | 75% | 100% |
| Pavilion | 83% | 63% | 88% |
| Maternity | 82% | 55% | 97% |
| Surgical ward | 81% | 84% | 96% |
| Pediatric ward | 80% | 21% | 93% |
| Overall OPD | 76% | - | - |
| Medical ward | 68% | 76% | 100% |
| HDU | 65% | 60% | 80% |
| Renal unit | 58% | 100% | 80% |
| Physiotherapy | 56% | 100% | 100% |
| NICU | 50% | 80% | 100% |
| ICU | -50% | - | - |
| A&E department | -50% | - | - |
| OPD pediatric | - | 86% | 100% |
| OPD surgical | - | 50% | 100% |
| Obs&Gyn | - | - | 100% |
| OPD Medical | - | - | 100% |
| **Overall average score** | **57%** | **67%** | **96%** |

admission, 75% signed consent for procedures or operations, and 73% reported receiving adequate information about their condition and planned procedures. Awareness of healthcare team members was reported by 83% of participants. Patient rights indicators demonstrated mixed

findings. While respondents reported high levels of respect for personal values and beliefs (93%), privacy during consultations (93%) and handling of personal information (96%), only 55–57% reported receiving information regarding patient rights, including the right to refuse or discontinue treatment. Awareness of complaint procedures was also moderate, ranging from 52% to 67%. The overall score for this domain was 77% (Table 2).

**End-of-Life Care**

Among patients and families involved in end-of-life care decisions, satisfaction was high. Discussions regarding withdrawal of life-sustaining treatment were reported by 75% of respondents, while discussions regarding withholding resuscitation were reported by 57%. Overall satisfaction with involvement in end-of-life care decisions reached 92% (Table 2).

**Facilities and Equipment**

Patient perceptions of facilities and equipment were generally positive. Cleanliness of bathroom and toilet facilities was reported by 80% of respondents, while cleanliness of medication utensils and medical equipment was rated highly at 94% and 91%, respectively. In contrast, responsiveness to the nurse call system represented the poorest-performing indicator across all domains, with only 33% of patients reporting timely responses. The overall facilities and equipment score was 77% (Table 3).

**Variation Across Hospital Units**

Performance varied considerably across hospital units (Figure 2). Five of the fourteen assessed units achieved scores above the 80% benchmark, indicating strong PCC implementation. The highest overall scores were observed in the Cardiac Intensive Care Unit (93%), Urusaro Unit (89%), and Maternity Ward (84%). In contrast, the Neonatal Intensive Care Unit (NICU) and Accident and Emergency (A&E) Department recorded the lowest overall scores, at approximately 49% and 18%, respectively, indicating substantial opportunities for improvement.

**Unit-Specific Performance**

Unit-level analysis demonstrated substantial variation in the implementation of patient-centered care (PCC) across clinical departments. Regarding diagnosis and treatment, performance ranged from 53% in the Neonatal Intensive Care Unit (NICU) to 100% in the Intensive Care Unit (ICU), with consistently high scores also observed in Physiotherapy (90%) and the Cardiac ICU (89%).

**Table 6: Distribution of receiving information about hospitalization costs and Patients' rights per unit**

| | Average score | |
|---|---|---|
| **Unit** | **Receiving Information about costs** | **Patiets'rights** |
| Cardiac ICU | 88% | 89% |
| Renal unit | 80% | 57% |
| Physiotherapy | 75% | 69% |
| Surgical ward | 52% | 75% |
| Pavilion | 50% | 76% |
| Medical ward | 47% | 79% |
| Maternity | 32% | 83% |
| Pediatric ward | 18% | 75% |
| NICU | 0% | 55% |
| Urusaro | 0% | 70% |
| HDU | 0% | 71% |
| Overall OPD | - | 73% |
| A&E department | - | 33% |
| **Overall average** | **40%** | **70%** |

Pain management was strongest in the Urusaro Unit (100%), Cardiac ICU and Pediatric Ward (92% each), and Maternity (90%), whereas no positive responses were recorded in the NICU. Informed consent practices performed well in most units, achieving 100% in the Physiotherapy Department, Renal Unit, and High Dependency Unit (HDU), while the Overall Outpatient Department (29%) showed the lowest performance, indicating important opportunities to strengthen patient communication and shared decision-making (Table 4).

