



RESEARCH ARTICLE

A STUDY ON THE EFFORT FOR QUALITY IMPROVEMENT AND INITIATIVE PERFORMANCE WITH REFERENCE TO A SUPER SPECIALITY HOSPITAL IN CHENNAI

¹Kavitha Madhavan, ²Dr. Muthuswamy, P. R., *²Sunil Franklin, A. and ²Anitha, P.

¹G.M-International Patients, Global Healthcare City, Chennai, Tamilnadu, India

²Department of Hospital Administration, Dr. N. G. P Arts and Science College, Coimbatore – 48, Tamilnadu, India

ARTICLE INFO

Article History:

Received 27th May, 2014
Received in revised form
10th June, 2014
Accepted 16th July, 2014
Published online 06th August, 2014

Key words:

Quality, Patient safety,
Quality management,
Quality Improvement,
Quality indicators.

ABSTRACT

Quality refers to excellence of a product or a service, including its attractiveness, lack of defects, reliability, and long-term durability. Quality assurance provides the mechanisms to effectively monitor patient care provided by health care professionals using cost-effective resources. Quality is defined as the extent of resemblance between the purpose of healthcare and the truly granted care. The main function of the quality department in a hospital is to implement quality system & to establish quality and safety culture. Improvements are based on many, small changes rather than the radical changes that might arise from Research and Development. As the ideas come from the workers themselves, they are less likely to be radically different, and therefore easier to implement. Small improvements are less likely to require major capital investment than major process changes. All employees should continually be seeking ways to improve their own performance. It helps encourage workers to take ownership for their work, and can help reinforce team working, thereby improving worker motivation. Patient safety is a new healthcare discipline that emphasizes the reporting, analysis, and prevention of medical error that often leads to adverse healthcare events. The frequency and magnitude of avoidable adverse patient events was not well known until the 1990s, when multiple countries reported staggering numbers of patients harmed and killed by medical errors. Recognizing that healthcare errors impact 1 in every 10 patients around the world, the World Health Organization calls patient safety an endemic concern.

Copyright © 2014 Kavitha Madhavan et al. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

INTRODUCTION

One of the significant trends in the development of modern healthcare is the involvement of patient / clients in the management of their care and treatment. This is recognised in current health strategies both in Ireland and in other jurisdictions. The Health Strategy – Quality and Fairness (DOHC 2001) makes a particular reference to the inclusion of patient/clients in both the principles and the National Goals. To support this development it is important to acknowledge that the experiences of patients/clients of health care vary considerably. Some may have an occasional intervention while others have a more permanent and long-term relationship with a service provider depending on the nature and extent of their need. Person centred health care respects the dignity and value of each person. It is entirely desirable and proper that the views of patient/clients should be sought on their experiences and expectations of health care. These documents are designed to provide both a helpful and supportive guide to patient satisfaction for service providers. The guidelines explain what is involved in establishing a measure of patient/users

satisfaction and the various methods available. A detailed guide to support staff involved in this work is also included. Many American health systems are significantly underinvested in quality management Infrastructure, Process, and Organization. In order to achieve breakthrough improvement in quality and patient safety, hospitals and health systems need to develop a "world class" quality management foundation that includes: Strategy including a clear linkage of quality and patient safety to the organizational strategy and a Board-driven imperative to achieve quality goals. Infrastructure incorporating effective quality management technology, EMR and physician order entry, evidence based care development tools and methodologies, and quality performance metrics and monitoring technology that enables "real time" information. Process includes concurrent intervention, the ability to identify key quality performance "gaps," and performance improvement tools and methodologies to effectively eliminate quality issues. Organization providing sufficient number and quality of human resources to deliver quality planning and management leadership, adequate informatics management, effective evidence based care and physician order set development, performance improvement activity, and accreditation planning to stay "survey ready every day."

*Corresponding author: Sunil Franklin, A.

Department of Hospital Administration, Dr. N. G. P Arts and Science College, Coimbatore – 48, Tamilnadu, India.

Quality Improvement Programmes Include

- All direct patient care direct services and indirect services effecting patient health and safety.
- Medication management.
- Utilization management and hospital payment monitoring programme.
- Healthcare acquired infections.
- Professional staff credentialing & privileging.
- Surgical care review.
- Blood utilization review.
- Medical record review.
- Risk management activities.
- Morbidity /Mortality review.
- Safety of high alert medication.
- Implementing universal protocol for right patient, right side, right site surgery.
- Hand washing compliance.
- Reducing patient falls.
- Wound care.
- Emergency drug availability.
- Reducing medication errors.
- Infection control for housekeeping department.
- Waiting time in emergency department.
- Emergency room assessment criteria.
- Specimen rejection in laboratory.
- Repeat procedures in radiology department.
- Waiting time in OPD.
- Discharge Process.
- Consent forms compliance.

