

THE UNIVERSITY OF HULL

**Knowledge, attitude and practice of hospital senior and middle
management towards health care quality programs in
Eastern Saudi Arabia.**

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by

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**KNOWLEDGE, ATTITUDE AND PRACTICE
OF HOSPITAL SENIOR AND MIDDLE
MANAGEMENT TOWARDS HEALTH CARE
QUALITY PROGRAMMES IN EASTERN
SAUDI ARABIA.**

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ABSTRACT

Quality programs are not new to Saudi hospitals. The first known quality program was started in ARAMCO Hospital in 1982. Besides the Ministry of Health, the main provider of health care, more than 15 providers share in the delivery of the health care in Saudi Arabia. Quality activities being sporadic, with no national control, the programs depend heavily on the top management commitment and support.

The success of quality programs varies among the different health care providers. Hence the need to investigate the knowledge, attitude and practice of the senior and middle managers (HSMM) towards quality programs. The findings of their investigation could throw some light on some incorrect concepts and explain the reasons behind the ineffective practice of quality.

Two studies were conducted simultaneously for this research. A descriptive study to investigate the knowledge, attitude and practice of the HSMM, for which two data collecting tools were used. The HSMM self administered questionnaire was completed by the HSMM of 20 selected hospitals in the Eastern Saudi Arabia; 173 HSMM responded to the study giving response rate of 86.5%. The other tool used for the descriptive study was a check list completed by the researcher on each studied hospital. The other part of this research was the action research aimed at exploring the amount of the support HSMM extends to these activities in order to enhance quality services in their hospitals.

The study revealed that a majority of senior and middle managers had enough knowledge to initiate very promising quality programs, but there seemed to be a problem with their attitude on quality which affected the implementation of the quality program.

Attending training courses on quality subjects made a significant difference to the general information, factor enhancing quality program, causes of quality program failure and the ranking of HSMM towards quality programs. Combining all of these significant variables and classifying them based on their relation with the patient, quality program and staff gave a clear indication that most were related to attitude.

The study concluded that the input and the output of the hospital had less impact on quality programs compared to the process reflected by the knowledge, attitude and practice of the HSMM.

Recommendations cover the input, output and the process of quality programs, with more emphasis on the process. The HSMM should pave the way for a quality culture in the hospital which pays proper attention to the development of the skills of the staff and their orientation to the quality environment.

TABLE OF CONTENTS

	Page No.
TITLE PAGE	
ACKNOWLEDGEMENT	
ABSTRACT	i
TABLE OF CONTENTS	ii
LIST OF TABLES	x
LIST OF FIGURES	xii
CHAPTER ONE: INTRODUCTION	1
1.1 Statement of the problem	1
1.2 Rationale of the study	1
1.3 Scope of the study	2
1.4 Research aim and objectives	3
CHAPTER TWO: STUDY AREA PROFILE	4
2.1 Saudi Arabia	4
2.1.1 Background	4
2.1.2 Geography	6
2.1.3 Socio-demography	8
2.1.4 Political structure	9
2.1.5 Health system	10
2.2 Eastern Province	18
2.2.1 Introduction	18
2.2.2 Main Health Problem	21

CHAPTER 3: QUALITY AND MANAGEMENT	23
3.1 Introduction	23
3.2 Historical development	24
3.3 Quality Management Gurus and their contributions	28
3.3.1 Deming's contribution	28
3.3.2 Juran's contribution	32
3.3.3 Grosby's contribution	33
3.3.4 Ishikawa's approach	34
3.4 Quality of Health Care	35
3.5 Total Quality Management: Concepts and Definitions	39
3.6 Quality Assurance	44
3.7 Quality Assurance in Health Care	46
3.8 Quality and Quality Assurance in developed countries	47
3.9 Quality and Quality Assurance in developing countries	49
3.10 Quality Assurance in Saudi Arabia	52
3.11 The role of Top Management and Managers in Health Care Quality Programmes	57
CHAPTER 4: METHODS	67
4.1 Overview of Methods Used	67
4.1.1. Litereature Search and Review	68
4.1.2 Search Strategy	68
4.2 Introduction	69
4.3 Research Design	71

4.3.1	Descriptive study	71
4.3.2	Action Research Study	71
4.4	Research site	72
4.5	Sampling procedure	72
4.5.1	The sample of the descriptive study	72
4.5.2	The sample of the action research	76
4.6	Data collection tools	78
4.6.1	Manager questionnaire (Appendices 1 & 2)	78
4.6.2	Hospital checklist (Appendix 3)	79
4.6.3	Validity and reliability	80
4.6.4	Measures taken to increase response rate	81
4.6.5	Action research cycle	82
4.6.5.1	<i>The workshop activity</i>	83
4.6.5.2	<i>Patient satisfaction questionnaire</i>	85
4.6.5.3	<i>Head nurse bi-weekly report</i>	87
4.6.6	Precautions taken to increase response rate	88
4.7	Research process	88
4.7.1	The process of the descriptive study	88
4.7.2	The flow diagram for the descriptive study	90
4.7.3	The process of the action research	91
4.7.4	The flow diagram for the action research	93
4.8	Data analysis	94
4.9	Ethical consideration	95
4.10	Limitation of the study	96
4.11	Summary	96

CHAPTER 5: RESULTS	99	
5.1	General overview	99
5.2	The descriptive study	100
5.2.1	Overview of the hospitals	100
5.2.1.1	<i>Information about the quality program</i>	<i>102</i>
5.2.1.2	<i>Information about the person in-charge of quality program</i>	<i>102</i>
5.2.1.3	<i>Information about the outcomes</i>	<i>103</i>
5.2.2	Hospital senior and middle managers' information	103
5.2.2.1	<i>Distribution of hospital senior and middle managers according to their place of work</i>	<i>104</i>
5.2.2.2	<i>The characteristics of hospital senior and middle level managers</i>	<i>104</i>
	<i>Managerial level</i>	<i>104</i>
	<i>Age</i>	<i>104</i>
	<i>Gender</i>	<i>105</i>
	<i>Nationality</i>	<i>105</i>
	<i>Qualification</i>	<i>105</i>
	<i>Training</i>	<i>105</i>
	<i>Ownership of the hospital</i>	<i>106</i>
5.2.2.3	<i>Hospital senior and middle managers' definition of quality</i>	<i>106</i>
5.2.2.4	<i>Knowledge and attitude of hospital senior and middle managers according to their managerial level</i>	<i>107</i>
5.2.2.5	<i>Knowledge and attitude of senior and middle managers of hospitals according to their training on quality</i>	<i>107</i>
	<i>Definition of quality</i>	<i>107</i>

	<i>General information about quality</i>	107
	<i>Factors necessary for the implementation of quality programs</i>	108
	<i>The causes of quality program failure</i>	108
	<i>Ranking of priorities in the implementation of quality programs</i>	108
5.3	The action research	118
5.3.1	Orientation and follow-up of the action research	118
5.3.2	Nurses' characteristics and background	118
5.3.3	Nurses' contribution	120
5.3.4	The findings of nurses bi-weekly reports	122
5.3.5	Patient feedback	124
5.3.6	Patient characteristics	125
	<i>Nationality</i>	125
	<i>Residence</i>	125
	<i>Gender</i>	126
	<i>Age</i>	126
	<i>Marital status</i>	126
	<i>Education</i>	126
	<i>Occupation</i>	126
	<i>Main source of health care</i>	127
5.3.7	Patient satisfaction	127
5.3.8	Overall observations on the action research	134
5.3.9	Researcher's overall observations on the action research	137
5.4	Summary of results	139
5.4.1	The descriptive study	139

5.4.1.1	<i>Overview of the hospitals</i>	139
5.4.1.1.1	<i>General information on the hospitals</i>	139
5.4.1.1.2	<i>Information on quality program</i>	140
5.4.1.1.3	<i>Information on the in-charge of the quality program</i>	140
5.4.1.1.4	<i>Information on the outcomes</i>	140
5.4.1.2	<i>Hospital senior and middle managers information</i>	141
5.4.1.2.1	<i>Distribution of hospital senior and middle managers according to their place of work</i>	141
5.4.1.2.2	<i>The characteristics of hospital senior and middle managers</i>	141
5.4.1.2.3	<i>Hospital senior and middle managers definition of quality</i>	141
5.4.1.2.4	<i>Knowledge and attitude of hospital senior and middle managers according to their managerial level</i>	141
5.4.1.2.5	<i>Knowledge and attitude of hospital senior and middle managers according to their training on quality</i>	142
5.4.2	<i>The action research</i>	143
5.4.2.1	<i>Nurses' characteristics and background</i>	143
5.4.2.2	<i>Nurses' contribution</i>	143
5.4.2.3	<i>Patient characteristics</i>	144
5.4.2.4	<i>Patient satisfaction</i>	145
5.4.2.5	<i>Researcher's overall observations on the action research</i>	146
CHAPTER 6 :DISCUSSION		148
6.1	<i>The descriptive study</i>	149
6.1.1	<i>The structure</i>	149
6.1.2	<i>The outcome</i>	150
6.1.3	<i>The process</i>	153

6.1.3.1	<i>HSMM definition of quality</i>	157
6.1.3.2	<i>HSMM's knowledge, importance and priority of quality program</i>	158
6.2	The action research	160
	Previous experience	162
	Expectation	162
	Physical environment	163
	Communication and information	163
	Participation and involvement	164
	Interpersonal relationship	164
	Medical and Technical competency	165
	Overall satisfaction	165
6.3	Summary	166
6.4	Limitations of the present study	167
CHAPTER 7: CONCLUSION & RECOMMENDATIONS		169
7.1	Conclusions	170
7.1.1	Input	171
7.1.2	Process	172
7.1.3	Output	175
7.2	Recommendations	177
7.2.1	Input	177
7.2.2	Process	179
7.2.2.1	<i>The culture of quality</i>	179
7.2.2.2	<i>The staff</i>	180

7.2.3	Output	180
7.3	Contribution of the study	181
7.3.1	Analysis of quality programmes failure	182
7.3.2	Solution	183
7.4	Further Research	184
REFERENCES		185
APPENDICES		
Appendix One	Manager Questionnaire – Arabic	204
Appendix Two	Manager Questionnaire – English	211
Appendix Three	Checklist (Structure and Outcome)	218
Appendix Four	Introduction to Health Management	224
Appendix Five	Time Management	233
Appendix Six	Managerial Creativity and Leadership	238
Appendix Seven	Problem Solving and Decision Making	244
Appendix Eight	Timetable of Workshop	253
Appendix Nine	Questionnaire of Workshop	254
Appendix Ten	Agreement between Researcher and Hospital Manager	257
Appendix Eleven	Patient Questionnaire	263
Appendix Twelve	Head Nurses' Biweekly Report	273

LIST OF TABLES

		Page no.
Table 4.1	Number and percent distribution of hospitals in Eastern Province according to region and number of beds per hospital	73
Table 4.2	Number and percent distribution of hospitals in Eastern Province of KSA according to ownership	74
Table 4.3	Number and percent distribution of hospitals that meet the inclusion criteria in Eastern Province of KSA according to region, and ownership that me the inclusion criteria	75
Table 4.4	Selected hospitals for action research based on ownership, with the number of beds and head nurses in medical and surgical wards	76
Table 4.5	Comparison of different aspects of MOH run hospitals and the privately- owned ones in KSA	77
Table 5.1	Cross tabulation of courses attended by hospital senior and middle managers and their perception of general concepts on quality	110

Table 5.2	Cross-tabulation of courses attended by hospital senior and middle managers and their perception of the factors necessary for the implementation of quality program	112
Table 5.3	Cross-tabulation of courses attended by hospital senior and middle managers and their perception of the reasons for the failure of quality programs	114
Table 5.4	Cross tabulation of courses attended by hospital senior managers and their views on priority factors in quality program implementation	116
Table 5.5	Comparison of different observations between the two hospitals through nurses' bi-weekly reports	123
Table 5.6	Variables that showed significant differences in patient satisfaction in the 1 st and 6th periods of action research	130
Table 5.7	Overall comparison of different observations on the two hospitals	137

LIST OF FIGURES

	Page no.	
Figure 2.1	Map of Kingdom of Saudi Arabia	7
Figure 2.2	Map of Eastern Province of Saudi Arabia	19
Figure 5.1	HSMM perception of the general concepts of quality according to background training	111
Figure 5.2	HSMM perception of the factors important for implementing quality programs according to background training	113
Figure 5.3	HSMM perception of reasons for the failure of quality programs according to background training	115
Figure 5.4	HSMM views on priority setting factors affecting quality programs according to background training	117
Figure 5.5	Progress of patient satisfaction during action research at an MOH hospital	128
Figure 5.6	Progress of patient satisfaction during action research in a private hospital	129

Figure 5.7	Differences in patient satisfaction of selected variables between MOH and private hospitals during 1 st period of action research	132
Figure 5.8	Differences in patient satisfaction of selected variables between MOH and private hospitals during 6 th period of action research	133

CHAPTER ONE

INTRODUCTION

1.1 STATEMENT OF THE PROBLEM

Apart from Ministry of Health which is the main provider of health care in Saudi Arabia, there are more than 15 others who share in the provision of health care in the Kingdom. Each provider has its own target population, medical and administrative set-up, budget and other resources necessary for their work. Since the private sector forms the largest provider, reorganization of the health services should be given serious thought. An important factor in a successful and effective reorganization is quality management. To disseminate quality culture through a newly planned system, the support of the top management is essential. It is therefore, of the utmost importance that the level of their knowledge and attitude towards quality programmes and their practice be investigated. The results of these investigations would identify the incorrect concepts and explain the underlying reasons for ineffectiveness of the practice of quality. It is envisaged that by correcting these shortcomings the future success of the implementation of health quality management programmes would be assured.

To the knowledge of the researcher, no such study has been conducted in Saudi Arabia on the same subject. The information on this is very limited all over the Arabian Gulf.

1.2 RATIONALE OF THE STUDY

Apart from primary health care services, there are no officially agreed unified well-defined national health care standards in the Kingdom of Saudi Arabia (Khoja, 1995).

However, some health care providers have their own quality standards set by the local managing contractor who operates their hospital(s). In the absence of a national quality plan, variations and overlaps among the health care providers are expected. In fact, the evaluation of the method of delivery was just as important as the care provided. Quality standards assess a combination of what is provided and how it is provided. Saeed (1999) indicated that more than one-half of the health care managers of Saudi hospitals were dissatisfied with the initiatives their hospitals make to improve quality. Consequently, a comprehensive exploratory study on which the design of the national health quality program can be founded is urgently required.

1.3 SCOPE OF THE STUDY

Because of the constraints of time and resources, the scope of the study was limited to hospital senior and middle management (HSMM) in Eastern Saudi Arabia (ESA). Owing to the wide range of nationalities working in the Eastern Province, multiplied health providers and the variety of industries present, the region is unique and is, therefore, perhaps the best suited for studies and research. People in this province have high expectation of the quality of health care to be provided. Decision makers, therefore, have a difficult task in satisfying these clients and their needs.

Although quality is part of everyone's routine duties, the key persons for the successful implementation of programs are middle and senior managers. Regardless of the ownership of the hospital or the background of its clients, quality concepts are more or less the same. Nevertheless, more than the commitment of knowledgeable HSMM is required to support a good quality program. The role of health care providers in the life of patients is essential. Consequently, the scope of the study will

be the knowledge, attitude and practice of HSMM of all of the hospitals of the eastern province of Saudi Arabia.

1.4 RESEARCH AIM AND OBJECTIVES

This study aims to identify the role of HSMM in providing quality health care in the hospitals of Eastern Saudi Arabia by ascertaining their knowledge, attitude and practice of the quality of health care, and their effectiveness in supporting an action research designed to improve the quality of nursing services in their hospitals.

These objectives will be achieved by answering the following questions:

- Q. 1. How correctly do HSMM define and perceive quality health care?
- Q. 2. In the actual practice of HSMM, what level of importance and priority do they give to the provision of quality health care services?
- Q.3. What measures are HSMM currently undertaking to ensure and enhance the provision of quality health care in their hospitals?
- Q.4. How supportive will they actually be to the small action quality research to be implemented in their hospital?

CHAPTER TWO

STUDY AREA PROFILE

2.1 SAUDI ARABIA

2.1.1 Background

The Kingdom of Saudi Arabia occupying most of the Arabian Peninsula was founded in 1932 by King Abdul Aziz Ibn Saud as an Islamic monarchy in the Middle East. It is a land of vast deserts and little rainfall. Huge deposits of oil and natural gas lie beneath the sands of the deserts. Saudi Arabia was a relatively poor nation before the discovery and exploitation of oil. Since the 1950s, income from oil has made the country wealthy. Islam developed in Arabia and soon came to influence nearly all aspects of Arabian cultural life (Anthony, 2004).

When the Kingdom of Saudi Arabia was established in 1932, its economy was fragmented and small. People in the Al Hijaz cities of Makkah, Medina and Jeddah derived most of their income from the annual influx of thousands of hajj pilgrims. Coastal settlements on the Red Sea relied on trade and fishing, while those on the Arabian Gulf grew dates and other products. In the central Najd region, economic activity revolved around trade between nomads who raised camels, sheep, goats and horses – and settled groups, who grew crops and produced handicrafts. Principal Saudi exports were dates and livestock and imports included textiles, grains, other foodstuffs and various manufactured products (Anthony, 2004).

Oil revenue transformed the Saudi economy in the mid – 20th century. Oil revenues were channeled to development programs into areas such as transportation, housing, health, education and defense (Anthony, 2004).

Fossil remains of elephants, hippopotamuses, crocodiles and other large animals found in parts of the Arabian Peninsula indicate that the climate was able to support much more vegetation between 11 million and 4 million years ago than it does today. The region's arid climate, however, seems to date back to at least 5000 years. Prehistoric flint tools, rock drawings in various parts of the peninsula, provide evidence of scattered habitation by Stone Age peoples (Anthony, 2004).

Muhammad (PBUH), the prophet of Islam, was born in Makkah in about 570 AD to a family belonging to a branch of the Quraysh, the dominant tribe of Makkah. His first attempts to preach the oneness of God had only partial success, gaining him both followers and opponents in his home city. Muhammad (PBUH) had more success with tribes in nearby Medina, where he moved in 622. Muhammad's (PBUH) emigration, known as Hegira (*hijrah* in Arabic) marks the first year of the Islamic calendar. In 630, he returned with his followers and conquered Makkah.

After Muhammad's (PBUH) death in 632, the Islamic community (*ummah*) was guided by caliphs (*khalifah*, Arabic for "successor"), who succeeded Muhammad (PBUH) in his role as Islam's political leader. The first four caliphs ruled from Makkah and Medina, overseeing the rapid expansion of an Islamic empire through conversion and military conquest. By 650 an organized Islamic state ruled a newly unified Arabian Peninsula as well as the entire Fertile Crescent (what is now Iraq,

Syria, Lebanon and Palestine) and Egypt. The Umayyad dynasty of caliphs moved the seat of the caliphate to Damascus in 661. The political center of the great Islamic empire would remain outside the peninsula from this point onward, relegating Arabia to the fringes of Islamic culture and power until modern times. After 1269, most of Al hijaz was ruled by the Egyptian Mamluks. The Ottoman Empire gained control of Al hijaz when it conquered Egypt in 1517. Neither the Mamluks nor the Ottomans extended their authority into the central Arabian Najd region, which remained the domain of Bedouin, tribal chiefs (Anthony, 2004).

2.1.2 Geography

The Arabian Peninsula is essentially a huge, tilted block of rock, highest in the west and sloping gradually down to the east. Most of this slab of rock is covered with the sands of several large deserts. Saudi Arabia's landscape also contains mountain ranges, flat coastal planes, and the rocky remains of hardened lava flows. The country's climate is hot and dry, with no permanent rivers or lakes (Royal Embassy of Saudi Arabia, 2004; Anthony, 2004).

Saudi Arabia is bounded on the north by Jordan, Iraq and Kuwait; on the east by the Arabian Gulf and Qatar; on the southeast by the United Arab Emirates and Oman; on the south by Yemen; and on the west by Red Sea and the Gulf of Aqaba (Figure 1).

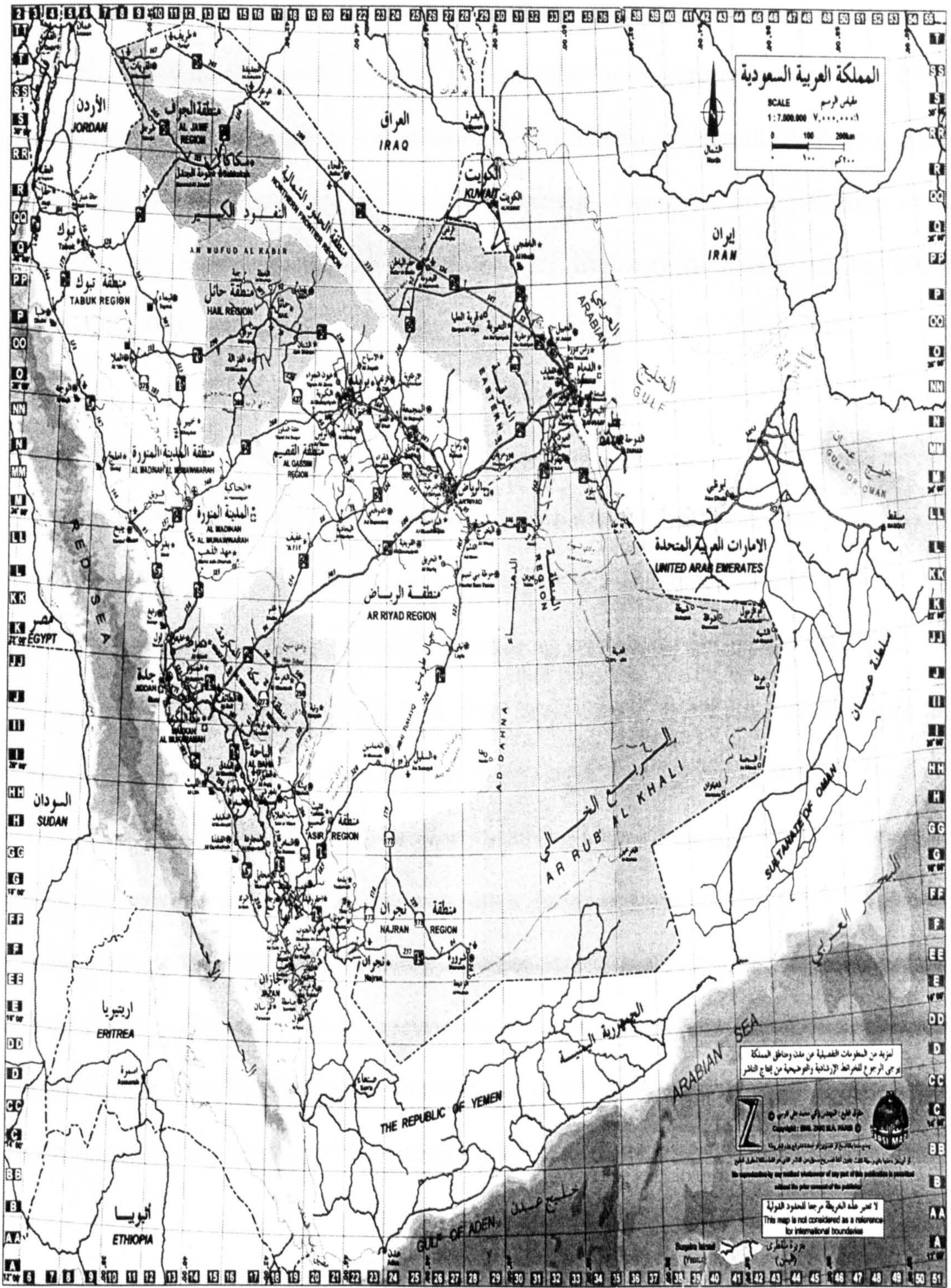


Figure 2.1: Map of Kingdom of Saudi Arabia

Saudi Arabia has an area of about 2,240,000 sq km (about 864,900 sq mile) with Riyadh as its capital. It can be divided into four natural regions: the mountainous western highlands, the rocky central plateau; the more fertile, eastern low lying coastal plane; and the sandy desert areas of the north, east, and south. To have a sense of its size, the land area of Saudi Arabia exceeds that of Western Europe or is approximately one third that of U.S.A. (Royal Embassy of Saudi Arabia, 2004; Anthony, 2004).

2.1.3 Socio-demography

In 2003, the estimated population of Saudi Arabia was 24.3 million, with a density of 10.8 persons per sq km (28.1 persons per sq mile). About 23 per cent of the population (about 5.4 million people) is made up of foreign nationals. The country's population growth rate is 3.27 per cent. The rapid rate of population growth and the large percentage of foreign workers and their dependants have significant political, social and economic implications for Saudi Arabia. Foreign workers play an important role in the country, making up a large portion of the labor force and consumer base. However, due to a series of economic downturns, the government has introduced a policy of Saudization to reduce its reliance on expatriates in the work force. Of the Saudis, Bedouins constitute around 10% of the population (Royal Embassy of Saudi Arabia, 2004; Anthony, 2004).

The large, foreign-born population of the kingdom consists mainly of Arabs from other Arabian Gulf states, Egypt, Jordan, Lebanon, Syria and Yemen. In addition, many people from India, Pakistan, Sri Lanka, Bangladesh and Philippines live and work in Saudi Arabia. Arabic is the national language of Saudi Arabia and is used by

most of its native population. English is an important second language, used in government, commerce and the media and among the non-Arab expatriate community (Royal Embassy of Saudi Arabia, 2004; Anthony, 2004).

2.1.4 Political structure

The chief governor and the custodian of the two holy mosques of Saudi Arabia is the King. Various rules of succession have been developed since the founding of the kingdom in 1932. In 1992, King Fahad decreed that the king could designate or remove the crown prince. Furthermore, the crown prince would not automatically ascend to the throne upon the death of the king, but would serve only as provisional ruler until fully confirmed by religious and government leaders (Royal Embassy of Saudi Arabia, 2004; Anthony, 2004).

Saudi Arabia has no separate legislature and no political parties. Laws are issued by the king and his ministers. In 1992, King Fahad called for the creation of a consultative council, whose members were selected by him. The council was officially inaugurated in 1993 with a membership of 60. The council's membership was increased to 90 in 1997, and to 120 in 2001. The council has no legislative powers, but has the right to summon and question ministers, and to offer recommendations to the King (Royal Embassy of Saudi Arabia, 2004; Anthony, 2004). The country is divided administratively into 18 regions; each of which is governed by a prince who is nominated by the Minister of the Interior Affairs, but is appointed by the King. These princes are accountable to the King, the Crown Prince and the Minister of the Interior Affairs. Each large town in the regions is governed by a Mayor appointed by the prince of the region. Each region has the authority to run its

own affairs. The heads of each government department in the region including, for example, the General Director of Health in Dammam, are appointed by their ministers. These heads are accountable to the ministers concerned, deputy ministers and the regional princes. In each region, there is a Regional Council which is chaired by the regional prince and whose members are heads of government departments as well as some appointed key community leaders. In towns, like Qateef, there is also a local council whose members are the heads of government departments in the town. These councils meet, regularly to discuss various issues relating to the general development of the area (Royal Embassy of Saudi Arabia, 2004; Anthony, 2004).

2.1.5 Health System

Other than Aramco (Saudi Aramco Oil Company) medical services, there is no clear documentation as to the type of health services available before 1950. In addition to the medical and health care provided by Aramco and which was available mainly to the employees of the company and their dependants, people used to travel to neighboring countries, especially Egypt and Bahrain for the necessary health care. The organization of the government health service system began in 1950, developing slowly in the early years until the mid-seventies when there was a rapid expansion, together with socio-economic progress. As a matter of fact, until the late 1970s, the curative services used to be delivered through hospitals, dispensaries and health posts, while the preventive services were provided by what was then known as health offices, and later through mother and child health centers. Communicable disease control was dealt with centrally through vertical programs (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004).

The country is divided into 19 health areas, general directorates of health, each administered by general director or a director with limited authority. As resources diminish, the tendency towards centralized decision making increases with the aim of limiting the level of spending (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004).

In recent years, providing health care needs for Saudis has become an important priority for the leaders of the Kingdom. There have been astonishing successes in the health care services, such as free medical treatment for all citizens, and the virtual eradication of epidemic diseases. Moreover, Saudi Arabia was the first among only a few nations to adopt the Alma-Ata Document of WHO, and do so almost completely. These health facilities and sincere efforts have led to a significant reduction in child mortality rates, falling from 68 per 1000 in 1980 to less than 30 per 1000 in 1993 (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004). The development of a comprehensive and modern health care system in the country is evident in the number of facilities and specialized services, as well as the reduction in the number of those seeking treatment abroad. Since the introduction of the series of five-year development plans in 1970 by the government, Saudis have had access to thousands of hospitals and clinics throughout the country. The Fifth Development Plan (1990-1994) led to a 13.92 billion dollar investment in the health sectors aimed at building new facilities or improving the existing ones. The number of hospitals, clinics and health centers has increased five-fold in the last two decades, while the number of physicians has increased 21-fold, and the nursing and technical staff has grown 16 – fold (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004).

In line with the government's interest and attention to the quality of health care services and their provision for all citizens, the development plans have been particularly directed at the health sector. This has enabled it to effect significant improvements in the past 32 years (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004).

The Ministry of Health is the major government agency entrusted with the provision of preventative, curative and rehabilitative health care for the citizens of the Kingdom. The Ministry provides primary health care (PHC) services through a network of health care centers (1786 centers) throughout the Kingdom. It also provides specialist curative services through general and specialist hospitals (190 hospitals with 28,140 beds) (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004). The military and security agencies provide health services for their staff and other segments of the general public, while school health units, affiliated to the Ministry of Education provide primary health care for students. However, the General Organization for Social Insurance and the General Presidency of Youth Welfare provide medical services to certain categories of the population, while the Royal Commission of Jubail and Yanbu provides health services for its staff (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004).

The Kingdom's universities have specialist curative services in their specialist medical colleges and hospitals, besides medical education and training programs. Furthermore, they also conduct research in collaboration with other research centers on health-related matters (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004). The Faisal Specialist Hospital and Research Center

uses highly qualified international medical cadres to provide advanced specialist curative services for citizens require advanced medical care. The research center at the hospital also conducts research in medical areas to fulfill the needs of the society (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 ; Anthony, 2004).

The Saudi Red Crescent Society undertakes significant tasks in the domain of emergency services throughout the Kingdom in addition to its unique services for pilgrims and Umrah performers at the Holy Places (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 ; Anthony, 2004).

The private sector is keeping abreast with the process of health development in the country by complementing significantly the services provided by the government through several health facilities, the quality of which is supervised by the Ministry of Health. These facilities comprise 93 hospitals with 9039 beds, 714 dispensaries and 798 clinics. The number of health manpower in the health establishments of the private sector reached 9168 physicians, 12925 nurses and 6895 assistant technicians. The private sector, along with some government health facilities, also participates in the manufacture of drugs and medical supplies, as well as in the supply of medical equipment and appliances (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 ; Anthony 2004). Owing to the government's ardent objective to provide health services to all citizens, ambitious programs have been inaugurated throughout the Kingdom in successive development plans. During the period 1970 (1390) –2001 (1421), the number of hospitals increased from 74 hospitals with 9039 beds to 322 hospitals with 46345 beds, while the number of health centers went up from 591 to 3556. In the same period, the total number of physicians increased from 1172 to

31,399, the nursing staff from 3261 to 66772 male/female nurses, and the number of allied health personnel including pharmacists rose from 1741 to 41,173 (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004).

The aforementioned achievements have contributed in raising the standard of health services, the growth rate of which indicates the attainment of qualitative improvement and progress. This is clearly reflected by the significant decline in infant mortality rate from 118 cases in 1390 to only 19 cases per 1000 birth in 1421. Furthermore, the rate of infectious diseases per 100-thousand inhabitants declined to a minimal level i.e. to zero for poliomyelitis and diphtheria, and 0.02 for whooping cough. Life expectancy rose from about 53 years in 1390 to more than 71 years in 1421 (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004). Development efforts continue to raise the standard of health and provide very efficient health care to all citizens. In the seventh plan, a number of health programs and projects are to be implemented in order to match the growing needs in the health services associated with the population growth. The continuous desire to enhance service efficiency and upgrade health standards is to be fulfilled through the achievement of the following objectives (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004):

- To continue to proving preventive and curative primary health care and facilitate their accessibility through primary health care centers alongside the maintenance of continuous support of specialist curative services.
- Continue to upgrade health standards and to reduce morbidity and mortality rates.

- Prepare and develop health manpower in order to meet the quantitative and qualitative needs.
- Develop health management, improve information system and conduct health research.
- Ensure coordination and integration of all health activities and services provided through various health care agencies, as well as optimal use of available resources.
- Enhance the role of the private sector in providing health services and financing the construction and management of health facilities (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004).

All these facilities, both existing and planned, have led to an unprecedented improvement in the health sector and have resulted in 98 per cent coverage of health care provision throughout the Kingdom. Developmental efforts continue to upgrade health standards (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004).

In recent years, the provision of health care needs of the Saudi people has been a priority of the Kingdom's leaders. Saudi Arabia has achieved astonishing success in health care services, such as free medical treatment for all citizens and the virtual eradication of epidemic diseases.

Moreover, Saudi Arabia was the first among a few nations to adopt the Alma-Ata Document, and did so "almost in full". The document was created during a meeting held in Alma –Ata, Kazakhstan and sponsored by the World Health Organization in the early 1980s. The result was a call for a comprehensive health care package for

children, including compulsory vaccination and primary health care. Due to advances in both health care services and facilities, the Kingdom has been able to make great strides towards implementing the document. Children are vaccinated against diseases, such as tuberculosis, hepatitis, tetanus, whooping cough, diphtheria, measles and mumps. This has led to a significant reduction in child mortality rates from 68 per 1000 in 1980 to less than 30 per 1000 in 1993 (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004).

The development of a comprehensive and modern health care system in the country is evident in the number of facilities and specialized services, as well as the decrease in those seeking health care treatment abroad. Since the government initiated its series of five-year development plans in 1970, Saudis have had access to thousands of hospitals and clinics throughout the country. The Fifth Development Plan (1990 – 1994) led to a billion-dollar investment in the health sector aimed at building new facilities or improving existing ones. The number of hospitals, clinics and health centers has increased five-fold in the last two decades, while the number of physicians has increased 21-fold and nursing and technical staff grew 16-fold (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004). All of these facilities, both existing and planned, are strategically located in order to make them easily accessible to all in Saudi Arabia. The Kingdom is already home to one of the largest hospitals in the Middle East, the King Fahad Medical City, which includes five hospitals and various health centers. This unprecedented development has resulted in 98 per cent coverage of health care in the Kingdom. Twenty years ago, hospitals and clinics provided only general services. Today, however, the quality of health care has improved with many facilities specializing in numerous fields, such as

obstetrics and gynecology, psychiatric care, contagious diseases and eye disorders. In fact, one of the biggest eye hospitals in the world is the King Khalid Eye Specialist Hospital in Riyadh (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004).

Research and education also play a vital role in improving the health of the nation. The Ministry of Health sponsors health awareness programs through the distribution of publications, posters and media advertising. These projects are aimed at informing the public about various diseases, nutrition, preventive vaccination, the dangers of smoking and the effects of environmental pollution. Health research in the Kingdom not only improves the quality of life within Saudi Arabia, but also contribute to the improvement of health throughout the world. For instance, the research conducted at the King Saud University's School of Pharmacology has resulted in the development of new drugs, including one for the treatment of diabetes. The King Khalid University Hospital has been in the forefront of cancer research. Numerous charitable and benevolent societies are active throughout the nation, addressing the needs of the disabled and senior citizens. One significant provider is the Saudi Red Crescent Society which offers health services both within the Kingdom and abroad. The Red Crescent Society operates 141 medical centers, as well as a fleet of mobile clinics, medical evacuation helicopters and 500 ambulances (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004).

The Kingdom's Pharmaceutical dispensing is another indication of the attainment of high medical standards. Besides maintaining prices, the Kingdom assures appropriate dosage and dispensing by monitoring these transactions. Furthermore, the Ministry of

Health prevents unethical practices, such as the sale of sample products or expired medicine, by conducting routine inspections (Ministry of Planning, 2002; Royal Embassy of Saudi Arabia, 2004 and Anthony, 2004).

2.2 EASTERN PROVINCE

2.2.1 Introduction

Eastern Province is one of the most developed provinces of Saudi Arabia because of the natural resources of oil and related industries. It comprises major cities like Dammam, Dhahran, Al-Khobar, Alhasa, Jubail, Hafar Al-Batin as well as the smaller towns of Qatif, Seehat, Safwa and Naria (figure 2). This area is situated on the Eastern Coast of Arabian Peninsula on longitude 50-degrees east and on latitude 26-degrees north. The temperature of the region ranges between 5 degrees to 45 degrees centigrade and a humidity of up to 90 percent in the summer months.

The Eastern Province became world famous as a result of the discovery of oil in 1933 which, thereafter, completely changed the socio-economic face of the region. Historically, it belongs to an old civilization known as the Delmon civilization that included the entire western coast of the Arabian Gulf.

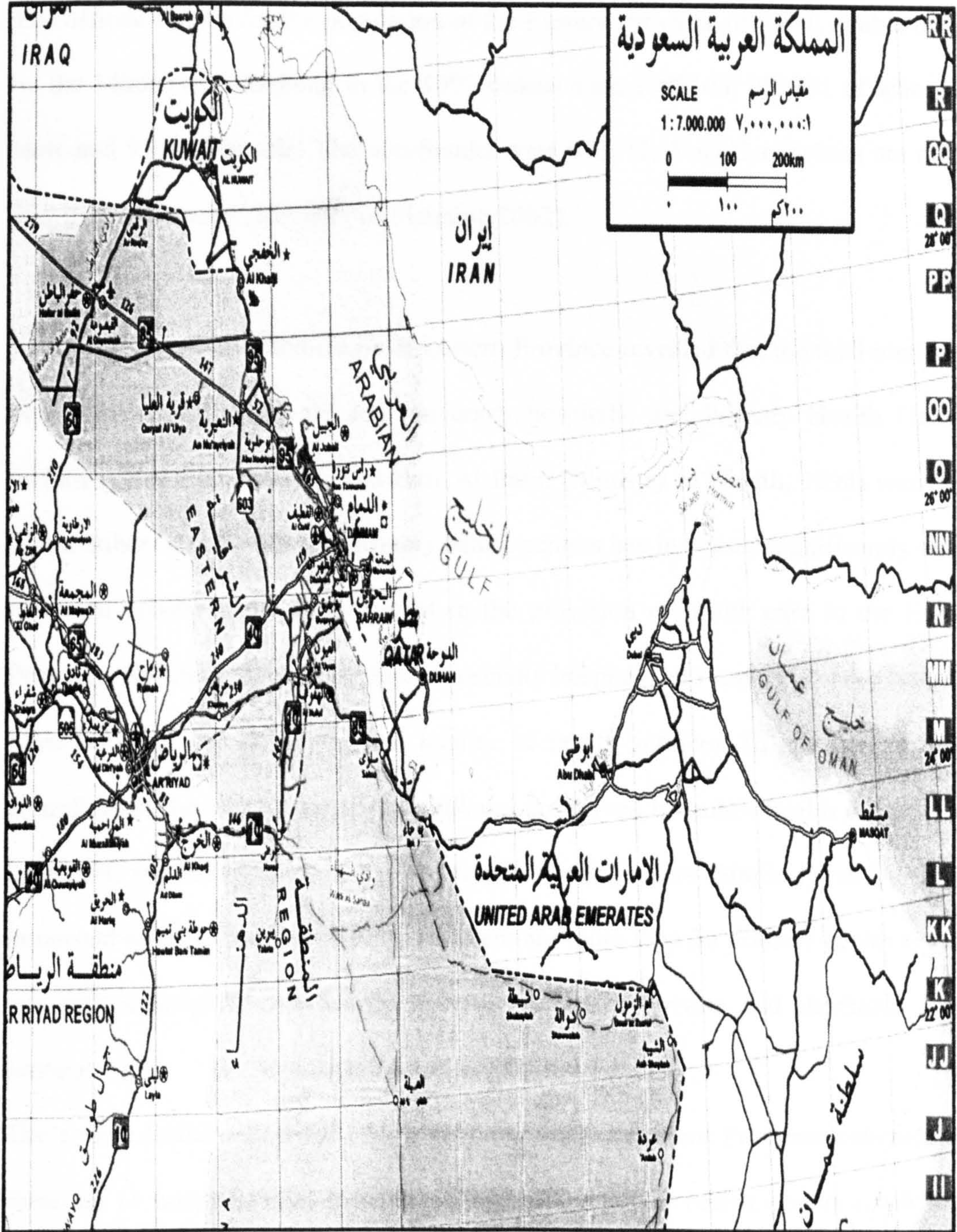


Figure 2.2: Map of Eastern Province of Saudi Arabia

The official figures for the population of the Eastern Province of Saudi Arabia issued by the Ministry of Planning in the 1992 census state 1902108, 987301 of whom are male and 914807 female. The non-Saudis were 673712, 516123 of whom are males, and 157589 females (Ministry of Planning 2002).

Information on Health Indicators of Eastern Province revealed that the total number of hospitals, including private and university hospitals, and Primary Health Centers, including those in Al-Hassa and Hafr Al-Batin (Ministry of Health, 1998) were 190. The number of hospitals and primary health centers has increased significantly owing to recent private sector involvement in the provision of health care in the Eastern Province. Several clinics, polyclinics, specialty hospitals and super specialty hospitals have been set up, improving the quality of health services. In addition to these, regardless of the size or population, villages are served by public health centers. For examples, in Dammam there are 22 primary health centers. Similarly, in Qateef, an important area of the Eastern Province there are more than 30 primary health centers, one central hospital, one general hospital as well as private and charitable health centers.

The annual health report for health indicators in the Eastern Province indicates that there are 19 hospitals with more than 3500 beds and 189 health centers (Al Mutraf, 1999).

The total number of physicians is as follows: There are more than 400 Saudi physicians, more than 900 non-Saudis totaling more than 1300 physicians working in Ministry of Health hospitals. There are about 1500 hospital beds with a thousand physicians in other government agency hospitals. Of these, about 300 are Saudi and

650 are non-Saudi. In the private sector of Eastern Province, there are 16 hospitals with more than 2000 beds and about 1300 physicians. About 40 of the physicians are Saudis and 1260 are non-Saudi physicians (Al Mutraf, 1999). Similarly, the number of nurses working for the Ministry of Health in the Eastern Province is more than 3500, 1000 of whom are Saudis. In the private sectors there are more than 2500 nurses, 25 of whom are Saudis and the rest non-Saudis (Al Mutraf, 1999).

2.2.2 Main Health Problem

The area was well known historically as a malaria endemic area. It also used to be a trachoma endemic. Blood genetic disease, especially sickle cell disease, constitutes the major health problem in the area. Other problems are those mainly related to mother and child that could be found in any developing country. The Aramco Epidemiology Unit (Aramco 1982) has recorded no malaria cases that has spread locally since 1975. Aramco's health surveillance activities date back to the early days of oil exploration in Saudi Arabia. The impact of these early efforts is illustrated by the Malaria Control Program initiated in the 1940's. In 1947, working under the authorization of the Saudi government and using an independent Saudi contractor, Aramco began the Malaria Control Program in the Qateef and Al Hasa Oases. As a result of this the prevalence of malaria among Aramco employees and their dependents fell from 85 per cent in 1947 to 14 per cent in 1949 to 1.5 per cent by 1952 and finally to zero by the end of 1957 when the World Health Organization entered a cooperative effort to achieve full eradication of malaria in the Eastern Province (Al Qatari, 1997). With regard to trachoma, a report from the research department in King Khalid Eye Specialist Hospital, (1990), found out that both infectious trachoma and blindness resulting from trachoma dramatically declined in

the Eastern Province between 1984 and 1990, with an even greater reduction in the Dammam area that includes Qateef, mainly as a result of the socioeconomic improvement in the area mentioned earlier. The chances are that the infection will be entirely eliminated from the population provided there are active case findings and family follow-up programs (Al Qatari, 1997). Sickle cell disease and other blood genetic diseases remain a major health problem in the area. The latest estimate of the incidence of sickle cell disease in Qateef area is 2.2 per cent and that for the carrier state, sickle cell trait, is 29.8 per cent (Al Qatari, 1997). Since it is impossible to legislate an abortion and the prevention of the marriage of carriers for traditional reasons, the propagation of the disease and an increase in its prevalence is likely to occur. Tremendous efforts are needed to reduce or completely arrest this propagation. The improvement of education will definitely help. With the control of communicable disease, problems related to lifestyle are likely to become more pronounced. The area is experiencing epidemiological transition. In the adult population of Saudi Arabia road accidents constitute the commonest cause of death, followed by cancer (Ministry of Health, 1994).

CHAPTER THREE

QUALITY MANAGEMENT

3.1 INTRODUCTION

Health is best defined by the World Health Organization as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1992), whereas care is the management of, responsibility for, or attention to the safety and well-being of another person or other persons.

Without question, “quality” is expected to be an integral component of all health care services. Despite this universally accepted belief, the measurement of quality and what constitutes an acceptable level of quality is still debatable. Scholars and researchers, health care providers and individual consumers of health care all bring different perspectives into the debate.

As health care delivery systems struggle to achieve a balance between cost and access, clarifying the roles of clinical quality and service community in achieving the desired outcomes becomes increasingly important. Health care organizations and other service industries will, inevitably, compete for quality. Orme (1992) succinctly described the goals of quality improvement (QI) efforts in health care as the improvement of the processes of delivering care, thereby increasing customer satisfaction with the quality of care (service outcomes), to improve the health of patients (clinical outcomes) and to reduce the cost of providing care.

Quality in medicine is a concept that is as old as medicine itself, though there are better means of achieving it now. Concerns about quality in all aspects was the idea

behind many of the events written or told about ancient pioneers in medicines of the Mesopotamia, Egypt, Greece or Arabia. They all sought to perfect their procedures, however unscientific, and confirm certain rules known then to achieve the best results for their patients. This is evident in the writings of many Islamic Scholars (Ashoor, 1984; Salman, 1991). This concept of quality was propagated through different civilizations and has developed considerable momentum as the means of acquiring and accumulating knowledge improved. It is understandable that Maxwell (1984) stated that a genuine concern for quality, however well intended, cannot be equated to evidence-based evaluation.