Performance for facilities and equipment, infection-control education, hospital safety, cost communication, and patient rights also varied markedly across units. The Urusaro Unit achieved the highest facilities and equipment score (100%), followed closely by the Cardiac ICU (98%), whereas the ICU and A&E showed the weakest performance (50% each). Education on infection prevention reached 100% in the Renal Unit and Physiotherapy but remained below the hospital average in several wards. Perceived hospital safety was consistently high (overall 96%), with many units reporting 100%. Cost communication remained the weakest PCC component overall (40%), despite strong performance in the Cardiac ICU (88%) and Renal Unit (80%). Patient rights awareness ranged from 89% in the Cardiac ICU to only 33% in the A&E Department, highlighting persistent disparities in patient empowerment across services (Tables 5 and 6).

## DISCUSSION

This study assessed patients' perceptions of the implementation of PCC at KFH, Rwanda, and provides one of the few comprehensive evaluations of PCC from the patient perspective in the country. Overall, the hospital achieved a PCC score of 77%, indicating generally favorable patient experiences but remaining slightly below the institutional benchmark of 80%. The findings reveal important strengths in communication, patient engagement, informed consent, privacy, and end-of-life care, while also identifying deficiencies in cost transparency, patient rights awareness, infection-control education, and responsiveness to patient requests. These results provide valuable evidence for strengthening quality improvement initiatives and advancing PCC implementation in Rwanda and similar low- and middle-income country (LMIC) settings.

One of the most notable findings was the high level of patient engagement in clinical communication. More than 90% of participants knew their diagnosis, understood the reason for admission, and reported being involved in decisions regarding their care. Similarly, most respondents received sufficient information about proposed treatment and expected outcomes. These findings suggest that clinicians at KFH have successfully incorporated key PCC principles, including shared decision-making, effective communication, and patient empowerment. The high informed consent scores observed across most hospital units further reinforce this conclusion. Shared decision-making has consistently been associated with improved treatment adherence, patient satisfaction, trust in healthcare providers, and better clinical outcomes because patients become active partners in their care rather than passive recipients of treatment (Barry & Edgman-Levitan, 2012; Epstein & Street, 2011). The present findings therefore indicate that KFH has established a strong foundation for delivering respectful and collaborative care.

Another important strength was the consistently high performance in ethical and interpersonal aspects of care. Patients reported high levels of respect for privacy, confidentiality, personal beliefs, cultural values, and religious preferences, with most indicators exceeding 90%. Likewise, perceived hospital safety reached an overall score of 96%, suggesting that patients feel secure during hospitalization. Satisfaction with involvement in end-of-life care decisions was particularly high (92%), demonstrating that patients and families value opportunities to participate in sensitive healthcare decisions. Previous studies have shown that respecting patients' dignity, autonomy, cultural preferences, and spiritual beliefs substantially improves trust, emotional well-being, and overall healthcare experiences (WHO, 2016; Alkhaibari et al., 2023). These relational dimensions are considered fundamental pillars of patient-centered care and distinguish high-quality healthcare organizations from those that remain predominantly disease-centered.

Despite these strengths, several important deficiencies emerged. The most significant weakness was communication regarding treatment and hospitalization costs. Only 41% of patients received information about expected treatment costs and just 40% were informed about

hospitalization expenses. Financial communication is increasingly recognized as an essential component of patient-centered care because healthcare costs directly influence treatment choices, adherence, and patient satisfaction. Failure to discuss anticipated expenses may leave patients and families inadequately prepared for financial obligations and may contribute to dissatisfaction, delayed decision-making, or treatment discontinuation. Similar challenges have been documented across many LMICs, where discussions about healthcare costs are often overlooked despite increasing out-of-pocket expenditures (Kruk et al., 2018). Developing standardized financial counseling procedures at admission may therefore substantially improve patient experiences.