According to Marrtje De Vos *et al.* (2007) in his study about strategy for Implementing quality indicators in hospital care, and their effectiveness in improving the quality of care. In improving the quality of care found that the implementation of quality indicators in hospitals is most effective if feedback reports are given in combination with an educational implementation strategy and/or the development of a quality improvement plan. Effective strategies to implement quality indicators in daily practice in order to improve hospital care do exist, but there is considerable variation in the methods used and the level of change achieved. Feedback reports combined with another implementation strategy seem to be most effective. According to 1997 literature review carried out by Harry Cummings and Associates for HPRAC (1997), this report noted the absence of QA literature specific to the issue of regulated health professions: "most of the published literature on QA is focused on hospital or facility-based QA rather than QA for specific health professions." The report speculated that this could be because mandatory QA for professions is a relatively recent development in Canada. It also speculated that the absence could be because much QA literature arises in the United States, which has a more loosely regulated private-market model. This conclusion does not mean that there is no literature concerning the role of regulators in ensuring professional quality: but that literature is more likely to be discussed in the language of continuing competency and regulatory roles, rather than in the language of the QA literature.

The study, led by Eugene Kroch and Michael Duan of Care Science, Inc., (Eugene Kroch and Michael 2007) and described in the companion report, Hospital Performance Improvement: Trends in Quality and Efficiency, found significant improvements in mortality rates, likely indicating that hospitals have been getting better at keeping people alive through error reduction, improved technologies, adherence to evidence-based protocols, and other strategies.² The improved mortality scores may also be attributed in part to more conscientious coding of co morbidities, and to discharging of sicker patients who may expire in home or hospice settings. According to the study of Sixma, Herman *et al.* (1998) the authors examine how patient satisfaction with health care providers relates to either the individual characteristics of respondents or the characteristics of health care providers and the structural setting in which they work.

Statement of the research problem

Implementing quality management system in hospital and establishing quality and safety culture is very much important in a hospital sector. Quality assurance provides the mechanisms to effectively monitor patient care provided by health care professionals using cost-effective resources. Quality is defined as the extent of resemblance between the purpose of healthcare and the truly granted care. The researcher chooses the topic to find out effort for quality improvement and initiative performance by the organization.

Objectives of the study

1. To study about the quality and safety of care in hospital.
2. To study about the implementation of quality management system at the hospital.
3. To assess the level of patient satisfaction
4. To evaluate the quality improvement programmes in the hospital.

Population and Sample Size

The overall population taken for the study is 1200. The sampling unit is in patient and from the employee side all the department heads. The sample size for the study is 600. The researchers have used stratified random sampling method for the study on effort for quality improvement and initiative performance among the patients and employees.

Data analysis and interpretation

Table 1. Showing the experience of the respondents

Experience	Number of respondents	Percentage
Below 3 years	27	18
3 – 5 years	50	33.4
5 – 10 years	43	28.6
Above 10 years	30	20
Total	150	100

Interpretation: From the above table it can be found that 18 % of the respondents are having below 3 years of experience, 33.4 % of the respondents are having 3-5 years of experience, 28.6 % of the respondents are having 5 – 10 years of experience, 20

% of the respondents are having above 10 years of experience. It is found that majority (33 %) is having 3-5 years experience.

Table 2. Showing the hospital visible leadership in maintaining an environment that supports quality improvement

Hospitals leadership in quality improvement	No. of respondents	Percentage %
Strongly agree	30	20
Agree	103	69
Neutral	16	10.4
Disagree	1	0.6
Strongly disagree	0	0
Total	150	100

Interpretation

From the above table it can be inferred that 20 % of the employees strongly agree that the hospital is showing visible leadership in maintaining an environment that supports quality improvement, 69 % of the respondents rate it as agree, 10.4 % of the respondents rate it as neutral and 0.6 % of the respondents disagree with the statement. None of the respondents strongly disagree with the statement. It can be found that majority (69 %) of the respondent's rate it as they are agree with the statement.

Table 3. Showing the physician's leadership involved in quality improvement efforts

Hospitals leadership in quality improvement	No. of respondents	Percentage %
Strongly agree	54	36
Agree	67	45
Neutral	25	17
Disagree	4	2
Strongly disagree	0	0
Total	150	100

Interpretation

From the above table it can be inferred that 36 % of the employees strongly agree that the physicians leadership is highly involved in quality improvement efforts, 45 % of the respondents rate it as agree, 17 percent of the respondents rate it as neutral and 2 % of the respondents disagree with the statement. None of the respondents strongly disagree with the statement. It can be found that majority (45 %) of the respondent's rate it as they are agree with the statement.

Table 4. Showing whether employees are given adequate time to plan and test improvements

Hospitals leadership in quality improvement	No. of respondents	Percentage %
Strongly agree	41	27.4
Agree	87	58
Neutral	16	10.6
Disagree	6	4
Strongly disagree	0	0
Total	150	100

Interpretation

From the above table it can be inferred that 27.4 % of the employees strongly agree that the employees are given

adequate time to plan for & test improvements, 58 % of the respondents rate it as agree, 10.6 % of the respondents rate it as neutral and 4 % of the respondents disagree with the statement. None of the respondents strongly disagree with the statement. It can be found that majority (58 %) of the respondent's rate it as they are agree with the statement.