3.2 HISTORICAL DEVELOPMENT

Health care can be traced back 7000 years, when primitive tribes sought out the medicine man or shaman with a reputation for supernatural powers to rid tribal members of whatever ailed them. Much like the physicians of today, primitive medicine men attempted to remove foreign bodies (stones and splinters), but unlike modern physicians, they sucked out the object. Interestingly, they were often successful in their primitive treatment (Ackerknecht, 1982).

The earliest written record of health care dates back 2700 BC, to a time when the literature describes Egyptian physicians and dentists. Information on health care during the Egyptian period is recorded on papyri, material made from the papyrus plant. These papyri document the practice of medicine more than 5000 years ago. One of the more famous of these documents is the Edwin Smith Papyrus, which shows a case approach that includes a provisional and final diagnosis, examination technique, signs of disease and treatment including magic formulas, prayers and manipulations (Ackerknecht, 1982).

It is not exactly known when the notion of quality began. However, ancient Egyptian civilization and the remains of ancient structures indicate that by the time of the construction of the pyramids every effort was made to ensure quality through strict controls. The perfection of the pyramids was the earliest formalized effort to control quality, their chief contribution being in engineering (Banks, 1989). The code law of Hammurabi, King of Babylonia (1800 BC) has been considered by authors like Ashoor (1984); Banks (1989); Salman (1991); Dale (1994); and Merry (2001) as evidence of the control of quality in a relatively advanced civilization.

The Greeks contributed to the quality movement motivated by trade and commerce. They produced high quality pottery and vases, differing in type, decorations and methods of production. They also contributed to literature, medicine and mathematics and developed an enormous literature on human experience and values and advanced mathematical methods for use in statistics. Interestingly, they also contributed to the quality movement by means of the oath of Hippocrates that is still used today, and which clearly states that physicians should give the best possible health care to their patients (Banks, 1989). Ancient Romans also continued building on what the Greeks had started. They left a legacy in quality, especially in architecture and engineering (Banks, 1989). It is evident from the review of literature that the modern concept of quality has been around at least as long as Taylorism, which championed the attainment of quality through inspection (Taylor, 1914).

Many developing countries did not realise that any health care system should be based on the real health needs of its people, so even after independence from colonial rule, they continued to imitate and adopting the system of previous rulers which were as mentioned earlier, curative, low impact, elite-oriented health services (Rhode,1983).

Hence, we find that countries colonized by the French adopted the French system, while those colonized by the British, adopted the British system. The independence period of major developing countries was when hospitals were in the stage of progress and it was natural for any nationalist to resort to what, at the time, was the sign of excellence in health. Unfortunately, by so doing, developing countries used up their limited resources for health; building hospitals that were expensive to run and which needed costly foreign expertise mostly from the ex-colonizer. This was the gigantic non-stop cycle operating a system that could not meet the real health needs of the people.

This was reinforced by the fact that developed countries did not regard health and other social dimensions of welfare in general as part of development during the period when major developing nations were gaining independence (Ebrahim, 1988). This concept was known as the modernization concept in health care. The success of the Japanese in the global market place in the 19th century brought the philosophy of quality improvement to international attention.

Although it can be said that physicians had embraced the quality philosophy since the time of Hippocrates, the historical roots of QI in medical care was frequently attributed to such early leaders as Dr Ernest A. Codman who promoted the concept of "end result" at Massachusetts General Hospital in the early 1900s; Dr George Gray Ward at New York women's hospital, who pioneered the medical audit and Dr. Thomas Porton, who instituted one of the first risk classification systems.

However, it became more prominent by the role of American College of Surgeons in the early 19th century. The original Minimum Standard adopted by ACS Board of Regents in December 1919 was an important first step toward improving the quality

of health care. By 1950, through the efforts of the ACS, more than half of the hospitals in the US had demonstrated compliance with the current version of the standards. (Roberts, 1987)

Literature of this period suggests that learning-based models of quality assurance successfully improved hospital standards throughout the two decades. However, in the 1950s and 60s something went seriously wrong with peer review (Merry, 2001). It has been stated by the above authors that Avedis Donabedian's structure – process – outcome quality model and Paul Ellwood's outcome measurement concepts played a role in health care quality and its history, until 1999 which is regarded the critical turning point by Merry, (2001).

In the late 1960s and 1970s, many of the above-mentioned ideas were to prove not just inappropriate but also ineffective in both the developing and developed countries. The importance of dealing with the real health problems and the inability of hospitals to meet them became obvious (Bryant, 1975; UNICEF, 1976; and King, 1978). Consequently, the importance of health and other social services in the overall development of nations started to gain attention. Other developments in the 1970s paved the way directly for the concept of primary health care. This was the notion that a community should be involved in its own health care. Many countries developed their own national health policies based on community participation (Rhode, 1983; WHO, 1983). This also led to the evaluation of primary health care approach set out in the Alma Ata conference in 1978 with WHO playing a major role in promoting and marketing it (WHO, 1983).

Deming's quality principles have been used as major health care applications by several hospital managements for quality enhancement and been found highly

beneficial. As one of the first hospitals to adopt a Deming-approach to quality, Brazosport Memorial was involved in a trail-blazing effort that Quorum Health Resources strongly supported and helped to implement in several of its hospitals (Lynn , 1991).

3.3 QUALITY MANAGEMENT GURUS AND THEIR CONTRIBUTIONS

Arguably, the best-known names in Quality Management literature are W. Edwards Deming, Joseph M. Juran, Phylip B. Crosby, Kaoru Ishikawa and Avedis Donabedian. Although several different philosophies exist, in general, the foundations of QM can be traced to the writings of these men. (Crosby, 1979; Donabedian, 1980; Juran, 1980; Deming, 1982 and 1986; Peters and Austin , 1986; Robbins, 1988; Rudman , 1992).

3.3.1 Deming's contribution

W. Edwards Deming is an American management consultant who has gained distinction for his work with Japanese manufacturing companies. He is widely credited for the Japanese shift in manufacturing, from low quality merchandise to many of the world's highest quality products today.

In the 1950s, Dr Deming gave lectures and conducted training sessions for top managers, convincing the Japanese business community that it could compete with the rest of the world on the basis of quality. He emphasized the importance of quality and helped educate Japanese manufacturing leaders in statistical quality improvement methods that they adopted and still use today. Deming's efforts received widespread recognition in the United States after the airing of 1980 NBC documentary stating "if Japan can do it, why can't we?" Many US manufacturing firms including Ford and

General Motors hired Deming as a consultant and implemented his principles of quality management (Lynn, 1991).

Deming is seen in his classic, Out of the Crisis, as the original QM advocate (Deming, 1982, 1986 ; Logothetis, 1992). However, his philosophy was not endorsed or accepted by mainstream North American Management theorists or by practitioners until the early 1970s. His initial success in promoting his management style came when the Japanese adopted his ideology after World War II. Deming, more than any other QM philosopher, took a humanistic approach to management. His management theory is based on the belief that employees want to come to work, put in the maximum effort, strive for personal excellence and are committed to the best interests of the organization as long as these interests are in agreement with their personal needs and priorities (Deming, 1986).

Deming's approach is process rather than outcome oriented. He assumes that workers are committed both to excellence and to working at maximum capability and that management leads in the desired direction. Therefore, the evaluation of workers is superfluous. Deming suggests that organizational problems are more likely to result from inefficient management or work procedures rather than from a lack of worker effort. Indeed, Deming suggests that about 85 % of the quality problems experienced within organizations lie with management and only 15 per cent with workers (Deming, 1986).

In Deming's "Conception of management", there are no merit raises, formal evaluation, or individual status. Differentiation at the individual level leads to conflict, dissatisfaction and lower rates of productivity, (Deming, 1982, 1986 and Logothetis, 1992).

Deming's view is that economic stability of the organization requires the development of an atmosphere of constant change and innovation. A reactive strategy of knee-jerk response to adversity without a guiding vision or strategy leads to economic decline and threatens the survival of the organization. Top managements must take the initiative to ensure an open atmosphere of creativity, innovation and creative risk taking, even if the consequences in the short term are negative. This philosophy implies the belief in developing continuous educational programs for all employees. In this way, management is able to make use of all the skills and expertise of the empowered work force (Deming,1982,1986 and Logothetis, 1992).

While manufacturing companies were the first organizations to implement Deming's ideas, many service organizations - from public utility companies to hotels – began experimenting with his philosophy. Deming's ideas are detailed in *Quality, Productivity, and Competitive position* (1982) and *Out of the Crisis* (1986).

Deming's philosophy revolved around the concept of continuous process improvement and a belief that management should create a work environment that promotes continual improvement in all processes within the organization. He emphasized that employees who are closest to the day-to-day operations must be involved in improving quality and must be appreciated for their efforts. Deming also advocated training workers in process improvement techniques, and applied these to all aspects of a firm, including product design, marketing, operations, purchasing, administration, record keeping and service. Consequently, Deming criticized the use of slogans, campaigns and incentives to motivate workers to improve quality, unless techniques and methods for quality improvements were also provided. He suggested

that organizations should develop positive, cooperative relationships with a few suppliers and vendors so that quality problems can be eliminated (Deming, 1986).

Deming was also a strong proponent of market research aimed at pleasing customers. He believed that for organizations to survive, they must learn what customers require in the way of products and services and do whatever is necessary to fulfill those requirements. He criticized traditional North American management methods of ignoring long-term investments aimed at improving quality and productivity for the sake of short-term profits. Overall, Deming's approach was an amalgamation of loosely related and often unoriginal ideas, but when implemented, these ideas formed a management style and organizational processes that yielded quality improvement throughout the organization (Deming, 1986).

The Deming approach should not be confused with quality circles that are much more limited in scope and typically focus on individuals identifying problems in their functional areas rather than incorporating cross-functional teams and an organization wide management philosophy. Deming's ideas should also be differentiated from many productivity improvements measures (Koshuta , 1989) that increasingly focus more on the use of productivity indexes and quotas. After attending a Deming seminar and reading extensively about his work, administrators at Brazosport Memorial Hospital decided to adopt many of Deming's principles. Using the 14 points – Deming's own summary of his ideas – the hospital developed an ongoing “ Quality Improvement Process” (QIP), which was not a program or procedure, but a style of management (Deming, 1986)

3.3.2 Juran's Contribution

Juran's major contribution to quality management involved the trilogy of quality planning, quality control and quality improvement, and the redesign of an emphasis on control charts as a primary method of evaluating performance (Juran, 1980 , 1988 and Logothetist, 1992)

Juran's emphasis on planning, control and improvement, suggests that both process and outcome measures must be continually monitored. Unlike Deming, Juran believes strongly in evaluating worker productivity through continuous performance appraisal. When performance falls short of goal expectations, corrective action should be initiated. Corrective action, according to Juran, may be in the form of either incentives or coercive action to ensure excellence and quality performance. Juran's quality management program includes provisions for merit pay and individual monitoring (Juran, 1988; Logothetis, 1992).

To implement organization-wide evaluation standard of performance and evaluation criteria, Juran recommends using control charts. After a quality standard has been established Juran considers it necessary to monitor performance continually to detect lack of conformity and initiate change to achieve reduction in both error rate and variation over time. Perhaps the most intriguing feature of Juran's modified control chart is the extreme fluctuation that occurs during the periods of change. Juran seems to recognize that when change is introduced and the status quo is disrupted, work performance becomes erratic during the adjustment period. After workers have become adjusted to the change, performance should improve in terms of the reduction in the number of errors and the degree to which performance fluctuates (Juran, 1980,1988; and Logothetis, 1992). In conclusion, Juran's contribution focuses mainly

on the use of statistics and quality circles involving employees for a general quality management (Koch, 1992; Abdelhak, 2001; and Slovensky, 2001).

3.3.3 Crosby's Contribution

For Crosby, quality is complete conformity to standards (zero defects), a much more rigid definition of quality performance and excellence than employed by either Deming or Juran (Crosby, 1979; and Logothetis, 1992). Even a 99.9 per cent efficiency level would be unacceptable. This definition may be especially applicable in health care, where errors are likely to lead to irreversible consequences (e.g.: death).

In contrast to Deming, Crosby is a strong advocate of goal setting, merit pay, recognition of “champions” or “stars” and exhortation of employees through slogans and competitions. Quality is implemented through the development of educational programs, mass media and human relations promotions and management’s total and visible commitment to quality. Although Deming and Juran both advocate team building and group process, Crosby strongly focuses on the value of team decision making as the primary method of worker empowerment (Crosby, 1979).

Crosby’s work can be summarized briefly as an advocate of the zero defect, cost of quality and the use of slogans which will improve the quality. The seven statistical tools and seven management and planning tools form the core of Crosby’s approach. He concluded that though technology and the methods of distribution can be very different, the motivations and reactions of the people involved will be the same. What works in one industry to improve quality will work in others – if time is taken to understand quality and contents (Crosby, 1979).

Another important factor described by Crosby (1979) is uncertainty. To Crosby, it has no merit as a management tool. People in a state of uncertainty tend to blame the quality department for quality problems. This is because of the lack of information on the subject. He states that it is important to recognize the real meanings of words and functions. Uncertainty belongs in the present, for each day reveals a new world and each night ends that world. Problem prevention is not a real part of uncertainty's operation, since to prevent it, one must look into the future (Crosby, 1979).

3.3.4 Ishikawa's approach

With their philosophy of quality, the Japanese have had a considerable global influence. In addition to collaborating with North Americans to improve the quality concept, Japanese contributors like Ishikawa, Tagguchi and others have provided useful working models for health quality programs. Ishikawa, a Tokyo-born engineer was an early collaborator with Deming and Juran, during their visits to Japan in the early 1950s. He is the author of many books and articles on quality control. He developed the cause and effect diagram, or fishbone diagram and was a strong proponent of quality circles.

Ishikawa believed that information about processes and output was a crucial precursor to the improvement of quality and is credited with the maxim that the bedrock of quality is education (Peters and Austin, 1986). Ishikawa's contributions to quality control and quality management have been recognized by the prestigious awards received in both Japan and United States, notably the Deming prize, the Second Order of the Treasure, The Grant Award and the Shewhart Medal.

It can be concluded that these scholars differ in their approach to how quality can be measured or improved, but more importantly, their basic ideas are the same. Slovensky, (2001) broadly grouped these similarities as follows: leadership and vision to achieve quality objectives; organizational infrastructure or culture that fosters quality; customer focus in all aspects of operations; use of problem-solving methodologies; employee training and empowerment and continuous improvement (Slovensky, 2001).

3.4 QUALITY OF HEALTH CARE

There is no single definition of quality of care, as various authors view them from different angles: medical, social, economic and psychological. According to Donabedian, (1980) good quality care is the kind of care in which medical science and technology are applied in a manner that maximizes their benefits to health without increased corresponding risk. Donabedian (1980) advocates that the quality of care provided depends on the expected benefits as well as risks.

Feigenbann (1983) described quality as a way of managing an organization, and Maxwell, (1984) interpreted quality service as that which gives dignity, personal worth, individual fulfillment, respect and individuality to all human beings. A useful model for evaluating health services is that developed by Maxwell (1984). The model concentrates on six dimensions of quality: access, equity, relevance to need, social acceptance, efficiency and effectiveness.

Quality of health care has also been defined by Roemer (1988) as the degree to which the resources of health care services utilized in health care corresponds to specific standards. In evaluating Donabedian's (1980) definition of quality, Linsk (1990)

added three limitations to his definition of quality. These are the lack of consideration for non-consideration of other clients in health care, the static approach to quality and the tendency to focus on physicians and certain aspects of physician's performance (Linsk, 1990).

It is widely believed that the systematic application of industrial quality improvement in clinical processes and medical care outcomes has yielded significant results (Berwick, 1990; Berwick, 1989; James, 1989; Laffel, 1989). Reports suggest, however, that hospital leaders internationally narrow the focus of the quality improvement efforts to business or service processes to avoid the appearance encroachment of management on physicians' autonomy in making clinical decisions (Berwick,1990).

This tactical approach is consistent with the view that quality improvement projects directed at physician's practice patterns and utilization should be run by and for physicians (Kralovec 1990). Yet reports also indicate that with hospital leaders, there are substantial barriers to cultivating clinical involvement in QI projects (Mclaughtin,1990; Merry, 2001).

In fact, barriers to physician involvement may be the most important impediment to the success of quality improvement in medical care. (Berwick,1990). Beyond the difficulty of securing physician participation, hospital leaders seeking to reap the full benefits of CQI/TQM face the additional challenge of removing the departmental and professional barriers that frequently make it difficult for cross- functional teams to address clinical cost and quality issues. Results suggest that leadership from the top is key to the success of meeting those challenges. For example, hospital leaders can enhance CQI/TQM effort by the kind of support they give to the organization's

mission and strategic objectives, allocation of financial and human resources for CQI/TQM aligning of compensation and performance appraisal systems to QI objectives to continue improvement (Berwick,1990)

Pajak (1992) defined quality of care as consisting of three elements: responsiveness, effectiveness and reliability. Similarly, Ovretveit (1992) defined quality service as that which fully meets the needs of those who need the service, at the lowest cost to the organization, within the limits and directives set by higher authorities and purchasers. This is probably one of the best definitions of quality although it falls short of consideration for those who need the service the least. It also fails to define the role of professionals and providers in health services quality.

The hospital board also plays an important role in creating a corporate culture for quality. As the organizational entity legally held accountable for the quality of care, the board is ultimately responsible for developing and overseeing quality improvement (Arrington, 1995).

Physicians are apparently reluctant to participate in QI projects as a result of distrust of the hospitals' motives, lack of time and fear that reducing variation in clinical processes will compromise their ability to tailor care to individual patient's needs (Blumenthal, 1995; Shortell, 1995). Thus, low clinical involvement in QI efforts seems to be due as much to management's reluctance to recruit physicians as to physicians' reluctance to participate. Low clinical involvement rates are unfortunate, for it is precisely in the application of industrial QI methods to clinical processes that the greatest impact can be made on health care costs, quality and outcomes.

Given the central role that clinical personnel play in the allocation of resources and decisions, hospital leaders will have to devise strategies to increase clinical involvement in QI if they wish to realize the full benefits of this new approach (Blumenthal, 1995; Shortell, 1995). In industrial settings, leadership from the top seems to be a critical factor in overcoming the skepticism and reluctance of organizational process owners and middle managers (Deming, 1986; Ishikawa, 1985; Juran, 1988, 1989).

Leadership from the top is often cited as a critical determinant of successful QI implementation (Deming, 1986; Ishikawa 1985; Juran, 1988, 1989). Only the senior leadership, it is argued, can establish quality as top priority, create a corporate culture for quality and mobilize the financial and human resources necessary to support organizational learning. The importance of high-level leadership may be especially critical in cultivating clinical involvement in CQI/TQM.

As Blumenthal (1995) observed, health care managers often lack direct control over the incentives and work conditions that affect physician behavior. Even when they are employed by health care organizations, physicians possess a unique body of knowledge that confers a certain measure of autonomy in making clinical decisions.

Some quality experts, such as Crosby (1980), defined quality as conformity to requirement. In this case, it is assumed that quality variables are taken care of by the 'requirement' which Dr. Deming defined as a never-ending cycle of continuous improvement. For Deming, quality is not a destination, but rather a journey (Asubonteng, 1996). Morgan (1994) defined quality as the totality of features of a product or service that bears on its ability to satisfy given needs. According to Glynn (1995) quality is an objective and systematic approach.

3.5 TOTAL QUALITY MANAGEMENT: CONCEPTS AND DEFINITIONS

Total Quality Management (TQM) has proved very successful and promising in the manufacturing industry. It has also been applied with success in the service industry. Owing to the distinctive nature of health-care services, however, the application and success of TQM have been limited to administrative and other supportive functions only in most healthcare organizations.

TQM is also referred to as continuous quality improvement (CQI) and has no single theoretical formulation, nor any definitive shortlist of practices that are associated with it (Lawler, 1994). Different authors have defined TQM differently. Some definitions from the TQM literature reported by Ho and Cicmil (1995) are as follows:

- TQM is a totally integrated effort to gain competitive advantages by continuous improvement of every facet of organizational culture (Ho , 1995).
- TQM is total (every person in the firm is involved) quality (customer requirements are met ex-management (senior executives are fully committed) (Ho , 1995)
- TQM is the total quality control's throughout the organization (Ho , 1995).

TQM, or continuous quality improvement (CQI), as some prefer to call it, is the marriage of four disciplines—systems theory, organizational behaviour, marketing, and statistics. Hence the goals of a TQM process in health care are multifold: to improve the process of delivering care and thereby increase customer satisfaction with the quality of care (service outcomes); to improve the functional health of patients (clinical outcomes); and to reduce the costs of providing care. A major focus of TQM is to help all participants in a health care delivery organization understand how the individual processes they are responsible for, work together to create a complete system of interrelated processes. Another component of the TQM processes identifies

quality costs, or poor quality costs. Some experts estimate that quality cost in health care organizations can be as high as 40 per cent of the revenues (Anderson , 1991).

TQM was first popularized in Japan by Japanese manufacturing firms whose entire philosophy was based mostly on the teachings of doctors Deming and Juran, two important North American experts in quality who went to Japan to teach the Japanese how to run modern manufacturing plants after World War II. The old fashioned type of management became less and less productive in the face of increasing customer demands for products of better quality. Because of the heavy emphasis placed on inspection to satisfy growing demands of quality products, many successful companies of 1950s and 1960s had turned into unproductive ones by the end of 1970s. This created a situation in which North American companies felt compelled to try the new idea that reportedly had been so successful in Japanese companies.

Developed by North Americans in the 1940s and implemented by the Japanese in the 1950s, TQM made its North American debut in the early 1980s, primarily in manufacturing organizations (Katz 1988 and Walton 1986). In the late 1980s, many health care organizations saw the vision of quality and began applying the ideas of such American quality gurus as W. Edwards Deming, Joseph M. Juran, and others (Gillem, 1988;Lynn, 1991). In spite of a late start, the health care industry has moved to the forefront of the TQM movement in North America.

Among the most reported TQM benefits was a study carried out by Garving (cited in Dobyys, 1991) who studied the quality of Japanese room air-conditioners over several years in the early 1980s. The conclusion of his study was that Japanese companies were far superior to their US counterparts. The best North American manufactured

item was about 10% worse than the worst Japanese manufactured piece (Dobyns, 1991).

This revelation by Garving, coupled with the 1980 NBC document which said, "If Japan can, why can't we?" helped to underline the importance of industrial practices in the US. In the manufacturing industries, where the benefits of TQM first became evident, the performance of companies improved in several areas when product defects were eliminated, the attractiveness of product design enhanced, service delivery speeded up and cost reduced. In health care, one encountered a number of strategies designed to improve quality and reduce cost (Asubonteng, 1996).

The quality chain reaction popularized by Dr Deming specifies that improvement is followed by reduction in cost because of less rework, fewer mistakes, fewer delays, snags and better use of machine, time and material, which in turn increases productivity and therefore, enables the company to become more competitive with a better chance of survival and more jobs provided (Ho , 1995).

In the health care industry, if TQM is successfully adhered to by employing Deming's quality chain reaction, not only will cost and administrative functions be reduced, but costly mistakes which result in much loss of life and law suits will also be avoided. Hamilton (1982) reported that 90% of the drugs prescribed, result in waste of money and serious risks involving unnecessary surgery and loss of life.

The core ideas of TQM have been well-accepted in the US management community for more than a decade now (Hackman, 1995) which is in collaboration with several earlier studies such as Meyer, 1982; Barnett, 1996; Doz, 1996; Drazin, 1996; Dyer, 1998; Nahapiet, 1998; and Klein,1999. All these above-quoted studies highlight the

potential of both TQM adaptations and the broader issues of organizational adaptation.

With its emphasis on customer satisfaction, continuous improvement, problem solving processes and employee empowerment (Hackman, 1995 ; Westphal,1997), TQM stands out as one of the most obvious ways for hospitals to reduce cost and increase revenue. The operational details of how to implement TQM are certainly of great consequence for the health practitioner. However, a no less important inquiry for organizational researchers is to view TQM as an organizational learning vehicle that can help organizations adapt to a constantly changing and uncertain circumstances (Stikin ,1994; Hackman, 1995; Horng , 2002).

Quality has been a central issue in health care organizations and among health care providers. The works of Donabedian (1980, 1988), Maxwell (1984), Berwick (1990), Graham (1990) as well as organizations such as the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and WHO have major contributions to make to the definition of measurement, understanding and improvement of the quality in health care. There are several definitions of quality in use. WHO (1999) defined quality as the highest attainable level of professionalism; an effective utilization of resources; minimum risk to the patient; high level of patient satisfaction and the resulting effect on health.

Quality of care based on JCAHO (1992) criteria includes a feature of excellence that goes beyond the client's expectation. The definition of quality is formulated as anticipating, meeting and exceeding customer expectations. It is therefore, recommended that the principles of Total Quality Management be applied in Health Care .

In sum, the purpose of quality management in health care is to establish a system that measures and manages patient care in the way that provides the best care for all patients. It identifies opportunities for improvement as well as problems that require resolution. It also fulfils a social commitment of the health profession to the public. Nevertheless, problems will undoubtedly arise when management is immature. Longo (1994); Oakland (1998), emphasized that all quality approaches require systematically planned managerial work, and attention to the details of a process, mastery of new knowledge and skills for innovative improvement, work with people and time. Respect to the "soft" part of the quality models, such as culture, communication, and commitment are inevitable. Thus, ultimately, education and training for quality should be addressed (Berwick, 1989).

Many health care organizations have applied the principle of TQM to reduce waste, rework and complexity (Berwick, 1989). One way of helping to facilitate quality transformation in a health care organization is to implement a customer information system (CIS): a system for collecting, archiving, and accessing information on customers. Health care organizations that establish a CIS will have greater success in their effort for quality improvement (Berwick, 1989).

While some health care professionals are concerned that TQM is another "fad", Richard L. Clark, President of the Healthcare Financial Management Association (HFMA), stated that TQM will endure because when properly implemented, it forces management to be customer- oriented. In the past decade, health care organizations have seen the advent and demise of many programmes, but TQM is not a programme that will be popular for a season and fade away in the next. It is appropriately defined

as a management process for ensuring quality, and as such it will endure (Anderson , 1991).

Quality improvement programmes in health care vary. Some emphasize the clinical outcome improvement process (Kralovec, 1990), while others stress the process of improving the quality of service (White, 1990). However, on the whole, most programmes include both clinical and non-clinical improvement projects. Health care professionals often disagree on the definition of quality. Some health care organizations define it as meeting or exceeding customer expectations. Others say that quality is doing the right things correctly. How health care organizations choose to define quality is not important. Anderson (1991) believes that a good definition of quality should not only be comprehensive to be applicable to the entire organization but also terse to facilitate recall.

The TQM movement has now spread almost all over the world and could be considered a new strategy for improving the delivery of services in public organizations. It is also an innovative strategy of public management for meeting the challenges of globalization, and for building human capital capacity towards sound governance and public administration. As an innovative strategy, public organizations across the world need to adopt the concept of TQM and make it applicable at the local, national and international level (Ali, 2002).

3.6 QUALITY ASSURANCE

Quality assurance means ensuring that all the steps which must be taken in order to provide the customer with quality are actually taken. It can also mean convincing a customer that certain standards are maintained to achieve quality. A strict definition

would limit its applicability to the process whereby customers, in particular, become convinced (Ellis ,1993). In addition, quality assurance should be based on a sound system design, followed by continuing performance evaluation leading to appropriate educational- motivational activities and to readjustment in system design (WHO 1994).

Shaw's (1992) distinction between quality assurance and quality assessment, states that the former is not only a measurement of provision against expectation, which is the definition of the latter, but also the intention and the ability to correct any demonstrated weaknesses. To be ongoing, its sustainability is to be guaranteed; To be sustainable it has to seek achievable standards. The problem it deals with should be real and reflect the actual needs of community. All this should be done within the limits of the available resources (WHO 1994).

Also related to the issue of sustainability in the quality assurance process is the commitment, the honesty and the competence of the staff, all of which are central to the process. This comes through the complete involvement of every member of staff in the entire process of the quality assurance. This is not an easy task and many approaches have been suggested. The essence is that the quality and the effectiveness of all the human services depend on the commitment and involvement of every staff member, especially those at the lower level who form the front-line providers of all aspects of the organization's product (DeFriese, 1992; Gould, 1992; Ellis, 1993; WHO, 1994; ; De Geyndt, 1995).

3.7 QUALITY ASSURANCE IN HEALTH CARE

The WHO working group on quality assurance (1994) maintained that the main objective of any quality assurance programme is to establish that the health care enterprise is performing as it was designed to perform; to improve the performance and make it less variable. Various countries might have different reasons for adopting quality assurance programmes. In England, for example, Shaw (1992) listed many factors that constituted influences on the UK Health Services and were considered reasons for adopting QA

The rising expectations of people in almost every country through education and general interest and the inadequacy of resources to meet these heightened expectations have led to an increasing need to maintain standards so that resources could be used as effectively as possible (Holland, 1984; Ellis, 1993).

Though important, this economic argument alone cannot explain the move towards quality assurance. Ellis (1993) further added such social factors as public demand for health and the consumer movement, political pressure and professional appeal. The immeasurable increase in the complexity of the health services over the years has also contributed to the move towards evaluation (Holland, 1984). In the US, one of the reasons for quality assurance is the need for the medical practitioner to ensure quality to avoid litigation (Ellis, 1993).

Although quality assessment, on certain occasions, requires direct prospective personal observation of performance (Roemer, 1988), much of the quality assurance process is a retrospective effort in which previous work is checked against present, explicit standards. This means that much of the process of quality assurance depends

on clinical notes and so the importance of good records management is not to be underestimated (Donabedian, 1966, 1988).

One might say that legible well-maintained medical registers are equally important. Quality assurance could be “institutionalized” by incorporating it in the routine health information system (Sandiford, 1992 and Johansson, 1992). This will have the mutual benefit of guaranteeing the sustainability of the quality assurance effort and at the same time give the health information system the chance to impact on health by influencing decision for action, a characteristic of quality assurance.

As a service, health care is no more than a collection of things that people do to, for and with other people. This is taken by Ellis (1993) to imply that its evaluation is subject to many problems. These problems occur specially in relation to measurement in quality assurance. One of the problems is the difficulty of relating outcome to quality health care. (Donabedian, 1966 ,1988; Buck , 1980; Opit, 1991 and Harley, 1991). Opit (1991) says that this is mainly due to inconsistent, broad and ambiguous interpretation of outcome that are easily corrected by the use of scientific methods and a valid epidemiological approach. Secondly, it is advised that the emphasis on outcome should not be overplayed since it has own weaknesses (Davies, 1995). Consequently, resorting to the process of care with the precondition that it is supported by research evidence is justifiable.

3.8 QUALITY AND QUALITY ASSURANCE IN DEVELOPED COUNTRIES

Globally speaking, a conceptual framework for quality health care is a recent development. In the US, apart from a few examples in the latter part of the last century and the early part of the present one, the major conceptual advance occurred

in the middle of the last century when attention again turned to quality assessment. In the UK, it is difficult to find explicit reference to QA before 1980 although its gestation has a much longer history as described by Ellis, (1993) particularly in the guise “of patient satisfaction”. One reason for the delay in adopting quality assurance in the UK was the doctors’ discomfort about airing their work to be externally judged. This is best explained by Maxwell (1984) as “self-audit is good: external audit is threat”.

A review of the literature about quality assurance in some developed countries revealed several important points. (Vouri, 1992; Gardini, 1992; Collopy, 1991; Giraud, 1992; and Sunol,1991). First, QA is looked upon as a priority regardless of the extent of the actual efforts made. Secondly, the experiences in these countries indicate many ups and downs, thought to be a natural process because of the nature of the issue and the varied backgrounds of those contributing to it. However, the positions for launching quality assurance programs are generally good. A third point is the tendency to favor a decentralized approach to QA to increase interest through the creation of a sense of ownership that guarantees sustainability in these programs. A fourth point is the tendency to avoid intimidating professionals, especially doctors by not imposing these ideas on them. A fifth point is that although professionals other than doctors are now involved, there are still sharp divisions among the QA programs of different groups. Finally, patient satisfaction studies are increasingly being introduced into QA programs in various countries. All these points might have some implications for the efforts to establish QA programmes in many countries (Giraud, 1992; Gardini, 1992; and Vouri, 1992).

3.9 QUALITY AND QUALITY ASSURANCE IN DEVELOPING COUNTRIES

Until recently, the situation in developing countries, with a few exceptions, with regard to quality and QA was one of apathy. These countries only paid lip service to the concept even though much benefit could be derived from an age of escalating costs of health care and increasing population demands and expectations. Roemer (1988) states in the WHO report that not much has been accomplished in the evaluation of public health programs particularly primary health care. Even less has been done to assess the quality of primary health care in developing countries, and how quality can be maintained (Roemer, 1988).

As a solution, 'ritualising' data analysis and interpretation have been suggested, but there are no appropriately trained personnel. Simple training activities can resolve this problem. Another problem is the lack of local standards and appropriate equipment such as computers. It has been mentioned that in the absence of validated standards, a program can develop its own standards using consensus methods or agreed norms. Though these problems in QA are serious in developing countries, there are ways of addressing them (Roemer, 1988).

Engelkes, (1990) recommended using routinely collected data with direct observation. In his study, WHO protocols were used for process evaluation and many methods used for data collection; e.g. interviewing health care providers, patients in the centers, people in their homes, village leaders and traditional healers including traditional birth attendants and direct observations. Although many methods, both quantitative and qualitative are used (a credit to the study), it is rather complex and not easily adaptable to situations in many developing countries (Engelkes, 1990).

Garner, (1990) advocated the development of simple checklists focused on common clinical tasks and performance indicators. His method dealt mainly with structure or its characteristics and so fails to reveal how well facilities are performing. Amonoo-Larson, (1985) focused on the collection of the data of processes in a modified methodology. This utilized the most commonly encountered complaints or diagnosis, based on frequency of occurrence at health centers. This took into consideration the fact that each was mainly conducted by a specific health worker. For each of the problems, standards or criteria were developed on the expected level of the performance of the health workers, to be compared later with the actual level of performance using patient medical record as the data source.

Although the above method is quite practical and usable in various settings, there are limitations. The first is related to its applicability in many developing countries. The screening of children presenting with symptoms of malaria before being seen by the health worker who is unaware of the screening procedure is an obstacle in many settings towards the achievement of quality. Another problem is performance modification usually done by directly observing the health worker's performance. Most of the criteria, however, could be obtained through records without personal observation (Amonoo-Larson ,1985).

Walker (1987) used process criteria for 12 tracer conditions to reflect important health problems, and represent age, sex and other aspects of medical care. These criteria were developed through a consensus of doctors in all government hospitals in Jamaica. The criteria agreed on were to be compared with the actual performance revealed in case notes. This is a satisfactory methodology for a range of settings, enabling the identification of valid criteria for quality assessment as well as

determining the action necessary to complete a cycle of quality assurance (Walker, 1987).

Nicholas, (1991) similarly focused on the process through the system analysis methodology. This is done through system analysis in which activities are broken into component tasks. An indicator is then defined for each task in quantifiable terms that would allow the measurement of changes in performance using WHO guidelines as well as expert consensus. The process is conducted by observing the health workers while they carry out their duties. This methodology proved to be adaptable to widely varying circumstances in 12 developing countries (Nicholas, 1991).

It is evident that each of the various methods mentioned above was used to meet the special circumstances of the area of the study, but could also be adapted and applied to the situations in other developing countries. Evidently, no particular method could be considered as suitable for all countries, whatever their stage of development. Much of the literature on quality assurance in developing countries reviewed, advocates the use of process evaluation, thought to be feasible although complex, rather than a focus on outcome evaluation which is difficult (Amonoo-Lartson,1985; Walker, 1987; Garner, 1990; Engelkes, 1990; Nicholas,1991; Baker, 1991). The main concern is to search for a sustainable and adaptable instrument for incorporation into health information or statistics systems in other developing countries.

Another related concern was to try to find an easy means of developing standards and criteria. Many advocate the use of output or intermediate variables or performance indicators that are easy to get, and useful for planning and decision-making. This is especially true if the main surveys using routine data dealing with coverage and health practice are supplemented by community surveys that elicit information on use

and effectiveness (Baker, 1991; Majeed, 1995). Other authors advise that WHO protocols be used after being adapted (Engelkes, 1990).

Another point of importance is that the use of multiple methods in the collection of data is far better than using only one method. There are also some other important concerns in addition to that of sustainability. De Geyndt (1995) lists six barriers to the successful initiation of quality assurance programmes in the developing countries. These are deficiencies in: (1) the commitment to quality improvement by the entire organization concerned, but especially by its leadership, (2) the supportive organization culture for quality improvement, (3) staff skills in quality management and teamwork, (4) the capability to install and manage information systems, (5) a decentralized decision-making structure including an authority to control and manage resources and, (6) active participation of the various professional disciplines.

Nevertheless, De Geyndt (1995) states that some developing countries have successfully initiated quality assurance programmes which means that all these barriers or some are surmountable. However, the extent of the resolution is usually related to the country's level of socioeconomic development. In many countries, overcoming these barriers is not easy and it is advisable to use alternative approaches known as a phased-quality improvement.

3.10 QUALITY ASSURANCE IN SAUDI ARABIA

Quality assurance is a relatively new phenomenon in Saudi Arabia. Most of the efforts made so far have been focused on technical skills. No comprehensive quality assurance programme, incorporating technical skills, interpersonal care and patient

satisfaction is known to exist. But there are many positive aspects to the sporadic quality assurance experiences in the country. There is a tendency to stress ritualization of the processes of quality assurance in the routines of the departments concerned. This is evident to some extent in the Saudi primary health care quality assurance project (Al-Mazrou, 1994; DeFriese, 1992).

Patient satisfaction as a part of a large-scale comprehensive quality assurance programme is unknown. The first hospital quality assurance programme in the country was established at Aramco hospital in 1982 (Soltis, 1988). There have been numerous quality assurance efforts in many other hospitals including those in Saudi Military hospitals started in the early 1980s but not much is known about them. Dixon (1982) identified several factors that she thought affected the provision of quality medical and health care in Saudi Arabian hospitals. These referred to the pace of construction and of opening of new hospitals, the staffing of hospitals by personnel trained in several different countries, the lack of long-term comprehensive medical care for most Saudi patients, and the difficulty in securing and maintaining adequate hospital supplies and equipment. Whereas the factors mentioned are important, what is more significant is the lack of what De Geyndt (1995) terms the "quality culture" which actually hinders the installation of successful quality assurance programmes in the country. This is as true for primary health care centres as it is for hospitals (Dixon, 1982).

The primary health care quality assurance project in Saudi Arabia (Al Mazrou, 1994) was established with the objective of setting standards for some of the various primary health care services and activities. Another objective was to define sensitive indicators to assess continuously and monitor compliance with preset standards and

outcome measures. The third objective was to define planning, monitoring and evaluation processes. Both intrinsic and extrinsic standards were used bearing in mind the Donabedian model of quality. This had its framework, the structure, process and outcome (Al Mazrou, 1994).

Taking into consideration the contribution of the various levels of the primary healthcare system in the Kingdom, the intrinsic standards were designed, while the extrinsic standards were set by various sources such as university staff, society members, WHO...etc not directly involved in the target activity. It was pointed out that those standards were subject to change and a process by which standards were modified, deleted or substituted periodically clearly stated. No doubt this vitalized the programme and ensured sustainability as currency (Al Mazrou , 1994).

Dossary (1991), quoted extensively from analyzed health care system in Saudi Arabia and compared it with other economically weak countries. He found two major differences in the health care system of Kingdom of Saudi Arabia and other developing countries. First, as a result of its oil wealth, Saudi Arabia has experienced an extremely rapid growth of income in the last 30 years. Second, a very strong value system, Islam has a persuasive effect, including the organization of its health care systems, upon Saudi society (Dossary, 1991).

Dossary (1991) also described for the first time the framework of the Saudi health sector, including the roles of health service providers, other than the Ministry of Health (MOH). This, together with contributions of rising living standards and their effect on the Saudi health system, is comprehensively documented. He concluded that economic growth, rather than the expansion of the health services, is the principal

explanation for better standards of health in Saudi Arabia (Dossary, 1991).

Later, Al Qatari (1997) evaluated the quality of primary health care in Qatif, Eastern Saudi Arabia. He identified certain problems, such as inadequate staff training on quality assurance, and non-implementation of quality assurance policies. He recommended that a survey on patient satisfaction be incorporated to make it more effective in creating the necessary quality culture and give it importance (Al Qatari, 1997).

Al Qatari (1997) also recommended that training of staff, communication between health care providers and the development of better approaches to quality assurance should be incorporated into the total quality management concept. He also found that there were certain lacunae, such as the importance of structure and utilization patterns of quality care. He advocated that in order to maintain continuous monitoring of quality, more surveys should be integrated into the quality program. And, lastly, he stated that more qualitative studies should be conducted to explain in depth the causes of low satisfaction or dissatisfaction of various aspects of health quality management (Al Qatari, 1997).

A recent study of patients' expectation and satisfaction in a teaching hospital emergency department at King Fahad Hospital, Alkhobar, Saudi Arabia by Al-Almaie, (1998) revealed reasonable rates of patient's satisfaction with emergency care. It also showed that an improvement was needed in certain areas of patient expectations and satisfaction. Some of these included the communication skills of the emergency department health team, the judicious and effective use of the available manpower, as well as an effective triage and the adoption of the use of nurse

practitioners in the emergency department (Al-Almaie ,1998).

Another recent study on implementation of total quality management in Saudi Arabia health care system by Algaman (1999), reported that health sectors were mostly run by western companies who are able to import the latest technology and health facilities because of the Kingdom's wealth. These companies usually bring with them their own procedure and practices including TQM. However, the adoption of TQM has not reached expectation because though the relevant concept of TQM is put in place by the management, the personnel required to implement it were unable to do so (Algaman, 1999).

Algaman (1999) also pointed out that the traditional values of Saudi Arabian society seemed to undermine the implementation of TQM programs. Consequently, the country's health care system operated under the notion of tradition rather than the deserving. He further stated that Saudi Arabia is a society in which people did not offer their opinion, so difficulties in the health sector and its quality assurance persist (Algaman, 1999).

Very recently, Iftikharuddin, (2002) carried out an assessment of physician's awareness of quality and their desire to adopt quality measures in hospitals of the Qassim region in Saudi Arabia. It was reported that there was a significant dearth of knowledge of health and quality, but the attitude towards adopting quality measures in day-to-day health practice was positive. The study showed that it was fallacious to say that physicians were not concerned about quality. As reported by Iftikharuddin, (2002) physicians looked forward to understanding quality. In spite of their lack of understanding, their perception about quality was positive. The overall impression is

that there is little knowledge about quality in health care and little awareness of how to implement total quality management. Iftikharuddin, (2002) concluded that negative perception was less prevalent in the Al Qassim region than expected.

3.11 THE ROLE OF TOP MANAGEMENT AND MANAGERS IN HEALTH CARE QUALITY PROGRAMMES

Management owes a great deal to Frederick W. Taylor, who is called the father of scientific management for his outstanding commitment to this concept. He was determined to prove that good management was a true science that was based on defined laws, rules and principles (Taylor, 1914). According to Duncan, (1987) the best manager is not necessarily the person with the best academic qualification but a person with a high moral fibre, who is adaptable, sensitive to the needs of others and has a good sense of fair play.

It is ironic that from the time Fayol wrote at the beginning of the 20th century until almost half of a century later, there were few serious attempts to understand what managers really did in the course of their day, a typical week or a fiscal year . This concept changed, however, with the publication of Mintzberg's, 'The nature of managerial work' (1975) a reaction against Fayol's view of the manager. It posited another view that managers simply tackled their tasks (Duncan, 1987), rather than performed as "reflective calculators" who carefully planned actions, patiently structured organizations and work-groups to accomplish the plans and continuously monitor for results.

Mintzberg argued that managers were far from systematic planners, organizers and controllers. Based on his research, Mintzberg claimed that managers seldom spent

more than nine minutes on any tasks and that in his sample, only 10% of the activities of high level executives required more than one hour to complete. According to this view, brevity, fragmentation and constant movement and responses to the demands of another characterizes the manager's job (Mintzberg, 1975).

Good management and leadership are critical for organizations to function and thrive. When organizations are well managed, they operate effectively and efficiently. They have clear plans and organized structures, systems and processes. Staff are able to carry out activities efficiently and monitor and evaluate results. When organizations are well led, they adapt to changes in the environment and develop cultures that inspire commitment and innovations. Both good management and good leadership are necessary to sustain organizational performance (Goleman, 2001).

Leadership plays a very important role in any workplace whether it is a health care system or an industrial one. Management without leadership can be compared to a car without a steering wheel, able to move but without purposeful direction. Good management does not, however, ensure results in all circumstances. When conditions are variable, intricate and interconnected, managers must do more than apply traditional management functions to a consistent process of delivering services. They must also lead their staff through a change process that enables them to face strategic challenges and focus their energy on achieving sustainable results that will satisfy clients (Goleman, 2001).

Managers need to support their staff in questioning assumptions, altering beliefs and changing ways of working to overcome obstacles that would otherwise undermine the quality of the services their organization provides to clients (Goleman, 2001). The board can also play a key role in promoting clinical involvement in CQI/TQM by

maintaining continuity of purpose in situations of executive turnover (Blumenthal, 1995). CQI/TQM takes several years to yield significant cost savings and measurable quality improvement (Deming, 1986; Juran, 1988, 1989).

An active board involvement in CQI/TQM increases the likelihood that the hospital's quality focus will remain constant despite the absence of stability in executive positions (Weiner, 1997). Steady, visible board leadership creates a climate of trust and assures staff and physicians of the hospital's unwavering commitment to CQI/TQM.

Leadership from the top promotes clinical involvement in CQI/TQM. This finding has considerable practical significance given the central role of clinical personnel in resource allocation decisions and the substantial impediments that confront hospital leaders in cultivating clinical involvement (Weiner, 1997).

