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ORIGINAL ARTICLE

"impact Of Continuous Quality Improvement On Patient (customer) Satisfaction In Madhya Pradesh Hospitals With Special Reference To Jabalpur District"

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Abstract:
The importance of quality in the Health care sector has been recognized relatively recently, but it has been accelerated over the past years through the development of quality assurance, quality improvement programs and patients' agendas. Quality was very popular in the marketing literature where the notion of «satisfying the customer» was a dominant model of quality of service provided and consumer satisfaction. This movement initiated a global research on assessing customer satisfaction in the past years and articles on Medline measuring somewhat patient satisfaction with care. The vast majority of these articles developed and used a patient satisfaction scale.Only few researchers developed a conceptual framework for conceptualization of service quality and patient satisfaction, before validating their scale.

Measurement of patient satisfaction lacks a conceptual soundness as it reflects dimensions considered important by researchers and not by respondents. In fact, several times we measure what researchers think that quality of care consists of Perhaps the most consistent predictor of satisfaction is patient's age with older people being far more satisfied with health care than do younger people. This could be attributed to a halo effect as vulnerable patients give socially favorable answer and are not willing to challenge physician and nurse authority. It is difficult to distinguish between true correlations and halo effects and that the density of the problem relates to the importance of service provided. Their meta-analysis state that although patient satisfaction has been assessed across various patient groups and care settings, few studies have focused specifically on vulnerable patients. This could indicate a low priority to the investigation of vulnerable patients' view of their care. The aim of this article is to explore and generate a holistic view of vulnerable patient satisfaction and its determinants.

KEYWORDS: Quality Assurance, Employee Satisfaction, Patient Satisfaction, Hospital Infection control.

STRUCTURE OF HEALTH CARE DELIVERY

Like the rest of the country, the state of Madhya Pradesh has also tended to focus more on selective vertical programmes aimed at specific diseases, rather than comprehensive health care at the Primary level. The

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state has focused on Reproductive and Child Health and other National Programmes aimed at controlling TB, Blindness, Malaria etc. However, there is a growing realization at the national as well as state level, that such an approach, though successful in terms of specific diseases such as Polio and Leprosy, has not yielded desired results in many cases. It has also kept the community involvement away from health care. The National Rural Health Mission aims at integrating the vertical programmes and providing horizontal linkages that will strengthen the health delivery system and lead to greater involvement of the community. The state of Madhya Pradesh is also moving in a similar direction.

Health care delivery options are available in the public sector as well as the private sector. These include allopathic, Indian system of medicine (Ayurvedic, Unani) and Homeopathy. However, Allopathy is the dominant system in both public and private sectors.

1. PUBLIC SECTOR

The allopathic health care delivery system in rural areas is based on a network of 8835 sub health centres, 1194 private health centres and 227 community health centres. These have been set up in accordance with GoI policy/guidelines: · Sub Health Centre (SHC): staffed by a MPW (male) and a MPW(female)/ANM, the SHC is envisaged to cater to a population of 5000 (3000 in hilly areas), provide limited primary care and act as a stock point for basic medical and family welfare supplies. In MP, a population of 5000 could be scattered across 6 villages. There is minimal curative service at the SHC. Primary Health Centre (PHC): is envisaged to have a qualified medical officer, cater to a population of 30,000 (20,000 in hilly areas), provide in patient services (6 beds) and act as a referral unit for 6 SHCs; · Community Health Centre (CHC): is envisaged to have 4 medical specialists (including surgeon, physician, gynecologist, pediatrician), 30 beds, operating theatre, laboratory facilities and act as a referral centre for 4 PHCs. In urban areas there are 48 district and 57 civil hospitals, which are also expected to act as referral centers for CHCs. In addition, there are specialized hospitals (TB, leprosy, mental) as well as hospitals attached to medical colleges. Tertiary health care is provided almost exclusively by specialist and medical school teaching hospitals and by the district and civil hospitals in the larger cities. ISM&H has a parallel health delivery system consisting of about 1622 dispensaries spread across the state in both rural and urban areas as well as hospitals and teaching colleges. The total number of public health facilities is summarized in Table V. As shown, the allopathic public sector is estimated to have a total of about 26,000 beds including 9300 beds in rural areas.