Table 5. Showing whether the employees are involved in developing plans for improving quality

Employees are involved in quality improvement plans	No. of respondents	Percentage %
Strongly agree	50	34
Agree	77	51.4
Neutral	22	14.6
Disagree	1	0.6
Strongly disagree	0	0
Total	150	100

Interpretation

From the above table it can be inferred that 34 % of the employees strongly agree that the employees are involved in developing plans for improving quality, 51.4 % of the respondents rate it as agree, 14.6 % of the respondents rate it as neutral and 0.6 % of the respondents disagree with the statement. None of the respondents strongly disagree with the statement. It can be found that majority (51.4 %) of the respondent's rate it as they are agree with the statement.

Table 6. Showing whether the employees are given education and training to identify and act on quality improvement

Employees are given training & education for quality improvement	No. of respondents	Percentage %
Strongly agree	45	30
Agree	80	53.4
Neutral	25	16.6
Disagree	0	0
Strongly disagree	0	0

Interpretation

From the above table it can be inferred that 30 % of the employees strongly agree that the employees are given education and training in how to identify and act on quality improvement, 53.4 % of the respondents rate it as agree, and 16.6 % of the respondents rate it as neutral. None of the respondents disagree or strongly disagree with the statement. It can be found that majority (53.4 %) of the respondent's rate it as they are agree with the statement.

Table 7. Showing whether the hospital regularly checks equipment & supplies to make sure they meet quality requirements

Hospital regularly checks equipment & supplies to make sure they meet quality requirements	No. of respondents	Percentage %
Strongly agree	40	27
Agree	90	60
Neutral	19	12.4
Disagree	1	0.6
Strongly disagree	0	0
Total	150	100

Interpretation

From the above table it can be inferred that 27 % of the employees strongly agree that the hospital regularly checks equipment & supplies to make sure that they meet quality requirements, 60 % of the respondents rate it as agree, 12.4 % of the respondents rate it as neutral and 0.6 % of the respondents disagree with the statement. None of the respondents strongly disagree with the statement. It can be found that majority (60 %) of the respondent's rate it as they are agree with the statement.

Table 8. Showing whether the hospital has effective policies to support and improve the quality of care & services

Hospital has effective policies to support improving the quality of care & services	No. of respondents	percentage
Strongly agree	54	36
Agree	90	60
Neutral	6	4
Disagree	0	0
Strongly disagree	0	0
Total	150	100

Interpretation

From the above table it can be inferred that 36 % of the employees strongly agree that the hospital has effective policies to support improving the quality of care & services, 60 % of the respondents rate it as agree, 4 % of the respondents rate it as neutral..None of the respondents disagree & strongly disagree with the statement. It can be found that majority (60 %) of the respondent's rate it as they are agree with the statement.

Table 9. Showing whether the hospital practices an effective infection control system to prevent communicable diseases

Hospital practices an effective infection control system to prevent communicable diseases	No. of respondents	Percentage
Strongly agree	55	36.6
Agree	65	43.4
Neutral	30	20
Disagree	0	0
Strongly disagree	0	0
Total	150	100

Interpretation

From the above table it can be inferred that 36.6 % of the employees strongly agree that the hospital practices an effective infection control system to prevent communicable diseases, 43.4 % of the respondents rate it as agree, and 20 % of the respondents rate it as neutral. None of the respondents disagree or strongly disagree with the statement. It can be found that majority (43.4 %) of the respondent's rate it as they are agree with the statement.

Conclusion

This report focuses on the dynamics of hospital performance: how hospitals achieve and sustain improvements over time. For the improvement organizational and structural changes such as multidisciplinary teams, quality- related committees, and technology investments, a systematic problem-identification and problem-solving process, new treatment protocols and practices, improved are needed. Success strengthens commitment to quality improvement and turns this temporal pattern into an ongoing cycle. The entire process reflects the establishment, growth, and reinforcement of a culture of quality. A companion report, Hospital Performance Improvement: Trends in Quality and Efficiency, presents results of a quantitative examination of the degree to which hospitals are improving (or deteriorating) in quality and efficiency over time. The quality improvement programmes include Safe: avoiding injuries to patients from care that is intended to help them. Effective: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those unlikely to benefit (avoiding underuse and overuse). Patient-centered: providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide clinical decisions. Timely: reducing waits and sometimes harmful delays for both those who receive and give care. Efficient: avoiding waste, such as waste of equipment, supplies, ideas, and energy. Equitable: providing care that does not differ in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

REFERENCES

- Cummings, Harry & Associates (HCA). A Framework for Evaluating the Quality Assurance Programs of the Colleges of Health Professions in Ontario Toronto: *Health Professions Regulatory Advisory Council*, 1997.
- de Vos M, Graafmans W, Keesman E, Westert G, van der Voort PHJ. Quality measurement at intensive care units: which indicators should we use? *J Crit Care*. 2007;22:267-274. doi: 10.1016/j.jcrc.2007.01.002.
- Eugene Kroch and Michael Duan of Care Science, Inc., The companion report, Hospital Performance Improvement: Trends in Quality and Efficiency April 2007
- Sixma, H.J., Spreeuwenberg, P.M.M., Pasch, M.A.A. van der. Patient satisfaction with the general practitioner: a two-level analysis. *Medical Care*: 1998, 36(2), p. 212-229