Leadership for quality in healthcare settings may issue from several sources including managers, boards, and physician leaders. This finding is significant because it suggests that health service researchers and health care providers need to broaden the concept of leadership from the top and, therefore, modify the prescriptions that quality experts give to organizations in other industries. Furthermore, leading from the top may be crucial in breaking down departmental and professional barriers that impede the efforts of cross-functional teams to address clinical cost and quality issues (Weiner, 1997).

Physicians may respond more positively to CQI/TQM when senior managers demonstrate through word and deed that the hospital is committed to providing high quality medical care. By leading through example, senior managers build credibility

and trust with clinical staff which, in turn, may encourage greater clinical involvement in CQI/TQM. Further, by creating a corporate culture for quality, senior managers encourage improvement projects. The main purpose of decentralizing a health system is to improve access to the health services and, ultimately, the health of the population. Under a decentralized system, local health managers can better address deficiencies in cost-effectiveness, efficiency and performance, which are not easily resolved in a centralized system. The local level assumes responsibility for primary health services, while the central level focuses on policies and standards. Yet, the lengthy transition towards a decentralized health system can fragment parts of a health system that previously functioned adequately, without immediately solving pre-existing problems (Aitken, 1999).

In places where a decentralized management system functions well, managers at the central and decentralized levels come together to define new management responsibilities and create supportive management structures, systems, resource flows, and activity plans. To make such changes, health managers at all levels need to become leaders who can mobilize people inside and outside their organizations to formulate new avenues toward improved health (Aitken, 1999).

According to Riitta-Liisa (1999), health managers can develop solutions to its challenges only through deep, sustained dialogue with colleagues and key stakeholders. Developing leadership skills will help these managers guide others to find collective, long-lasting solutions. Applying management functions such as scanning, focusing, alignment, mobilization, inspiration, planning organization, implementation, monitoring and evaluation will strengthen the health system and improve the performance of the entire management.

Recently, an article by Wilk (2003) argued for developmental maturity as an important causal factor for effective TQM behavior and success, by drawing on a case study of a Swedish top management team whose members were practitioners of the Transcendental Meditation (TM) technique. It suggests that first, increased maturity permits the expression of more effective cognitive, effective and team TQM behavior, as indicated by improved team performance and successful TQM planning. Secondly, the practice of the TM technique promoted the psychological maturation that allowed a greater range of appropriate TQM behavior. Thus, the inner development provided by the Transcendental Meditation program had a practical value for managers engaged in the implementation of TQM.

Narine (2003) proposed that in order to effect change, implementers must first be committed to the change. This is done by ensuring organizational readiness for change, bringing to the fore dissatisfaction with the present state, communicating a clear vision of the proposed changes, promoting participation in the effort for change and developing a clear and consistent communication plan. However, gaining initial commitment is not enough.

Many programs for change were initially perceived as successful, but failed in the long-term. Therefore, commitment must be maintained during the uncertainties of the transition period. This can be done by successfully managing the transition through action steps, such as, consolidating change by means of feedback mechanisms and making the change a permanent part of the organization's culture (Narine, 2003).

A recent paper by Locock (2003) explores the meaning of redesign using practical illustrations. It examines its theoretical origins, particularly TQM's continuous quality

improvement and re-engineering, and accesses evidence, which may inform its application.

This evidence suggests that clinical ownership and senior management support is essential. Redesign seeks to balance the more gradual approach of TQM with the organization-wide lateral thinking of re-engineering. An incremental negotiated approach seems more likely to ensure clinical ownership, but carries a risk that quality improvement will remain small scale with little impact on the wider organization. Inclusion of some re-engineering techniques may help to overcome this difficulty. Evidence suggests that most quality improvement techniques achieve only partial success. This may pose some difficulties for redesign, generating high political expectations for the solution of long-term problems in health care (Locock, 2003).

Lilford (2003) recently tried to clarify the amorphous literature on action research and management. Both action research and TQM are cyclical activities involving examination of existing processes, change, monitoring the apparent effects of the change and initiating further change. Both emphasize an active participation of stakeholders. The examples used to illustrate action research would serve equally well as samples of total quality management and vice versa. Second, the methods used in action research are neither specific to action research nor are they specific. It, therefore, follows that action research, in so far as it purports to describe a unique or discrete form of research rather than a process of change is a misnomer. Organizational change should be described in terms of the steps actually taken to effect change rather than in terms of art, which, like the various brands of post-Freudian psychotherapy, obscure what they have in common rather than illuminate substantive differences. Besides, the research embedded in any cyclical managerial

process can have broad (non-exclusive) aims: to help local service managers to take the next step, or to assist managers in other places to make decisions in the future (Lilford, 2003).

According to a recent report by Hasan (2003), quality is an effective strategic weapon for improving productivity in the organization. A quality management framework based on the attribute theory of service quality was used to show how the organizational performance is affected by various quality dimensions. Using a questionnaire and subsequent data analysis, an empirically valid and reliable measurement instrument of quality dimensions was developed. Several multiple regression models developed, indicated that the dimensions "role of management" and "customer satisfaction" are among the most important for their effect on organizational performance (Hasan, 2003).

TQM is currently in vogue and has been found to be highly effective in improving bottom lines (Kren, 2003). In operations, difficulties arise when new methods and measurements challenge vested interests, upset departmental agendas, and threaten egos and power bases. This presurises the top-level management to remain with the status quo. This must be overcome. Once management starts to compromise, the failure of the program is inevitable. Management must provide a vision of future leadership and program sponsorship and do so with strong resolve (Kren, 2003).

Kanji (2003) recently demonstrated that the health care sector is one of the fastest growing areas of the economy of most developed countries. Governments (and taxpayers) are investing increasingly larger amounts of money in it and expect high quality services in return. The reality, however, is often different: long waiting times, inefficiency, low productivity, stressed medical staff and less than satisfied patients.

In one of very few longitudinal research studies of the link between implementation and successful outcomes, Taylor (2003) reported on perceived success for a cohort of 109 firms over a five-year period. Some 42 firms, predominantly small in size, had discontinued TQM, while the remaining 67 firms reported varying degrees of success. The data suggested that the firm, the nature of the customer base and the holding of ISO 9000 series certification has had no significant effect on TQM outcomes. Research has also highlighted some necessary antecedents for TQM success. In particular, the manager needs to understand the nature and the purpose of TQM, its relationship to ISO 9000, and the potential benefits to be derived from its implementation. These authors have shown that these factors are significantly associated with perceived TQM success. They are also significant for the discontinuing firms. Achievement of the success of TQM has also been shown to be significantly associated with (i) the time since adoption, (ii) the inclusion of quality objectives in the strategic planning process, and (iii) the need for the managers to take charge of TQM and to ensure that the majority of employees are involved in its implementation (Taylor, 2003).

While these findings are supportive of assertions in the literature, Taylor's report (2003) provides further robust empirical data from a cross-section of UK companies in the longitudinal research design. The research has also contributed to the debate about the effects of firm size and ISO 9000 certification. The paper concludes by proposing the next phase of analysis of these firms, based on five additional performance variables during both studies of the cohort.

Scrutiny of the detailed literature on the quality of health care reveals that there are several lacunae, unanswered questions and specific difficulties in health care concepts

in Saudi Arabia. As there are no officially agreed, unified and well-defined national health care standards for the maintenance of a quality health care system, the problem becomes more complicated and needs to be systematically addressed. Saudi Arabia, a developing nation with a booming economy has problems of its own. More than fifteen providers apart from Ministry of Health, the principal provider share the health care system in Saudi Arabia. Each one of these health providers has their own target population, medical and administrative setup, budget and other resources. However, there is a lack of quality plan on standards of quality. Health quality concepts need serious attention. In fact, both 'what' is being delivered and the method of delivery are equally important. Quality standards must be used to evaluate both concepts. Hence, the present study which was designed to address these issues.

There is always an imbalance between cost and access in a health care delivery system, which can affect the expected quality and outcomes. There is a need to assess whether the setup in this country suffers from this imbalance and to what extent. It is vital to find out if the health care system in this country is based on the real needs of its people or a mere imitation of the west!

The present study also evaluates whether the organizational problems in the health care system is the result of inefficient management or work procedure, or from the lack of worker efforts, and whether the management of the health providers are taking initiatives to ensure an atmosphere of creativity, innovation and creative risk taking even if there are possibilities of short-term negative consequences.

As middle and senior managers form the foundation of a successful quality programme and have a vital role in maintaining the health quality care system, an assessment will be made of the main objective of the present study. How do these

managers define and perceive quality health care? How important the provision of quality health care is to these managers, and how they seek to control and enhance it will also be some of the issues to be explored in the study. Are these managers satisfied with their hospitals' overall quality improvement initiatives? The study will also ask what these managers do, how they work, with whom they work and what else they do? What qualities the managers display, will also be an important issue to be dealt in this work.

The study also aims to explore whether there are incentives for quality performance, the monitoring of individuals and merit pay schemes. Also, to be discussed are the corrective measures taken when performance falls short of goal expectation; the role of middle and senior managers in relation to team building, team decision, group discussion and problem solving and its impact on health quality system.

Overall, it will be interesting to see how senior and middle management of hospitals in the Eastern Province of Saudi Arabia tackle quality health care. The role of health care providers in relation to patients will be an essential dimension to consider. It is expected that information on the knowledge, attitude and the practice of senior and middle managers of all the hospitals of the Eastern Province of Saudi Arabia will contribute to a better understanding of the work of health providers in providing quality health care.

CHAPTER FOUR

METHODS

4.1 OVERVIEW OF METHODS USED

The research questions, which were given at the end chapter 1 and will be reiterated in the following chapter on the results (chapter 5) were, as follows:

- Q. 1. How correctly do HSMM define and perceive quality health care?
- Q. 2. In the actual practice of HSMM, what level of importance and priority do they give to the provision of quality health care services?
- Q.3. What measures are HSMM currently undertaking to ensure and enhance the provision of quality health care in their hospital?
- Q.4. How supportive will they actually be to the small action quality research to be implemented in their hospital?

Different methods were used to access information for this study. The primary sources included visits to quality programmes of some hospitals in the region, a review of their quality plans, minutes of their meetings, and meetings with some of the members of quality committee. Meetings were also held with some of the senior and middle management of the hospitals to get their views on quality management activities in their hospitals. Secondary sources included a review of related masters and doctoral theses and dissertations, articles in journals, textbooks and other publications.

4.1.1 Literature search and review

The baseline of the literature search and review was the proposal for the research. A review of the works of the leaders in quality management such as Donabedian, Deming, Juran, Crosby and Ishikawa, as well as discussions with the supervisor enabled the researcher to formulate the framework of the research. The main features of the research included:

- Historical development of quality as a concept.
- The contribution of quality management gurus.
- Quality in health care.
- The concept and definition of total quality management.
- Quality and quality assurance in developed and developing countries.
- Quality assurance in Saudi Arabia.
- The role of top management in health care quality programmes.

4.1.2 Search strategy

The strategy for the literature review included an exploration of a variety of terms used in the main areas of the research.

First was the search in the national libraries and research centers including:

- King Abdulaziz City for Science and Technology (KACST)
- King Fahad National Library.
- Institute of Public Administration.
- King Faisal Center for Studies and Research
- King Faisal Specialist Hospital and Research Center

Contact was then made with the Health Ministers Council for Gulf Countries, which has a full record of all studies conducted in the Arabian Gulf region.

The purpose of these visits and contacts was to find out if there were any national or regional studies related to the current research.

The third was the electronic search. I was given the authority to search through the data bases linked to the library at King Faisal University. Of all the data bases available, the following were the most useful and relevant to my research:

- www.prodquest.com/cookiecutter
- www.infotrac.galegroup.com/itweb/kingfais
- www.blackwell-synergy.com
- www.theses.com
- www.emeraldinsight.com

The methodology used for the literature search started with the selection of a term broad enough to encompass all the main topics. Based on the results of each search, the following criteria were applied:

- If there was too much material more specific words were added.
- If the number was still high, the most recent literature was chosen.

4.2 INTRODUCTION

The current work comprises two types of study done simultaneously. First was a cross-sectional study designed to investigate knowledge, attitude and practice of senior and middle managers and their impact on the prevalent top-down approach of management in the health care delivery system in the Eastern Province of Saudi Arabia. Five senior top management positions including hospital directors, assistant directors, quality program managers, continuous education and training officers, and public relations managers were involved. Five middle management positions

comprising the medical and nursing directors, heads of information centers, directors of administrative affairs and chiefs of support services departments participated in the study. The classification into senior and middle managers was based on the span of control. The responsibility of the senior management encompasses the entire health care facility, while middle managers have specific areas of control. The Hospital Senior and Middle Management (HSMM) form the foundation for a successful quality program.

A pre-designed Action Research Model (ARM) was the interventional approach utilized as the second part of the study. Action research in the quality of health care is defined as the process through which providers evaluate their own performance in order to identify areas of weakness and provide a method for the improvement of quality performance (Beverly, 1993; Wadsworth, 1998).

Action research was developed by Kurt Lewin, a psychologist, in 1946 and later adapted for use in the social sciences and management. Lewin identified a four-stage framework for action research as follows: flexible planning, taking action, observing, and reflecting (Paul, 2000). Another step-wise approach by Meadows (1998) has three stages: problem diagnosis, action implementation and action evaluation.

In the last 50 years, action research has met with various levels of acceptability. The need for action research in nursing emerged as an example of collaborative research in nursing practice (Meyer, 1993). Al-Kandari (1998) reported that nursing care is a major determinant of successful health care delivery world-wide.

4.3 RESEARCH DESIGN

The present research was designed in two parts to take place concurrently as follows:

4.3.1. A Descriptive study detailed the current knowledge, attitude and practice of the HSMM in selected hospitals with regard to the importance of a system-wide program of quality improvement, the methods required for the implementation of a quality care program as well as the means for appropriate assessment.

4.3.2. An Action Research study was a comparative approach based on the literature review of the action research between two selected hospitals. The effectiveness of the action research was demonstrated by a patient satisfaction survey of selected departments during the intervention period. This research aimed at providing a model for preparing the front-line worker as part of the quality program. This approach is the bottom-up technique (Lofman, 2004)

4.4 RESEARCH SITE

The research study was carried out in selected hospitals in the Eastern Province of Saudi Arabia, which is divided into three administrative sub-regions: Dammam, Al-Hassa, and Hafr Al-Batin. The total number of hospitals in the Eastern Province is 51 distributed as follows: 35 hospitals in the Dammam region, 11 in Al-Hassa, and 5 hospitals in Hafr Al-Batin as shown in Table 4.1. The distribution of hospitals in Eastern Province according to ownership is presented in Table 4.2. Senior and middle managerial positions were more or less of the same pattern among MOH, military and private hospitals.

4.5 SAMPLING PROCEDURE

4.5.1. The sample of the descriptive study

A multi-stage sampling method was used to obtain the sample of HSMM for the descriptive study. The first stage involved the selection of all hospitals that met the following criteria:

1. Not less than 100 functioning beds
2. Presence of HSMM as the top-down approach for the current health care system.
3. Availability of multi-disciplinary health services in order to facilitate the integrated health care delivery approach in the hospital.
4. Located in an urban area. Ownership of the health care facility was not considered.

Twenty out of 51 hospitals were selected. The number and percentage distribution of hospitals which fulfilled the inclusion criteria in the three administrative regions of the Eastern Province are shown in Table 4.3.

The second stage of sampling process was the selection of the HSMM from the hospitals identified. Ten HSMM from each of the selected hospitals were included in the survey. The study was to cover their knowledge, attitude and practice of health care quality programs. The total HSMM sample size was 200.

Table 4.1 Number and percent distribution of hospitals in the Eastern Province according to region and number of beds per hospital

<i>No. of beds per hospital</i>	<i>No. of hospitals</i>	<i>No. & % of hospitals per region</i>			<i>Total %</i>
		<i>Dammam</i>	<i>Al-Hassa</i>	<i>Hafr Al-Batin</i>	
<100	22	14 (27.5 %)	5 (9.8 %)	3 (5.9 %)	43.2%
100- < 200	13	9 (17.6 %)	4 (7.8 %)	-	25.4%
200-300	8	6 (11.7 %)	-	2 (4.0 %)	15.7%
>300	8	6 (11.7 %)	2 (4.0 %)	-	15.7%
Total	51	35 (68.5 %)	11 (21.6 %)	5 (9.9 %)	100%

Table 4.2 Number and percent distribution of hospitals in the Eastern Province of KSA according to ownership

<i>Ownership</i>	<i>No. of hospitals</i>	<i>No. & % of hospitals per region</i>			<i>Total %</i>
		<i>Dammam</i>	<i>Al-Hassa</i>	<i>Hafr Al-Batin</i>	
Ministry of Health	21	12 (23.5%)	6 (11.7 %)	3 (5.8 %)	41%
Private Sector	23	17 (33.3%)	5 (9.8 %)	1(1.9 %)	45%
Ministry of Defense	4	5 (9.8%)	-	1 (1.9 %)	11.7%
University Hospital	1	1 (1.9 %)	-	-	1.9%
National Guard	1	1 (1.9 %)	-	-	1.9%
ARAMCO	1	1 (1.9 %)	-	-	1.9%
Total	51	35 (72.3%)	11 (21.5%)	5 (9.6 %)	100%

Table 4.3 Number and percent distribution of hospitals in the Eastern Province of KSA, according to region, and ownership that met the inclusion criteria

<i>Region</i>	<i>No. of Hospitals</i>	<i>Nature of Ownership</i>				<i>Total</i>
		<i>Ministry of Health</i>	<i>Private Sector</i>	<i>University Hospital</i>	<i>ARAMCO</i>	
Dammam	16	4 (18.2%)	10(45.5%)	1(4.5%)	1(4.5%)	72.7%
Al-Hassa	5	2(9.1%)	3(13.7%)	-	-	22.8%
Hafr Al-Batin	1	1(4.5%)	-	-	-	4.5%
Total	22	7(31.8%)	13(59.2%)	1(4.5%)	1(4.5%)	100%

4.5.2. The sample for the action research

Convenience sampling method was used for the action research. An MOH Hospital comparable to a general hospital in the private sector in Dammam city, were selected.

The head nurses of medical and surgical male and female wards for the three shifts in both hospitals were selected to participate in the action research. The total number of head nurses involved was 24 (12 head nurses from each hospital).

Table 4.4 shows the selected hospitals for the action research with regard to ownership, number of beds and participating head nurses.

Table 4.4 Selected hospitals for action research based on ownership with the number of beds and head nurses in medical and surgical wards

<i>Ownership</i>	<i>No. of beds</i>	<i>No. of participating head nurses</i>
Ministry of Health	391	12
Private Sector	310	12

Table 4.5 presents major differences between the two selected hospitals that participated in the action research. In fact, these features from the predominant differences between MOH and private hospitals in Saudi Arabia. Slovensky (2001) considered them important parameters for measuring and improving quality.

Table 4.5 Comparison of different aspects of MOH run hospitals and privately owned ones in KSA

<i>Factor</i>	<i>MOH Hospital</i>	<i>Private Hospital</i>
Administration	Assignment is based on qualification rather than productivity	Productivity is a major determinant of getting a job
Services	services are totally free	Services are chargeable
Patient satisfaction	No feedback for patient dissatisfaction	Patient satisfaction driven
Resources	Allocated centrally from MOH regardless of quality of service provided	Influenced by market rules (better quality of service means better resources)

4.6 DATA COLLECTION TOOLS

In the descriptive part of the study, data collection tools were based on the Donabedian system of quality evaluation in terms of structure, process and outcome (Donabedian, 1976). The following tools were included:

4.6.1 Manager questionnaire (Appendices 1 and 2)

The building of the questionnaire started with the literature review on all variables affecting HSMM perception of health quality management. A first draft of the questionnaire was discussed with particular peers of hospital managers. The experts and academics in quality management were then consulted. The questionnaire was revised and redesigned taking their feed-back into consideration and pre-tested in a pilot study to collect the views of the managers on the quality of health care. The comments of the experts and the feed back of the pilot study indicated that the following changes were required:

- Item number 1.7 of the biodata of the HSMM which concerns the number of training courses attended by the HSMM in the course of the past year was changed to the number of courses attended in the last five years since the number of courses attended in the last year was negligible.
- Item number 2.9 of the HSMM general concepts on quality was changed from, QP moves away from follow up to process improvement to, QP moves away from inspection –based management to process improvement, because HSMM felt that follow up and process improvement were the same.
- Item number 3.8 on the important factors affecting the implementation of quality programmes was changed from encouraging health care providers to discuss patient-related problems in quality to encouraging health care

providers to discuss all problems in quality. This was because HSMM thought that patient-related problems would limit the problems to only those between the physician and the patient.

- Item number 3.11 on the important factors affecting the implementation of quality programmes was changed from educating technical staff on administrative concepts to educating all staff on administrative concepts because all staff including administrative staff needed education on administrative concepts.

There were five main areas in the questionnaire itemized as follows:

1. Bio data (7 items).
2. General concepts about quality starting with the definition of quality in health care using Maxwell's perception of quality (1984). This includes access to services, relevance to need, effectiveness, equity, social acceptability, efficiency and economy. Eleven other items also evaluated were included in the questionnaire.
3. The important factors to be considered when implementing a quality program (QP) (11 items).
4. Factors causing failure of the implementation of QP (15 items).
5. Priority assessment (25 items).

4.6.2. Hospital checklist (Appendix 3)

This was completed by the researcher during his visit to each of the selected hospitals to measure the structure and outcome of QP. The list was written in English and Arabic to standardize the questions for greater reliability for both English and Arabic

speakers. Managers of quality programs were invited to fill the HSMM questionnaire before being interviewed with the checklist in order not to distort their responses to the HSMM questionnaire. There were four sections in the checklist:

1. General information about the hospital (7 items)
2. Information about QP (8 items)
3. Information about the in-charge of QP (10 items)
4. Information about the outcome (6 items).

4.6.3. Validity and reliability

The validity of the manager's questionnaire was emphasized to assess the degree to which the study accurately reflected the specific concepts that the researcher was attempting to measure.

Face validity of the questionnaire was developed by using available sources of literature to ensure the appropriateness of the questions from the researcher's point of view, taking cognisance of the educational, social and cultural backgrounds of the interviewees. In addition, personal contacts were made with colleges with similar scientific and professional interests in the nature, sequence, concepts and context of the questions. Peers of the administrators of some government and non-government hospitals in the Eastern Province were asked for their comments.

To ensure *Construct validity* the researcher examined conformity between theoretical concepts and the measurement of knowledge, attitude and practices of senior and middle managers of participating hospitals in quality-oriented management Maxwell's definition of quality was adopted as the standard definition in the development of the questionnaire. Experts of health quality, Professor A.F. Assaf, WHO Consultant and

Professor of Medicine and health administration at the University of Oklahoma were consulted on the construct validity of the HSMM questionnaire. The questionnaires were also scrutinized by Dr. Badran Al-Omar, Associate Professor of Health Administration and Dr. Ahmed Al-Shaikh, Assistant Professor of Health Administration at King Saud University, Riyadh, Saudi Arabia.

Criterion related validity, also referred to as *instrumental validity* was dealt with. Here an inference was made on performance by comparing the scores of the questionnaire to those of the hospital check list.

Reliability of the managers' questionnaire was dealt with in a pilot study done in three hospitals (two Ministry of Health and one private). 15% (30) HSMM were included in the pilot study. Based on the results of the pilot study, appropriate clarifications and modifications were made to the questionnaire. The response of the HSMM of the pilot study was fed into the SPSS to calculate Cronbach Alpha Reliability Coefficient which turned out to be 0.8948 suggesting high reliability of the questionnaire.

4.6.4 Measures taken to increase response rate

1. The general director of health affairs in the Eastern Province gave the written approval of the research and recommended that the hospital directors cooperate with the researcher.
2. On the strength of the above-mentioned letter, an appointment was made by phone for the researcher to meet the hospital directors and brief them on the study.
3. The hospital directors were asked to arrange with HSMM to participate in completing the questionnaires.

4. A personal visit to the hospital directors was made to start collecting data from HSMM.
5. If any of the HSMM was unavailable, a copy of the questionnaire was left with his secretary and a follow-up phone call was made.
6. All of the questionnaires were collected by the researcher after completion by the HSMM.

4.6.5 Action research cycle

Action research is a 'bottom-up' approach that considers all the related 'key players' Hart (1995). It depends heavily on the collaborative role of all concerned individuals in order to achieve the desired result Holter (1993). Action research is inquiry or research in the context of focused efforts to improve the quality of an organization and its performance. It typically is designed and conducted by practitioners who analyze the data to improve their own practice This therefore made action research the most appropriate method for answering the fourth research question of this study as given at the end of the first chapter, which stated: How supportive will HSMM actually be to the small action quality research to be implemented in their hospital?

The action research was designed to study the system of nursing in the selected hospitals, with the aim of improving nursing practices through the commitment and support of the HSMM of the hospital. Patient satisfaction was the indicator of success across different stages of the action research. Nurses were trained during the workshop, on how to define the needs of the patient, and devise different methods of satisfying those needs. Attempts were made to discover their knowledge of the problems that hinder patient satisfaction at the same time as solutions to these

problems were being discovered. In order to prepare the nurses for this role there was an educational workshop on the basic skills of empowerment and decision making.

In this part of the study, the criteria described by Hart (1995), were fulfilled by involving the head nurses who were participants in the hospital departments studied, and members of the change process of health quality management in their hospitals. The action research was implemented by following the steps described by Stringer (1996) i.e. setting the stage, looking, thinking and acting. The action research model used in the present study dealt with nursing practice as a three-month educational program in which a mutual collaborative approach of the action research was used (Holter, 1993). The researcher, the head nurses and quality management scrutinized the obstacles to patient's satisfaction. The head nurses implemented the suggested corrective actions and followed up the results on the implications on patient satisfaction. More specifically, the insider model was utilized in the Ministry of Health Hospital, while the outsider model was used for the private hospital (Titchen, 1993). The justification for the use of the different approaches was the researcher's position in the health affairs of the Eastern Province. Being the Director of the Quality Assurance Department he had the authority to effect change in the Ministry of Health hospitals, whereas in the private hospitals in the study there could only be consultations. The following tools were used to collect the data from the action research:

4.6.5.1 The workshop activity

The action plan focused on changes in nursing practice through a well-defined field of action. Four different topics were dealt with in one group session (workshop) in each of the two selected hospitals. The topics were selected on the basis of their importance

in facilitating patient satisfaction through nursing care. Since the nurses had not much administrative background, it was essential that they be trained in problem identification, and effective problem resolution.

The topics of the workshop were:

- Introduction to health quality management (Appendix 4). This topic was included in the workshop to give the participants an introduction and a broad view of the action research and relate it to the quality activities of the hospital and to the final goal of the quality programmes of the hospital which also concern patient satisfaction.
- Time management (Appendix 5). Nurses have many tasks to perform during their limited duty hours; therefore, they need to manage their time very skillfully. In order to satisfy patients' needs effectively, nurses should be skillful in prioritizing their activities and avoiding time killers, a fundamental part of this topic.
- Managerial creativity and leadership (Appendix 6). Nurses in general have little training in management, though they need this in managing their work effectively. Moreover nurses have very close links with different disciplines in the hospital which makes it vital for them to handle this relationship carefully for the benefit of the patient. Nurses constitute the greatest proportion of health care providers in a hospital. Therefore, they need to be very creative in their thinking in order to ensure the best outcome. Otherwise, they jeopardize the success of quality programmes.
- Problem solving and decision-making (Appendix 7). This was the core subject of the workshop, which was to provide the nurses with the means of analyzing

problems that hinder patient satisfaction in order to arrive ultimately at the best possible resolution.

In the follow-up meetings with the nurses and the quality management, the emphasis was on how to use each topic to solve the problems and overcome the obstacles which prevent nurses from giving the patients satisfactory care.

A well-planned timetable of four hours was produced (Appendix 8). All the nurses in the selected wards were invited to attend this session. In order not to disturb or affect work and staffing, the workshop was repeated on two subsequent days so that all nursing staff in the study unit could attend. Their feedback on the topics discussed at the workshop was presented at the end of the workshop on a pre-designed two-part questionnaire (Appendix 9), the first of which was on the bio-data of the nurse (8 items) and the second on the evaluation of the workshop (8 items).

In order to get the maximum cooperation of the hospital management, an agreement on the action research, its objective, time frame and various stages of the study methodology was drawn up and sent to the hospital manager. Finally, a list of what was required from the hospital management in order to facilitate a productive action research study was produced. This took into account ethical considerations, such as the consent and the confidentiality of the responses (Appendix 10).

4.6.5.2 Patient satisfaction questionnaire

A patient questionnaire (Appendix 11) was designed and pre-tested in a pilot study to evaluate the level of patient satisfaction of nursing care during admission. The tool

used to collect patients' views was a structured questionnaire, while the method used to complete this questionnaire was face to face interview. The quality management department was asked to participate in the action research by interviewing the patients by means of the pre-designed questionnaires before being discharged from the hospital to evaluate patients' views on the care provided. Data collectors were trained on how to conduct the interviews with the patients. The researcher trained the data collectors by going over each questions on the questionnaire. The training session focused on providing trainees with the following skills:

- Introducing the aim of the study and its expected benefits before asking for responses to the items in the questionnaire.
- Educating respondents on their rights, including confidentiality of data collected and freedom to withdraw at anytime.
- How to speak in a neutral non judgmental manner.
- How to encourage respondent to participate.
- How to make sure that the respondent understood the question.
- The extent to which the data collectors should clarify questions.
- How to avoid human errors and bias.
- How to be always mindful of the ethical considerations for all patients.

The extent to which the results obtained by the interviewers in both hospitals agree for similar populations was tested. Random questionnaires from each hospital were chosen and fed into the computer to run kappa test. The effectiveness of training and close follow up during the course of the action research were reflected in the score of 0.83 in the kappa test which indicates excellent agreement in the data collected.

The following ten parameters described by Hallstrom (2001) were used in the questionnaires on patient care: basic care, communication, competence of caregivers, continuity, contact with relatives, empathy, integrity, pain relief, participation in decision making and treatment by staff. There were two main parts as follows:

- A. Bio data (4 items).
- B. Patient satisfaction level (8 items). These eight items were divided into 20 variables; each variable answerable on a five-point scale. Consequently, the higher the grade given to each variable, the higher the value of the score. This facilitated the evaluation of overall patient satisfaction, as well as monitoring of the precise level of patients' satisfaction by nurses and the researcher.

4.6.5.3 Head nurse bi-weekly report

A pre-designed form with five columns was used. In the first column was the list of 20 variables in the patient survey used as a guideline for nurses to help satisfy their patients. Johansson (2002) grouped those factors into two. The first was under the direct control of the nurse, but the second was not. Nevertheless, both groups had to be handled by the nurse because she was at the forefront of the services in the hospital. Good administrative skills were necessary for the integration of nursing care with all other services provided by the hospital in order to achieve maximum patient satisfaction. The second column dealt with the obstacles to patients' satisfaction. The third column dealt with the corrective actions taken to solve the problems. The fourth column was about the results of the corrective actions. The last column was for the nurses' remarks on the content of the report. The head nurse for every shift completed this form and submitted it to the researcher for discussion and further planning (Appendix 12).

4.6.6. Measures taken to increase response rate

1. A letter of approval for the research was sent by the general director of health affairs in the Eastern Province to the hospital directors asking for their cooperation.
2. An appointment was made by phone with the hospital directors prior to the researcher's visit, on the strength of the above mentioned letter, to brief them on the study.
3. There was coordination between the nursing and quality management directors on the implementation of the action research for the scheduling of the workshops, the collection of the biweekly reports and patient satisfaction questionnaires.

4.7 RESEARCH PROCESS

The descriptive part of the study and the action research part were conducted simultaneously in a period of three months from 26/3/2005 to 13/7/2005. The process of each activity was as follows:

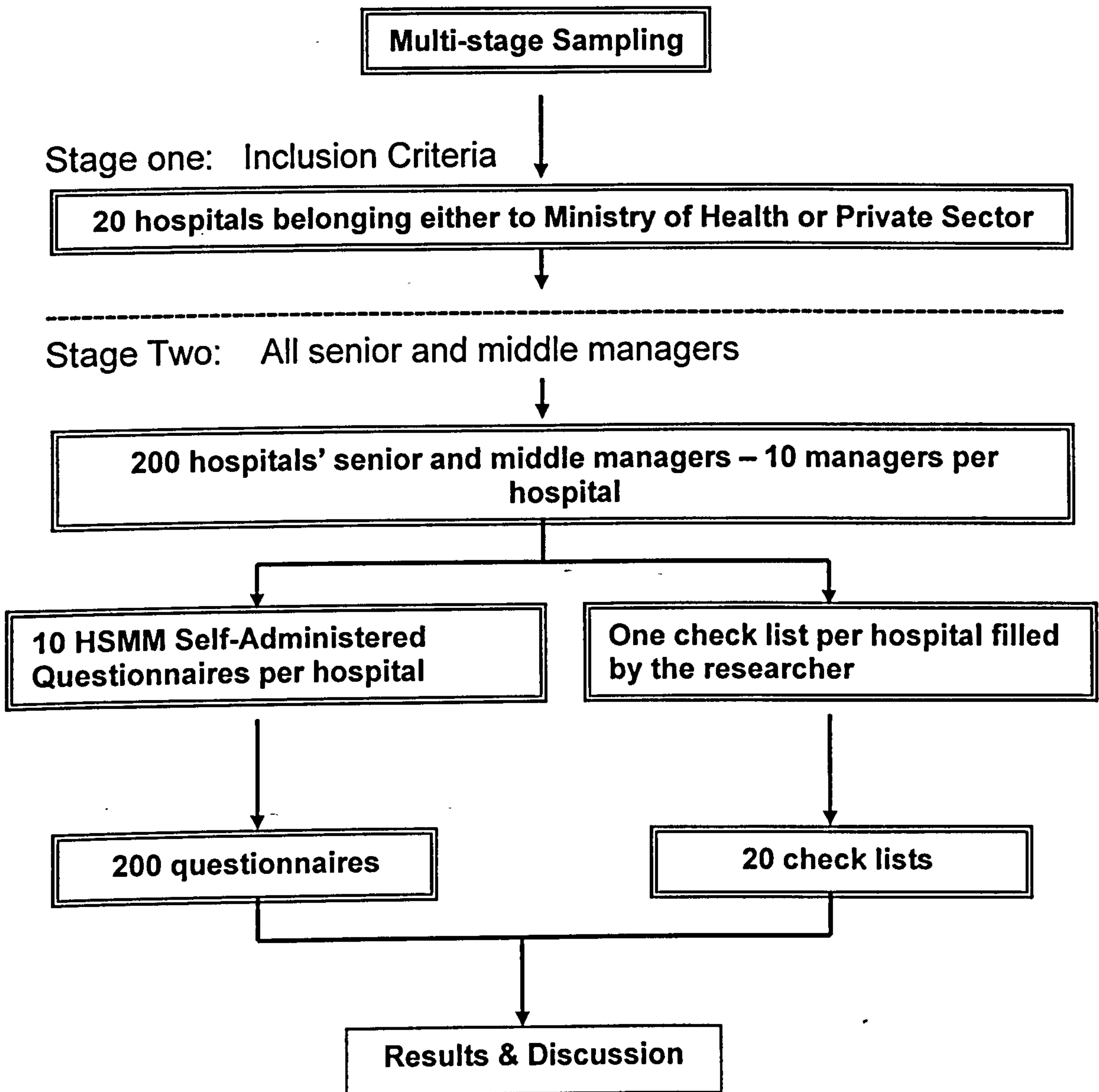
4.7.1 The process of the descriptive study

1. A letter signed by the director general of health affairs in the Eastern Province was sent to the director of each selected hospital (total of 20 hospitals, selected through the previously mentioned sampling procedure) asking for their support and cooperation.
2. Each selected hospital was visited by the researcher. Each senior and middle manager included in the study was asked to complete a self-administered questionnaire (Appendices 1 and 2).

3. While the questionnaires were being completed, the researcher toured the hospital and completed the checklist with the help of the quality management officer after he had completed his own questionnaire. This was to prevent any bias to the information needed on the check list (Appendix 3).
4. The researcher collected the questionnaires from each respondent and reviewed them before leaving the hospital.
5. The researcher entered the data into dummy tables in preparation for data analysis.

4.7.2 The flow diagram for the descriptive study

Health care facilities in Eastern Province
51 hospitals (Ministry of Health, Private, Military, Others)

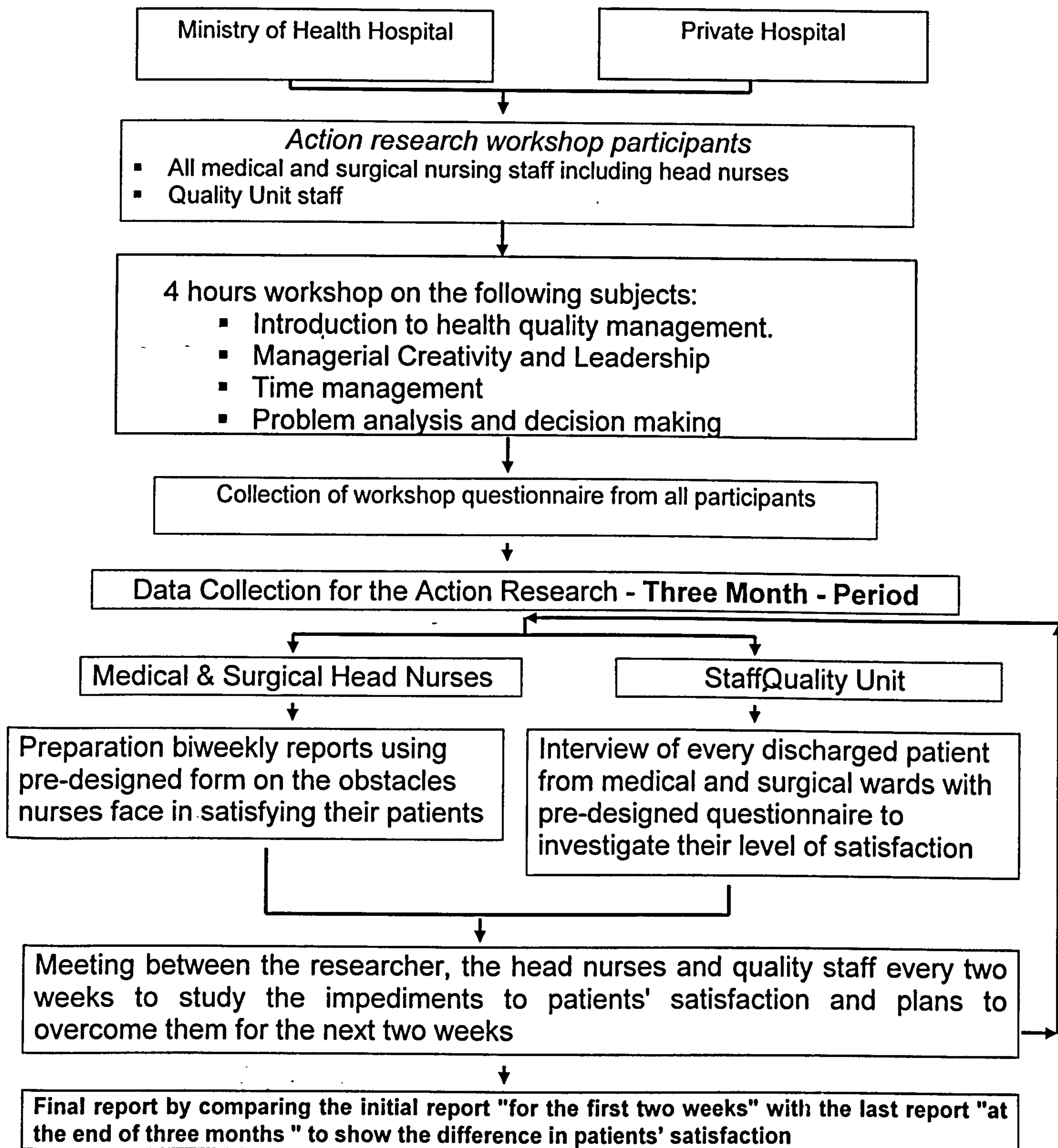


4.7.3. The process of the action research

1. The same letter was sent by the director general of health affairs in the Eastern Province to the 20 hospitals, for the descriptive study. This time it mentioned the action research to be conducted in the two hospitals.
2. The researcher also sent the directors of the two hospitals a letter giving them full details of the action research (Appendix 10).
3. The researcher met the nursing director of each hospital and gave her full details of the action research and its expected benefits. Another meeting was set-up with the head nurses of the departments concerned.
4. The researcher met the head nurses of medical and surgical wards in both hospitals and explained an operational plan for the action research to be conducted in a period of three months.
5. Taking their workload into account, arrangements were made to conduct a four-hour workshop for all of the nurses in the selected wards (Appendix 8).
6. All the nurses who attended the workshop were asked to fill the workshop questionnaire (Appendix 9).
7. Head nurses submitted their bi-weekly reports using the form shown in Appendix 12.
8. Quality management staff were to interview each patient discharged from those wards using patient questionnaires (Appendix 11).

9. The researcher collected the patient questionnaires and the head nurses' bi-weekly reports for an evaluation of the responses and a search for opportunities for quality improvement. Discussions with head nurses and quality management staff were held in order to agree on a quality improvement operational plan for the next two weeks.
10. There was a two-week cycle of data collection from patients, compilation of bi-weekly reports from the head nurses for analysis and the planning for the next two weeks.
11. At the end of the three months set for the action research, a final report on how much nurses could contribute to the improvement of quality in the hospital when supported by the senior and middle managers was prepared by the researcher and the head nurses.

4.7.4. The flow diagram for the Action Research



4.8 DATA ANALYSIS

The data collected from the questionnaire, checklist and group discussions were coded and edited. The questionnaire and checklist were verified, validated and their reliability tested in a pilot study and sent to the Academicians and WHO experts. The data was entered by the researcher on a Personal Computer (PC) using Statistical Program for Social Survey (SPSS) epidemiological model. The data analysis was done using SPSS statistical package. Univariate analysis was used to describe the knowledge, attitude and practice of HSMM in the studied hospitals adopting different tests for significance and taking p-value of 0.05 as the cut-off point for statistical significance. A multivariate analysis was applied to study various relationships between different variables. Logistic regression analysis was used to identify the effectiveness of the action research with regard to knowledge, attitude and practice of HSMM, as well as the impact of a quality health program on health care delivery systems in the studied hospitals. Qualitative analysis of the action research findings was conducted so that a model of quality nursing services could be designed.

Qualitative data were collected using the head nurses' biweekly report (Appendix 12). The aim of the qualitative analysis was to compare the results of the patient interview with views of the head nurses regarding patient satisfaction. The six parameters included in both head nurse biweekly report as well as the patient questionnaire, through which the comparison was made were as follows:

- Physical environment of the hospital.
- Communication and information.
- Participation and involvement.
- Interpersonal relationship.

- -Medical and technical competency.
- Influence of hospital system on staff.

Nurses were asked to write down the obstacles, corrective actions taken, and the results of those corrective actions. The researcher collected those reports every two weeks and reviewed them by examining the most problematic areas for the nurses in their desire to satisfy their patients. It reviewed also how much nurses utilized the concepts discussed in the workshop to facilitate the search for solutions to their problems. The reports also covered the use of their creativity and time management skills to overcome adverse circumstances to achieve their department goals. Emphasis was placed on the most frequent problem raised in two or more of the twelve reports collected. The highest priority was given to a problem for which the nurses could find no solution and which was indicated in the results of the corrective actions, as well as the level of satisfaction with the results. Three main problems were chosen for the nurses to try to resolve with the guidance of the researcher. The result was discussed in the next session as an affirmation of the achievement of the nurses in eliminating problems.

4.9 ETHICAL CONSIDERATION

The purpose and importance of the study were explained to the senior and middle managers in the studied hospitals. All aspects of the action research, issues relating to staff concerned and patients were agreed on with the hospital management prior to commencing the action research. In other words consent, confidentiality and other ethical considerations were addressed (Lofman , 2004). The final dissertation did not identify any hospital by name since the names of the studied hospitals were coded for confidentiality.

The next important ethical consideration was that respondents should not be negatively affected as a result of participating in the study. Therefore, patients were interviewed upon their discharge. The interviewers were trained to get verbal consent from the respondents before the start of the interview. The study was thoroughly explained to the respondents and their rights were made known to them beforehand. The effective dissemination sessions held by the researcher with nurses and quality management of each hospital, every two weeks in the course of the action research were discussed with the key persons in the hospitals. This was to improve the quality of nursing services during the action research period to enhance the implementation of the corrective actions suggested by the nurses and satisfy the patients.

4.10 LIMITATION OF THE STUDY

1. Some hospitals such as military hospitals could not be included in the study because information on their HSMM is classified.
2. Some of the private hospitals were new i.e. recently opened and only had a limited number of in-patients.
3. Some private hospitals had very few beds and therefore, did not satisfy the criteria for inclusion.

4.11 SUMMARY

This chapter discussed the methodology of the study in the light of the research questions. The study was built on two main ideas. The descriptive cross-sectional study and the action research study.

There were 51 hospitals in the eastern province of Kingdom of Saudi Arabia. By the inclusion and exclusion criteria applied to those hospitals, only 20 were eligible for

study. Ten HSMM of every selected hospital were investigated. The descriptive study aimed at answering the first three research questions:

- ✓ Q1. How correctly do HSMM define and perceive quality health care?
- ✓ Q2. In the actual practice of HSMM, how much importance is given to the provision of quality health care?
- ✓ Q3. What measures are HSMM currently undertaking to ensure and enhance the provision of quality health care in their hospitals?

In order to answer these questions, two data collection tools were used:

1. Managers' questionnaire: This was given to HSMM of each hospital by the researcher in person and all questions and queries of HSMM were answered immediately.
2. Checklist: While the HSMM were completing the questionnaires, the researcher filled the checklist revealing the real picture of the input and the output of the quality programmes in the hospital.

The fourth research question, which was to find out the actual support of HSMM for quality programmes was answered by the action research.