2. PRIVATE SECTOR

The private sector health care delivery system consists of: Traditional Practitioners including herbalists who are based in the village and provide low cost treatment for minor ailments; payment is quite often in kind and can be deferred; Dais (traditional birth attendant) are also based in the village and are normally the most experienced person available for assistance during child birth. They provide a personal touch and offer a convenient and affordable method of payment; · Registered Medical Practitioners (RMPs)/unqualified practitioners are again accessible since they would be based in the same or nearby village. Quite often, they are the only help available during emergencies especially for those who cannot travel large distances. Qualified Private Practitioners, both allopathic and ISM&H (ayurvedic, unani and homeopathy); Private nursing homes and hospitals including those for profit and nonprofit; Private tertiary health care establishments. In addition, there are a number of pathological laboratories/diagnostic centers. Pharmaceutical chemists would also quite often provide diagnostic/prescriptive services. Public sector doctors also practice privately. Qualified private practitioners, nursing homes/hospitals and tertiary health care establishments are based in urban areas, while traditional practitioners, dais and RMPs are present in both rural and urban areas.

PROBLEM STATEMENT:

Since now most research efforts have concentrated on the measurement of patients' satisfaction and perceived quality of care provided without any theoretical underpinning for these two concepts. Concentrating on measurement alone, is rather like shutting the stable door after the horse has bolted. Our findings support the need to develop a conceptual framework for patients' satisfaction interpretation, based on their own assumptions regarding quality of care. This is also obvious in our study as patients' in-depth interviews gave them the chance to express their concerns about different aspects of care provided in a manner more confident and humanitarian. This is the first step for the development of a valid and reliable scale for measuring quality of care.

Firstly we have to decide whether we measure satisfaction as an acceptable or expectable quality

of care indicator, or as a perceived patient judgment that is multidimensional and some times indescribable. Then we have to confirm the antecedents of patient satisfaction. Satisfaction is a composite word and is derived from the verb “I arrive”. Then patient satisfaction could be interpreted as «I make a patient capable to evaluate his own care», based on his quality of care perception. The word quality is derived from the word “what kind” and relates to all these characteristics of a service that distinguish it from the other similar services. So, it is easier to describe quality dimensions than to define quality. For Indian vulnerable patients quality of care is whatever patients perceive and whenever they do it. It is also defined by all these care dimensions that assure a good health or a recovery from the illness. The absence of disease, disability as well as pain defines what Indian patients perceive as health and wellness. This will also stress in a recent researches. We identified five factors that explain vulnerable patients' satisfaction and perceived quality of hospital care provided. These factors were the following: food, nursing care, medical care, room characteristics, and treatment /diagnosis. Wilde et al. by using a grounded theory approach they identified four factors that explain quality of care from the patient's perspective. These factors are: the medical-technical competence, the physical technical conditions, the identity oriented approach and the socio-cultural atmosphere.

REVIEW OF RELATED LITERATURE

With the growing importance of health and Hospital sector in India development, there is small number of research and literary work has been done. Which is why our review part has been quoted in the following foreign books or research papers.

in the book “Quality in health care: theory, application, and evolution 1995 “This article discusses how focusing on improving high-volume patient care processes would result in improvement opportunities that would leverage overall organizational performance, describe a specific process for improving.

Trisha Greenhalgh, Paul Bate in the book “Diffusion of innovations in health service organizations2005” ... by multiple users, and the low absorptive capacity of so many parts of the system despite recent capacity-building input, we are not optimistic that it will spread and be sustained without major problems.

Mickey L. Parsons in the book “Guide to clinical resource management1997” The value of an organized multidisciplinary effort to improve the quality of patient care and to reduce resource utilization through clinical process redesign is unlimited. The clinical service teams have created a forum to

Donald E. Lighter, Douglas C. Fair in the book “Principles and methods of quality management in health care
2000 “Statistical Process Control has significant potential for directing and monitoring change in the health care industry. By adding the SPC scientific approach to a QI plan, the validity of the program can be improved

Curtis P. McLaughlin, Arnold D. Kaluzny in the book ” Continuous quality improvement in health care : theory
1994 CONCLUSION Health care organizations and health service providers are predisposed to "meet the needs of the patient." This has taken the general form of the "doctor- patient" model, with the patient presenting and the doctor providing.

Norbert Goldfield, Michael Pine, Joan Pine in the book ” Measuring and managing health care quality: procedures1991” This chapter documents the value of information derived from the customer and outlines many of the practical issues involved in measuring patient-derived information

Andrew F. Long, Stephen Harrison in the book ” Health services performance: effectiveness and efficiency” SOME QUESTIONS It seems possible therefore that the three models, taken together, will help to raise ... At its crudest, there are two opposing ways in which information can be used: either to lead to the conclusion that .