Another area requiring urgent improvement was responsiveness to patient needs. The nurse call system achieved only 33%, the lowest-performing indicator in the entire assessment. Delayed responses to patient requests may negatively influence patient perceptions of care quality, particularly among patients requiring assistance with pain management, mobility, or urgent clinical concerns. Although cleanliness of facilities and medical equipment was rated highly, timely responsiveness remains a critical operational component of patient-centered care. Previous studies have demonstrated that staff responsiveness strongly predicts overall patient satisfaction and perceptions of hospital quality (Jameel et al., 2025). Strengthening nurse staffing, improving workflow organization, and implementing routine monitoring of response times may therefore enhance both patient safety and patient experience.

The study also identified considerable deficiencies in patient education. Awareness of patient rights was moderate, with only about half of respondents reporting that they had received information regarding their rights, including the right to refuse or discontinue treatment. Similarly, education regarding infection prevention and immunization remained relatively low. Patient education represents a fundamental element of patient-centered care because informed patients are better equipped to participate in treatment decisions, adhere to recommended therapies, and protect themselves from preventable complications. Similar findings have been reported from Ethiopia, Kenya, and Uganda, where limited communication regarding patient rights and healthcare processes continues to constrain effective PCC implementation (Waweru et al., 2019; Ewunetu et al., 2023; Oluoch-Aridi et al., 2021). KFH could strengthen this component by introducing multilingual educational materials, structured patient orientation sessions, and routine reinforcement of patient rights throughout hospitalization.

An important contribution of this study is the identification of substantial variation across hospital units. Units such as the Cardiac ICU, Urusaro, Maternity, and Physiotherapy consistently demonstrated excellent performance across multiple PCC domains, whereas the NICU, A&E Department, and some outpatient services showed comparatively lower scores. These differences likely reflect variations in staffing patterns, workload, patient acuity, organizational culture, and unit-specific leadership. Rather than indicating isolated deficiencies, the observed variability presents opportunities for organizational learning. High-performing units may serve as internal models of best practice, allowing successful communication strategies, workflow processes, and patient engagement approaches to be adapted across lower-performing departments. Unit-level performance monitoring may therefore provide a practical framework for continuous quality improvement.

Overall, the findings compare favorably with reports from several African healthcare settings. Studies conducted in Malawi, Ethiopia, Kenya, and Uganda have documented lower overall PCC performance, particularly regarding shared decision-making, communication, privacy, and individualized care (Makwero et al., 2025; Ewunetu et al., 2023; Oluoch-Aridi et al., 2021; Waweru et al., 2019). While King Faisal Hospital demonstrates stronger performance in these core PCC domains, the challenges identified in financial communication, patient rights awareness, infection-control education, and responsiveness remain consistent with broader health system constraints reported across LMICs. Consequently, this study contributes important evidence that even relatively high-performing tertiary hospitals continue to face opportunities for improving the completeness and consistency of patient-centered care.

Several limitations should be considered when interpreting these findings. The cross-sectional

design captures patient experiences at a single point in time and therefore cannot establish causal relationships between PCC practices and patient outcomes. Patient-reported measures may also be influenced by recall bias, social desirability bias, or individual expectations. Furthermore, the study was conducted in a single tertiary referral hospital, which may limit generalizability to lower-level health facilities. Nevertheless, the inclusion of multiple clinical departments and comprehensive assessment across several PCC domains provides a robust overview of patient experiences and generates practical evidence to guide hospital quality improvement and future multicenter studies in Rwanda.

## CONCLUSION

This study evaluated patients' perceptions and satisfaction with the implementation of patient-centered care at King Faisal Hospital. Findings indicate strong awareness of diagnosis and treatment, high involvement in care decisions, and high satisfaction with end-of-life care and respect for privacy, reflecting key strengths in PCC implementation. However, gaps in cost transparency, responsiveness to patient needs, and awareness of patient rights highlight areas requiring improvement to strengthen patient empowerment and communication. These findings have informed ongoing improvements at KFH, including enhanced staff training and service adjustments to promote more responsive, patient-centered care. As a pilot assessment, the results also provide direction for advancing PCC in other Rwandan health facilities and for future research in similar settings. Overall, while patients perceived many aspects of PCC positively, further efforts are needed to fully align care delivery with PCC standards and enhance patient satisfaction.

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