An action research was conducted in two wards of two hospitals. The research concerned the formulation of a quality plan for the nursing services in the two wards. The immediate objective of the study was to check the level of HSMM support to the quality programme. The ultimate objective of the study was to set up a practical quality programme for the nursing services in the studied wards for use as a model for quality programmes in the entire hospital.

The education aspect of the action research was satisfied by inviting the nurses to participate in a four-hour workshop. The main subjects discussed at the workshop

were: introduction to health quality management, leadership, time management and problem solving.

Two control and follow-up measures for the progress of the action research were taken:

1. The survey of each discharged patient for his level of satisfaction with the care given, noting the actual level of the quality of nursing given to the inpatients of the two wards.
2. Bi-weekly reports written by the head nurse of each shift on the frustrations they had in trying to satisfy their patients during the two weeks.

A meeting was held every two weeks to check the result of the patients' survey and head nurses' reports.

CHAPTER FIVE

THE RESULTS

5.1 GENERAL OVERVIEW

Two studies were conducted simultaneously for this research. A descriptive study to investigate the knowledge, attitude and practice of hospital senior and middle managers (HSMM). Two data collecting tools were used for it. Self-administered questionnaire were completed by 173 HSMM of 20 selected hospitals in the Eastern Province of Saudi Arabia giving a response rate of 86.5%. This is a considerably high rate considering the limitations discussed later in chapter six. The other tool used for the descriptive study was a checklist from each studied hospital completed by the researcher. This tool gave a clear picture of four different aspects of the hospital and some general information which brought out the differences among HSMM as well as information about the quality program and the person in-charge of the program. The outcomes of the hospital could be seen at a glance. A high percentage of the selected hospitals was private. In general, they were reluctant to disclose any information about their hospitals. This study demonstrates no significant differences among HSMM at their managerial level. Nevertheless, undergoing training in quality did create a change.

The other part of this research was the action research. This was a new experience in both hospitals. The private hospital tried to utilize this study towards the planning for their intended accreditation. The participation of the MOH hospital was based on interested individuals more than willingness of the hospital management although an agreement was signed with the director of the hospital before the action research. The findings of the action research were more qualitative, except for the patient

satisfaction survey. Despite the major differences between the two hospitals in terms of most of the studied variables, medical competency was almost the same.

5.2 THE DESCRIPTIVE STUDY

This part of the research aimed to answer the following research questions:

1. How correctly do HSMM define and perceive quality of health care?
2. What level of importance and priority do they give to the provision of quality health care services?
3. What measures are HSMM currently taking to ensure and enhance the provision of quality health care in their hospitals?

Two data collecting tools were used for this study. The first tool was a self-administered questionnaire to answer the first two research questions. The questionnaires were distributed to 200 hospital senior and middle managers (HSMM). One hundred seventy three responded, giving 86.5% response rate. The other tool was a checklist completed for each one of the 20 studied hospitals completed by the researcher in answer to the third research question. Data were collected from the beginning of April until the end of June 2005. The data in each of those tools were processed. The researcher adopted the checklist to give a summary of the structure and outcome of the 20 hospitals where the HSMM work. Four main groups of data were collected through the checklist.

5.2.1. Overview of the hospitals

Six different general aspects about the hospitals included in the study were investigated. These included ownership, location of the hospital, capacity of the hospital, average occupancy rate and the management style of the hospital

The first part comprised the structure of the hospital in general about the ownership, the location, the total number of beds, occupancy rate, the type of medical management as well as the type of non medical management. The hospitals numbered 20, more than half of which were private hospitals. Although the MOH is the major provider of health care in Saudi Arabia, the number selected for this sample showed that there were more private hospitals. This discrepancy could be attributed to two reasons:

- Some of the MOH hospital did not meet the inclusion criteria for the study, so were excluded.
- MOH policy of increasing primary health care centers and small hospitals to meet the needs of the small scattered population.

Most of these hospitals are located in Dammam, the centre of the eastern province. The Dammam region is made up of several cities hence the presence of more than half of the hospitals in this region. Al Hasa and Hafar Al Batin regions, however, are less well-developed and smaller than the Dammam region.

The total number of beds explains the high number of private hospitals in the study. Private hospitals tend to operate hospitals with a moderate number of beds compared to the MOH which has either very large or very small hospitals, and primary health care centers.

Half of the hospitals indicated that their occupancy rate was more than 50%. This shows that private hospitals were doing well because they formed the majority in the studied hospitals. This level of performance could be attributed to the level of quality care they provide.

There is a marked contrast between the performance of the hospital management and the non-medical hospital administrators. This is clear because the main business of a hospital is to provide medical services, which requires constant attention and vigilance by the management. The responsibility rests on hospital management rather than the non-medical managers, the latter being answerable to the holding company.

5.2.1.1. Information about the quality program

Five different features of the quality program were investigated. These features clarify the status of the quality program in the hospital. First is the availability of the program. Nineteen of the 20 hospitals had quality programs, most of which started in 2004, one year prior to the study period, indicating the awareness of the top management of the importance of quality program. The CEOs of the 15 hospitals appreciated the importance of quality in their hospitals, so they encouraged the head of the quality department to report directly to them. Most of the hospitals that had quality programs also had written quality plans. These plans had not been fully implemented in all of the hospitals which is unfortunate. The same could be said about training in quality in hospitals since half of the hospitals studied did not train all of their staff on quality. The majority of the hospitals conducted training courses on quality limited to certain departments of the hospital only. This approach detracts from effective implementation of a quality program that would contribute to the achievement of the hospital's goals. New staff in 11 hospitals had no chance of knowing about quality programs since their hospitals did not have them.

5.2.1.2. Information about the person in-charge of quality program

The job title, specialty, qualification and experience of the person in-charge of quality program were the aspects of investigation. There were very few Saudis, only two

compared with 17 non-Saudis. This shows that there is a very urgent need to train Saudis for this very important role. There were more males than females, most of whom were medically trained. Private hospitals in particular did not feel the need to hire someone for a single function. This was evidenced by the fact more than half of them were assigned responsibilities other than quality. Most of them held specific jobs related to quality, had qualifications in quality, had attended courses and spent more than one year in their present positions. This indicates that those hospitals had good foundations of the quality programs.

5.2.1.3 Information about the outcomes

This section dealt mainly with the standards of health care leading to patient and staff satisfaction. When properly monitored and correctly evaluated, it formed the most important indicator of quality. Most of the hospitals had set standards to evaluate their services. Half of them had national and international standards by which they evaluated the overall services of the hospital. A high percentage of them were aware of the importance of patient satisfaction, so they monitored it and realized a certain level of satisfaction. However, attention to staff satisfaction was not at the same level though this was the key to patient satisfaction. This shows the narrowmindedness (nd) (he lack of concern of top management of the hospital for their staff.

5.2.2 Hospital senior and middle managers' information

Five main areas of information were included in the questionnaire. The response to each variable was analyzed and its results presented below. The first part of the questionnaire concerned data on the hospitals and the HSMM, the core of this study. The descriptive study as well as the action research were used as two different approaches to investigate their knowledge, attitude and practice of quality programs

from different angles. HSMM knowledge was evaluated by means of the variables of the general information about quality, the factors contributing to the success of the quality program, and the causes of failure of quality program. Their attitude was studied through their views on the ranking of the quality activities. Their real practice of quality in their hospitals was revealed through the checklist on quality program.

5.2.2.1 Distribution of hospital senior and middle managers according to their place of work

The hospitals are located in three distinct regions of the Eastern Province of Saudi Arabia. One-hundred-nineteen HSMM from 14 hospitals in the Dammam region constituted 68.8%, 45 HSMM from five hospitals in Al Hasa region constituted 26% and 9 HSMM from one hospital in Hafr Al Batin region constituted 5.2% of the total percentage.

5.2.2.2 The characteristics of hospital senior and middle level managers

Managerial level

There was not much difference in the percentages of two managerial levels, 51.4% for senior managers and 48.6% for middle level managers. This gives a clear picture of the comparison of the two groups on the variables.

Age

There was an equal number of those below 40 years of age and those above 40. This symmetry eliminates the effect of experience of the young managers over the older managers.

Gender

Most of the HSMM were male. Females held middle management positions such as nursing directors and heads of continuous medical education. This is the usual distribution of managerial positions in Saudi hospitals. Very few women were assigned top managerial positions.

Nationality

There were fewer Saudi managers than non-Saudis. From the researcher's point of view, this could be attributed to two reasons. Qualified Saudi managers tend to work for MOH because they felt there was greater job security there than in the private sector. The private hospitals tend to hire non-Saudi managers with less pay and more responsibility. This trend was predominant in the case of the people in-charge of quality in the studied hospitals where they had responsibilities other than quality.

Qualification

The reasons adduced to nationality discussed earlier also apply to qualification. The majority of the HSMM were physicians because of the higher salaries and the wider scope of responsibilities they had. HSMM who had nursing qualification formed 28.9%.

Training

More than 25% of the HSMM had received no training in quality. This percentage is very high in the studied hospitals, 95% of which had quality programs. It also reflected negatively when a comparison of the trained and non-trained HSMM was made on different aspects, to be discussed later.

Ownership of the hospital

The place of work has a remarkable impact on the HSMM style of work. The HSMM respondents were mostly from the private sector. Those from the MOH were the next and those from other hospitals were the least in number. The differences in nationality and qualifications of HSMM could be partly attributed to their place of work.

5.2.2.3 Hospital senior and middle managers' definition of quality

Questions on the six dimensions of quality health care asked by Maxwell (1984) were put at the beginning of the general concepts of quality to assess HSMM knowledge of them. A response of "Strongly agree" by HSMM on these six dimensions was considered a complete definition. The definition was otherwise considered incomplete. Questions on the same six dimensions of quality health care raised by Maxwell (1984) were again put in the general information part of the questionnaire. The 'strongly agree' response to all of the six dimensions was considered a complete definition of quality. The definitions were otherwise considered incomplete. In general, HSMM who defined quality correctly according to the researcher's criteria were more than those who did not. One of the important reasons revealed by the statistical analysis of the data was the nationality. It showed that there were significantly more non-Saudis who defined quality correctly than Saudis. This could be attributed to the limited health quality management courses generally taught in the Health Sciences Colleges and Health Institutes. There is now a strong move towards training/teaching courses in quality management in these colleges. A committee of high officials met to discuss and implement whatever was needed to fill this gap in knowledge.

5.2.2.4 Knowledge and attitude of hospital senior and middle managers according to their managerial level

Four different aspects of different variables of the knowledge of the HSMM were investigated. They covered general information on quality, factors that enhance quality programs, the causes of quality program failure and the ranking of priorities in the implementation of quality programs. There were no significant differences in all variables of the four aspects in the responses of HSMM based on managerial levels. The overall response of both senior and middle managers tended to strongly agree or agree to all of the variables. This high level of knowledge and attitude among both senior and middle managers indicates that the failure of quality programs cannot be attributed to lack of knowledge.

5.2.2.5 Knowledge and attitude of senior and middle managers of hospitals according to their training on quality

In order to investigate HSMM contribution to the success of quality programs more fully, the effect of participating in training programs in quality aspects was evaluated. The response of HSMM to the different variables of the four aspects of the questionnaire was tested with regard to the effect of training in quality attended.

Definition of quality

Attendance at courses in quality made no significant difference to the responses of HSMM towards the definition of quality. The percentage responses were the same.

General information about quality

Significant differences of the following variables of the general concepts of quality emerged as a result of the training of the HSMM. The statistical analysis of the differences is illustrated in table 5.1 and displayed in figure 5.1.

- Giving the staff an opportunity to participate in the preparation of quality programs from the initial stages.
- Changing of quality programs (QP) from inspection based management to process improvement.
- The knowledge of how to implement QP.
- The importance of QP in the survival of the hospital.
- The difficulty of implementing QP.
- Understanding the continuous nature of QP

Factors necessary for the implementation of quality programs

The perception of HSMM on the factors necessary for implementing quality programs is determined by their training background. Trained HSMM differed significantly from the untrained on the following variables as illustrated in table 5.2 and displayed in figure 5.2:

- Advocating zero defect principle.
- Evaluating quality through the assessment of mistakes.
- Measuring quality through its compliance with patient requirements.

The causes of quality program failure

Trained HSMM attributed the failure of QP more significantly to the following variables as illustrated in table 5.3 and displayed in figure 5.3:

- Inadequacy of time allocated for the implementation.
- Ignorance of good results.

Ranking of priorities in the implementation of quality programs

Trained HSMM gave greater priority to the following variables as illustrated in table 5.4 and displayed in figure 5.4:

- Meeting patient needs.
- Ensuring availability of information on quality.
- Commitment of the staff to the mission of the hospital.
- Reinforcing technical staff's managerial skills.
- Getting patient's views about the health care provided.
- Giving staff power to improve quality health care.
- Getting staff's views about their job satisfaction.
- Providing staff autonomy.

Table 5.1 Cross tabulation of courses attended by hospital senior and middle managers and their perception of general concepts on quality

In order to highlight the differences between the perceptions of quality of those who had attended some training courses on the subject and those who had attended no courses at all, the five-category Likert scale adopted in the questionnaire was condensed into three categories; strongly agree and agree, as agree; strongly disagree and disagree, as disagree; and neutral was not altered

<i>Variable</i>	<i>n</i> <i>Trained in quality = 128 , Not trained in quality = 45</i>				<i>χ² test</i>
	<i>Training level</i>	<i>Agree</i>	<i>Neutral</i>	<i>Disagree</i>	
(*)					<i>df = 2</i>
2.8	Trained	111(86.7)	6(4.7)	11(8.6)	$\chi^2 = 15.5$ $p < 0.001$
	Not trained	29(64.4)	11(24.4)	5(11.1)	
2.9	Trained	113(88.3)	8(6.3)	7(5.5)	$\chi^2 = 18.9$ $p < 0.001$
	Not trained	28(62.2)	4(8.9)	13(28.9)	
2.13	Trained	87(68.0)	39(30.5)	2(1.6)	$\chi^2 = 12.9$ $P < 0.01$
	Not trained	35(77.8)	5(11.1)	5(11.1)	
2.14	Trained	123(96.1)	3(2.3)	2(1.6)	$\chi^2 = 19.4$ $P < 0.01$
	Not trained	35(77.8)	10(22.2)	0(0.0)	
2.15	Trained	89(69.5)	12(9.4)	27(21.1)	$\chi^2 = 6.2$ $P < 0.05$
	Not trained	30(66.7)	10(22.2)	5(11.1)	
2.16	Trained	126(94.4)	1(0.8)	1(0.8)	$\chi^2 = 10.6$ $p < 0.01$
	Not trained	39(86.7)	4(8.9)	2(4.4)	

(*) See Appendix A for variables codes

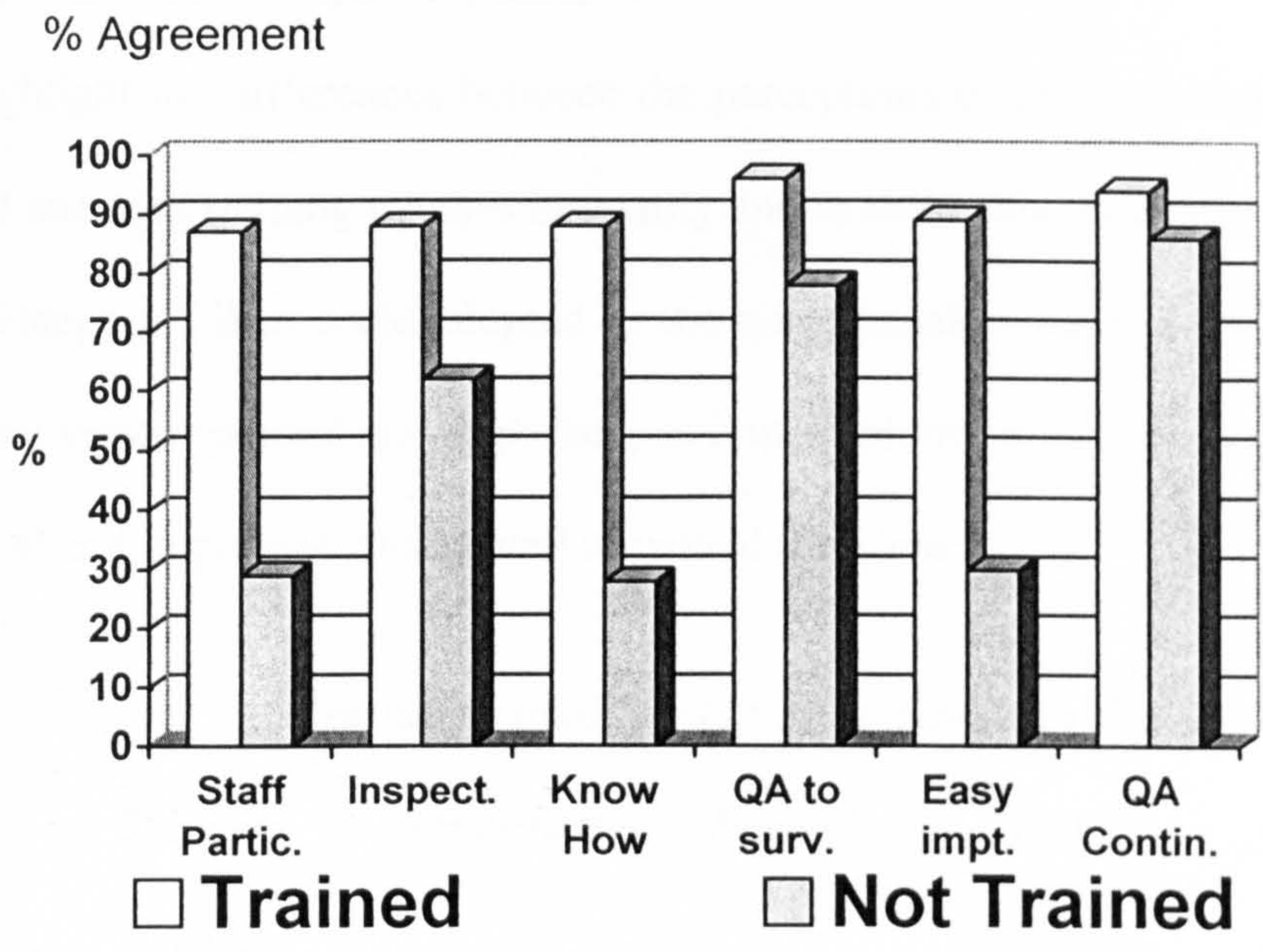


FIG 5.1 HSMM perception of the general concepts of “Quality” according to background training

Table 5.2 Cross tabulation of courses attended by hospital senior and middle managers and their perception of the factors necessary for the implementation of quality programs

In order to highlight the differences between the perceptions of quality programs of those who had attended training courses in quality and to those who had not attended any, the five category Likert scale adopted in the questionnaire was condensed into three categories; very important and important, as important; not important at all with not important, as not important; and neutral remained the same.

Variable (*)	<i>n</i> Trained in quality = 128 , Not trained in quality = 45				χ^2 test df = 2
	Training level	Important	Neutral	Not important	
3.2	Trained	104(81.3)	24(18.8)	0(0.0)	$\chi^2 = 11.5$
	Not trained	26(57.8)	18(40.0)	1(2.2)	p < 0.01
3.3	Trained	120(93.8)	6(4.7)	2(1.6)	$\chi^2 = 16.1$
	Not trained	35(77.8)	2(4.4)	8(17.8)	p < 0.001
3.5	Trained	122(95.3)	5(3.9)	1(0.8)	$\chi^2 = 22.5$
	Not trained	32(71.1)	13(28.9)	0(0.0)	P < 0.001

(*) See Appendix A for variables codes

% Agreement

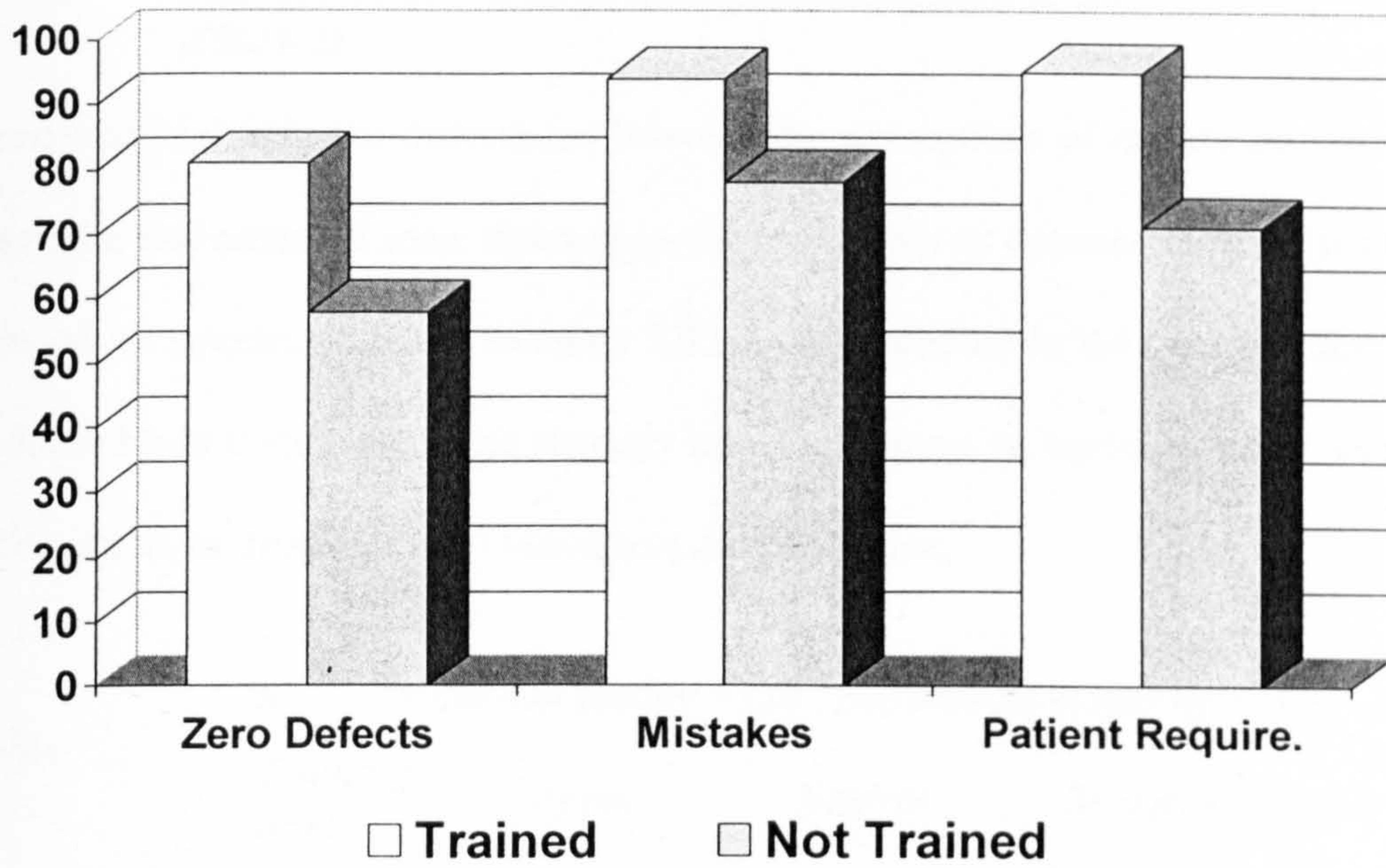


Figure 5.2 HSMM perception of the factors important for implementing quality programs, according to background training

Table 5.3 Cross-tabulation of courses attended by hospital senior and middle managers and their perception of the reasons for the failure of quality programs

In order to highlight the differences between the perceptions of quality programs of those who had attended some training courses in quality as opposed to those who had attended no courses, the five category Likert scale adopted in the questionnaire was condensed into three categories; strongly agree and agree, as agree; strongly disagree and disagree, as disagree; and neutral remained the same.

Variable (*)	<i>n</i> Trained in quality = 128 , Not trained in quality = 45				χ^2 test df = 2
	Training level	Agree	Neutral	Disagree	
4.2	Trained	90(70.3)	15(11.7)	23(18.0)	$\chi^2 = 8.0$
	Not trained	23(51.1)	13(28.9)	9(20.0)	P < 0.05
4.12	Trained	115(89.8)	9(7.0)	4(3.1)	$\chi^2 = 6.6$
	Not trained	37(82.2)	2(4.4)	6(13.3)	P < 0.05

(*) See Appendix A for variables codes

% Agreement

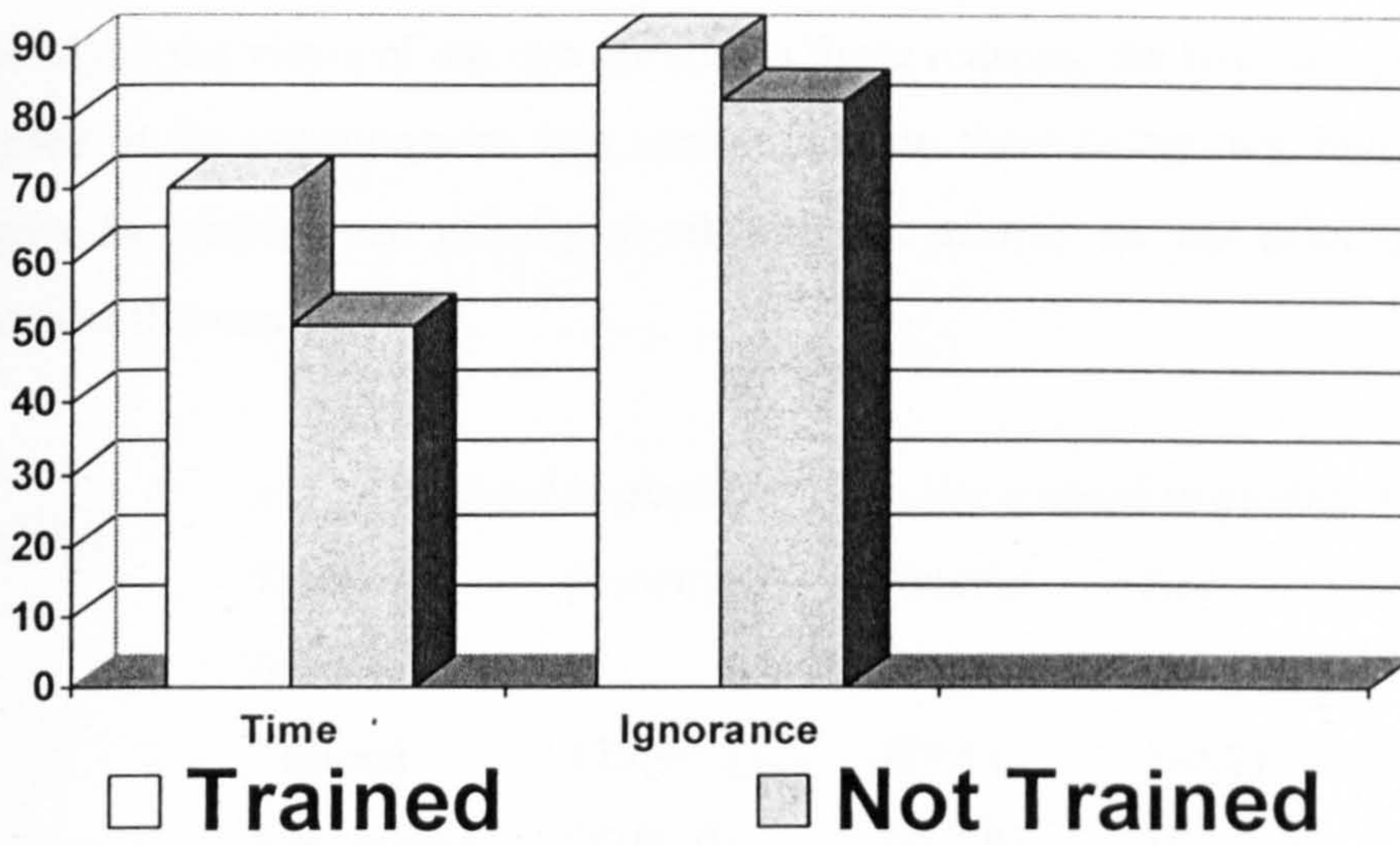


Figure 5.3 HSMM perception of reasons for the failure of quality programs according to background training

Table 5.4 Cross-tabulation of courses attended by hospital senior managers and their views on priority factors in quality program implementation

To analyze the views of the two groups on those reasons, the five category likert scale adopted in the questionnaire was condensed into three categories; high priority with priority as priority; not priority at all with not priority as, not priority; and neutral remained the same.

<i>Variable (*)</i>	<i>n Trained in quality = 128 , Not trained in quality = 45</i>				<i>χ² test df = 2</i>
	<i>Training level</i>	<i>Priority</i>	<i>Neutral</i>	<i>Not priority</i>	
5.2	Trained	123(96.1)	4(3.1)	1(0.8)	$\chi^2 = 11.8$
	Not trained	36(80.0)	8(17.8)	1(2.2)	$p < 0.01$
5.4	Trained	127(99.2)	1(0.8)	0(0.0)	$\chi^2 = 18$
	Not trained	38(84.4)	1(2.2)	6(13.3)	$p < 0.001$
5.6	Trained	123(96.1)	4(3.1)	1(0.8)	$\chi^2 = 11.8$
	Not trained	36(80.0)	8(17.8)	1(2.2)	$p < 0.01$
5.11	Trained	120(93.8)	4(3.1)	4(3.1)	$\chi^2 = 12.6$
	Not trained	34(75.6)	3(6.7)	8(17.8)	$p < 0.01$
5.12	Trained	120(93.8)	4(3.1)	4(3.1)	$\chi^2 = 12.6$
	Not trained	34(75.6)	3(6.7)	8(17.8)	$p < 0.01$
5.13	Trained	115(89.8)	7(5.5)	6(4.7)	$\chi^2 = 7.4$
	Not trained	33(73.3)	6(13.3)	6(13.3)	$p < 0.05$
5.14	Trained	121(94.5)	4(3.1)	3(2.3)	$\chi^2 = 24.6$
	Not trained	30(66.7)	5(11.1)	10(22.2)	$p < 0.001$
5.21	Trained	107(83.6)	19(14.8)	2(1.6)	$\chi^2 = 15.6$
	Not trained	28(62.2)	10(22.2)	7(15.6)	$p < 0.001$

(*) See Appendix A for variables codes

% Agreement

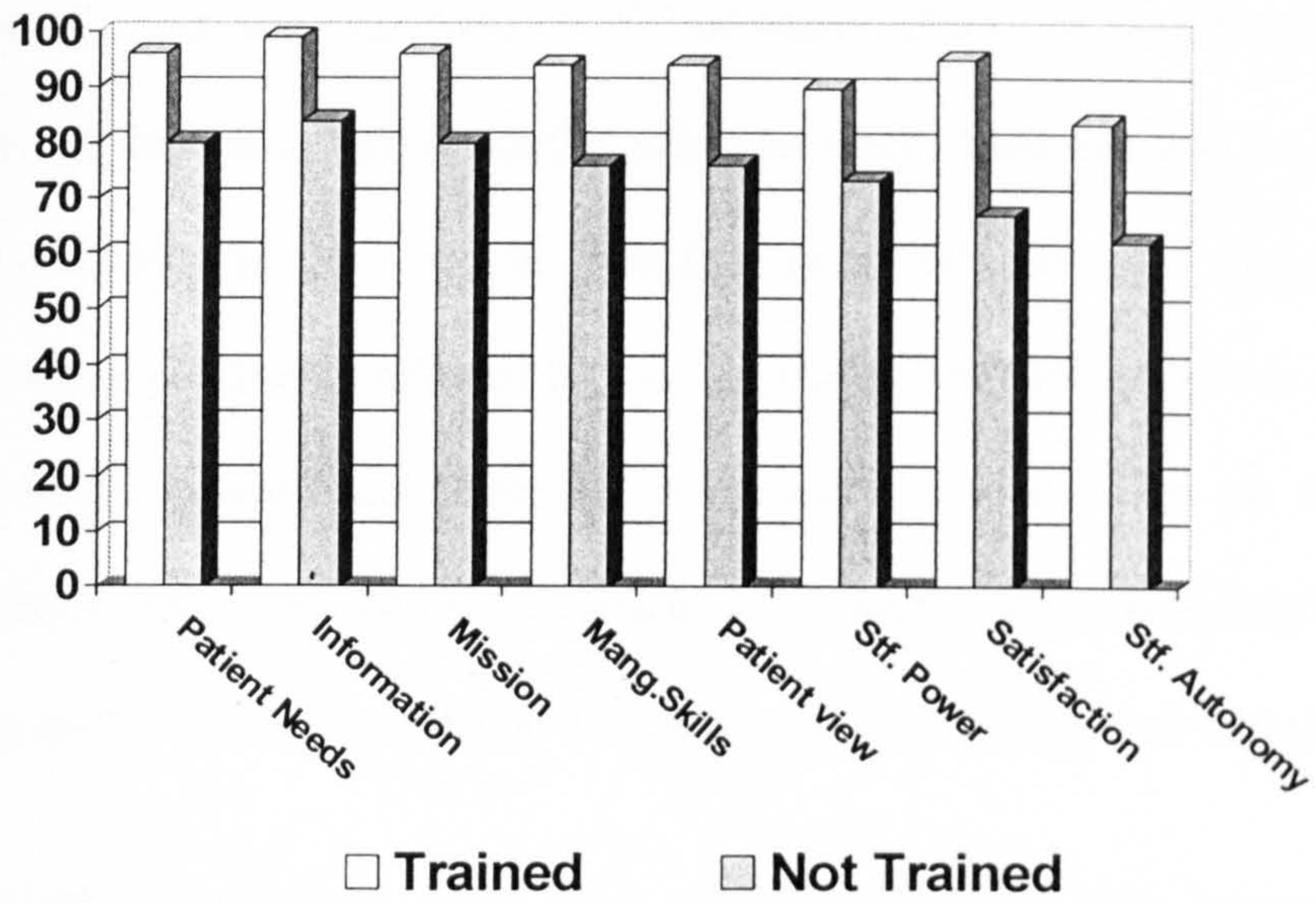


Figure 5.4 HSMM views on priority setting factors affecting quality programs according to background training

5.3 THE ACTION RESEARCH

5.3.1 Orientation and follow-up of the action research

Orientation meetings were held on 21st of March 2005, in each hospital to give the participants general details about the action research, their role and the data collecting tools to be used in the research. The first practical activity of the action research started was workshop conducted by the researcher. The workshop was repeated twice in the MOH hospital and once in the private hospital based on the number of participants. The total number of participants from the MOH hospitals were 44; 20 in the first and 24 in the second, and 20 participants from the private hospital.

Six follow-up meetings were held with a two-week gap between every two consecutive meetings to monitor the progress, help the group to achieve the immediate objective of each period and subsequent final objective of patient satisfaction.

5.3.2 Nurses' characteristics and background

All nurses working in the medical and surgical wards were invited to attend the action research workshop. At the end of each workshop, self-administered questionnaires were distributed to them to get their demographic data as well as their views on the content of the workshop.

The number of nurses from the two hospitals who participated varied because of the difference in the number of beds in the hospitals and the distribution of their patients.

The MOH hospital had four different wards. One each for male medical, female medical, male surgical and female surgical. The private hospital had one male medical ward, one male surgical ward and one combined medical and surgical female ward.

Consequently, the number of nurses from the MOH participating was 44, but only 20 came from the private hospital.

The experience of both was considerably good. Their average age was less than forty. There were few male nurses in the programme since the majority of nurses all over the world are females. More Saudi nurses work in the MOH hospital than in the private hospitals. The common trend is for graduates to look for positions in government hospitals rather than the private sector for reasons of job security which cannot be guaranteed in the private sector. The majority of nurses had university degrees in nursing. The number of MOH nurses who had had training in quality was less than that in the private hospital. This could be considered one of the early indicators of HSMM for quality.

The information presented to them during the workshop was not new to most of them, which is another indicator that there is no serious lack of information, though there was a problem of function. The majority of them also indicated that the information delivered was practical and could be implemented to satisfy hospital patients.

The nurses of the MOH hospital and those of the private hospital had almost the same experience in most of the areas. There was a major difference however, in the nationality, for more Saudi nurses than foreigners were employed in the MOH hospital. The other parameter which also showed an obvious difference was the training courses in quality attended by the nurses. Only 20% of the private hospital nurses had attended no courses in contrast to 38.6% of the MOH nurses.

5.3.3 Nurses' contribution

In a real sense, the activity of the nurses during the course of this action research was a clear indicator of the support of HSMM of the hospital for quality program.

Nurses of the MOH including the director of nursing showed very little interest in participating in the action research. To show the seriousness of the problem, some of the nurses admitted that this research was very vital for the patients, but were not willing to participate positively because of the lack of interest of the administration. The private hospital nurses were a little hesitant since they initially saw this study as an addition to their overloaded schedule. They looked for ways of avoiding participating in this program. They eventually enjoyed it and realised it was a means of improving their performance.

To make the comparison easier, the same domains were used for the bi-weekly reports as the patient questionnaire. The two tools were set to evaluate patient satisfaction from different angles. This means that the domains had no relation with the staff problems. Nevertheless, the nurses of the MOH persistently raised issues and problems relating to their hospital despite being told in all follow-up meetings that those issues were outside the scope of the research. The nurses of the private hospital however, accepted this clarification and started looking for creative solutions for the problems hindering patient satisfaction.

The level of MOH patient satisfaction fluctuated during the period of the study. It seemed to depend on the mood of the nurses rather than driven by patient satisfaction. Satisfaction of the private hospital patients steadily improved which could indicate the rising interest of the nurses.

One of the subjects discussed in the workshop was problem-solving and decision-making. Group sessions and exercises were conducted to give the participants full confidence in the application of these skills. Despite all the encouragement given, the nurses of MOH hospital were not interested in investigating problems properly. Consequently, their solutions were also very superficial. Nurses of the private hospital tried to view critically anything that stood in the way of patient satisfaction. They started by looking for the external factors contributing to low patient satisfaction, and went on to investigate their own work. They adhered strictly to concepts and skills taught in the workshop in order to improve patient satisfaction.

The corrective action suggested by the nurses of MOH hospital was very superficial and could not have had any effect whatsoever on the problems. Private hospital nurses spent a long time investigating the root causes of the problems, and as was to be expected came up with bright and creative solutions.

The biweekly reports of nurses of MOH hospital was hurriedly written towards the end of each period, so there was no time to follow-up and monitor of the corrective actions decided on. The private hospital nurses utilized the entire two-week period thinking of corrective measures for their problems and monitored them in the remaining time.

Nurses of MOH hospital were not keen to implement the suggested corrective actions and always found excuses for their inaction. Private hospital nurses looked for all opportunities to apply their corrective actions.

There was no follow-up on the result of implementing the corrective actions from the nurses of MOH hospital. For this reason the satisfaction level of each variable is not

reliable, and would not reflect the true level of patient satisfaction. However, the nurses of the private hospitals were conscientious in following up the results of their corrective actions. Their follow up shown in the satisfaction column of the report is to a large extent a true reflection of patient satisfaction.

5.3.4 The findings of nurses bi-weekly reports

There were major differences between the reports of the two hospitals (the MOH and private hospitals) in the comparison of the main features of the nurses' bi-weekly reports throughout the six periods of the action research. Table 5.5 gives a clear comparison of the findings of the two hospitals.

Table 5.5 Comparison of different observations between the two hospitals through nurses' bi-weekly reports

<i>No.</i>	<i>Variable of comparison</i>	<i>MOH hospital</i>	<i>Private hospital</i>
1	Interest of the nurses	Low although some of them admitted that it was very important for the patients	Nurses were hesitant at the beginning because of the workload. They later became interested and enjoyed it.
2	Relevance of the reports to patient satisfaction	Continuous evaluation of the report variables from the staff point of view despite the emphasis to look at the variables from the patient point of view	There was misunderstanding in the first two periods in some of the reports but they improved with time.
3	Consistency of the reports	Sometimes reports were acceptable but mostly not	Progress in preparing the reports is remarkable, both in content and documentation.
4	Specifying the root causes of the obstacles to patient satisfaction	Did not delve into the root causes of problems. Dealt with only superficial signs.	Specified the root causes of the problems precisely, and also criticized their own skill and practice.
5	Visibility of the corrective action	Persisted in putting the blame on others for not doing their job correctly	Specified visible corrective actions
6	Implementation of the corrective action	Blamed others for not implementing what they had suggested	Always looked for ways and means of getting the corrective action implemented
7	Follow up of the corrective action	The reports were prepared at the end of the period so follow-up was minimal, if at all.	Utilized the entire two weeks period to follow up the impact of the corrective action
8	Job satisfaction regarding the corrective actions	High level of satisfaction despite persisting problems.	Low level of satisfaction because the problems were not totally eliminated

5.3.5 Patient feedback

The methodology of this study required that all of the available discharged patients in the selected wards of the two hospitals be surveyed. This meant that nursing aids from the MOH and the social workers of the private hospital had to repeat the survey ten times every two weeks on different patients in order to satisfy the requirements of the action research. The support of senior and middle management together with the enthusiasm of the surveyors affected the number of surveyed patients. Access to the discharged patients varied between the two hospitals. Certain limitations such as those listed below lowered the number of patients surveyed in the two hospitals:

- Discharged against the medical advice.
- Refusal to participate in the study.
- Discharged at the weekend.
- Discharged after the duty hours of the surveyors.
- Short notice from the nursing office to the surveyors about those discharged.
- The surveyors occupied with matters relating to their routine daily work.

In addition to all of these factors, there was another major obstacle in the MOH hospital. The nursing aids had a very short time to interview patients. This particularly lowered the number of patients interviewed in the MOH hospital dramatically.

At the end of the action research, 348 patients had been surveyed from the MOH hospital out of 2951, giving percentage of 11.8%. The total number of patients discharged from the private hospital was 1205, out of which 649 were surveyed constituting 53.9% of the total discharged.

A varied number of patients was surveyed in each period. One of the factors affecting this fluctuation was the long period of the research. The drop in the number of surveyed patients in MOH hospital started from the third period and continued declining till the end. The private hospital started better than MOH, with the percentage respondents increasing until the third period. The last three periods fluctuated, ending with the lowest percentage. In general, the private hospital did much better.

These variations are acceptable, for because of its qualitative nature, the action research which was based on investigating the level of support which HSMM provided for quality programs in their hospitals and not aimed at generalizing its results for the remaining hospitals.

5.3.6 Patient characteristics

Nationality

All Saudi patients are eligible for treatment in MOH hospitals, while not all the non-Saudis have this privilege. Consequently, the percentage of Saudis in MOH hospital is greater than in the private hospital.

Residence

The two hospitals dealt mostly with patients from the urban areas around the hospital. This meant that the circumstances of the patients in both hospitals with regard to communication, environmental and other living conditions were similar.

Gender

There were more male patients in the private hospital than in the MOH hospital. The reason might be that private hospitals had health insurance contracts with different organizations, the staff of which are mainly male living here without their families.

Age

Surveyed patients were classified into two groups, those less than 40 and those more than 40 years of age. Again the private hospitals tended to have more patients below the age of 40 which confirmed the suggested reason behind higher percentage of males reporting to the private hospital.

Marital status

There were more unmarried patients in the MOH than in the private hospitals. A high percentage of these were either students or unemployed, so could not afford to pay the fees charged by the private hospital. The high percentage of married patients reporting to the private hospital confirms the reasons mentioned earlier i.e., the bills of most of the private hospital patients were paid by their medical insurance.

Education

Literacy among the private hospital patients was higher than among the MOH patients. Patients attending private hospital were employees of companies and numerous industries hired for their expertise based on their qualifications. Companies provide insurance cover for their staff to receive better treatment and care.

Occupation

Professionals and students formed a higher percentage of patients presenting to the MOH hospital. The private hospital on the other hand, saw more administrators and technical staff.

Main source of health care

Patients usually had more than one place where they went for health care, the main source and an alternative. A majority of the patients surveyed indicated that the hospital where they were surveyed was their main source of health care. This lends an indirect credence to the finding of the action research. Since there are more than 16 health care providers in the country, if the hospitals where the patients were surveyed was not their main source of health care, their views may not be reliable.

5.3.7 Patient satisfaction

The findings from the patients' questionnaire in each period were used as a guideline to form the actual picture of patients' level of satisfaction. The variables in the report which showed the lowest patient satisfaction were selected for discussion at the meetings with the participants from the hospital. It was agreed that emphasis be put on these in order to raise the level of patient satisfaction in the next period. Their interest and effort reflected in the results of patients' questionnaire. The results of every period formed the subject of discussion in the follow up meetings. The trends of patient satisfaction in the course of the action research in the MOH and private hospitals are displayed in figures 5.5 and 5.6 respectively.

In order to highlight the differences between the two hospitals, the differences between the first and the last periods are displayed in figures 5.7 and 5.8 The eight domains represent 19 variables.