Joint Commission Resources, in the book “Tools for performance measurement in health care2002” Improvement is based on measurement and assessment; it is the logical conclusion of the entire process of designing, measuring, and assessing. Once you have discovered the source of a problem, you can change it so that the process gets

OBJECTIVES OF THE STUDY

For the proposed research, the following main objectives are set:

I)To Study the quality scenario of hospitals in india.

II)To examine what factors were responsible for bringing reforms in Hospital sector.

III)To identify the areas in which reforms have taken place in hospital sector.

IV)T o examine what changes have been brought in by quality in the following areas : Responsibility of management

a)Facility management

b)Continuous quality assessment of the hospital

c)Human resource management

d)Hospital infection control

V)To make the comparative analysis of the existing hospitals quality status with the new quality guidelines in respect of the above areas.

VI)To make a comparative analysis of continuous quality improvement status of Jabalpur hospitals and other hospitals in Madhya Pradesh.

VII)To analyze the problem faced by the existing Hospitals quality system or improvement planning's.

5. METHODOLOGY

This study covers a sample of 295 respondents of Private and 295 respondents of Government Hospital employees and the survey was conducted at the Jabalpur during Octobe2011r-January 2012. Sampling is done by interviewing randomly selected employee(100 nurses, 100 doctors &100 Other staff of private and Government hospital both) at different times of the day, on every day of the week, over a four week period. A structured questionnaire was used for data collection. The questionnaire was divided into four sections, the first section reveals the demographic profile of respondents and second, third and fourth sections are designed to evaluate their overall experiences/Awareness they received from the Hospital services/Trainings. The questions were phrased in the form of statements scored on a 5-point Likert type scale, ranking from 1 "highly dissatisfied" to 5 "highly satisfied". Exploratory Factor Analysis issued for measuring airline service quality to determine the dimension of airline service quality. Factor analysis is a general name denoting a class of procedures primarily used for data reduction and summarization. Average score analysis is conducted to evaluate the different Hospital services. Service quality satisfaction has been analyzed on the basis of score assigned in the questionnaire, 5 marks is assigned to highly satisfied, 4 mark for satisfied, 3 mark for moderate, 2 mark for dissatisfied and 1 mark for highly dissatisfied. Pie-chart is prepared to check the patients willingness to give the priority to private and government different Hospitals. The variable and substances used in data collection is depicted in Table 1.

TABLE 1- VARIABLE MEASUREMENTS

Quality Measures	Variable Substances Scale
Clinical Quality Assurance	
	Awareness of BLS & ACLS
	Awareness of Medication error
	Awareness of safe & immediate ventilation
	Awareness of adverse events
	Proper Documentation practice
	Awareness of high-risk procedures
	Management of Anaphylactic Reaction
	Management of Blood transfusion
	Awareness on Anesthesia Use
Management Quality Assurance	
	Awareness of HR department Responsibility
	Awareness of own rights and responsibility
	Awareness of patient rights and responsibility
	Awareness of Informed Consent
	Awareness of Hospital Infection control Programme
	Awareness of Hand Hygiene Practices
	Awareness of Bio medical waste
	Awareness of Needle Prick Injury Management
	Awareness of Isolation requirements
	Awareness of high risk areas
	Awareness of invasive procedure monitoring
	Awareness of Hospital information system
Staff Satisfaction	
	Behaviors of seniors
	Hospital culture
	Salary satisfaction
	Training satisfaction
	Medical facility benefit
	Insurance benefit
	PF benefit
	Appraisal benefits satisfaction
	Attrition assumption
	Cleanliness
	Leave advantage satisfaction
	Job security
	feedback taken by hospital and use for correctness

(Source : Primary Data)

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Norbert Goldfield	Measuring and managing health care quality: procedures1991
Andrew F. Long	Health services performance: effectiveness and efficiency"
Joint Commission Resources	Tools for performance measurement in health care2002
David B. Nash	The quality solution 2006
Donald E. Lighter	Advanced performance improvement in health care 2011
Maulik Joshi	The healthcare quality book 2005
Christina W. Giles	The medical staff services handbook 2006
Cindy A. Gassiot	The medical staff services handbook:fundamentals and beyond 2006
American College of Medical Quality	Core curriculum for medical quality management 2005

1.WEBSITES

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2. www.searo.who.int/LinkFiles/2007_Audit_Instructions.pdf
3. www.allbusiness.com/Satisfaction/auditing/120414-1.html
4. www.qcin.org
5. www.nabh/standards.org
6. www.nabh/qualityindicator.org
7. http://www.hospitalproductivity.org/?gclid=COyVoNuL1qoCFY0c6wodFW6f7A