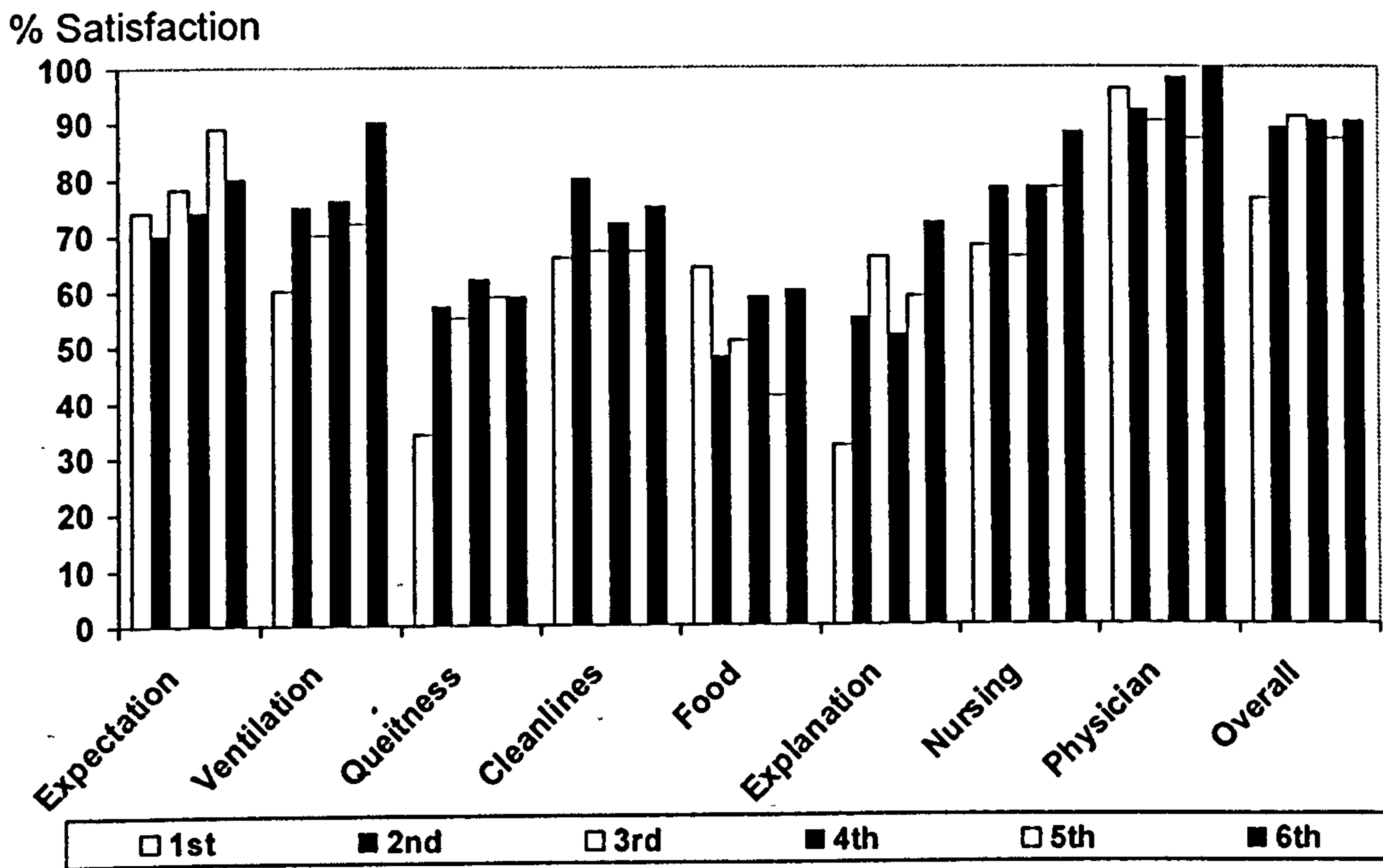


Figure 5.5 Progress of Patient Satisfaction During Action Research at an MOH Hospital

% Satisfaction

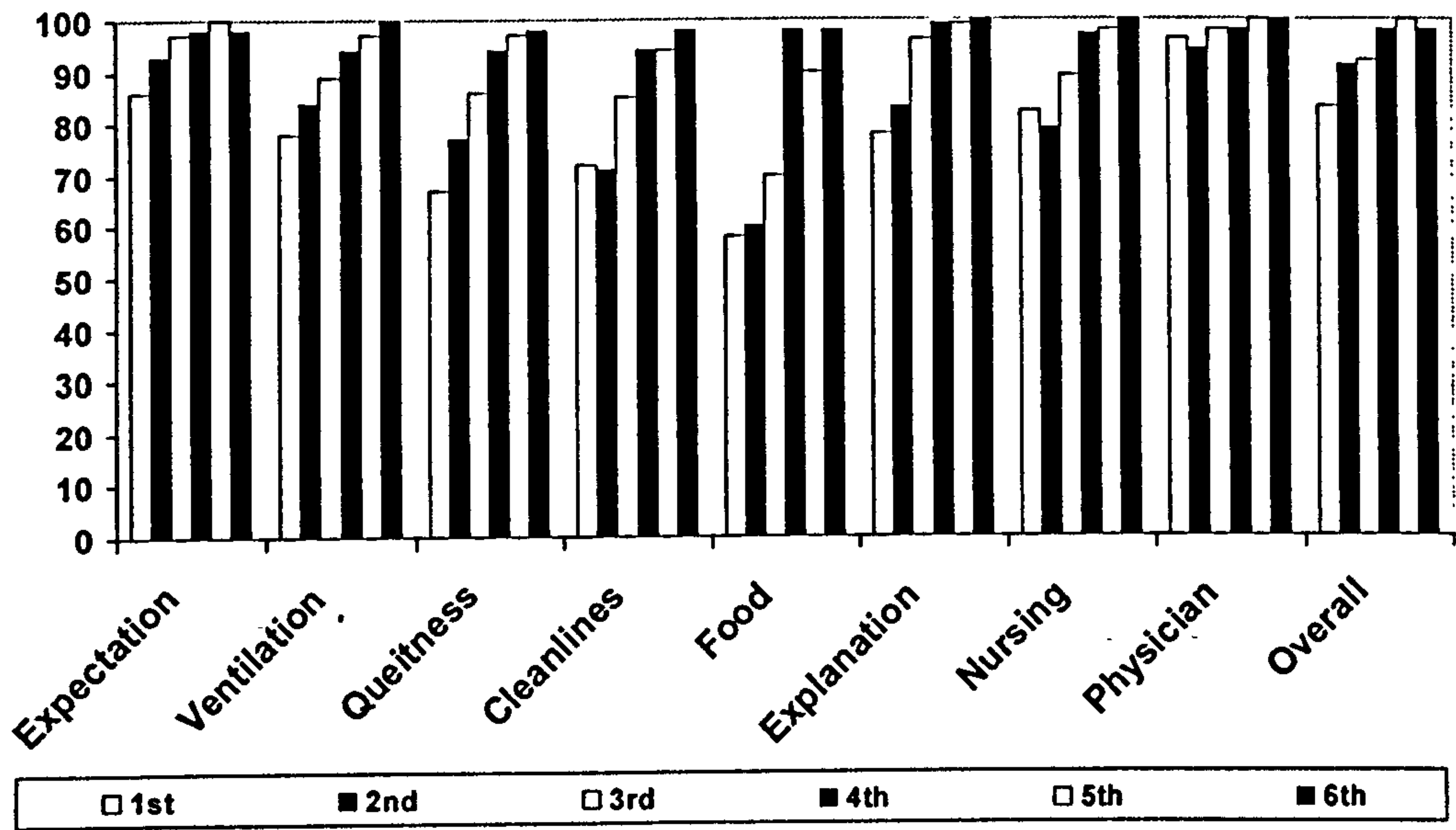


Figure 5.6 Progress of Patient Satisfaction During Action Research in a Private Hospital

Table 5.6 Variables that showed significant differences in patient satisfaction in the 1st & 6th periods of action research

'Agree' in the tables is the total of 'strongly agree' and agree while 'n' is the number of respondents for the same variable.

<i>Variables (*)</i>	<i>n (MOH patients) = 348</i>			<i>(private patients) = 649</i>	
	<i>Hospitals</i>	<i>First period (Agree/n)</i>	<i>χ² test</i>	<i>Sixth period (Agree/n)</i>	<i>χ² test</i>
Previous experience	MOH	35/50	χ ² = 8.7	31/40	χ ² = 11.8
	Private	79/89	P < 0.01	58/58	p < 0.001
Expectation	MOH	37/50	p > 0.05	32/40	χ ² = 7.4
	Private	76/89		57/58	p < 0.01
Ventilation	MOH	30/50	χ ² = 4.8	36/40	χ ² = 6.0
	Private	69/89	p < 0.05	58/58	p < 0.05
Quietness	MOH	17/50	χ ² = 14.5	24/40	χ ² = 24.2
	Private	60/89	P < 0.001	57/58	P < 0.001
Cleanliness	MOH	33/50	p > 0.05	30/40	χ ² = 12.9
	Private	64/89		57/58	P < 0.001
Food	MOH	32/50	p > 0.05	27/40	χ ² = 18.3
	Private	52/89		57/58	P < 0.001
Information about the ward	MOH	6/50	p > 0.05	14/40	χ ² = 47.5
	Private	17/89		57/58	P < 0.001
Information about the treatment plan	MOH	22/50	p > 0.05	28/40	χ ² = 17.1
	Private	40/89		58/58	P < 0.001

cont.

Explain procedures	MOH	16/50	$\chi^2 = 27.9$	29/40	$\chi^2 = 15.3$
	Private	69/89	$P < 0.001$	58/58	$P < 0.001$
Information made hospital stay better	MOH	13/50	$\chi^2 = 7.3$	38/40	$p > 0.05$
	Private	44/89	$P < 0.01$	58/58	
Participated in planning	MOH	18/50	$p > 0.05$	22/40	$\chi^2 = 25.7$
	Private	35/89		57/58	$P < 0.001$
participated in implementation	MOH	20/50	$p > 0.05$	27/40	$\chi^2 = 15.9$
	Private	48/89		57/58	$P < 0.001$
Nurses were attentive	MOH	34/50	$p > 0.05$	34/40	$\chi^2 = 6.8$
	Private	73/89		58/58	$P < 0.01$
Nurses responded when called	MOH	16/50	$\chi^2 = 24.5$	30/40	$\chi^2 = 8.3$
	Private	66/89	$P < 0.001$	56/58	$P < 0.01$
Nurses are competent	MOH	34/50	$\chi^2 = 10.4$	36/40	$\chi^2 = 3.8$
	Private	80/89	$P < 0.01$	58/58	$p < 0.05$

(*) See Appendix K for full details of the variables

% Satisfaction

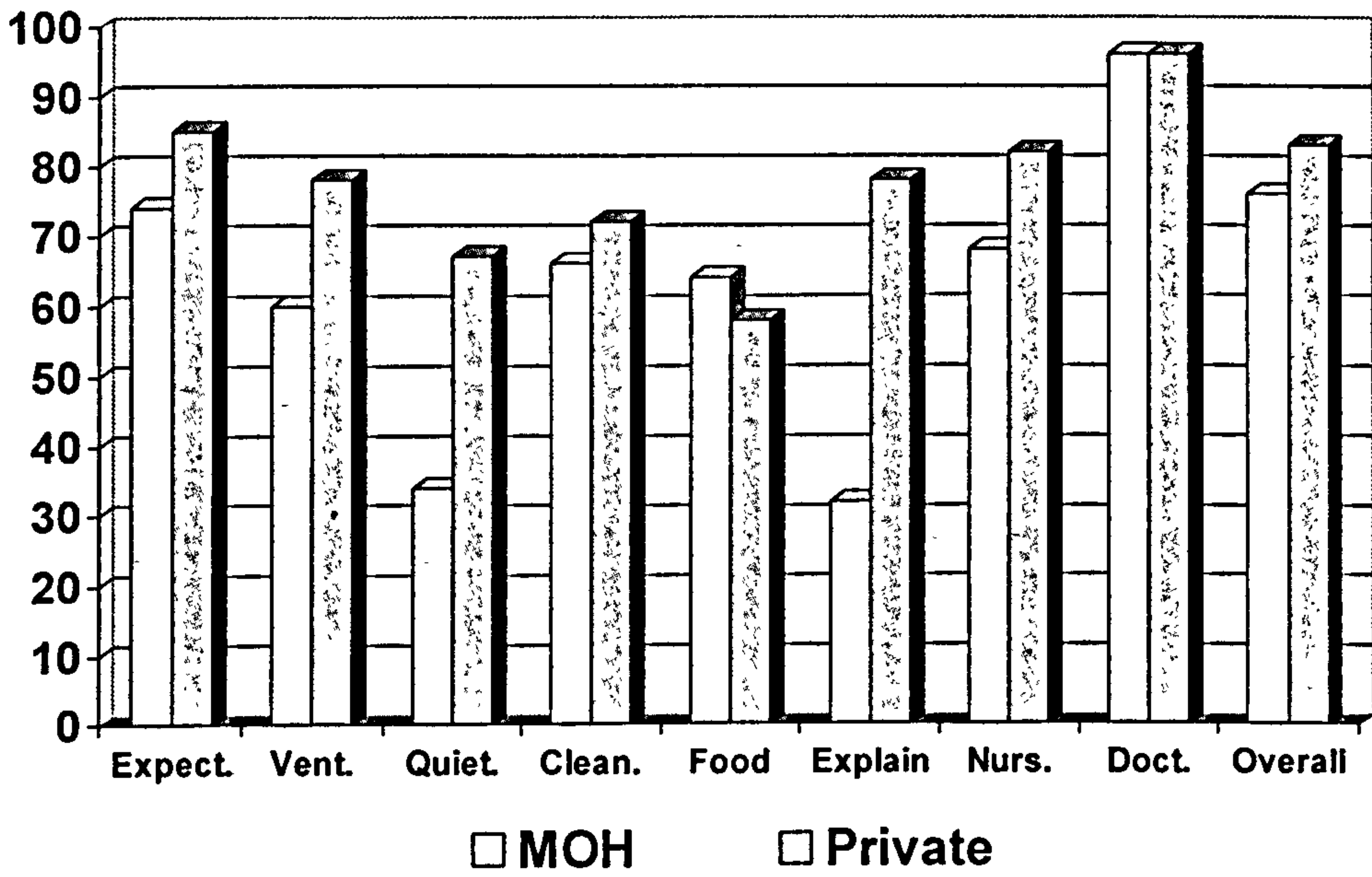


Figure 5.7 Differences in patient satisfaction of selected variables between MOH & Private hospitals during 1st period of action research.

% Satisfaction

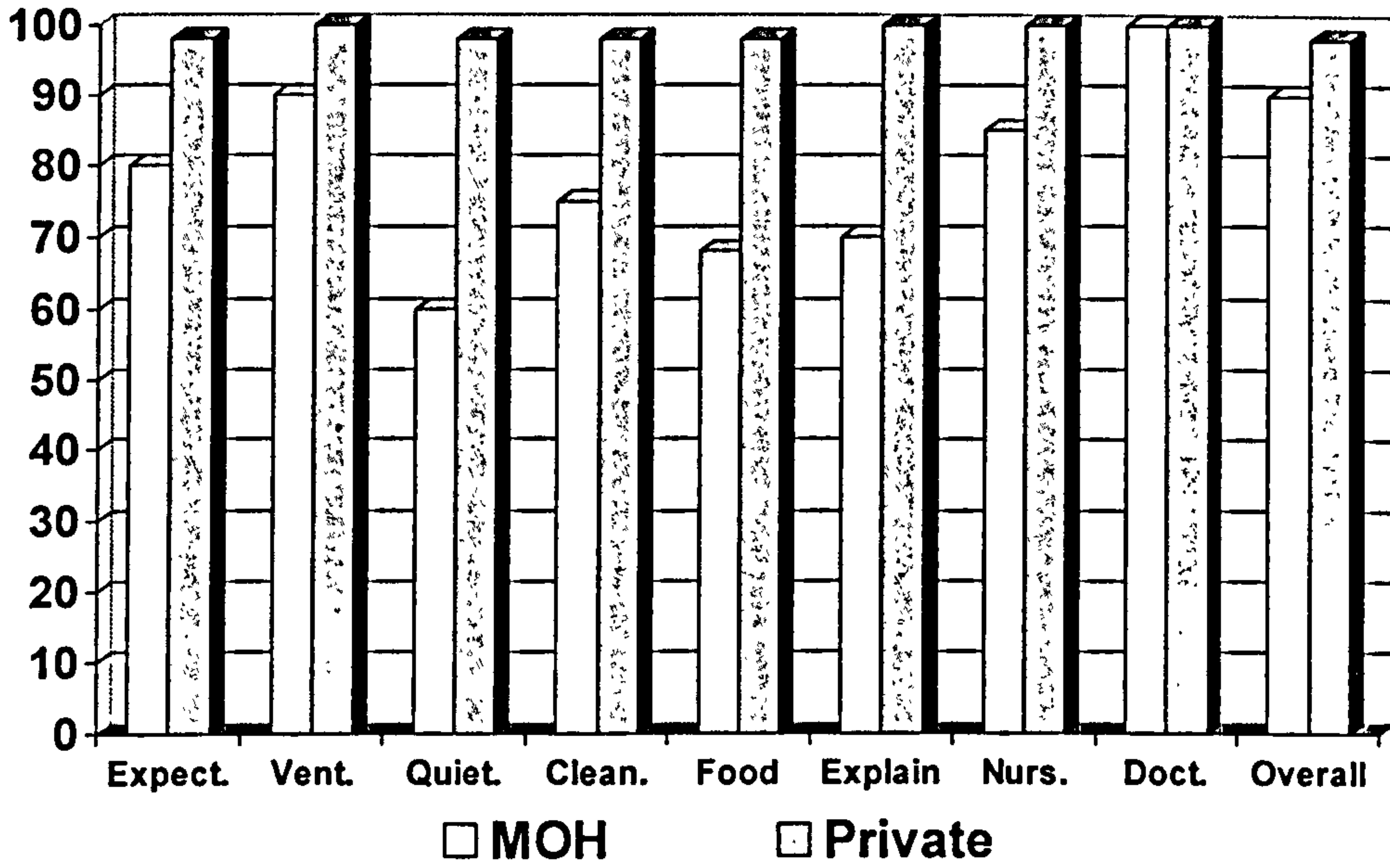


Figure 5.8 Differences in patient satisfaction of selected variables between MOH & Private hospitals during 6th period of action research.

5.3.8 Overall observations on the action research

The CEO of the private hospital attended all of the activities of the workshop and participated very actively in the group sessions and group discussions. In the course of the action research, the CEO left the hospital, but the same level of support was maintained. The CEO of the MOH hospital, the medical director and the director of nursing did not attend any of the sessions inspite of the fact that the workshop was conducted twice in their hospital.

Also the middle management of the MOH hospital showed no real interest. The director of nursing delegated all of the arrangement related to the action research to her assistant. In the private hospital, the Director of Nursing was a very active participant in all of the activities, starting from the initial meetings with the hospital top management until the end when her final report was submitted. Her keen interest and enthusiasm were very obvious, for she always waited patiently for the arrival of the researcher at the main entrance of the hospital for the follow up meetings. When she had to leave the hospital for few days, her deputy stood in to welcome the researcher.

Although a timetable for all of the activities of the action research had been distributed to all the concerned participants at the beginning, the delegated assistant director of nursing for the MOH hospital could not attend some of the meetings because she had to attend another meeting scheduled for the same time. Obviously, the lack of attendance at the meetings hampered the activities. The nursing director of the private hospital attended all of the meetings along with the staff concerned, although the meetings were held during their break.

One of the positive ~~bright~~ aspects of MOH hospital was the interest of quality manager, who exhibited a lot of enthusiasm for all the activities, but could do very little because of the lack of support from the top management. The quality manager of the private hospital participated in the workshop and all other activities.

The liaison with the nursing director of the MOH hospital was very weak, so the quality manager tried to fill this gap. However, she could do very little. The director of nursing played a very active role in the action research in the private hospital. She encouraged her staff during and after the meetings. Moreover, she wrote the minutes of the meetings and followed the implementation of the recommendations of each meeting.

Head nurses of the MOH hospital were very reluctant to complete the bi-weekly reports. Consequently, they failed to provide any constructive ideas to improve the action research in general. Head nurses for the three selected wards in the private hospital attended all of the meetings and participated actively in commenting on the findings in the patient questionnaire.

The bi-weekly reports submitted by the nursing supervisors for each shift in the selected wards revealed many differences between the two hospitals. The MOH nursing supervisors exhibited gross ignorance by leaving out some basic information about their wards. The nurse in charge of nursing education wrote their reports and most of the supervisors had very little to add to what had been written. Their stock reply when asked was that they had no problems in their ward. The bi-weekly reports of nursing supervisors of the private hospital were thoughtfully written and had really valuable information.

In order to eliminate the human factor and to get to real facts of patient questionnaires, the social workers were asked to interview the patients and complete the forms. The private hospital provided three Saudis social workers which made the data collection very smooth. In the MOH hospital, no social worker was provided to help, so the quality manager asked the nurses aids working in the nursing services to help.

Obviously, the number of patients in MOH hospital is far greater than in the private hospital, because it is free. There are more discharged patients and therefore, a greater number of patients should have been interviewed from the MOH. Unfortunately, that was not the case. More patients from the private hospital were interviewed despite the fewer number of patients discharged. It was evident that the help of the social workers with the interviewers could have made the difference.

5.3.9 Researcher's overall observations on the action research

The qualitative observations throughout the period of the action research are presented in the following table.

Table 5.7 Overall comparison of various observations on the two hospitals

<i>No.</i>	<i>Variables</i>	<i>MOH hospital</i>	<i>Private hospital</i>
1	CEO's commitment	Did not attend any function of the action research despite his verbal support at the start when the agreement of the action research was made	Attended the workshop for four hours. This support was not affected when the CEO was replaced one month prior to the end of the research.
2	Nursing director's participation	Did not attend any of the workshops. She delegated the arrangements to her assistant who participated in the first workshop	Attended all of the activities of the workshop and was an observer for the whole group.
3	Attendance at meetings	The assistant director of nursing could not attend some of the meetings despite having agreed to the schedule of meetings at the beginning of the action research.	The nursing director attended all of the meetings except one which was attended by her deputy.
4	Time	Although the meetings were fixed for the lunch break, the assistant nursing director could not attend some of them on time	Though the follow-up meetings were scheduled for the lunch break all of the participants attended
5	Quality management commitment	The manager of quality showed personal interest. She attended the first workshop and participated positively in all of the follow-up meetings	The manager of quality attended the first workshop and was part of the arrangements for the whole action research

cont.

6	Follow up	Contact with the nursing department was not close, so the quality manager took over	Direct liaison with the nursing director was good through personal contact, telephone calls and email
7	Head nurses' commitment	None of them attended the follow-up meetings Although they acknowledged the importance of the action research, they did not participate actively	All the head nurses from all of the participating wards attended all the follow-up meetings and actively participated.
8	Nurses biweekly reports	Their reports were not complete and did not comply with what had been discussed in the follow-up meetings	Their reports were complete and done according to the comments of the researcher during the follow-up meetings
9	Social workers' assistance	Social workers did not participate; the help of part time nursing aids to fill up patient questionnaires was sought.	Three social workers were assigned to administer the patient questionnaire and attend the follow-up meetings
10	Surveyed patients	With no full time social workers to survey the discharged patients, only 12% of the discharged patients were surveyed	Sinec social workers were assigned to administer the questionnaires, 54% of the discharged patients were surveyed
11	Consistency of the bi-weekly reports	The content of the reports showed fluctuating interest	The reports shows consistent logical progress
12	Application of the workshop concepts	The reports bore no relationship with what had been discussed in the workshop	The reports shows compliance with the concepts discussed in the workshop

13	Team work	The support for the implementation of the research was of personal interest to the quality manager and the assistant director of nursing only	All of the parties participating in the action research worked as a team toward the success of the ultimate goal of patient satisfaction
14	Human resources	The director of nursing argued that because of the lack of resources, she could not give support to the research.	Head nurses were given the authority to coordinate with other departments concerned to facilitate patient satisfaction for their patients
15	Material resources	The assistant director of nursing had no alternative but to use second-hand papers to Xerox patient questionnaire because of the lack of paper.	All of the forms were prepared and photocopied as needed and kept in files for the researcher to collect at the end of each period

5.4 SUMMARY OF RESULTS

5.4.1 The descriptive study

5.4.1.1 Overview of the hospitals

5.4.1.1.1 General information on the hospitals

- The total number of hospitals included in the descriptive study was 20, more than half of which were private.
- Most of the hospitals were located in the Dammam region because it is the main region of the province.
- Private hospitals tended to operate a moderate number of beds compared with MOH which has either very large or small hospitals, as well as primary health centers.

- The occupancy rate was more than 50% in most of the hospitals.
- Most of the hospitals run the medical services themselves and had contractors for other operational and support services.

5.4.1.1.2. Information on quality program

- Nineteen hospitals had quality programs
- Fifteen quality 'in-charge' of the hospitals report directly to the top management.
- Most of the hospitals had written quality plans, but not all of them implemented these plans in full.
- Most of the hospitals train their staff on quality.

5.4.1.1.3. Information on the 'in-charge' of the quality program

- The number of Saudis in this position was minimal.
- There were more males than females.
- They had responsibilities other than their oversight for quality.
- They were well-qualified and attended courses in quality.
- The turnover of the 'in-charge' of quality was limited.
- They had spent more than one year in their positions.

5.4.1.1.4. Information on the outcomes

- Most of the hospitals had standards to monitor their services.
- Most of them monitored patient satisfaction
- Scant attention was paid to staff satisfaction and there was little monitoring of this.

5.4.1.2 Hospital senior and middle managers information

5.4.1.2.1 Distribution of hospital senior and middle managers according to their place of work

- Most of the HSMM worked in the Dammam region, a smaller number in the AlHasa region and the fewest in Hafr Al Batin.

5.4.1.2.2 The characteristics of hospital senior and middle managers

- Almost half of the HSMM were senior managers while the other half was middle managers.
- Half the total number of HSMM were below 40 years of age and the other half were more than 40.
- Males were predominant in the senior level, while females occupied some of the middle management positions.
- Saudi nationals were fewer than non-Saudis in general.
- Physicians formed the majority of HSMM.
- Around one fourth of HSMM had had no training in quality.

5.4.1.2.3 Hospital senior and middle managers' definition of quality

- HSMM who defined quality correctly were more than those who did not.
- More non-Saudi HSMM than Saudis defined quality correctly.

5.4.1.2.4 Knowledge and attitude of hospital senior and middle managers according to their managerial level

- The response of HSMM based on their managerial level showed no significant differences among all of the variables of the four aspects.

- These aspects covered general information about quality, factors that enhance quality program, the causes of quality program failure and the ranking of priorities for the implementation of quality programs.

5.4.1.2.5 Knowledge and attitude of hospital senior and middle managers according to their training on quality

- There was no significant difference on the impact of attendance at courses in quality on the response given by HSMM for the definition of quality. Almost the same percentages defined quality in the same way.
- General information about quality. The trained HSMM showed significant difference towards the following variables :
 - Giving the staff the opportunity to participate in the preparation of quality.
 - Moving quality programs from inspection-based management to process improvement .
 - The knowledge of how to implement quality programs.
 - The importance of quality programs for the survival of the hospital.
 - The difficulty of implementing quality program.
 - The understanding of the continuous nature of quality programs.
- The important factors in implementing quality programs. There were significant differences among the trained HSMM towards the following variables
 - Advocating zero defect principle
 - Evaluation quality through evaluation of mistakes.
 - Measuring quality through its compliance with patient's requirements.
- The causes of quality program failure. There was a significant difference among the following variables
 - Shortage of time allocated for implementation.

- Ignorance of good results.
- Ranking of priorities in the implementation of quality programs. The trained HSMM showed significant differences towards the following variables
 - Meeting patients' needs.
 - Ensuring availability of information on quality.
 - Getting the staff committed to the mission of the hospital.
 - Reinforcing technical staff's managerial skills.
 - Getting patient's views about the health care provided.
 - Giving staff power to improve health care quality.
 - Getting staff's views on their job satisfaction.
 - Providing staff autonomy.

5.4.2 The action research

5.4.2.1 Nurses' characteristics and background

- Nurses of medical and surgical wards were included in the study .
- The number of nurses of the private hospital was approximately one half of the number of those in the MOH hospital.
- The experience, qualification, background about quality, age and gender distribution of the nurses was almost the same in both hospitals.
- The nurses of the private hospital got training in quality.
- Saudi nurses were more than the non-Saudis in the MOH hospital

5.4.2.2 Nurses' contribution

- The commitment of the senior and middle management was clearly indicated by the contribution of the nurses.

- Nurses of the MOH were not very interested in achieving the ultimate goal to satisfy the patients, while the nurses of the private hospital considered it a challenge.
- The nurses of the MOH hospital were indifferent to the patient satisfaction and looked at the parameters of the study from the staff point of view despite the repeated advice in the follow-up meetings not to do so.
- The bi-weekly reports of the MOH nurses showed sporadic interest to improve patient satisfaction.
- The private hospital bi-weekly reports showed steady improvement.
- The solutions of the problems with patient satisfaction suggested by the MOH nurses were very superficial, while those from the private hospital were well thought out and creative.
- The reports and the follow-up activities of the nurses of the private hospital were completed on time, but those of the MOH hospital were done hurriedly on the last day.
- The private hospital nurses looked for change, but the MOH nurses only blamed others for failure.
- The private hospital nurses followed up on their suggested solution, but the nurses of the MOH forgot about it.

5.4.2.3 Patient characteristics

- More Saudi patients went to the MOH rather than non-Saudis.
- Patients attending both hospitals were mostly from the urban areas.
- There were more male patients in the private hospital.

- Most of the patients attending the private hospital were less than forty years of age.
- Private hospital patients included one unmarried man.
- The patients of the private hospital were better educated.
- Professionals and students were more among those attending the MOH hospital, while there were more administrators and technicians in the private hospital.
- Both categories of patients indicated that their main source of health care was the hospital where they were surveyed.

5.4.2.4 Patient satisfaction

- The action research contributes to the improvement of the previous experience and expectations of the patients of both hospitals.
- The physical environment had a significant effect on patient satisfaction. The private hospital was able to achieve a higher percentage of patient satisfaction.
- The patients of the private hospital were more satisfied with the communication and information received from the nurses although the MOH hospitals had more Saudi nurses.
- The patients of the private hospital were given more opportunities to participate in planning their treatment than the patients of the MOH, which increased their satisfaction.
- The interpersonal relationship among nurses and the patients of the private hospital was better and contributed positively towards patient satisfaction.
- The patients of the private hospital were more satisfied with the nursing services.
- The overall satisfaction level was almost the same.

5.4.2.5 Researcher's overall observations on the action research

- The CEO and the nursing director of the private hospital exhibited a very keen interest and participated actively.
- The participants from the private hospital attended all the meetings and participated actively.
- Quality managers of both hospitals participated in the research.
- There was close communication with the director of nursing in the private hospital, but the managers of quality formed the link in the MOH hospital.
- All of the head nurses of the private hospital attended all the meetings, whereas none from the MOH hospital attended the meeting.
- The bi-weekly reports of the nurses of the private hospital were full, whereas those from the nurses of the MOH were not.
- The social workers of the private hospital completed the questionnaires, while nurses' aids completed those for the MOH hospital.
- The surveyed patients of the private hospital was 54%, whereas only 12% was surveyed in the MOH hospital.
- The content of the bi-weekly reports of the MOH were not consistent, but those of the private hospital were consistent and showed logical progress.
- The nurses of the private hospital were keener to apply the concepts learnt from the workshop in order to give greater satisfaction to their patients.
- The driving force of the research in the MOH was the personal interest of the quality manager and the assistant nursing director, while in private hospital there was a concerted effort and interest of all parties.
- The director of nursing in the MOH hospital argued that she did not have enough manpower to complete the questionnaires, whereas the director of nursing in the

private hospital was given the mandate to coopt staff from other departments to facilitate the implementation of the study.

- The top management of the private hospital made all material resources required for the study available to the Nursing Department, whereas the department of nursing in the MOH could not even manage paper for Xeroxing the forms.

CHAPTER SIX

DISCUSSION

In the previous chapter, the results of the descriptive study and the action research were presented. This chapter links the results with the Donabedian's (1980) approach to quality assessment. The main findings of the study were:

- No significant differences among HSMM at their managerial level regarding quality concepts.
- Attending training in quality did create a change in HSMM perception of quality.
- The findings of the action research demonstrate the importance of HSMM support for quality programmes.

Merry (2001) stated that the Avedis Donabedian's structure – process – outcome quality model and Paul Ellwood's outcome measurement concepts played a major role in the history and the quality of health care. Donabedian argued that there are three ways of assessing quality. The structure of the organization, the outcome of the system and the process. He stated that the process was the most important component of the three.

Evaluating the process of HSMM's support for quality programmes was the cornerstone of this study. The HSMM questionnaire, together with the action research, were meant to assess the process of quality in the selected hospitals. The checklist was used to present a picture of the structure of the resources and the physical and the organizational settings of the hospitals. The outcome of those

hospitals was also studied with regard to patient and staff satisfaction. The process of the descriptive study was assessed through the HSMM knowledge and attitude dimensions as revealed by the self-administered questionnaire distributed to HSMM.

The action research magnified the process to give a clear indication of the practice of the HSMM in quality programs. This offered the opportunity to investigate the process more fully by monitoring the support of the HSMM for the team implementing the action research in the two hospitals. The plan of the action research dealt with the structure of the studied wards with regard to the nurses and the patients. The main characteristics of the nurses and the patients were investigated. The outcome of the action research was also demonstrated by the response of the patients to the studied variables. The activities of the nurses during the period of the action research formed the process. The aim of the nurses was to satisfy their patients by means of specific variables. They were given the tools for time management, the means to take part in some of the managerial activities and develop problem-solving skills to improve the satisfaction of the patients in their wards. The support of the HSMM was monitored and documented at all stages of the action research.

6.1 THE DESCRIPTIVE STUDY

6.1.1 The structure

In order to provide quality health care services, HSMM should be aware of the rising expectations of people as a result of education and general interest in health. They should also be aware that all over the world the available resources are unable to meet the increasing patient expectations. This has led to increased emphasis on the maintenance of standards so that resources can be used as effectively as possible (Holland, 1984; Ellis, 1993). Although it does not reveal how well facilities are

performing, the simple effective method of investigating structure is by the use of a simple checklist and this approach is advocated by Garner (1990). The researcher therefore developed a checklist to get information about:

- the hospital.
- the quality program.
- the person in charge of the quality program.

In the present study, the information about the hospitals showed that the 20 hospitals included in the study had common features. Most had quality programs with written quality plans and an orientation training for their staff on quality concepts. All of the hospitals had quality departments. The turnover of the persons in-charge of quality was not high. Most of them had relevant qualifications and had attended a number of training courses on quality. Therefore, quality programmes is expected to achieve its goals. The internal as well as the external customers should be satisfied. Medical errors should be at their minimum level.

6.1.2 The outcome

Almost all of the hospitals included in the study had standards by which their services were monitored. Most of the hospitals routinely evaluated their patient and staff satisfaction. The monitoring of patients and staff satisfaction reflects the depth of understanding of the knowledge of the HSMM on how to achieve quality health care.

This trend shows the genuine desire to provide quality service in the hospital as advocated by the 'quality gurus'. Deming (1986) believed that, for organizations to survive, they must learn what products and services their customers required and do their utmost to provide them. He criticized the traditional North American management methods of ignoring long-term investments aimed at improving quality

and productivity for the sake of short-term profits. Overall, Deming's approach was an amalgamation of loosely-related and often unoriginal ideas which, on implementation, formed a management style and organizational process that improved quality throughout the organization.

With its emphasis on customer satisfaction, continuous improvement, problem solving processes and employee empowerment (Hackman, 1995; Westphal, 1997), TQM (total quality management) stands out as one of the most obvious ways for hospitals to reduce cost and increase revenue. While some health care professionals are concerned that TQM is another 'fad', Richard L. Clark, President of the Healthcare Financial Management Association (HFMA), stated that TQM will endure because when properly implemented management are compelled to be customer-oriented (Anderson, 1991).

Many health care organizations have applied the principle of TQM to reduce waste and complexity (Berwick, 1989). One means of facilitating quality transformation in a health care organization is to implement a customer information system (CIS) - a system for collecting, archiving, and accessing information about customers. Health care organizations that establish a CIS have a greater chance of success in their effect for quality improvement (Berwick, 1989).

The quality of care based on JCAHO (1992) criteria included a feature of excellence that goes beyond the expectation of the client. Therefore, quality is mainly concerned with anticipating, meeting and exceeding customer expectations. The principles of TQM are, therefore, recommended for application to Health Care.

One of the problems of health care is the difficulty of relating outcome to quality health care. (Donabedian, 1966 and 1988; Buck, 1980; Opit, 1991; Harley, 1991). Opit (1991) posits that scientific methods and a valid epidemiological approach are useful to inform about outcomes mainly because of the inconsistent, broad and ambiguous interpretations given. Secondly, it is advisable not to overplay the emphasis on outcome since it has its own weaknesses (Davies, 1995).

Quality assurance ensures that all steps necessary for the provision of quality care to patients are actually taken. It can also mean convincing a customer that certain standards are maintained to achieve quality. A strict definition would limit its applicability to the process whereby customers, in particular, become convinced (Ellis, 1993).

Kanji (2003) has recently demonstrated that the health care sector is one of the fastest growing areas of the economy of most developed countries. Governments (and taxpayers) are investing increasingly larger amounts of money, either directly or indirectly, and expect high quality services in return. The reality, however, is often different: long waiting times, inefficiency, low productivity, stressed medical staff and less than satisfied patients. The literature indicates very clearly that the expected outcome of quality health care are patient satisfaction and staff satisfaction. Whenever these two aims are not satisfactorily met, there might be a flaw in either the structure or the quality system process of the hospital

In this study, there was an in-depth investigation of the outcome of the studied hospital but this was not the ultimate goal of the study. The outcome indicators were used here to check the knowledge of HSMM of the importance of using this measure to monitor quality. This issue was doubly checked with the information collected

through the support of HSMM to the action research to be discussed later in this chapter. Interestingly enough, although the check list indicated that the hospitals monitor patient satisfaction, HSMM of the MOH hospital support for the action research was minimal. This shows that there is a gap between what is claimed and the actual practice.

6.1.3 The process

The driving force of the process in general in the hospital is the knowledge and the attitude of the HSMM. The tool used to assess the knowledge and the attitude of the HSMM was a pre-designed self-administrated questionnaire which comprised four different groups of variables:

- General information about quality.
- The important factors in implementing quality programs.
- The causes of quality program failure.
- Ranking of priorities regarding the implementation of quality.

In the 1950s, Deming gave lectures and conducted training sessions for top managers, during which he convinced the Japanese business community that it could compete favorably with the rest of the world on the basis of quality. He emphasized the importance of quality and helped educate Japanese manufacturing company heads in statistical quality improvement methods that they adopted and still use today. Deming's efforts received widespread recognition in the United States after the airing of a 1980 NBC documentary: "If Japan can do it, why can't we." Many US manufacturing firms including Ford and General Motors hired Deming as a consultant and implemented his principles of quality management (Lynn, 1991).

Deming's approach is process rather than outcome-oriented. He assumes that workers are committed both to excellence and to working at maximum capacity and that when management leads in a desired direction, workers' evaluation is superfluous. Deming suggests that organizational problems are more likely to result from inefficient management or work procedures rather than from a lack of worker effort. Indeed, Deming suggests that about 85% of the quality problems experienced within organizations lie with management and only 15% with workers (Deming, 1986).

Deming's view is that economic stability of the organization requires the development of an atmosphere of constant change and innovation. A reactive strategy of knee-jerk response to adversity without a guiding vision or strategy will lead to economic decline and threaten the survival of the organization. Top managements must take the initiative to ensure an open atmosphere of creativity, innovation and creative risk taking, even if the consequences are negative in the short term. Implicit in this philosophy is the belief in developing continuous educational programs for all employees. In this way, management is able to make use of all the skills and expertise of the empowered work force (Deming, 1982, 1986; Logothetis, 1992).

Deming's philosophy revolved around the concept of continuous process improvement and a belief that management should create a work environment that promotes continual improvement in all processes within the organization. He emphasized that employees who are closest to the day-to-day operations must be involved in improving quality and must be appreciated for their efforts. Deming also advocated training workers in process improvement techniques, and applied these to all aspects of a firm, including product design, marketing, operations, purchasing, administration, record keeping and service. Consequently, Deming criticized the use

of slogans, campaigns, and incentives to motivate workers to improve quality, unless techniques and methods for quality improvements were also provided. He suggested that organizations should develop positive, cooperative relationships with a few suppliers and vendors so that quality problems can be eliminated (Deming, 1986).

To implement organization-wide evaluation standard of performance and evaluation criteria, Juran recommends the use of control charts. After quality standard has been established, Juran considers it necessary to monitor performance continually to detect non-conformance and initiate change to achieve reduction in both error rate and variation over time. Perhaps the most intriguing feature of Juran's modified control chart is the extreme fluctuation that occurs during change periods. Juran seems to recognize that as change is introduced and the status quo is disrupted, work performance becomes erratic during the adjustment period. After workers become adjusted to the change, performance should improve in terms of the reduction in the number of errors and the degree to which performance fluctuates (Juran, 1980 and 1988; Logothetis, 1992). In conclusion, Juran's contribution focuses mainly on the use of statistical and quality circles involving employees for a general quality management (Koch, 1992; Abdelhak, 2001; Slovensky, 2001).

For Crosby, quality is complete conformance to standards (zero defects), a much more rigid definition of quality performance and excellence than employed by either Deming or Juran (Crosby, 1979; Logothetis, 1992). Even a 99.9% efficiency level would be unacceptable. This definition may be especially applicable in health care, where errors are likely to lead to irreversible consequences (e.g. death).

In contrast to Deming, Crosby (1979) is a strong advocate of goal setting, merit pay, recognition of 'champions' or 'stars', and exhortation of employees through slogans

and competitions. Quality is implemented through the development of educational programs, mass media and the promotions of human relations and management's total and visible commitment to quality. Although Deming and Juran both advocate team building and group process, Crosby strongly focuses on the value of team decision-making as the primary method of worker empowerment.

Ishikawa believed that information about processes and output was a crucial precursor to improving quality and is credited with the maxim that the bedrock of quality is education (Peters, 1986). Ishikawa's contributions to quality control and quality management have been recognized through prestigious awards in both Japan and United States, notably the Deming prize, the Second Order of the Treasure, The Grant Award and the Shewhart Medal. Another point worth mentioning is that quality assurance should be based on a sound system design, followed by continuing performance evaluation leading to appropriate educational- motivational activities and to readjustment in system design (WHO 1994).

Related to the issue of sustainability, and important in the quality assurance process is the commitment, is the honesty and the competence of the staff. These are all central to the process and come through the complete involvement of every member of staff in the entire process of the quality assurance, and by gaining the complete confidence of the staff in the process. This is not easy and many approaches have been suggested which emphasize the fact that the quality and the effectiveness of all the human endeavour depend on the commitment and involvement of every staff member, especially the lower level front-line providers of all aspects of the organization's product (DeFriese, 1992; Gould, 1992; Ellis, 1993; WHO, 1994; De Geyndt, 1995).

All the literature states that process is the cornerstone of good quality system. The only party who can translate the importance of process into work is HSMM. Consequently, the role of HSMM towards the implementation of quality services is crucial. Their knowledge about quality, their attitude towards the implementation of the concepts of quality and how much of it they really practice is of vital importance. Self-administered questionnaires were distributed to them, to elicit information on certain characteristics. Their knowledge of the definition of quality, basic information about quality aspects, the important factors in implementing quality programs, the causes of the failure of quality programs and the ranking of some of the important aspects of implementing quality program.

In the present study there was almost the same number of participants of senior and middle managers. Their responses on the variables of the questionnaire were classified according to managerial level, as well as the training courses on quality attended. The statistical analysis revealed that there were no significant differences in their responses based on the managerial level but there were numerous significant differences among some of the variables according to the training in quality they had received. Trained HSMM demonstrated better response with regards to the variables of the general information about quality, the important factors in implementing quality programmes, the causes of quality programme failure and the ranking of priorities of the implementation of quality programmes.

6.1.3.1 HSMM definition of quality

There are many definitions of quality such as those proposed by Roemer (1988) stating that it is the degree to which the resources of health care services provided in health care correspond to specific standards. While evaluating Donabedian's (1980)

definition of quality, Linsk (1990) put in three limitations: lack of consideration for other clients in health care, the static approach to quality and the tendency to focus on physicians as well as on certain aspects of physician's performance (Linsk, 1990). However, Maxwell's definition was adopted for this study because of comprehensiveness and the ease with which it allows the knowledge of HSMM to be assessed. The six dimensions of quality health care raised by Maxwell (1984) were at the top of the general concepts of quality used to assess the knowledge of HSMM. A "strongly agree" response by HSMM on these six dimensions was considered a complete definition; anything else was considered incomplete. These six dimensions were access, equity, relevant to need, social acceptance, efficiency and effectiveness.

There was no significant difference in the responses of HSMM on the definition based on the managerial level or on the training courses attended. In other words, all of the HSMM in this study correctly defined quality as stated by Maxwell. This may explain the cause behind the limited support HSMM provided to the action research because quality is something to practice not merely theories.

6.1.3.2. HSMM's knowledge, importance and priority of quality program

HSMM's knowledge, importance and priority of quality programs were investigated through four different groups of variables in the questionnaire. The responses of HSMM were statistically tested against their managerial level, senior and middle management. The same statistical tests were done with reference to the training courses on quality attended by the HSMM.

The first test revealed no significant differences between senior and middle managers with regard to the four groups of variables:

- General information about quality.

- The important factors in implementing quality programs.
- The causes of quality program failure.
- Ranking of priorities regarding the implementation of quality programs.

However, there were significant differences with regard to the training courses attended by the HSMM as stated in the results chapter. The consequences of this difference were reflected by certain variables in the responses of HSMM to the general concepts of quality. The variables listed below demonstrated the differences between the trained and untrained HSMM:

- Giving the staff the opportunity to participate in the preparation of quality programs (QP) from the initial stages as emphasized by Angie (2000).
- Moving quality programs from inspection-based management to process improvement as confirmed by Goleman (2001).
- The knowledge of how to implement QP.
- The importance of QP for the survival of the hospital as discussed by Narine (2003).

HSMM's perception of the important factors involved in implementing quality programs is determined by their training background. Trained HSMM differed significantly from the untrained in their support of the zero defect principle, assessing quality through the evaluation of mistakes and measuring quality through compliance with patient's requirements. From this point of view, Larson (2004) demonstrated that any unit in the hospital could be effective provided it functioned as a single entity to provide the quality of service which met the patient's needs. Jermyn (2000) was very conservative in dealing with the pressure of evaluating mistakes. He claimed it could create dishonesty and result in an environment in which mistakes are covered up rather than admitted, and opportunities for improvement missed.

Trained HSMM attributed the failure of QP more significantly to the shortage of time allocated for the implementation. This factor was also raised by Yasin (1999). They also gave more significant priority to meeting patients' needs (Goleman, 2001). Ensuring availability of information on quality was also one of the main issues according to Waldman (2003). Mintzbergs (1975) and Narine (2003) considered staff commitment to the mission of the hospital as an essential factor for QP. For Goleman (2001) and Sylvia Vriesendrop and Riitta-Liisa (1999), reinforcing technical staff's managerial skills is considered one of the most vital factors for the success of QP. Goleman (2001) concluded that getting patients' views about the health care provided was the most essential. The empowerment of staff was posited by Aitken (1999) as among the most important factor necessary for the improvement of the quality of health care. The importance of the staff's views on their job satisfaction was also emphasized by Goleman (2001) and Aitken (1999). The above discussed literature supports the findings of this study.

6.2 THE ACTION RESEARCH

This research was conducted alongside the descriptive study to discover how much of what they advocated in terms of quality program implementation the senior and middle managers practiced. In general, HSMM had the amount of knowledge necessary for the start of a good quality program. The most serious problem is the line of demarcation between a successful quality program and unsuccessful one. The provision of enough resources, and participation in the activities of quality in the hospital would help bring about a solution rather create problems. These values distinguish between supportive senior and middle managers in one hospital from another hospital which only pays lip service to quality.

The plan of the action research was built on the selection of a service in the hospital which could very clearly reflect HSMM support for QP. Choosing the indicator service was based on its strong effect on the success of QP. In every part of the globe, nursing is a major determinant of the quality of health care (Al-Kandari, 1998). Patient satisfaction was the indicator of quality service in the selected wards. Patient satisfaction is closely linked to the quality of nursing care because, as Mahon (1996) stated, most of health care is nursing care. Since there are no statistical differences between the patients in the surgical and medical wards in their perception of the quality of nursing care (Al-Kandary, 1998; Hallstrom, 2001), the patients of those wards were the participants in the action research. The overall objective of the action research decided in collaboration with the nurses of the two hospitals, was to achieve the maximum patient satisfaction possible by the end of the three months of the action research period. The activities of the action research started with an interventional aspect in the form of educational workshop on four subjects. The subjects were chosen to improve the critical thinking in looking for creative solutions to patient dissatisfaction (Bellman, 1996). Eight main domains (Johansson, 2002) were included in both patient questionnaires which were completed by the social workers and the head nurses in their biweekly reports. The head nurses were asked to utilize the information and skills discussed in the workshop to monitor patient satisfaction through the set domains and complete the report using spaces provided. They dealt with the obstacles preventing them from satisfying the patients, the corrective action taken to solve those problems and their level of satisfaction at the end of the two weeks, the time allocated for each period of the action research. This process reflected the planning, action taken and the observation which formed the stages of the action research as indicated by Paul (2000). The last stage was the reflection of the statistical

results of patient questionnaire and the nurses' biweekly reports which were discussed with the group at the subsequent meeting. These activities continued for three months with the collection of data every two weeks, before a follow-up meeting to discuss the opportunities for improvements. The end result of the action research was reflected in the patient views.

Previous experience

Although the prime objective of a patient in coming into hospital is to get relief from a disease, the facilities provided play a considerable role in a patient's previous experience of the hospital. Nevertheless, hospitals in general, are not favourite places. Shattell (2005) indicated that the experience of patients of a hospital was that it was a place they did not want to go to, where they did not want to be, and were always glad to leave as quickly as possible. MOH hospitals view amenities as a luxury which can be done without. In the private sector where competition for patients is keen, amenities are important. Nevertheless, building a good lasting image takes time. However, the improvement of patient satisfaction during the six periods by the action research could have contributed to the significant difference between the two hospitals when the sixth period was compared with the first.

Expectation

The majority of the patients of both hospitals had health care from the same source during the survey. This means that they were accustomed to a certain level of service with which they were satisfied. Kralik (1997) discussed the view that patients had certain ideas on how nurses should act. Therefore, nurses could have a positive or a negative impact on patients, and how they were perceived by the patients could reflect on the outcome of the nursing care. Thus, there was no significant difference on

patients' level of satisfaction regarding their expectations in the first period. There was a significant difference in the sixth period of the research. This difference could again be attributed partly to the image built during the period of the action research.

Physical environment

The four components of the physical environment form an area for possible improvement and competition among the private hospitals but not in the MOH hospitals. There is no urgent interest in improving the physical environment of the hospital because of the fact that limited resources are not utilized judiciously for the benefit of the patients. This had a negative reflection on patient satisfaction on two of the physical environment variables during the first period. Good ventilation and a quiet environment are very important physical features especially in a country with very high summer temperatures. The last period of the action research revealed a bigger significant difference among the four physical environment variables. Fottler, (2000) stated that the healthcare industry has recognized that the physical environment is a valuable resource that can and does affect all of its customers.

Communication and information

There was no significant difference between the two hospitals in the first two variables of communication. In the first period, there was no difference between the two hospitals in the first variable which dealt with the ward and the treatment plan. The nurses in both hospitals talked about their difficulties in communicating with the patients. Most of the nurses were non-Arabic speaking, so there was a serious language barrier in communicating with the patients. The nurses of the private hospital gave this problem as much attention as they could. They sought help from Arabic speaking staff members including social workers. They even tried hard to

solve their problems of communication with those patients who spoke neither Arabic nor English. They had a register of all the staff working in the hospital and the languages they spoke. They found that the hospital staff comprised 15 different nationalities with different languages. Arrangements were made to solicit help from those staff members whenever necessary. These innovative solutions made the differences more significant in the last period of the study. Pontin (1996) advocated that by facilitating communication between nurses and patients, the nurses' role is enhanced.

Participation and involvement

There was no significant difference in the two variables of this domain. Nurses usually decide for the patient; rarely are patients asked to participate in the planning of the management of their conditions or treatments. This situation was prevalent in both hospitals. The nurses of the private hospital realised this and in second period, started changing their practice until there was very high significant difference between them and the MOH hospital.

Interpersonal relationship

During the first period there was a significant difference between the nurses of the two hospitals regarding their response to the call for change. Thus, with three of the four variables of this domain, there were no differences between the two hospitals. The attentiveness, patience and the responsiveness to the patients' requests were similar in the two hospitals during the first period. The nurses of the private hospital were significantly more attentive during the last period than MOH nurses. This change in their attitude indicates their readiness to do whatever was necessary for the benefit of their patients and their hospital. Shattell (2005) concluded that patients

determine the quality of their care by their relationships with nurses. However, for Oermann (1999) interpersonal relationships of physicians, nurses, and other care providers with patients and families are also important factors that determine the quality of care.

Medical and technical competency

Medical care which was reflected by the physicians' attitude towards the patients was scored very high in the two hospitals during the first and the last periods. This was to be expected since the principal objective of any hospital is the medical care. The nursing care showed a difference between the two hospitals. The private hospital was significantly better than the MOH hospital. Since nursing services are more skill-based, Meretoja (2003) concluded that the competence of nurses could be measured by their performance. The variation between the two hospitals could be explained in terms of the nursing competency.

Overall satisfaction

Though patients might not be happy with some of the variables, their overall satisfaction is usually good if their condition improved. This was the case with most of the patients. It was unusual to have a patient respond 'neutral', 'do not agree' or even 'strongly disagree' to some of the variables and yet indicate an overall satisfaction of 'satisfied' or even 'very satisfied'. This could be the explanation for almost all similar overall satisfaction levels despite the significant differences in many variables between the two hospitals. The same conclusion was drawn by McColl (1996) who stated that overall satisfaction with nursing services was higher than specific satisfaction with certain variables.

The results of the patient satisfaction discussed earlier show that MOH failed to achieve a high level of patient satisfaction, since the results fluctuated within the same range throughout the study period. There was, however, very remarkable progress in the level of patient satisfaction in the private hospital. There was a vast difference between the two even though the two groups of nurses had the same characteristics and information. Moreover, the patients themselves had almost the same demographic characteristics. The only factor measured in the present study that could account for this difference is the support of the top management.

Therefore, the results of the action research of this study could be considered as evidence that the quality program in the hospital cannot succeed without total support of its top management.

6.3 SUMMARY

Obviously, the commitment of the top management is crucial to the implementation of a quality program (Lammers, 1996). This study could have gone further to investigate the extent of commitment needed for a successful quality program. It, however, revealed that a majority of senior and middle managers had enough knowledge to start very promising quality programs, but the strong positive attitude to quality was largely absent. This ultimately affected the genuine practice of quality programs. Senior and middle managers need to demonstrate their commitment to quality not simply verbally but by their active resolve to support it (Aitken, 1999).

Attending training courses in quality subjects made a significant difference to the general information, factors that enhance quality programs, causes of the failure of quality program and the ranking of HSMM towards quality programs. A classification

of all the significant variables according to their relation with the patient, to quality programs and to the staff showed clearly that most of these variables were related to the attitude. This may explain the similarity of the HSMM at their senior and middle managerial levels. However, the differences arising out of their training need to be explored.

This gap between verbal support and real active support was investigated and well documented in the action research. It showed the difference between the real supportive top management and the unsupportive management. The results of this action research may be utilized as a means of implementing a very successful quality program. The sequence of activities of the action research of this study could be used as a model for improving any service of the hospital.

Though the two hospitals had similar inputs in terms of patients and nurses, the output was markedly different. The researcher concludes that the process should be carefully examined. The greatest influence on the functions of the action research was probably the support of the top and senior management support. What the researcher observed in the course of the action research gave an indication of the final outcome and the differences that emerged. The results of patient satisfaction show that both hospitals had the potential to achieve the same results, provided, their top and senior managers were equally committed towards the implementation of quality programs.

6.4 Limitations of the present study

There are some limitations to the present study:

- A limited number of hospital was included in the study, due to time and resource constraints and generalizability beyond the study is limited.

- The views of staff usually affected by the quality programmes of the hospital, would have been valuable if included.
- Involving the researcher in visiting all of the hospitals included, to complete the check list was time consuming and may have affected the reliability of data.

To some extent these limitations could be overcome by:

- Increasing the number of hospitals involved in the action research which would give more detailed information about different hospitals with regards to the issues addressed in this study.
- More clinical specialties could be included to give a more complete picture of HSMM across the hospital setting.
- The results of the action research would be better if more time was allocated to it.

CHAPTER SEVEN

CONCLUSION & RECOMMENDATIONS

In the previous chapter, the theoretical concepts of quality and the results of this study were linked to the discussion of the data of the study. This chapter draws conclusions from the study and provides some recommendations.

This study set out to answer the following questions:

- Q. 1. How correctly do HSMM define and perceive quality health care?
- Q. 2. In the actual practice of HSMM, what level of importance and priority do they give to the provision of quality health care?
- Q.3. What measures are HSMM currently undertaking to ensure and enhance the provision of quality health care in their hospital?
- Q.4. How supportive will they actually be to small action quality research to be implemented in their hospital?

The first question was answered through the HSMM questionnaire. Their definition of quality as well as their perception of it was demonstrated by their views towards the variables of the questionnaire.

The second question was investigated through the effect of training on the views of HSMM towards the four groups of variables included in the questionnaire.

The third question was answered by the data gathered through the checklist about the hospitals included in the study. The general information about the hospitals, the information about the quality program, the information about the person in-charge of quality program and the information about the outcomes of the health care in the

hospital the analysis of all of these aspects gave good indications about the measures which HSMM currently undertake to ensure and enhance the provision of quality health care in their hospital.

The fourth question was answered by implementing an action research in two hospitals to compare the extent of HSMM support for it.

The answers to the research questions were analyzed to highlight the specific role of HSMM in implementing an effective quality program. The health care managers in the Saudi hospitals indicated that they were not satisfied with their hospitals' overall quality improvement initiatives (Saeed, 1999). The present study noted the issues behind the failure of quality program from the point of view of the HSMM.

7.1 CONCLUSIONS

This study could be considered a serious attempt to investigate the obstacles that lie in the way of adopting and implementing quality programs in hospitals. It traced the underlying causes for the failure of quality programs. In order to do so, two approaches were adopted. The main approach was top-down approach. The investigation through this approach started with HSMM downwards to the different departments of the hospital. The other approach was the action research which was a bottom-up approach. This approach started with the nurses as a first point of contact through the patient to the middle and senior management. The results of this study revealed very important hidden factor in the way of starting quality program in the hospital. As long these important issues remain, hospitals will continue to waste their resources when they try to start an effective quality program. It has been well

documented that HSMM should be really supportive for quality activities in their hospitals not just by paying lip-service to it.

The results of this research agreed with the concept that the top leadership is often a critical determinant of successful QI implementation (Deming, 1986; Ishikawa 1985; Juran, 1988, 1989). Only senior leadership, it is argued, can establish quality as top priority creating a corporate culture for quality, mobilizing the financial and human resources necessary to support organizational learning. The importance of high-level leadership may be especially critical in cultivating clinical involvement in CQI/TQM.

In order to give a complete picture of the knowledge, practice and attitude of the HSMM towards quality programs, it is necessary to shed some light on the input, output and the process of the studied hospitals. The role of the HSMM in their hospitals depends to a great extent on the resources allocated. Evidently, the output of the health care rendered in the hospital reflects the way the staff, headed by the HSMM functions. The following are the conclusions drawn from the results and the discussion in the previous chapters

7.1.1 Input

The hospitals included in the descriptive study and the action research have adequate inputs related to quality programs. They have well-established quality departments, qualified staff and quality plans.

The first hospital quality assurance programme in Saudi Arabia was established at Aramco hospital in 1982 (Soltis, 1988). Dixon (1982) identified several factors that she thought affected the provision of quality medical and health care in Saudi Arabian hospitals. These were the pace of construction and of opening of new hospitals, the

staffing of hospitals by personnel trained in several different countries, the lack of long-term comprehensive medical care for most Saudi patients and the difficulty in securing and maintaining adequate hospital supplies and equipment. Whereas the factors mentioned are still of importance, what is more important is the lack of what De Geyndt (1995) called the "quality culture" which actually hinders the establishment of successful quality assurance programmes in the country. This is as true for primary health care as it is for hospitals (Dixon, 1982).

Another recent study in relation to the implementation of total quality management in the Saudi Arabia health care system was done by Algaman (1999), who reported that health sectors were mostly run by western companies who were able to import the latest technical equipment and health facilities because of the Kingdom's wealth. These companies usually brought with them their own procedures and practices including the TQM concept. However, the adoption of TQM was not as expected, for though the bureaucrats installed the concept of TQM, the personnel were unable to operate the system (Algaman, 1999). The present study proved Algaman's point (1999), for the HSMM included in this study had a high level of knowledge about quality concepts. Nevertheless, there were significant differences in terms of many practical concepts because of their background training. This could explain the failure of some of the quality programs.

7.1.2 Process

The present study concludes that HSMM need more practical skills to deal with their staff. Duncan emphasized, (1987) that the best manager is not always the person with the most knowledge of management, but the person who understands people, who can adapt to changing situations, and who has high character and has a sense of fair play.

Juran's emphasis on planning, control, and improvement suggests that both process and outcome measures must be continually monitored. Unlike Deming, Juran believes strongly in evaluating worker productivity through continuous performance appraisal. When performance falls short of goal expectations, corrective action should be initiated. Corrective action, according to Juran, may be in the form of either incentives or corrective action to ensure excellence and quality performance. Juran's quality management program includes provisions for merit pay and individual monitoring (Juran, 1988; Logothetis, 1992).

The concept of the corrective action was observed in the action research at the initial stages. The workshop of the action research included a problem-solving session which oriented the participants to the analysis of problems and the design of suitable corrective measures. The nurses of the private hospital followed up with the techniques discussed in the workshop of the action research and were able to overcome most of the obstacles militating against patient satisfaction by formulating good corrective actions.

Thus, the training of staff in different aspects of quality becomes an essential component of the quality process. Vouri (1992) suggested that more comprehensive training sessions should be conducted to explore the concepts, importance and techniques of quality assurance. It was further suggested that there should be more studies to consider the position of the administration, nursing staff and other hospital personnel.

This study raises the issue of staff training that includes HSMM as suggested by Al Qatari, (1997) in his evaluation of the quality of primary health care in Qatif, Eastern

Saudi Arabia. He discussed certain problems such as inadequate training of staff on quality assurance, and implementation of quality assurance policies. He recommended the incorporation of a patient satisfaction survey to make it more effective to create the necessary quality culture that will make the quality of health a serious issue. Al Qatari (1997) also recommended staff training, communication between the health care providers and the adoption of a better approach to the development of quality assurance within the total quality management concept. He also found that there were certain lacunae, such as the importance of structure and the utilization patterns of quality care. He posits that in order to continuously monitor quality, there should be more surveys in the quality program. Finally, he states that more qualitative studies should be conducted to expatiate on the causes of low satisfaction or dissatisfaction of various aspects of health quality management (Al Qatari, 1997).

Quality assurance is a relatively new area in Saudi Arabia. Most of the effort has been focused on technical skills. No comprehensive quality assurance programme, incorporating technical skills, interpersonal care and patient satisfaction is known to exist. Nevertheless, there are many positive signs to the sporadic quality assurance experiences in the country. There is a tendency to stress ritualizing the processes of quality assurance in the routines of the concerned department. This is evident to some extent in the Saudi primary health care quality assurance project (Al-Mazrou, 1994; DeFriese, 1992).

In sum, the purpose of quality management in health care is to establish a system that measures and manages patient care in the way that provides the best care for all patients. It identifies opportunities for improvement as well as problems that require resolution. Moreover, it fulfils a social commitment of the health profession to the

public. However, problems would undoubtedly arise as we find with immature management.

All quality approaches require systematically planned managerial work, attention to a process, mastery of new knowledge and skills for innovative improvement, work with people and time, as emphasized by Longo (1994) and Oakland (1998). Respect to the “soft” part of the quality models, such as culture, communication, and commitment are inevitable. Thus, education and training for quality should be ultimately addressed (Berwick, 1989).

The process which is centered around the activities of HSMM in this study needs a lot of attention from the planners and decision makers to ensure that effective quality programs are implemented. The HSMM were knowledgeable about quality concepts but they were poor in the practical issues related to process and how to implement the programs.

7.1.3 Output

Most of the hospitals included in this study were aware of the importance of setting standards to evaluate their services. Half of them had national and international standards and evaluated the overall services of the hospital by these standards. A very high percentage of them saw the importance of patient satisfaction, so they monitored it and were able to achieve high levels of satisfaction. However, not the same level of attention was paid to staff satisfaction, which is the key to patient satisfaction. This shows the narrow view of the top management of the hospital.

Deming’s quality chain reaction suggests that in the health care industry, if TQM is successfully adhered to, TQM will not only reduce cost and administrative functions,

but will also prevent costly and mistakes, that cost much loss of life and law suits. Hamilton (1982) reported that 90% of the drugs prescribed, result in serious risks involving unnecessary surgery, loss of life and waste of billions of dollars each year.

The present study has revealed significant differences among the HSMM with regards to advocating zero defect principle, evaluation quality through the evaluation of mistakes and measurement of quality through its compliance to patient's requirements.

The high percentage of general patient satisfaction claimed by the hospitals as documented during the action research could be attributed to the conclusion drawn by Dossary, (1991). He described for the first time the framework of the Saudi health sector, including the roles of health service providers, other than the Ministry of Health (MOH). This had been comprehensively documented along with contributions of rising living standards and their effect on the Saudi health system. He concluded that economic growth, rather than the expansion of the health services, was the principal explanation of better standards of health in Saudi Arabia (Dossary, 1991).

Other than clinical competence which was observed during the action research, communication, ventilation, quietness, cleanliness and other amenities reflected the low percentage of satisfaction at the beginning of the action research. These services improved during the subsequent periods of the action research through the collaboration between the researcher and the nurses.

The above conclusion agreed with a recent study of patients' expectation and satisfaction in a teaching hospital emergency department at King Fahd Hospital, Alkhobar, Saudi Arabia, carried out by Al-Almaie, (1998) which revealed reasonable rates of patient satisfaction with emergency care. It also showed the need to improve certain areas in the light of patients' expectations and satisfaction, including the

communication skills of emergency department's health team and the judicious use of the manpower, as well as an effective triage and the use of nurse practitioners in the emergency department (Al-Almaie, 1998).

7.2 RECOMMENDATIONS

Quality programs should be comprehensive to achieve its goals. The recommendations of this study will cover the three aspects of the quality system. The input, process and the output.

7.2.1 Input

The hospitals included in the descriptive study and the action research have adequate inputs for quality programs. They have well-established quality departments and qualified staff as well as quality plans. However, Saudi nationals in charge of quality departments are very few. Priority should be given by the decision makers to the training of Saudis in quality management.

The number of nurses in private hospitals is very low. This should be increased because they implement quality programs relating to health care in their field. Moreover, they have the attitude to solve the problems of communication that many patients complain of.

Although quality program started in Aramco hospital in 1982, the national attention to health quality program began only few years ago. Evidence has shown the negative effects of the lack of coordination among the many health care providers in the country. There is a need for the institution of a single controlling body to oversee all quality control programs in the country.

Although the MOH started a directorate for quality management to arrange for quality activities, not much attention and support has been given to it by the decision makers. The MOH should plan to instill quality in all of the MOH projects from the initial stages rather than tailor quality programs to suit those in authority.

Since the medical competence of the MOH hospitals is comparable to that of the private sector, attention should be given to the provision of these amenities which though inexpensive can enhance patient satisfaction.

The directorate of quality management in the MOH in collaboration and with the concerned authorities in the other ministries, should utilize the facilities provided by the contractors (usually western companies) for some Saudi hospitals, to provide the HSMM with practical skills in health quality management.

Although there are quality programs in most hospitals, the persons in charge of quality department are not empowered to invest enough time in quality plans in the hospital. To promote continuity and produce good results of quality plans, the person in-charge of quality in the hospital should remain in that position for a minimum period of five years. This person should not be given any other responsibility in addition to quality management.

The action research approach demonstrated very clearly that it is one of the best means of introducing change to improve the quality of health care services. This study recommends that the action research approach is to be implemented in various health care services to improve the quality of health care with minimum resistance from staff.

Workshops, symposia, training and different educational aids should be emphasized to prepare the work environment and make it receptive to creative change and the practice of the HSMM in order to improve quality of health care.

7.2.2 Process

The recommendations on the process form the core of this study because they constitute pivotal aspect of the HSMM performance, which is the subject of this study. In this part, they will cover the culture of quality in the hospital and matters relating to staff.

7.2.2.1 The culture of quality

The HSMM should be trained to acquire practical skills in how to deal with their work environment in order to facilitate quality culture. Each skill mentioned below should be addressed in a workshop session to ensure HSMM familiarity and ability to practice it effectively:

- Change of quality programs from inspection-based management to process improvement.
- The knowledge of how to implement quality programs.
- The importance of quality programs on the survival of the hospital.
- The difficulty of implementing quality program.
- An appreciation of the continuous nature of quality programs.
- Advocating the zero defect principle
- Evaluation of quality by assessing mistakes.
- Evaluating the fulfilment of patients requirements as a means of measuring quality.

- Allocating enough time for implementation.
- Meeting patients' needs.
- Ensuring availability of information on quality.
- Getting patients' views about the health care provided.

7.2.2.2 The staff

Since health services are manpower intensive, staff should receive the maximum attention in order to provide quality service. The responsibility lies with the HSMM to take care of their staff. The following are the most important factors affecting staff in the implementation of quality programs.:

- Giving staff opportunity to participate in preparation of quality.
- Ignorance of good results.
- Ensure staff commitment to the mission of the hospital.
- Reinforcing technical staff's managerial skills.
- Giving staff the power to improve health care quality.
- Eliciting staff's views about their job satisfaction.
- Providing staff autonomy.

7.2.3 Output

Although most hospitals monitor their services through different types of standards, a national comprehensive standard is recommended. Such a standard should incorporate technical skills, interpersonal relations and patient and staff satisfaction. This study indicated very clearly that although technical competence in the two hospitals included in the action research were almost the same, patient satisfaction varied very much in the area of amenities and interpersonal relationship. The MOH has the

capacity to deal better with the issues of the interpersonal relationship and amenities than the private hospital provided the hospitals are managed by committed HSMM.

Although there was ample patient and staff satisfaction in all of the hospitals, the results indicated that monitoring was inconsistent. Proper measures should be taken using technical means to give clear indicators of the level of the services rendered to avoid misinterpretation and arrive at the appropriate decisions.

More attention should be paid to staff satisfaction because they form the driving force in achieving high quality standards. Their reluctance in providing quality services should be studied and proper constructive decisions taken.

Mistakes in the health care system are unacceptable regardless of the source because ultimately, it is the patient who suffers. This means that in order to save lives, reduce operating costs and improving health care quality, hospitals should operate well-organized quality programs initiated by committed HSSM.

7.3 CONTRIBUTION OF THE STUDY

The present study is in accord with the idea that HSMM is often a critical determinant of successful quality programme implementation. The study has demonstrated that knowledge of HSMM about quality concepts alone is not enough to implement successful quality programmes. Determination coupled with good practice is the key to the provision of quality health care. Limited training of HSMM on how to implement quality initiatives makes it difficult to identify the causes of failure of quality programmes. The study took an unusual comprehensive approach by identifying the causes of the failure of quality programmes and suggesting solutions.

7.3.1 Analysis of quality programmes failure

The following could be the causes of the failure of quality programmes:

1. Factors relating to the development of the culture of quality in the hospital.

The HSMM have the power to introduce or initiate new policy changes in the system of the work in order to curb these adverse causes so that successful quality programs could be developed. Educational material could be generated and programs organized to support the initiatives.

- Redirection of quality programs from inspection-based management to process improvement.
- Acquiring knowledge on how to implement quality programs.
- Emphasizing the importance of quality programs for the survival of the hospital.
- The difficulty of implementing quality programs.
- Appreciating the continuous nature of quality programs.
- Advocating zero defect principle
- Evaluation of quality through the assessment of mistakes.
- Measuring quality through the fulfilment of patients' requirements.
- Allocating enough time for implementation.
- Meeting patients' needs.
- Ensuring availability of information on quality.
- Getting patients' views about the health care provided.

2. Factors relating to staff. The failure of quality programmes is the result of the HSMM lack of proper attention to staff satisfaction. The causes related to staff are:

- Giving the staff opportunity to participate in preparation of quality.
- Ignorance of good results.
- Ensuring staff commitment to the mission of the hospital.
- Reinforcing technical staff's managerial skills.
- Giving staff the power to improve health care quality.
- Getting staff's views on their job satisfaction.
- Providing staff autonomy.

7.3.2 Solution

The present study presented an example of a solution which can be easily implemented to help solve the complicated issues relating to staff. The action research was a very effective tool in changing staff behavior and achieving the intended goal within a short period. The action research must be well-planned and be given enough support by the HSMM to achieve its goals. Assigning the researcher and practitioners, choosing the educational aids, setting the reporting system, discussing the development and the achievements at intervals with the practitioners, are all necessary for the success of the action research. Suffice it to say, any staff related factors could be studied through an action research to make the staff conscious of their importance to the HSMM. This approach will elucidate facts that will otherwise be obscure for HSMM. Finally, besides its scientific achievement, the action research approach adds very important practical dimensions to the study by improving staff behaviour and achieving the desired goals.

7.4 FURTHER RESEARCH

1. Repeating the same study in other regions of Saudi Arabia will give a clear picture of the requirements for quality programmes and the establishment of national health quality strategic plan.
2. The reasons for the absence of Saudis specialized in health quality management.
3. The effect of staff distribution on the provision of quality health care.
4. The effect of amenities in the hospital and the interpersonal relationship among health care providers on patient and staff satisfaction.
5. The use of the action research approach to improve the quality of care in the different services provided by the hospital.
6. Problems that trainees in health quality programmes face as they implement new concepts.
7. The reasons for the lack of commitment to quality concepts by HSMM.

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معلومات واتجاهات وسلوك الإدارة العليا والوسطى في مستشفيات المنطقة

الشرقية بالمملكة العربية السعودية تجاه برامج جودة الرعاية الصحية .

مقدمة :

أعد هذا المسح مدير إدارة ضمان الجودة بالمديرية العامة للشئون الصحية بالمنطقة الشرقية الأستاذ/محمد بن علي الغامدي وذلك لجمع معلومات لنيل درجة الدكتوراه من جامعة هل في بريطانيا .
تهدف هذه الدراسة إلى استطلاع آراء مدراء الإدارة العليا والوسطى في المستشفيات المختارة في المنطقة الشرقية في المملكة العربية السعودية تجاه تعريف جودة الرعاية الصحية وأهميتها وكيفية تحقيقها .

ملاحظات :

- ١- سوف تعامل جميع المعلومات بسرية تامة ولضمان ذلك سوف ترمز ولن يذكر مايدل علي مصدرها في رسالة الدكتوراه النهائي .
- ٢- تعد تعبئتك لهذه الاستبانة موافقه ضمنيه لإدراج رأيك ضمن عينة البحث .
- ٣- إذا احتجت إلى أي معلومات إضافية فلا تتردد في الاتصال بالباحث على الهواتف التالية:

الأستاذ/ محمد بن علي الغامدي

إدارة ضمان الجودة - المديرية العامة للشئون الصحية بالمنطقة الشرقية

هاتف (٨٤٣٣٣٣٣/تحويله ١١١٠-١١٤٩)

فاكس (٨٣٩٠١٠٧)

جوال (٠٥٠٥٨٥٩٢٢٣)

أشكر لك قبولك لتعبئة هذه الاستبانة وآمل ان تسهم المعلومات الكاملة والصائبة التي ستفضلها بصورة خاصة ونتائج رسالة الدكتوراه هذه بصورة عامة في إفادة متخذي القرار في بلادنا لتطوير برامج جودة الرعاية الصحية . وإذا كنت مهتما بموضوع الدراسة فيسعدني تزويدك بملخص البحث بعد نهايته ، آمل كتابة أسمك وعنوانك ووسيلة الإتصال أدناه .

الأسم والعنوان (إختياري)

----- الأسم :

----- العنوان :

----- وسيلة الاتصال : العنوان الإلكتروني (e - mail) :

----- الهاتف :

----- الفاكس :

----- الجوال :

أولاً - معلومات شخصية:

الاسم (إختياري):	
١-١	اسم المستشفى:
٢-١	الوظيفة التي تمارسها في المستشفى :
	<input type="checkbox"/> مدير المستشفى <input type="checkbox"/> مساعد المدير <input type="checkbox"/> مدير إدارة الجودة <input type="checkbox"/> مدير التعليم الطبي <input type="checkbox"/> مدير العلاقات العامة <input type="checkbox"/> المدير الطبي <input type="checkbox"/> مدير التمريض <input type="checkbox"/> مدير الشؤون الماليه والإداريه <input type="checkbox"/> مدير الخدمات المسانده <input type="checkbox"/> مدير مركز المعلومات
٣-١	العمر: ----- سنة
٤-١	الجنس: <input type="checkbox"/> ذكر <input type="checkbox"/> انثى
٥-١	الجنسية: <input type="checkbox"/> سعودي <input type="checkbox"/> غير سعودي
٦-١	التخصص <input type="checkbox"/> طب <input type="checkbox"/> تمريض <input type="checkbox"/> تخصصات طبية مساعدة <input type="checkbox"/> إدارة <input type="checkbox"/> أخرى (حدد)
٧-١	<p>كم عدد الدورات التدريبية والمحاضرات التي حضرتها في مجال إدارة الجودة خلال السنوات الخمس الماضية ؟</p> <p>لم أحضر دورات او محاضرات او لقاءات خاصه بالجوده .</p> <p>(١ - ٥) دورات او محاضرات او لقاءات خاصه بالجوده .</p> <p>اكثر من خمس دورات او محاضرات او لقاءات خاصه بالجوده .</p>

ثانيا : مفاهيم عامه عن الجودة :

حدد موقفك من المفاهيم التالية ؟ (ضع علامة في المربع الذي يمثل اختيارك أمام كل جملة)

م	المفاهيم	موافق تماما	موافق	محايد	غير موافق	غير موافق
2.1	من مواصفات الخدمة الصحية الجيده ، سهولة الوصول إلى موقع الخدمة					
2.2	من مواصفات الخدمة الصحية الجيدة ، ملائمتها لاحتياج المستفيد					
2.3	من مواصفات الخدمة الصحية الجيدة ، أنها تقدم لكل من يحتاجها دون تمييز					
2.4	من مواصفات الخدمة الصحية الجيدة ، كفاءتها الإقتصادية في استخدام موارد المستشفى لتقدم أفضل خدمة ممكنه					
2.5	من مواصفات الخدمة الصحية الجيدة ، تقبل المستفيدين لها					
2.6	من مواصفات الخدمة الصحية الجيدة ، تلبيتها لحاجة المستفيدين					
٢-٧	تنجح برامج الجودة اذا تبنتها الإدارة العليا في المستشفى					
٢-٨	يلزم إتاحة الفرصة لكل الموظفين للمشاركة في إعداد برامج الجودة في مراحلها الأولى					
2.9	تنأى برامج الجودة بمنهجها عن الإعتماد على مبدأ التفويض والتحري إلى تحسين نظام العمل .					
2.10	يمكن ان تقدم برامج الجودة حلولاً لمشكلات المستشفى					
2.11	تؤكد برامج الجودة على توثيق العلاقة بين مقدمي الخدمة الصحية والمراجعين					
2.12	يتحتم على المستشفى تطبيق برامج الجودة ليستمر في تقديم خدماته					
٨-٢	لا تعرف كثير من المستشفيات كيف تطبق برامج الجودة					
٩-٢	برامج الجودة مهمه للمستشفى					
١٠-٢	إجراءات برامج الجودة سهلة التطبيق					
١١-٢	برامج الجودة عملية مستمرة في المستشفى					

ثالثاً : ما مدى أهمية العوامل التالية في تطبيق برامج الجودة ؟

م	العوامل	مهم جداً	مهم	متوسط الأهمية	غير مهم	غير مهم مطلقاً
١-٣	الدعم الإداري لبرامج الجودة					
٢-٣	تطبيق قاعدة منع حدوث الأخطاء					
٣-٣	تقييم جودة العمل من خلال تقييم الأخطاء					
٤-٣	الإهتمام برضى مقدمي الخدمة الصحية في المستشفى					
٥-٣	قياس جودة الخدمات بمدى مطابقتها لمتطلبات المراجعين					
٦-٣	تطبيق مبدأ : " الجودة مسئولية الجميع "					
٧-٣	الأهتمام بشكاوى المرضى					
٨-٣	تشجيع مقدمي الخدمة الصحية على مناقشة المشكلات التي تعيق تقدم رعايه صحيه جيده					
٩-٣	قياس أداء مقدمي الرعاية بمقياس عادل					
١٠-٣	تشجيع المستويات الإشرافيه الأدنى على حل المشكلات التي تعيق الجودة					
١١-٣	تزويد جميع العاملين بالمفاهيم الحديثه في مجال الإدارة					
١٢-٣	إعتبار مصلحة المراجعين محور اهتمامات المدير					
عوامل أخرى تعتقد ان لها أهمية في سبيل تطبيق برامج الجودة (أذكرها وحدد درجة أهميتها أدناه):						
١٣-٣						
١٤-٣						
١٥-٣						

رابعاً : ما مدى موافقتك على أن اسباب عدم نجاح برامج الجودة يعود للأسباب التالية ؟

م	العوامل	موافق تماماً	موافق	محايد	غير موافق	غير موافق ابداً
١-٤	عدم كفاية مهارات مقدمي الخدمة لتطبيق برامج الجودة					
٢-٤	عدم توفر الوقت الكافي لتطبيق برامج الجودة					
٣-٤	ضعف التخطيط					
٤-٤	عدم إعطاء برامج الجودة الأولوية المناسبة					
٥-٤	قلة عدد الموظفين					
٦-٤	ضعف الاهتمام					
٧-٤	عدم وجود آليه للمشاركة					
٨-٤	عدم وجود دعم كاف من الإدارة العليا					
٩-٤	عدم العمل بروح الفريق					
١٠-٤	قلة الإعتمادات الماليه					
١١-٤	الخلافات التي تحدث بين الموظفين					
١٢-٤	تجاهل النتائج الجيده					
١٣-٤	كثرة تغير الموظفين					
١٤-٤	تناقض سلوكيات الموظفين مع فلسفة الجودة					
١٥-٤	عدم تعاون رؤوساء الأقسام					
أسباب أخرى تعتقد أنها ممكن أن تكون سببا في عدم نجاح برامج الجودة (أذكرها وحدد موقفك منها أدناه):						
١٦-٤						
١٧-٤						
١٨-٤						

خامسا: ما مدى ما تمثله العوامل التالية من أولوية في سبيل تطبيق برامج الجودة؟

م	المفاهيم	أولوية قصوى	أولوية	محايد	ليست أولوية	ليست أولوية أبدا
١-٥	إيجاد بيئة عمل تعاونيه في المستشفى					
٢-٥	الوفاء بإحتياجات المرضى					
٣-٥	إشراك جميع موظفي المستشفى لتحقيق الجودة					
٤-٥	التأكيد على توفير المعلومات اللازمة عن الجودة					
٥-٥	التأكيد على جدوى مبدأ العمل بروح الفريق					
٦-٥	الحصول على ولاء الموظفين لتحقيق الهدف المشترك للمستشفى (رسالة المستشفى)					
٧-٥	إشراك المرضى في مراحل العناية بهم					
٨-٥	إتصال المدراء الجيد بالموظفين					
٩-٥	مراقبة معايير الرعاية الصحية في المستشفى					
١٠-٥	تقييم اداء الموظفين					
١١-٥	تعزير المهارات الإدارية لدى الفنيين					
١٢-٥	جمع آراء المرضى عن مستوى الخدمات المقدمة لهم					
١٣-٥	إعطاء الموظفين الصلاحية لتحسين الرعاية الصحية التي يقدمونها					
١٤-٥	جمع آراء الموظفين عن رضائهم الوظيفي					
١٥-٥	إعداد قيادات جيده في المستشفى					

• تابع ٥٠ خامسا: ما مدى ما تمثله العوامل التالية من أولوية في سبيل تطبيق برامج الجودة؟

م	العوامل	أولويه قصوى	أولويه	محايد	ليست أولويه	ليست أولوية أبدا
١٦-٥	تقلص رعاية صحيه جيده للمراجعين منذ دخولهم المستشفى					
١٧-٥	تدريب الموظفين لتحسين الجودة					
١٨-٥	التأكيد على أن يعمل الموظفون في بيئة عمل جيده					
١٩-٥	تحسين صورة المستشفى لدى المجتمع					
٢٠-٥	التأكيد على حسن الإتصال بين مقدمي الرعاية الصحية والمراجعين					
٢١-٥	التأكيد على منح الموظفين الإستقلالية المناسبه					
٢٢-٥	مراقبة تحقيق النتائج المستهدفة من الرعاية الصحية					
٢٣-٥	التأكد من حصول الموظفين على التدريب اللازم					
عوامل أخرى تعتقد ان لها أولويه: (أذكرها وحدد أولويتها أدناه)						
٢٤-٥						
٢٥-٥						
٢٦-٥						

أشكر لك ما أتحت من وقتك الثمين لإستكمال هذه الإستبانة

والحمد لله رب العالمين

Knowledge, Attitude and Practice of Hospital Senior and Middle Management in Eastern Saudi Arabia Towards Health Care Quality Programmes.

Introduction:

This survey has been prepared by Mr.Mohammed Ali AL-Ghamdi, Director of the Quality Assurance Department in the Directorate of Health Affairs of the Eastern Province. The purpose of this survey is to gather information for a doctoral (Ph.D.) study in the University of Hull, U.K. The objective of the study is to explore the perception of senior and middle managers in selected hospitals in the Eastern Province of Saudi Arabia relating to their views of the importance of quality health care, how they define quality, ways to assess it and seek its control.

Notes :

1. The final dissertation will not identify any hospital by name. All names will be coded for confidentiality.
2. Your participation in filling up this questionnaire is considered an implicit agreement to include your views in the study sample of this research.
3. If you have any questions or need any further information please contact me;

Mr.Mohammed Ali AL-Ghamdi
Quality Assurance Department , Directorate
of Health Affairs ,Eastern Province.
Tel.(8432222 ext (1110 - 1149) .
Fax (8290107)
Mobile (0505859223)

Thank you for your assistance. I hope the valid and reliable information that you will state , and the results of the study will be helpful to the decision makers in our country to improve health care quality programmes.

If you are interested in the subject of the study write down your address. I will be glad to send you a copy of the abstract of the final dissertation

Name and address(optional):

Name :

Address :

e- mail :.....

Contact No. : Phone :.....

Fax :.....

Mobile :.....

1. Biodata:

Name (optional):

1.1 Name of the hospital:

1.2 Job title:

- Hospital Manager
- Assistant Hospital Manager
- Quality Programme Manager
- Continuous Education Manager
- Public Relation Manager
- Medical Director
- Nursing Manager
- Administration and Finance Manager
- Support Services Manager
- Information System Manager

1.3 Age: _____ years

1.4 Gender:

- Male
- Female

1.5 Nationality:

- Saudi
- Non Saudi

1.6 Specialty

- Medical
- Nursing
- Paramedical
- Administration
- Others (specify -----)

1.7

How many training courses , lectures , symposia or conferences on quality management have you attended within the last five years ?

- None
- 1-5
- More than five

2. General concepts about quality:

Indicate your views regarding the following concepts:

Put a tick mark in front of each statement of your choice

no.	Concepts	strongly agree	agree	neutral	disagree	strongly disagree
2.1	Accessibility to the place of the service is criteria for quality health care					
2.2	Relevance to the need of the patient is criteria of quality health care					
2.3	Fairness in providing the service is criteria of quality health care.					
2.4	Efficiency in utilizing hospital resources is criteria of quality health care.					
2.5	Acceptability of services by the patient is criteria of quality health care.					
2.6	Satisfaction of the patients needs is criteria of quality health care.					
2.7	Quality programmes (QP) can succeed if top management is committed					
2.8	All staff should participate in preparation of QP from the initial stages					
2.9	QP move away from inspection-based management to process improvement					
2.10	QP can provide solutions to the hospital problems					
2.11	QP emphasize patient-provider relationship					
2.12	QP are time consuming					
2.13	Most hospitals do not know how to implement QP					
2.14	The hospital will have to implement QP to survive					
2.15	QP are not easy to implement					
2.16	QP are continuous processes					

3 – To what extent are the following factors important in implementing quality programmes?

no.	Concepts	Very important	important	neutral	Not important	Not important at all
3.1	Administrative support for QP					
3.2	Advocating a zero defect principle					
3.3	Evaluating quality through the evaluation of mistakes					
3.4	Considering satisfaction of health care providers in the hospital					
3.5	Measuring quality through its compliance with patients' requirements					
3.6	Implementing quality is everyone's responsibility					
3.7	Consideration for patient complaints					
3.8	Encouraging health care providers to discuss all problems facing quality					
3.9	Measuring the performance of the health care providers fairly					
3.10	Encouraging line management staff to solve problem facing quality					
3.11	Educating all staff with administrative concepts.					
3.12	Considering the benefit of the patient the core of managers' responsibility					
Other important factors (specify and indicate their degree of importance)						
3.13						
3.14						
3.15						

4 – To what extent the failure of quality programmes attributed to the following reasons?

no.	Reasons	strongly agree	agree	neutral	disagree	strongly disagree
4.1	Insufficient QP skills of healthcare providers					
4.2	Not enough time for implementation					
4.3	Poor planning					
4.4	Low priority					
4.5	Staffing shortages					
4.6	Lack of interest					
4.7	No process – owner involvement					
4.8	No top-management support					
4.9	Poor teamwork					
4.10	Insufficient funding					
4.11	Interpersonal conflicts					
4.12	Ignorance of good results					
4.13	Rapid personnel turnover					
4.14	Contradiction of employees personality with philosophy of QP					
4.15	Non (or poor)-cooperation of key staff					
Other important (or significant) reasons (specify and indicate your views)						
4.16						
4.17						
4.18						

5 – How do you rank the following factors in quality programme implementation in order of priority?

no.	Factors	High priority	priority	neutral	Not priority	Not priority at all
5.1	Developing a “corporate culture” in the hospital					
5.2	Meeting patients’ needs					
5.3	Involving all the hospital staff to achieve quality					
5.4	Ensuring availability of information on quality					
5.5	Reinforcing the spirit of teamwork					
5.6	Having staff committed to a common purpose (mission)					
5.7	Involving patients in their care					
5.8	Communicating well with staff					
5.9	Monitoring standards of care					
5.10	Evaluating staff performance					
5.11	Reinforcing technical staff’s management skills					
5.12	Getting patients’ views about the health care provided					
5.13	Giving staff power to improve health care quality					
5.14	Getting staff’s views about their job satisfaction					
5.15	Developing good leaders in the hospital					

CONTINUE : How do you rank the following factors in quality programme implementation in order of priority?

no.	Factors	High priority	priority	neutral	Not priority	Not priority at all
5.16	Providing high quality (customer health care) on hospital arrival					
5.17	Training staff to improve quality					
5.18	Ensuring a good working environment for staff					
5.19	Developing a good image for the hospital					
5.20	Ensuring good communication between health care providers and patients					
5.21	Providing staff autonomy					
5.22	Monitoring outcomes of care					
5.23	Ensure effective staff development programmes					
Other important (or significant) factors (specify and indicate priorities) :						
5.24						
5.25						
5.26						

*THANK YOU
FOR YOUR PREVIOUS TIME*

قائمة التحقق: (المدخلات والمخرجات)
CHECK LIST (STRUCTURE AND OUTCOME)

First: General information about the hospital

أولاً: معلومات عامة عن المستشفى:

1.1. Hospital Name:	١-١- أسم المستشفى:
1. 2. Owner of the Hospital:	١-٢- مالك المستشفى:
<input type="checkbox"/> Ministry of Health	<input type="checkbox"/> وزارة الصحة
<input type="checkbox"/> Ministry of Higher Education	<input type="checkbox"/> وزارة التعليم العالي
<input type="checkbox"/> Saudi Aramco	<input type="checkbox"/> شركة أرامكو السعودية
<input type="checkbox"/> Private Hospital	<input type="checkbox"/> قطاع خاص
1.3. Location of the hospital (city):	١-٣- المدينة التي يقع فيها المستشفى:
<input type="checkbox"/> Dammam	<input type="checkbox"/> الدمام
<input type="checkbox"/> Dhahran	<input type="checkbox"/> الظهران
<input type="checkbox"/> Khobar	<input type="checkbox"/> الخبر
<input type="checkbox"/> Al-Hassa	<input type="checkbox"/> الأحساء
<input type="checkbox"/> Hafr Al-Batin	<input type="checkbox"/> حفر الباطن
1.4. Total number of beds in the hospital:	١-٤- السعة السريرية الكلية للمستشفى:
<input type="checkbox"/> 100- 200 beds	<input type="checkbox"/> ١٠٠ - ٢٠٠ سرير
<input type="checkbox"/> 201 - 300 beds	<input type="checkbox"/> من ٢٠١ - ٣٠٠ سرير
<input type="checkbox"/> More than 300 beds	<input type="checkbox"/> أكثر من ٣٠٠ سرير
1.5- Average bed occupancy rate:	١-٥- معدل نسبة إشغال الأسره:
<input type="checkbox"/> 75% - 100%	<input type="checkbox"/> أقل من ٥٠%
<input type="checkbox"/> 50% - 74%	<input type="checkbox"/> من ٥٠% - ٧٤%
<input type="checkbox"/> Less than 50%	<input type="checkbox"/> من ٧٥% - ١٠٠%
1.6. Medical management :	١-٦- ما هو نوع التشغيل الطبي:
<input type="checkbox"/> Managed by the owner	<input type="checkbox"/> ذاتي
<input type="checkbox"/> Contract with -----	<input type="checkbox"/> عقد مع -----
1.7. Non-medical management:	١-٧- ما هو نوع التشغيل غير الطبي؟
<input type="checkbox"/> Managed by the owner	<input type="checkbox"/> ذاتي
<input type="checkbox"/> Contract with -----	<input type="checkbox"/> عقد مع -----

Second. Information about QP**ثانياً : معلومات عن برنامج الجودة :**

٢-١- هل يوجد قسم لمراقبة الجودة في المستشفى ؟

2.1. Is there a quality department in the hospital?

Yes

نعم

No

لا

2.2. If there is a quality department when did it start functioning?

٢-٢- إذا كانت إجابة السؤال السابق (نعم) فمتى

بدأ القسم بممارسة أعماله فعلياً؟

Within the last year

في خلال السنة الماضية

Within the last four years

خلال الأربع سنوات الماضية.

More than four years ago

قبل أكثر من أربع سنوات من الآن

2.3. Who is responsible for the department?

٢-٣- لمن يتبع هذا القسم تنظيمياً ؟

Hospital Director

لمدير المستشفى

Medical Director

للمدير الطبي

Nursing Director

لمدير التمريض

If other specify -----

لآخر (حدده) -----

2.4. Is there a written plan to monitor?

٢-٤- هل يوجد خطة مكتوبة لمراقبة الجودة ؟

Yes

نعم

No

لا يوجد

2.5. Do the concerned employees implement this plan?

٢-٥- هل يقوم المعنيون بتنفيذ هذه الخطة ؟

Yes, the whole plan is implemented

نعم تنفذ كاملة

Implemented in the medical departments

تنفذ في الأقسام الطبية

Implemented in the nursing departments

تنفذ في أقسام التمريض

Implemented in the allied medical departments

تنفذ في الأقسام الطبية المساعدة

Implemented in other departments (specify)

تنفذ في أقسام أخرى (حددها) --

Not implemented

لا تنفذ

2.6. Which department(s) provide training for its staff on quality monitoring programmes?

- Medical departments
 Nursing departments
 Allied medical departments
 Other departments (specify) -----

 None

٢-٦- أي الإدارات تدرب موظفيها على برامج مراقبة الجودة؟

- الأقسام الطبية
 أقسام التمريض
 الأقسام الطبية المساعدة
 أخرى (حدد) -----
 لا يتم التدريب في أي من إدارات المستشفى

2.7. How many sessions on quality have been conducted in the hospital?

- None
 1-5
 More than five

- لم تعقد دورات
 ١ - ٥ دورات
 أكثر من خمس دورات

2.8. How may new employees know about their role in quality programmes?

- Through the hospital orientation course
 It is the responsibility of their departments
 Depends on their interest
 Others (specify).....

٢-٨- كيف يتعرف الموظفون الجدد على دورهم في برنامج الجودة في المستشفى؟

- من البرنامج التعريفي الذي يقام على مستوى المستشفى
 مسئولية القسم الذي يتبع له الموظف
 يعتمد على الإهتمام الشخصي للموظف
 أخرى (حدد)

Third : Information about the in-charge of quality programme.

ثالثاً: معلومات عن مسئول برنامج الجودة

3.1. What is his/her job title?

٣-١- ما هو مسمى وظيفته؟

3.2. What is his/her specialty?

٣-٢- ما هو تخصصه؟

Medical

طب

Nursing

تمريض

Paramedical

تخصصات طبية مساعدة

Administration

إدارة

Others (specify) -----

أخرى (حدد) -----

3.3. What is his/her qualification in quality management?

٣-٣- ما هو مؤهله في مجال إدارة الجودة؟

No specialized qualification

ليس لديه مؤهل متخصص في الجودة

Diploma in quality management

دبلوم تخصص

Bachelor

بكالوريوس

Master

ماجستير

Doctorate (Ph.D)

دكتوراة

Others (specify) -----

أخرى (حدد) -----

٣-٤- كم دورة تدريبية ومحاضرة تلقاها في مجال إدارة الجودة؟

3.4. How many lectures and training courses are attended in quality? (WHO?)

None

لم يتلق دورات

1-5 Courses

١-٥ دورات

More than five courses

أكثر من خمس دورات

3.5. Gender

٣-٥- ما هو جنسه؟

Male

ذكر

Female

أنثى

3.6. What is his/her nationality?

٣-٦- ما هي جنسيته؟

Saudi

سعودي

Non - Saudi

غير سعودي

٣-٧- كم عدد سنوات خبرته في مراقبة وإدارة الجودة؟

3.7. How long is his/her experience in quality programmes?

- None لا يوجد
 1-5 years ١-٥ سنوات
 More than five years أكثر من خمس سنوات

٣-٨- ما هي الفترة التي قضاها في عمله الحالي . . مسئولاً عن برنامج الدورة؟

3.8. For how long does he/she hold this post?

- Less than a year أقل من سنة
 1-5 years ١-٥ سنوات
 More than five years أكثر من خمس سنوات

٣-٩- هل يقوم بأي أعباء وظيفية أخرى غير مراقبة الجودة؟

3.9. Does he/she have any other responsibilities other than quality

- Yes نعم
 No لا

٣-١٠- كم عدد الأشخاص الذين شغلوا هذه الوظيفة خلال الخمس سنوات الماضية؟

3.10. How many persons occupied this position during the last five years?

- One person شخص واحد
 1-5 Persons ١-٥ أشخاص
 More than five persons أكثر من خمسة أشخاص

4.1. Are there standards for performance measurements?

٤-١- هل يوجد بالمستشفى معايير لقياس الأداء؟

Yes

نعم

No

لا

4.2. If Yes, in what departments?

٤-٢ إذا كانت إجابة السؤال السابق (نعم) فحدد أين توجد المعايير؟

Available in all of the departments

توجد في جميع أقسام المستشفى

Available in the medical departments

توجد في الأقسام الطبية

Available in the nursing departments

توجد في أقسام التمريض

Available in the allied medical departments

توجد في الأقسام الطبية المساعدة

In other departments (specify)

توجد في أقسام أخرى (حددها) -----

4.3. What are the sources of these standards?..

٤-٣ ما هو مصدر هذه المعايير؟

4.4. Is there evaluation of patient satisfaction?

٤-٤ هل يتم قياس رضى المرضى عن الرعاية الصحية

المقدمه؟

Yes

نعم

No

لا

4.5. What was the result of the last measurement of the patient satisfaction?

٤-٤ كم كانت نتيجة آخر قياس لرضى المرضى؟

Less than 50%

أقل من ٥٠%

50% - 74%

٥٠% - ٧٤%

75% - 100%

٧٥% - ١٠٠%

4.6. Is there evaluation of employees' satisfaction?

٤-٥ هل يتم قياس رضى الموظفين عن عملهم؟

Yes

نعم

No

لا

4.7. What was the result of the last measurement of the staff satisfaction?

٤-٦ كم كانت نتيجة آخر قياس لرضى الموظفين؟

Less than 50%

أقل من ٥٠%

50% - 74%

٥٠% - ٧٤%

75% - 100%

٧٥% - ١٠٠%

ACTION RESEARCH WORKSHOP

PRESENTATION ON:

INTRODUCTION TO HEALTH QUALITY MANAGEMENT

BY

**MOHAMMED ALI AL-GHAMDI
(Researcher)**

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

INTRODUCTION TO...

*HEALTH
QUALITY
MANAGEMENT*

MOHAMMED ALI AL-GHAMDI
B.Sc.,M.H.H.A.


MAIN POINTS

- ✓ QUALITY PHILOSOPHY
- ✓ QUALITY EVALUATION
- ✓ TEAM APPROACH
- ✓ OVERCOMING DIFFICULTIES

QUALITY HISTORY

RELIGIOUS TEACHINGS : ISLAM URGES EVERYONE TO DO HIS JOB CORRECTLY.

HISTORICAL EVIDENCES : CODE OF KING HAMURABI OF BABYLON 2000 B.C.

GENERAL AGREEMENT  QUALITY MUST BE GOOD

LESS AGREEMENT  HOW TO PURSUE IT

PHILOSOPHY

QUALITY ASSURANCE (QA)

QUALITY IMPROVEMENT (QI)

CONTINUOUS QUALITY
IMPROVEMENT (CQI)

PHILOSOPHY

TOTAL QUALITY
MANAGEMENT (TQM)

HEALTH QUALITY
MANAGEMENT (HQM)

WHAT IS QUALITY??

QUALITY

WEBSTER'S DICTIONARY
" THE DEGREE OF
EXCELLENCE WHICH A
THING POSSES "

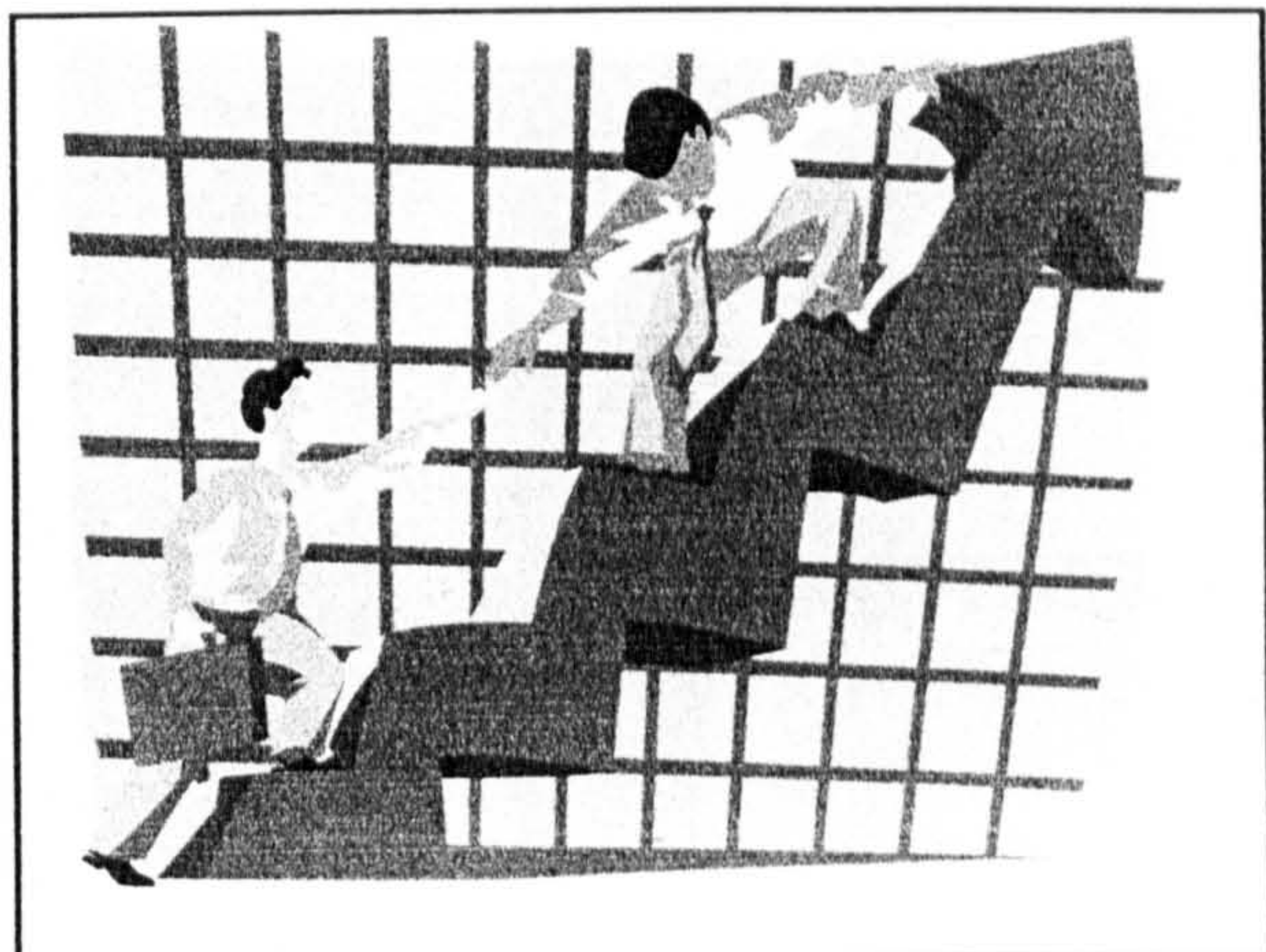
QUALITY READINESS

AWARENESS

KNOWLEDGE

IMPLEMENTATION

INTEGRATION



*QUALITY IN
HEALTH CARE
ORGANIZATIONS*

*QUALITY IN HEALTH
CARE ORGANIZATIONS*

THREE DIFFERENT ERAS
FOR QUALITY
MANAGEMENT IN HEALTH
CARE

*QUALITY IN HEALTH
CARE ORGANIZATIONS*

1- NIGHTINGALE , CODMAN
AND THE AMERICAN
COLLEGE OF SURGEONS

*QUALITY IN HEALTH
CARE ORGANIZATIONS*

2- DONABEDIAN AND
JCAHO

*QUALITY IN HEALTH
CARE ORGANIZATIONS*

3- DEMING , JURAN AND
"JAPAN INC. "

QUALITY ↔ *DISQUALITY*

WILLIAM FIFER :
DESCRIBES WHAT HEALTH
PROFESSIONALS AGREE SHOULD
NOT HAPPEN IN THE PROCESS OF
PATIENT CARE

MEASURING QUALITY

GONNELLA : ENTIRE PROCESS

THE SETTING

THE PATIENT

THE PROVIDER

QUALITY EVALUATION

DONABEDIAN :

THE ORIGIN FOR OUTCOMES RESEARCH

THE STRUCTURE , PROCESS AND
OUTCOME MODEL OF QUALITY
EVALUATION

Q. ESSENTIAL INGREDIENTS

DEFINED TARGETS

PERFORMANCE MEASUREMENTS

CHANGE MECHANISMS

WHY SHOULD WE CARE FOR QUALITY??

HEALTH CARE OUTPUT IS NOT
CLEARLY DEFINED

HEALTH CARE OUTPUT
CAN NOT BE MODIFIED

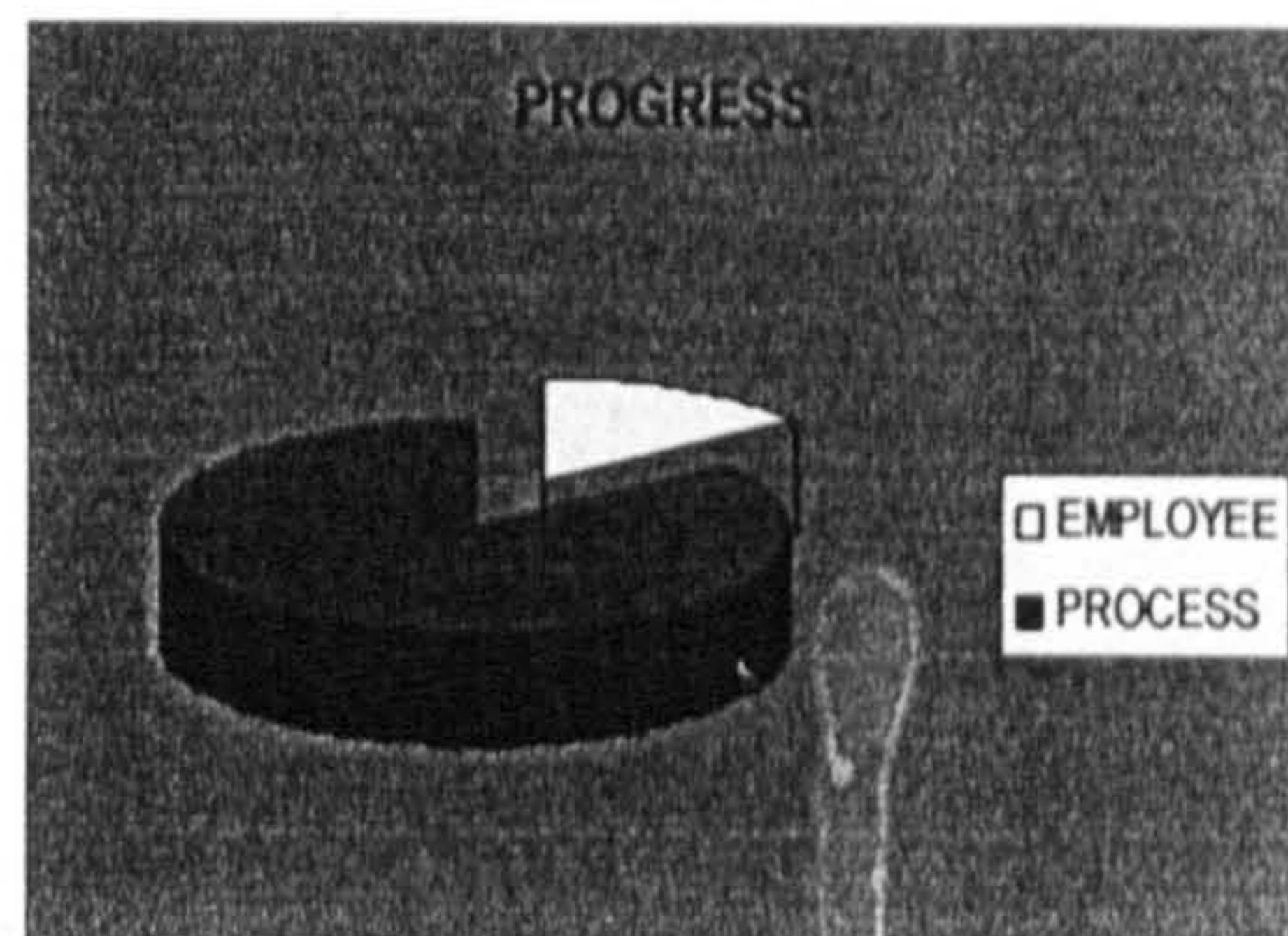
CHANGING BEHAVIOR

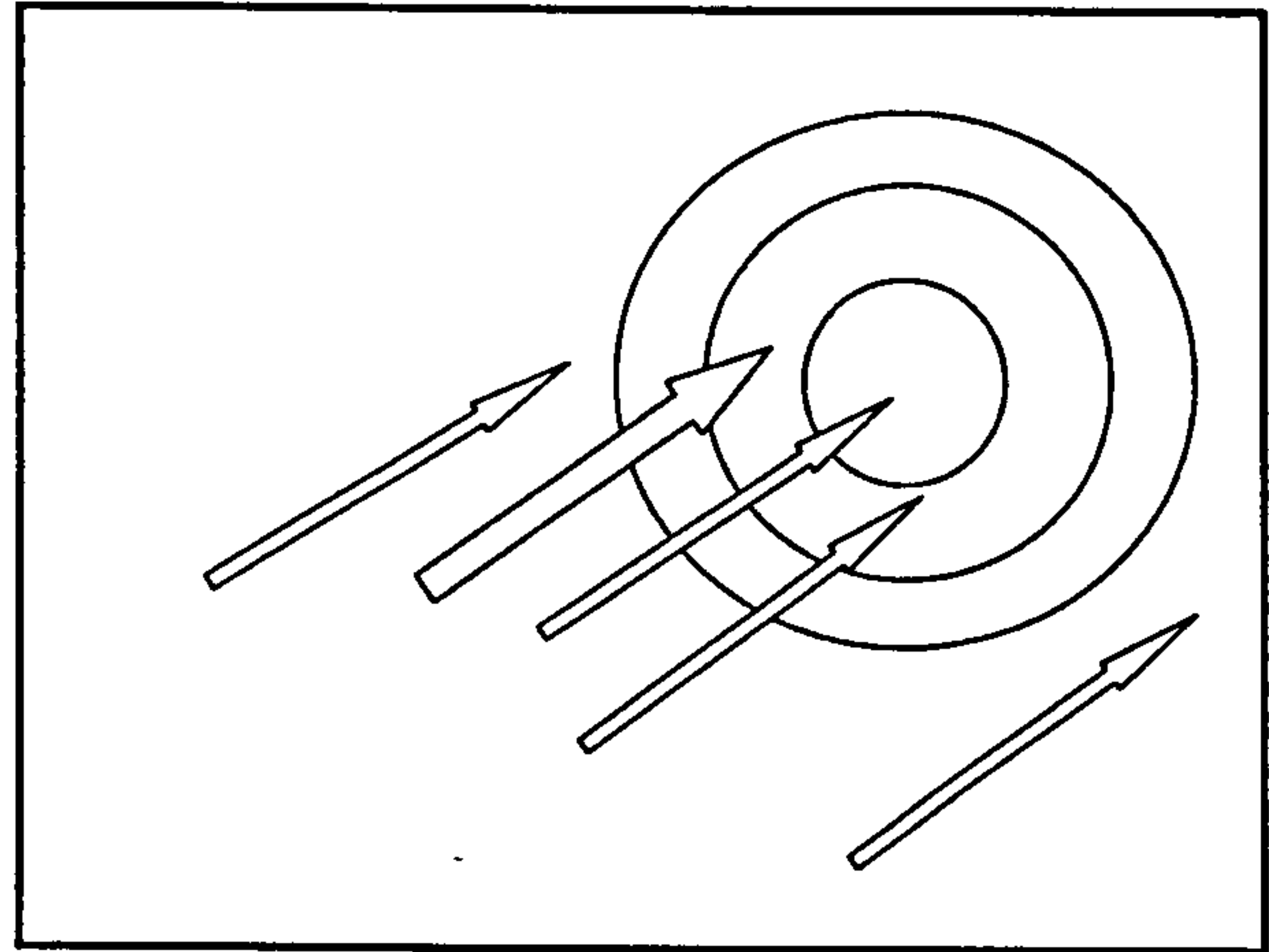
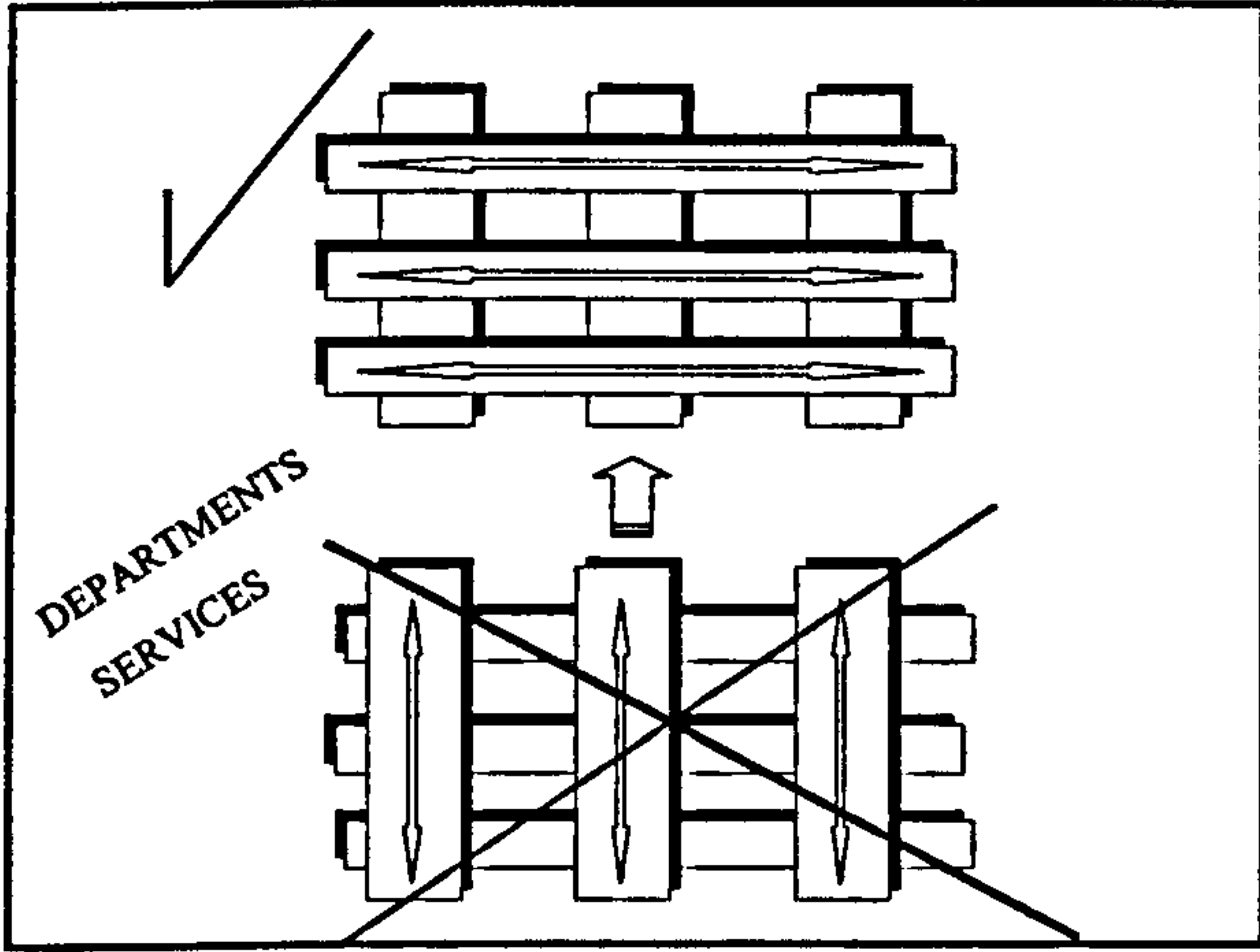
PROCESS RE-ENGINEERING

TRAINING

CONTRACTS

INCENTIVES





CHANGE AGENT

MISSION

OBJECTIVES

STRATEGIES

STAFF

CHANGE AGENT

TASKS

ORGANIZATION

TECHNOLOGY

EXPECTED RESULTS

IMPROVED CLINICAL OUTCOMES

HIGHER PATIENTS SATISFACTION

STAFF JOB SATISFACTION

DIFFICULTIES IN IMPLEMENTATION

NO ENOUGH RESOURCES

LOW MORAL

SHORTAGE OF STAFF

*DIFFICULTIES IN
IMPLEMENTATION*

POOR COMMUNICATION

LACK OF MANAGEMENT CONSISTENCY

LACK OF MANAGEMENT PARTICIPATION



*BASIC MANAGERIAL
EDUCATION*

STRENGTHS AND WEAKNESSES

COMMUNICATION

DOCUMENTATION

PROCESS ORGANIZING

*BASIC MANAGERIAL
EDUCATION*

IDENTIFY AND PRIORITIZE PROBLEMS

DECISION MAKING PROCESS

AUTHORITY AND DELIGATION

*BASIC MANAGERIAL
EDUCATION*

RIGHT QUESTIONS AT THE RIGHT TIME

MOTIVATE PEOPLE

UNDERSTAND THE EXTERNAL
ENVIRONMENT

*THE NEW ROLE OF
MANAGERS*

LEARN QUALITY LANGUAGE

HIRE QUALITY OFFICERS

USE STUDENTS – TEACHER APPROACH

USE COACH APPROACH

*WHAT
IS MY ROLE
IN QUALITY???*

TOGETHER EVERYONE ACHIEVE MORE

**T E A M
A P P R O A C H**

*OVERCOMING
DIFFICULTIES*

SET SHORT – TERM GOALS

TELL TRUTH

INVOLVE PEOPLE AT AN EARLY STAGE

ESTABLISH OVERALL STRATEGY

*OVERCOMING
DIFFICULTIES*

ESTABLISH POLICIES AND PROCEDURES

HOLD MEETINGS FOR INFORMATION AND
QUESTIONS

TRAINING , TRAINING AND MORE
TRAINING

*CHALLENGES ENCOUNTER
IMPLEMENTATION OF HQM
IN SAUDI HOSPITALS*

LACK OF TRAINED PERSONNEL

LACK OF RESOURCES

*CHALLENGES ENCOUNTER
IMPLEMENTATION OF HQM
IM SAUDI HOSPITALS*

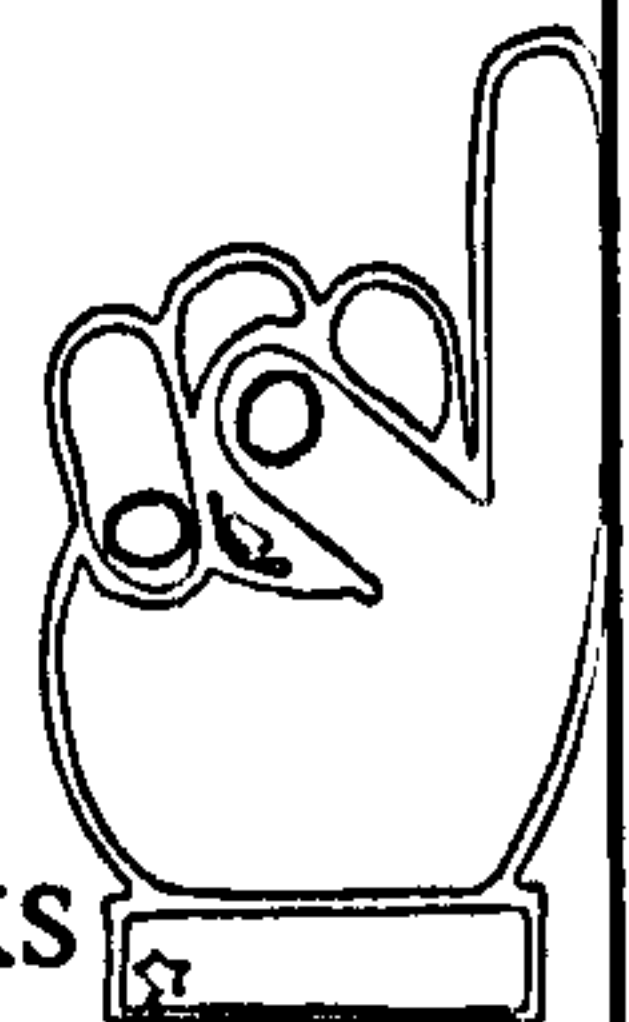
LACK OF INVOLVEMENT OF
TOP MANAGEMENT

LACK OF KNOWLEDGE
AMONG STAFF

REMEMBER...

CHAMPION NOT NECESSARILY
DIRECTORS (RESPECTED
PERSONS IN THE ORGANIZATION)

CHANGE AGENT
(PURPOSE, STRATEGY, PEOPLE, TASKS
, STRUCTURE AND TECHNOLOGY)



THERE

WILL BE

NO QUALITY

WITHOUT...



THANK YOU

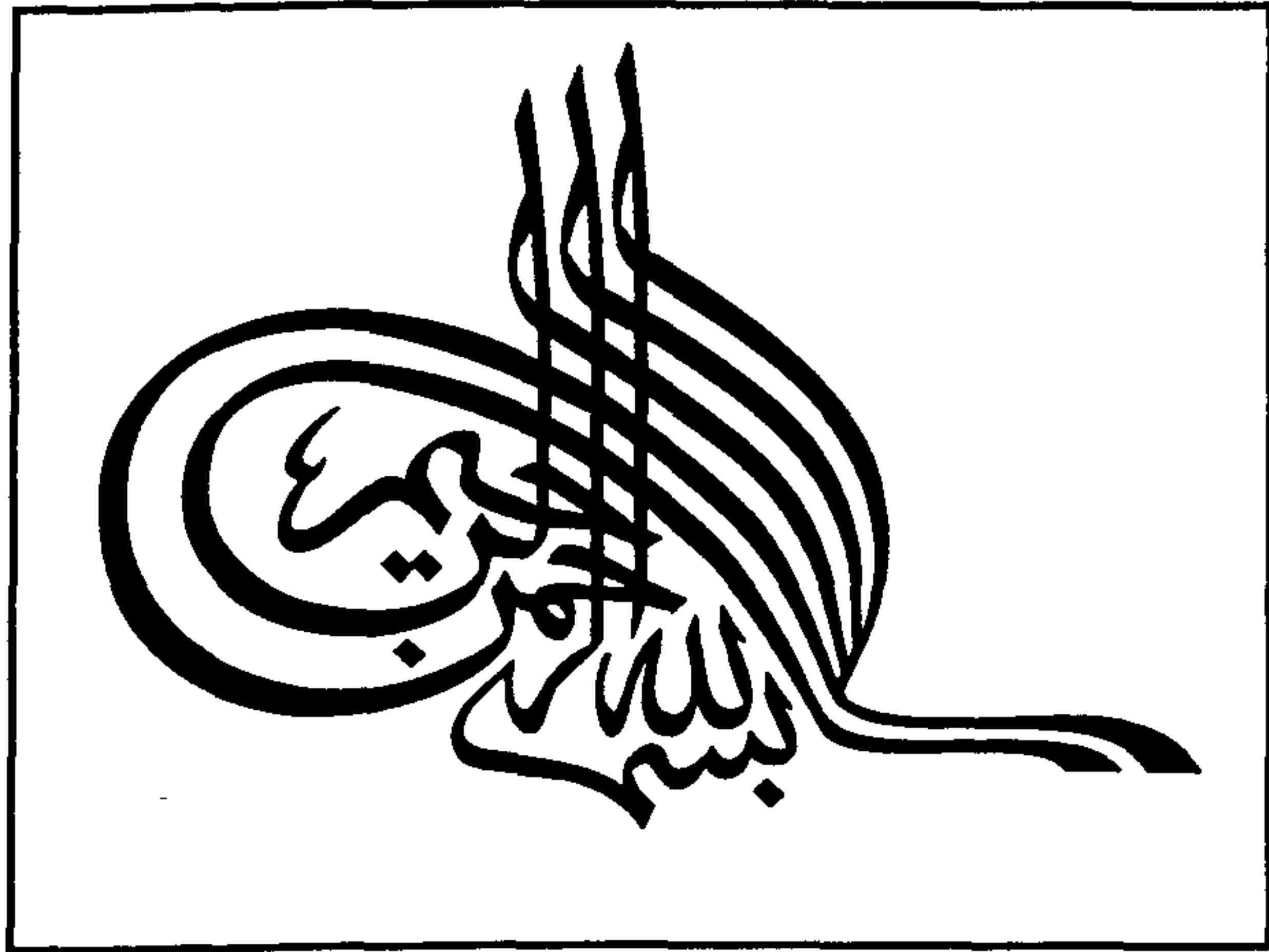


ACTION RESEARCH WORKSHOP

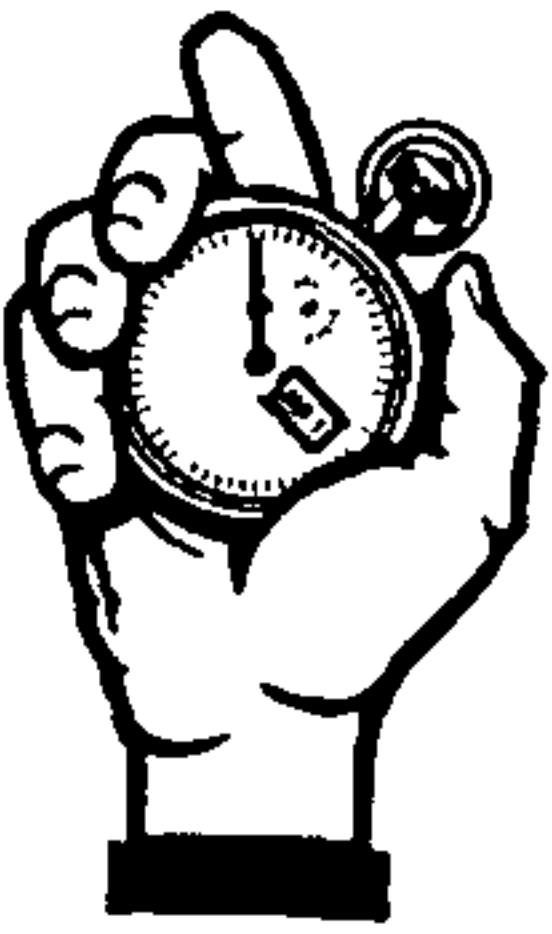
**PRESENTATION ON:
TIME MANAGEMENT**

BY

**MOHAMMED ALI AL-GHAMDI
(Researcher)**

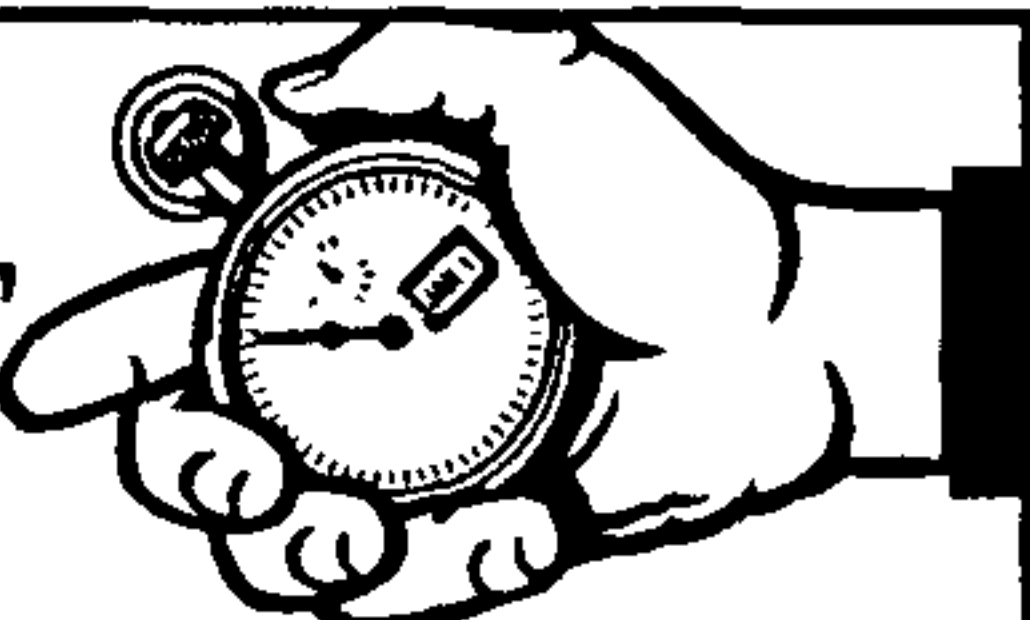


TIME ANAGEMENT

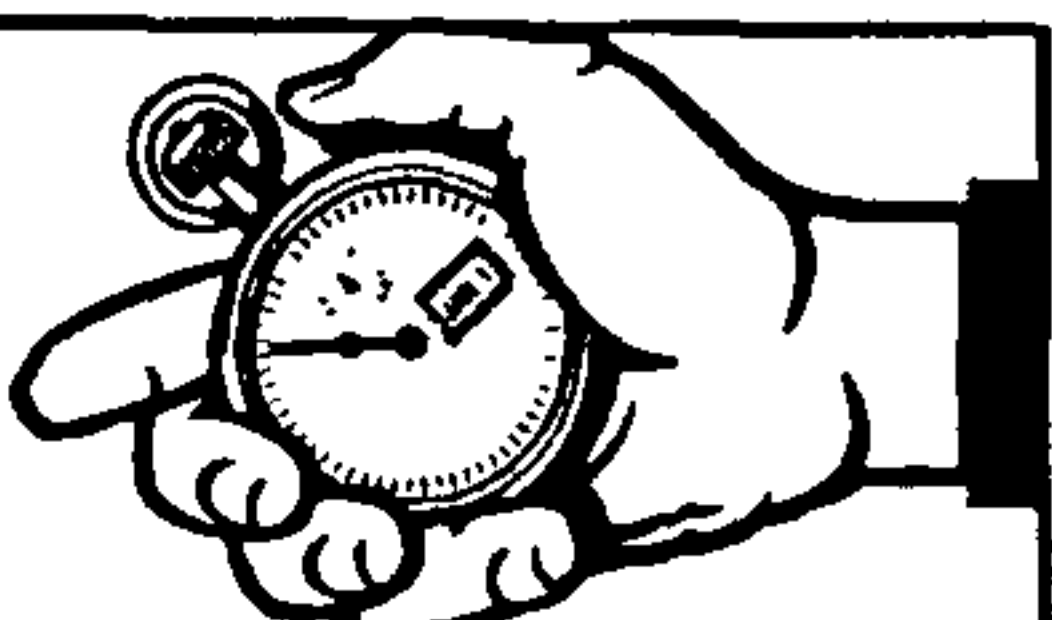


MOHAMMED ALI AL-GHAMDI
B.Sc., M.H.H.A.

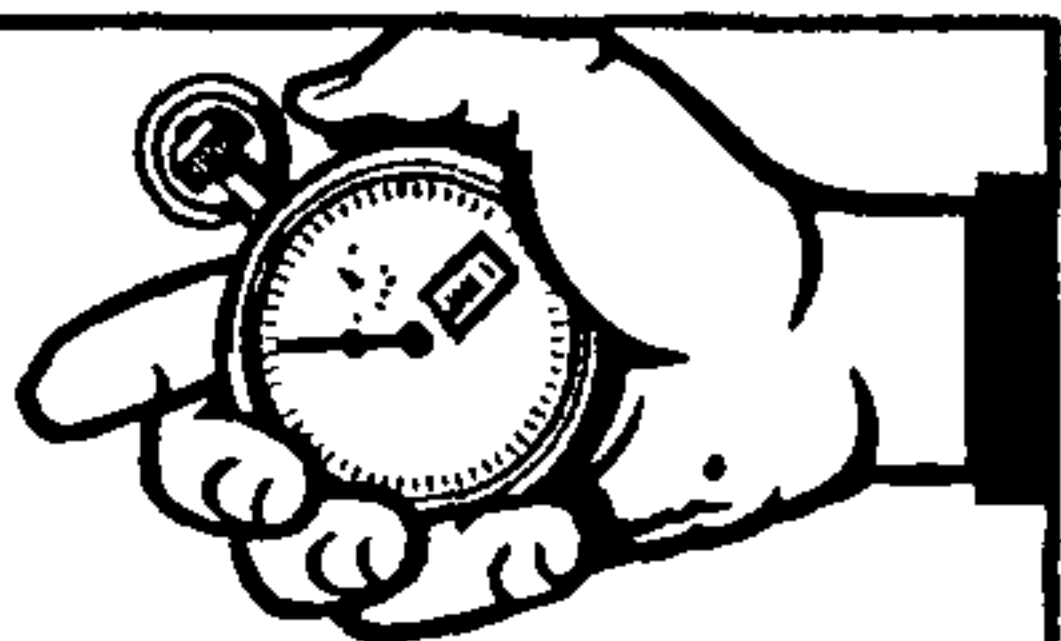
MAIN POINTS



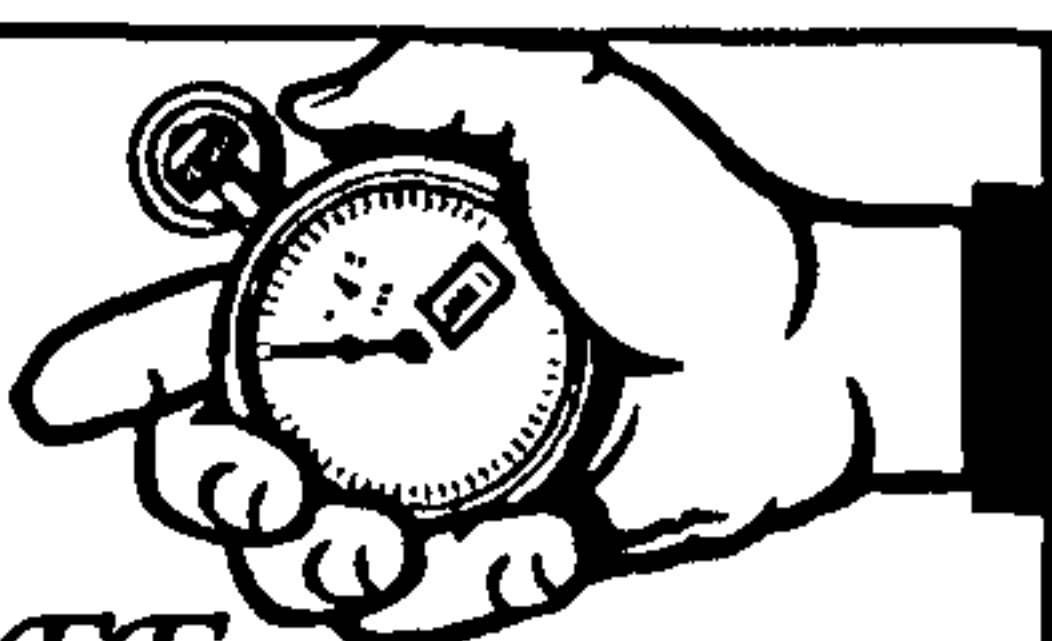
- INTRODUCTION
- TIME PILLARS
- TIME KILLERS
- RECOMMENDATIONS



INTRODUCTION

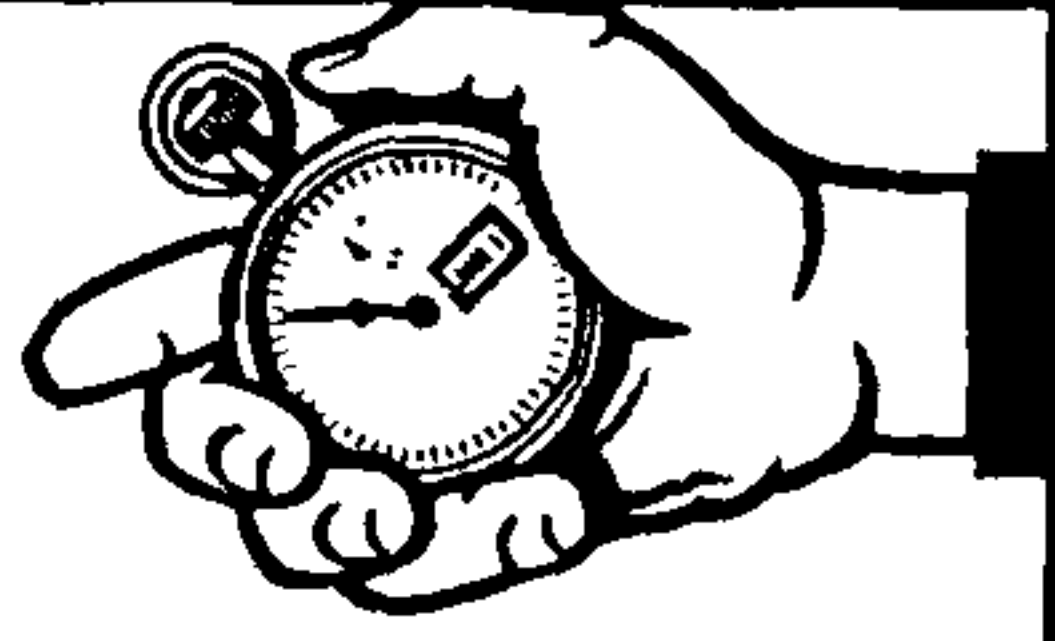


*WHAT DOES TIME
MEAN?*

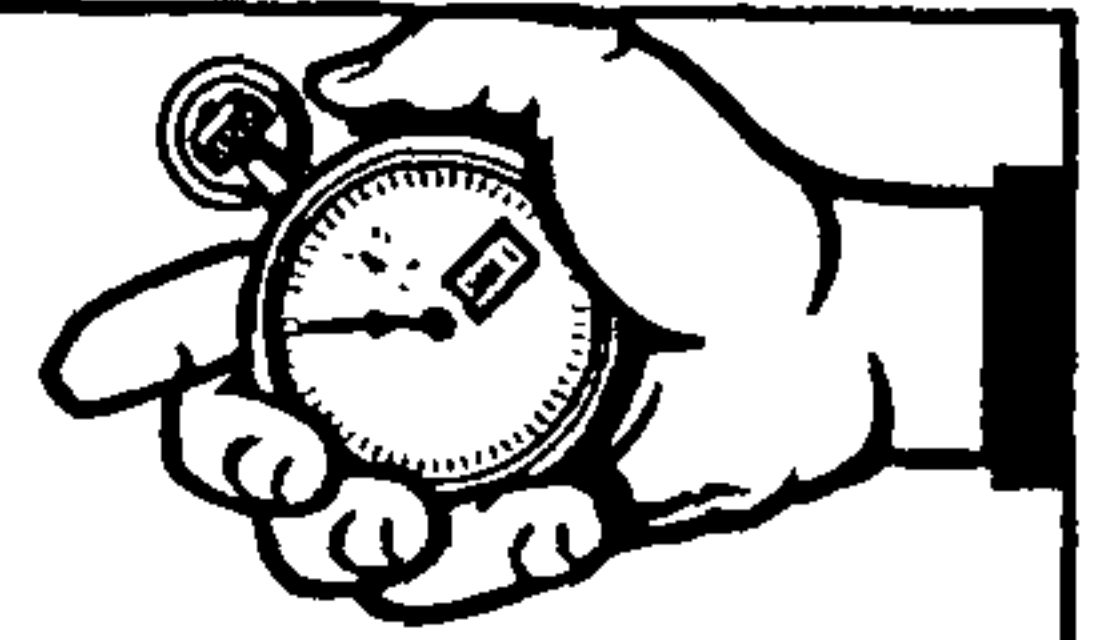


❖ *TIME IS LIFE*

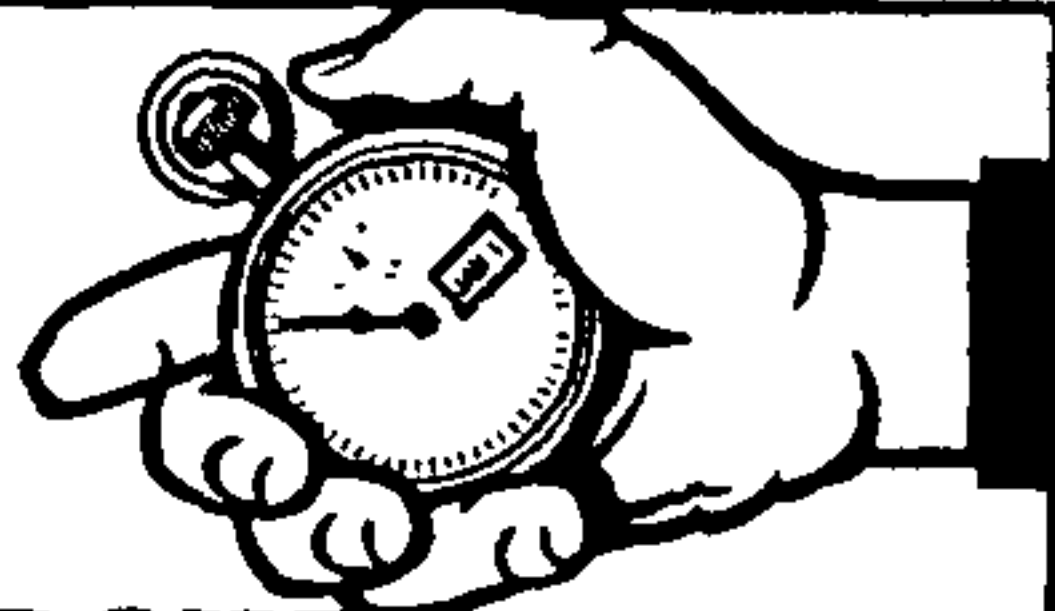
❖ *REAL ASSET*



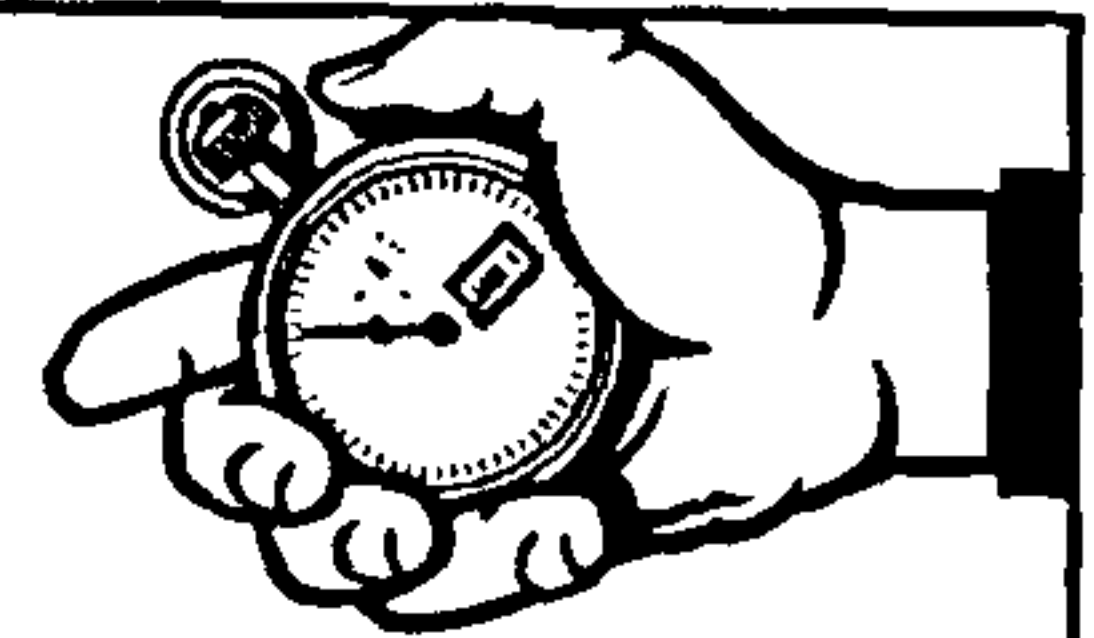
*IS
THE
TIME
VALUABLE?*



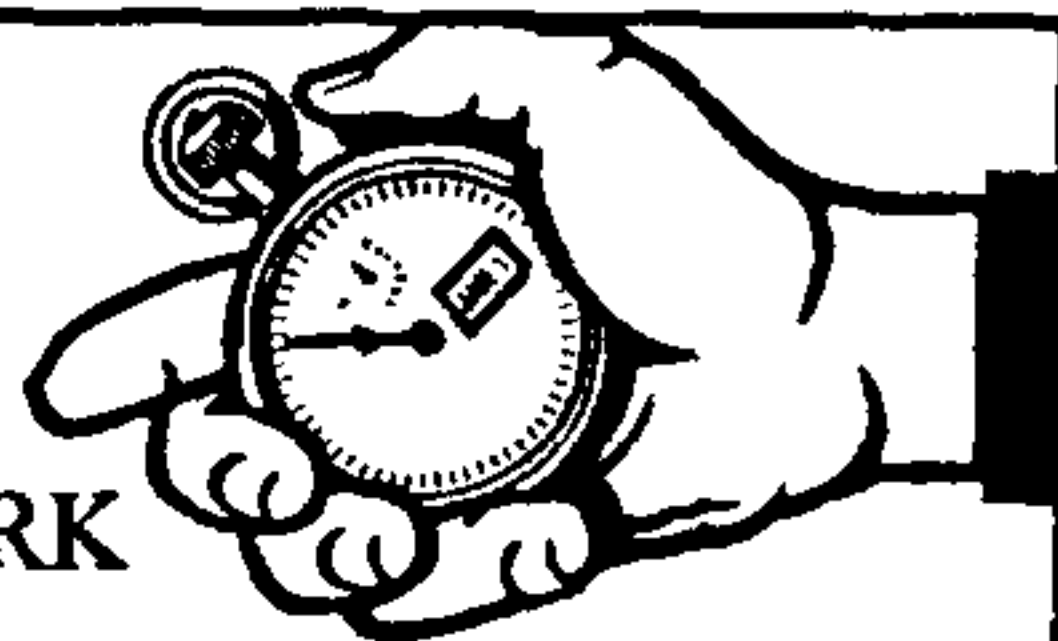
WHY ???



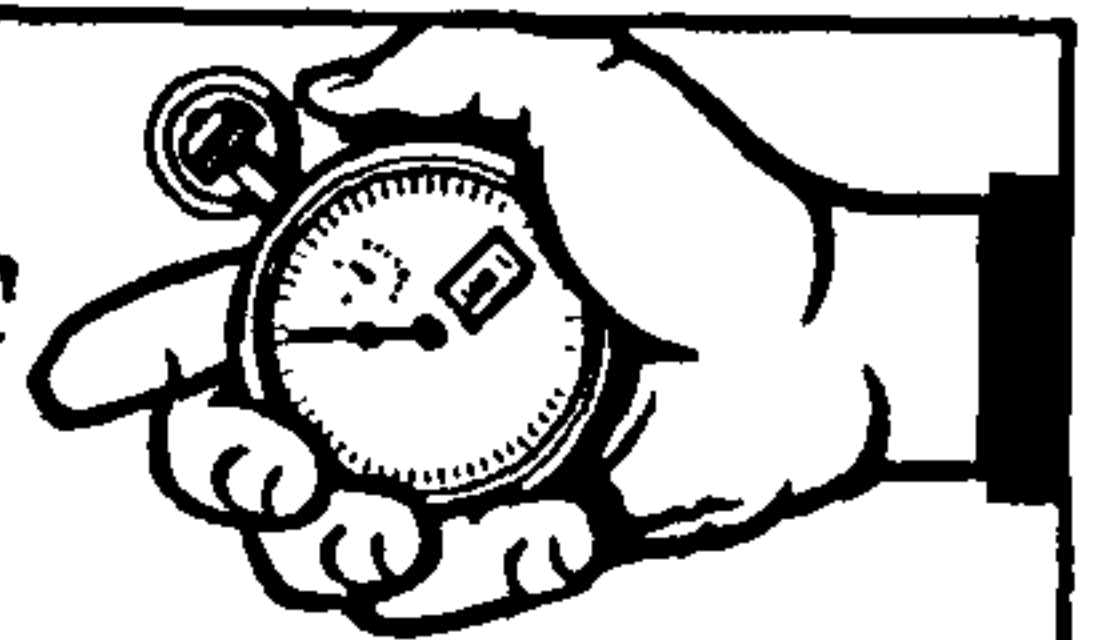
- CAN NOT BE BORROWED
- CAN NOT BE BOUGHT
- CAN NOT BE RENTED
- CAN NOT BE STORED
- CAN NOT BE MANUFACTURED
- CAN NOT BE REPLACED



TIME
MANAGEMENT
PILLARS



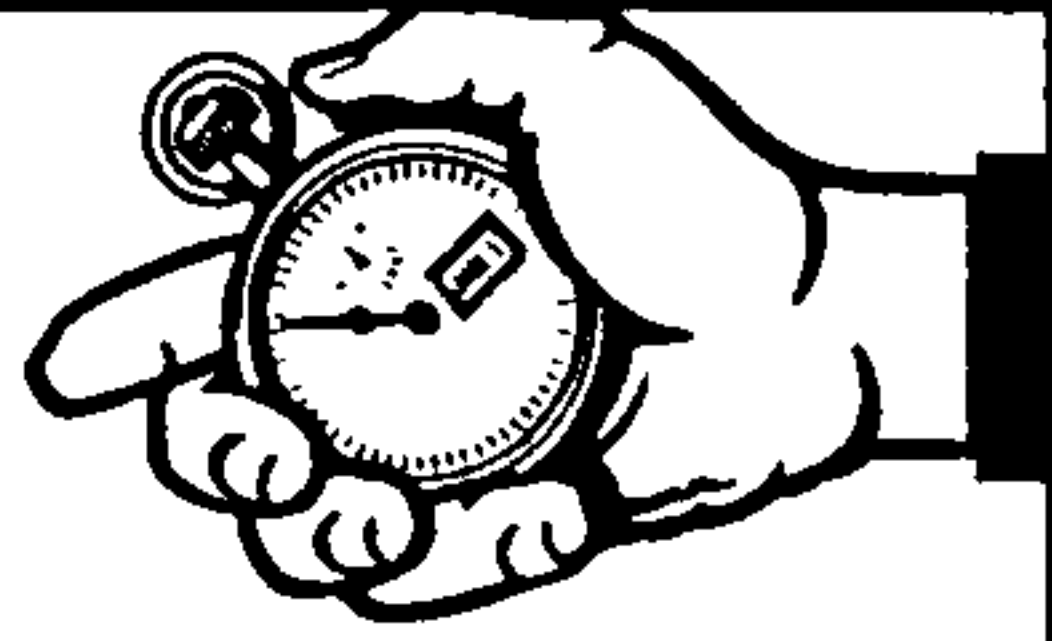
- ORGANIZING THE WORK
- CLEAR OBJECTIVES
- INTERPERSONAL RELATIONSHIP
- OPTIMIZATION



ORGANIZING

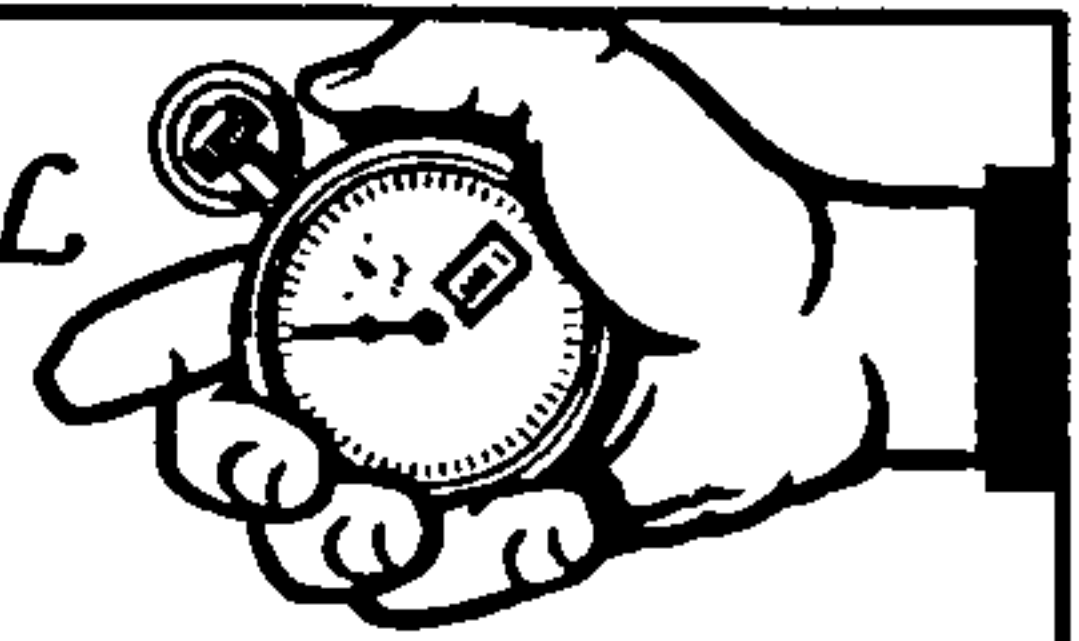
- ✓ WHO DOES WHAT ?
- ✓ HOW TO DO THINGS ?
- ✓ WHAT TO DO FIRST ?

CLEAR OBJECTIVES



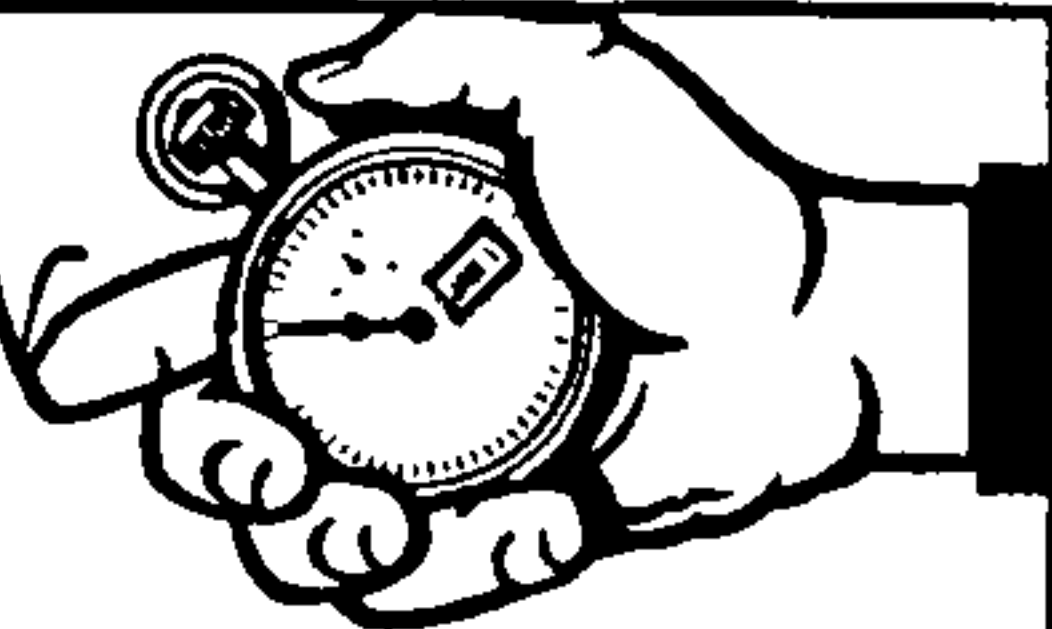
- ✓ EXPLORE THE ENVIRONMENT
- ✓ BASE OBJECTIVES ON FACTS
- ✓ ACHIEVABLE
- ✓ MEASURABLE

INTERPERSONAL RELATIONSHIP



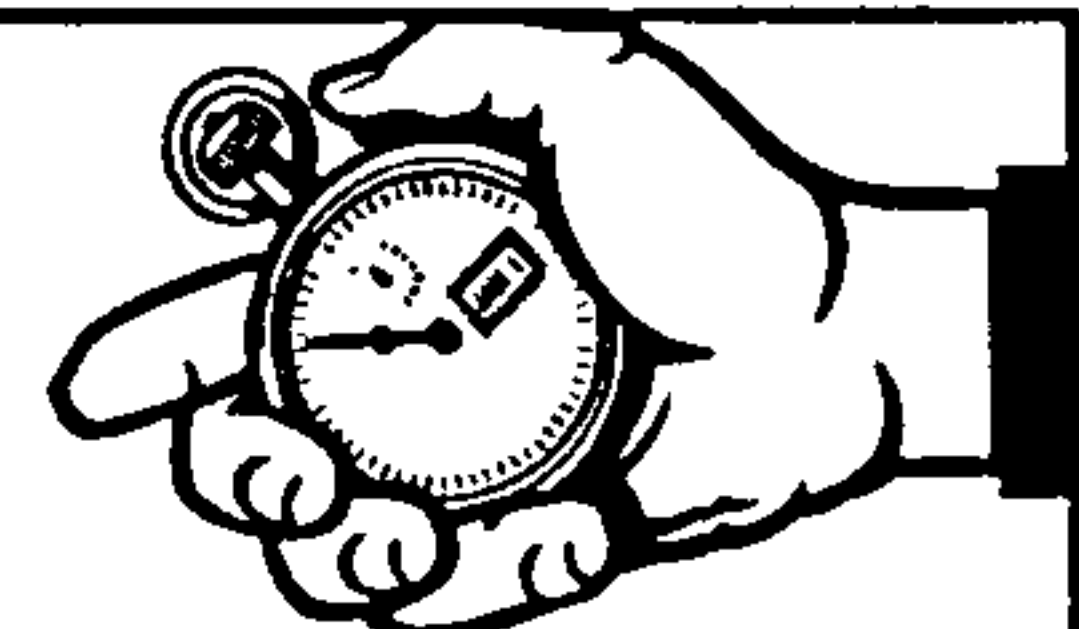
- ✓ HOW TO SAY "NO" POLITELY
- ✓ CONTROL OTHERS
- ✓ TELEPHONE CONTROL

OPTIMIZATION



- ✓ DON'T OVERBURDEN YOURSELF
- ✓ IF YOU DO A MISTAKE, DON'T QUIT, ASK HOW AND DO IT AGAIN
- ✓ GET THE BEST OF OTHERS VIEWS
- ✓ FINISH YOUR WORK, THERE IS ANOTHER WORK BENDING

TIME KILLERS

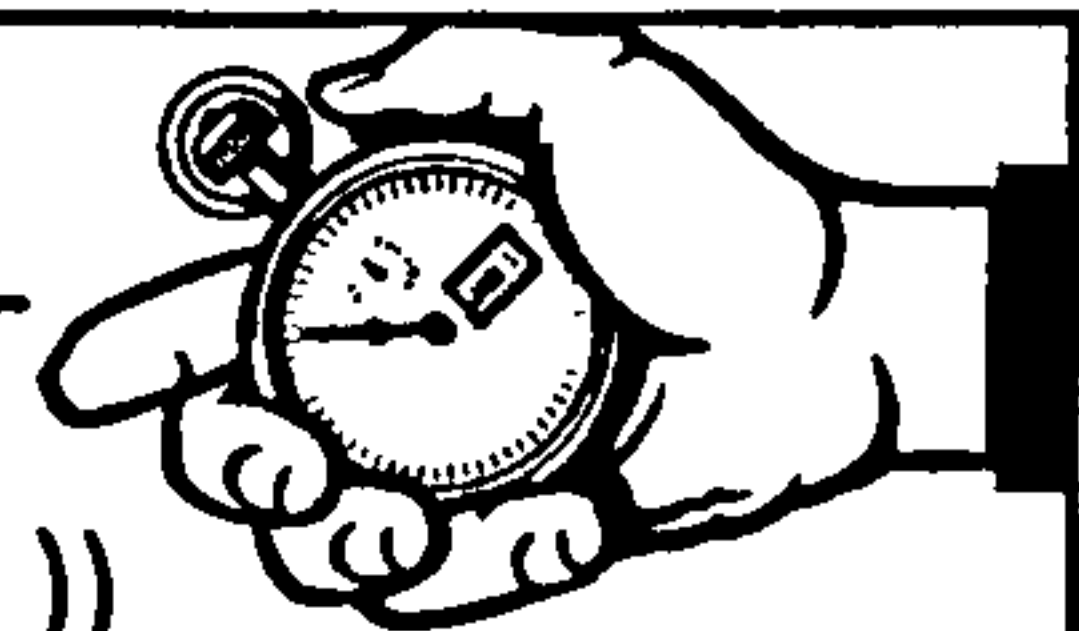


- ✓ NO PRIORITIES
- ✓ NO COOPERATION
- ✓ TELEPHONE MISUSES

PRIORITIES GRID

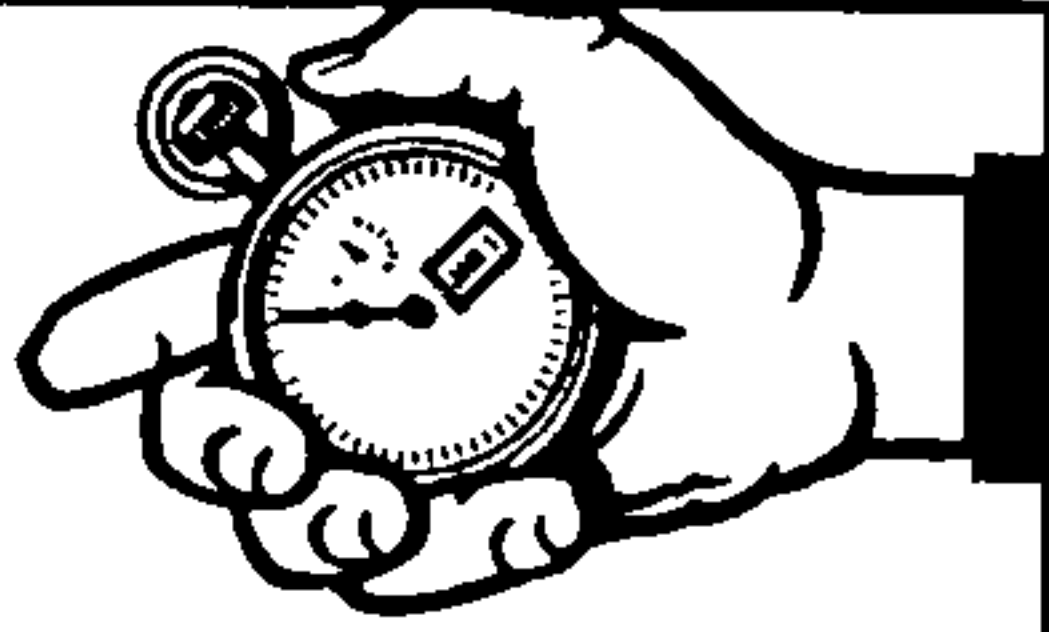
NOT URGENT	URGENT	
PLAN TO DO IT	DO IT IMMEDIATELY	IMPORTANT
DELAY IT	DELEGATE IT TO YOUR SUPPORDINATE	NOT IMPORTANT

COOPERATION ((TEAM WORK))



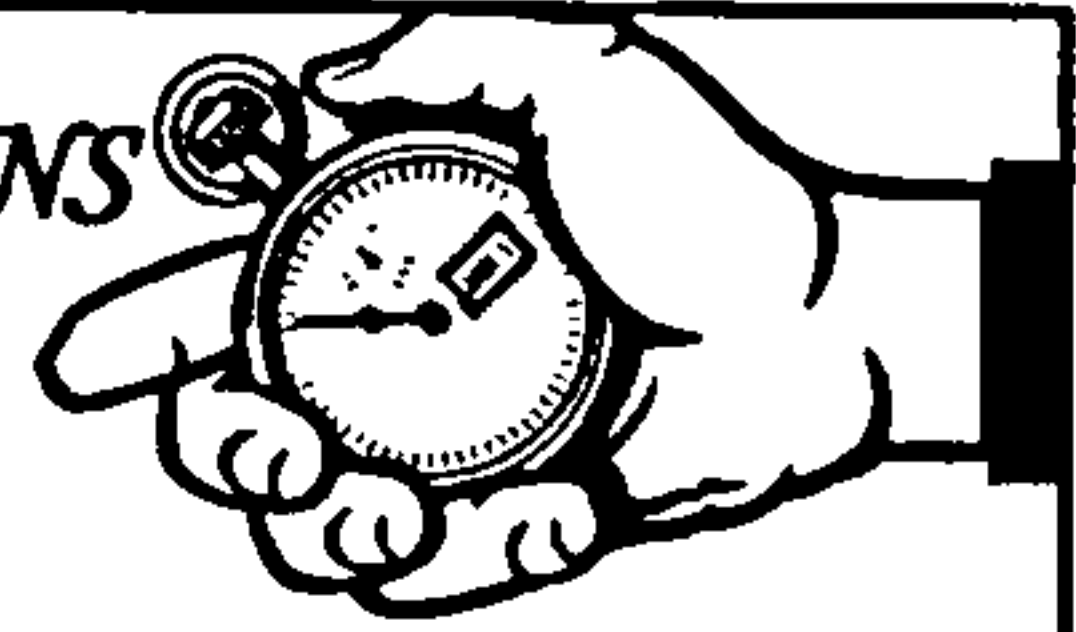
TOGETHER
EVERYONE
ACHIEVE
MORE

TELEPHONE MISUSES



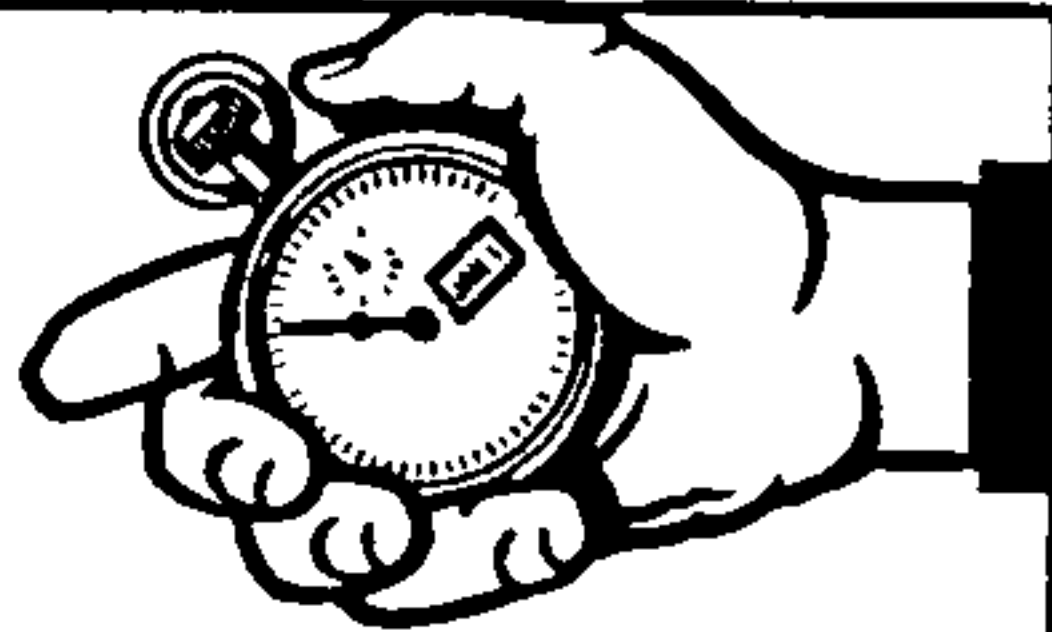
- SKILLS OF FIRST 30 SECONDS
- LISTENING SKILLS
- SUMMARIZING AND REFRAMING
- SKILLS OF ASKING QUESTIONS
- SKILLS OF GIVING INFORMATION

RECOMMENDATIONS



- WRITE WHAT SHOULD YOU DO
- SPECIFY TIME FRAME FOR EACH TASK
- PRIORITIZE YOUR TASKS

- DON'T LOOK AT YOUR WATCH FREQUENTLY
- GIVE VALUE TO EACH MINUTE OF YOUR TIME
- YOU HAVE NO TIME OTHER THAN "NOW"



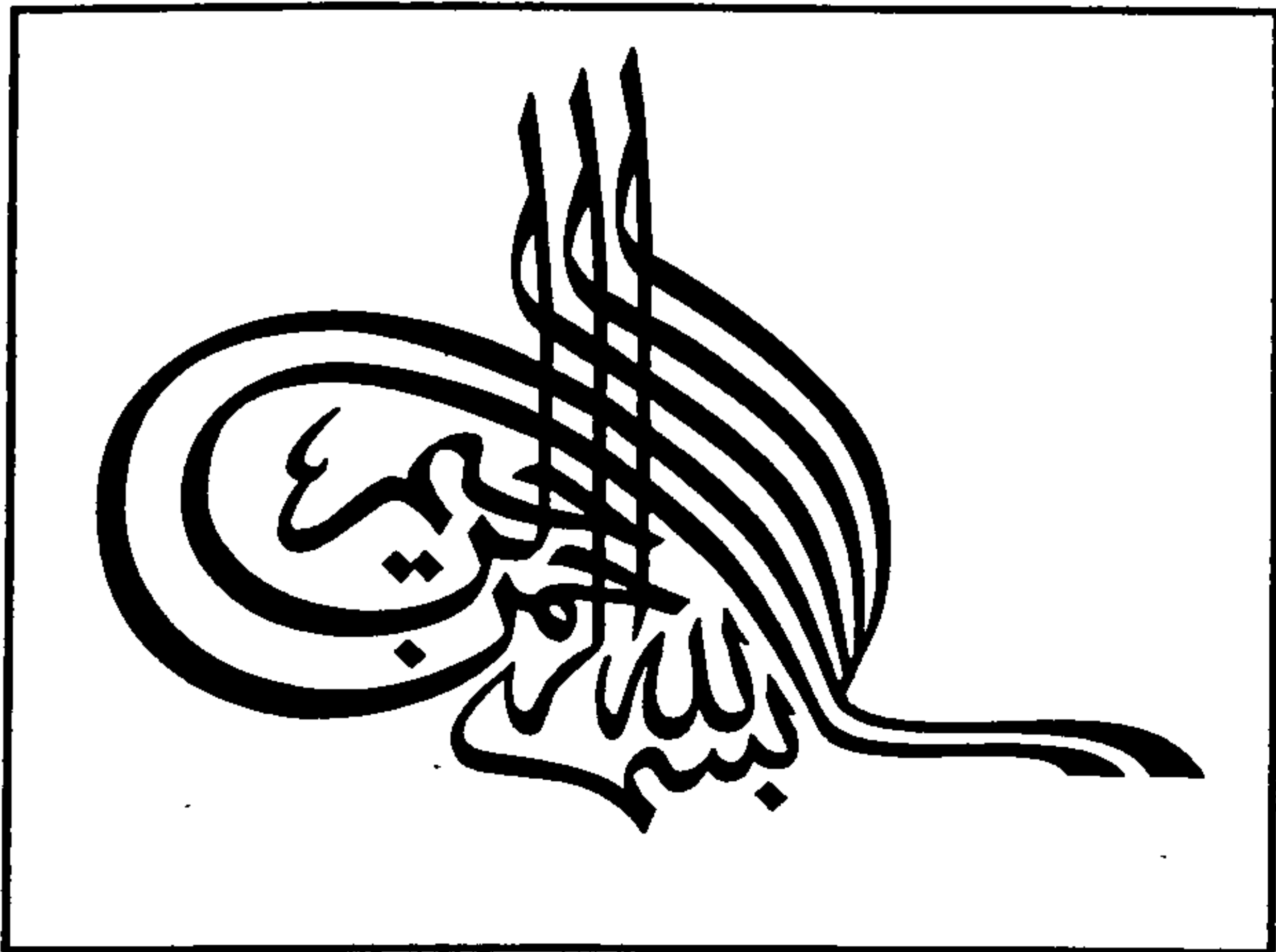
ACTION RESEARCH WORKSHOP

PRESENTATION ON:

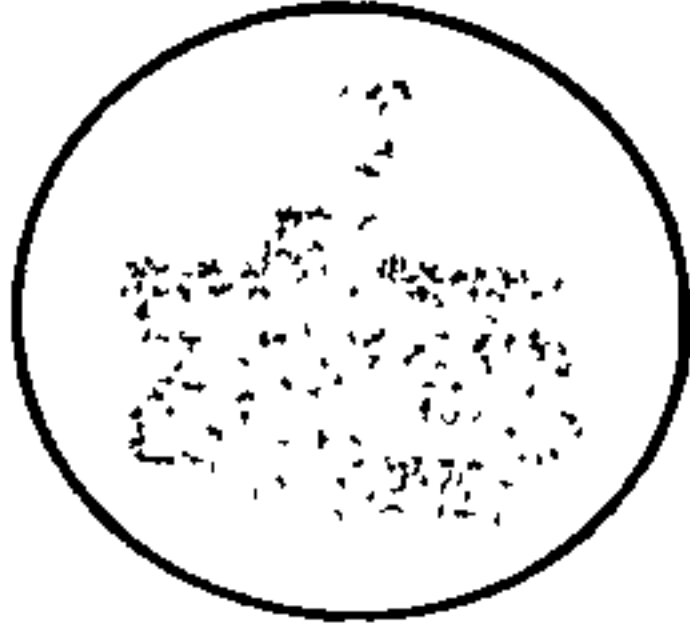
MANAGERIAL CREATIVITY AND LEADERSHIP

BY

**MOHAMMED ALI AL-GHAMDI
(Researcher)**



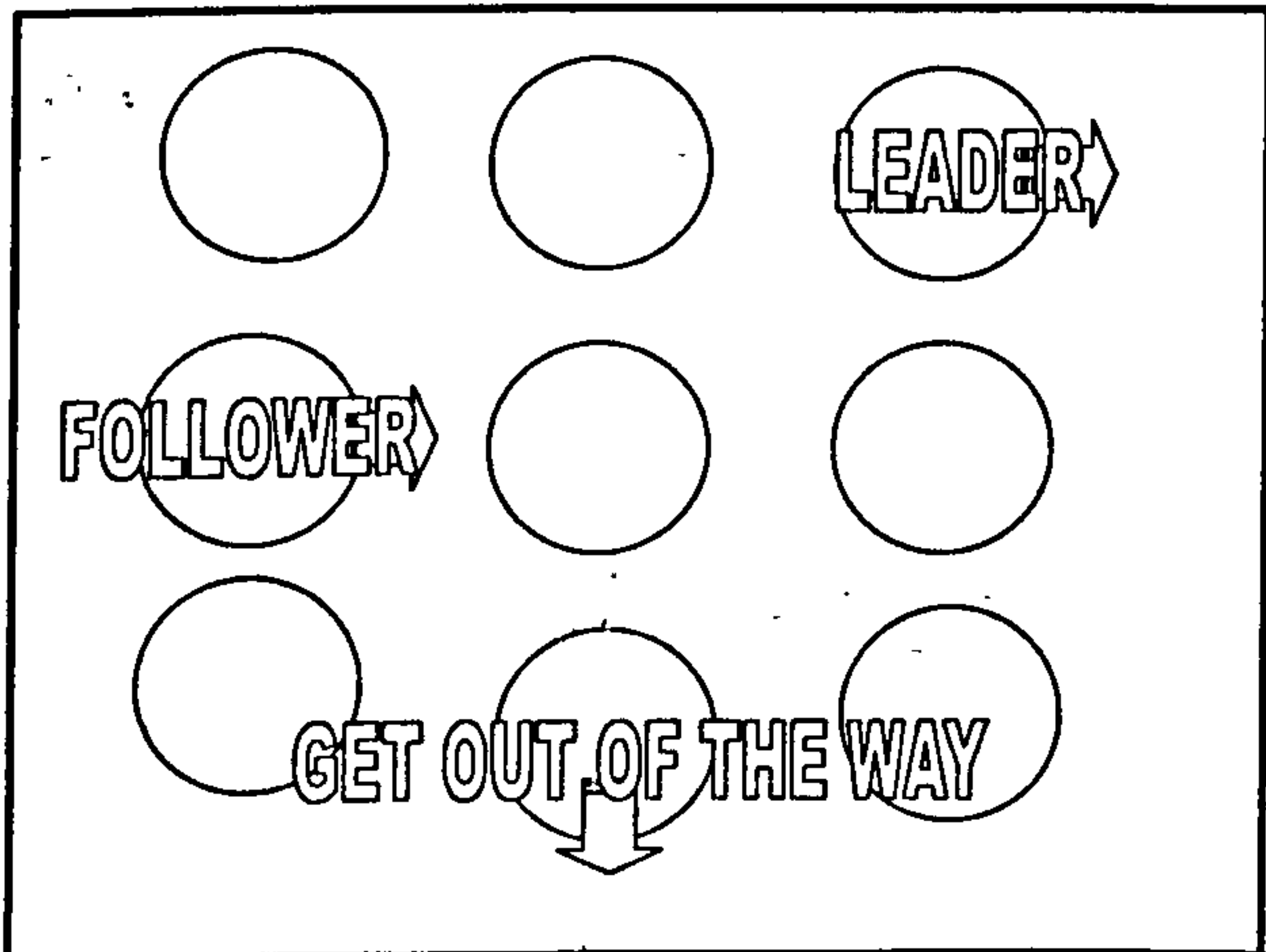
MANAGERIAL LEADERSHIP
AND CREATIVITY



MOHAMMED ALI AL-GHAMDI
B.Sc. , M.H.H.A.

- MAIN POINTS*
- DIFFERENCES BETWEEN MANAGERS AND LEADERS
 - LEADERSHIP LEVELS AND ITS LEVELS
 - LEADERSHIP THEORIES
 - HOW TO BE CREATIVE

*WHAT IS
YOUR
POSITION???*



MANAGER

LEADER

CREATOR

MANAGER LEADER

- | | | |
|------------|-------|-------|
| • PLAN | • YES | • NO |
| • ORGANIZE | • YES | • NO |
| • DIRECT | • YES | • YES |
| • FOLLOW | • YES | • NO |

MANAGERIAL



DIRECTING



*THE LEADER IS
PRESENT IN ANY
ORGANIZATION*

*FORMAL ORGANIZATION
MANAGER = LEADER*

*INFORMAL ORGANIZATION
MANAGER IS NOT LEADER*

**WHO
IS
THE
LEADER???**

THE LEADER IS
THE ONE WHO
CAN MAKE
OTHERS DO WHAT
HE WANTS

HOW???

LEADERSHIP POWER

- FORCE
- REWARD
- LEGAL
- EXPERIENCE
- ADMIRATION

LEVELS OF EXPERIENCE POWER

SENIOR LEVEL	M	H	P
MIDDLE LEVEL	E	U	O
EXECUTIVE LEVEL	N	M	R
	T	A	E
	A	N	S
	L		E

(Note: The table contains two upward-pointing arrows, one between the first and second columns, and another between the second and third columns.)

LEADERSHIP THEORIES

- X THEORY
- Y THEORY
- CONTINGENCY THEORY

X THEORY

- PEOPLE HATE WORK
- PEOPLE ARE LAZY
- PEOPLE DO NOT ACCEPT RESPONSIBILITY
- PEOPLE NEED TO BE CONTROLLED

Y THEORY

- ❖ PEOPLE LIKE WORK
- ❖ PEOPLE ARE TRUSTFUL
- ❖ PEOPLE ARE CREATORS
- ❖ PEOPLE WILL FULFILL THE OBJECTIVES OF THE ORGANIZATION

CONTINGENCY THEORY

REACT TO THE
SITUATION

CREATIVITY

INTRODUCTION
OF SOMETHING
TOTALLY NEW

WHAT DO WE
NEED IT FOR???

PROBLEM SOLVING

CREATION CRITERIA

- NEW
- USEFUL
- INTENTION

CREATION STAGES

1. PREPARATION
2. CONCENTRATION
3. INCUBATION
4. ILLUMINATION
5. VERIFICATION

CAN
I
BE A
CREATOR???

TRAIN YOURSELF

- I. BRAIN STORMING
- II. DEALING WITH
CONFLICT
- III. SMALL TEAM
BUILDING



ACTION RESEARCH WORKSHOP

PRESENTATION ON:

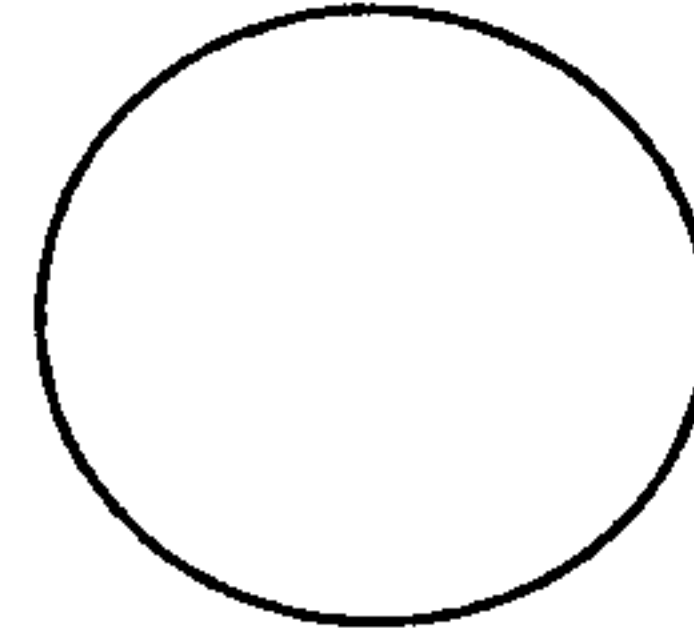
PROBLEM SOLVING & DECISION MAKING

BY

**MOHAMMED ALI AL-GHAMDI
(Researcher)**

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

*PROBLEM SOLVING
& DECISION MAKING*



MOHAMMED ALI AL-GHAMDI
B.Sc., M.H.H.A.

MAIN POINTS

- ❖ PROBLEM SOLVING ELEMENTS
- ❖ CLASSIFICATION OF PROBLEMS
- ❖ PROBLEM ANALYSIS
- ❖ DECISION MAKING

**SHOULD WE
HAVE A
PROBLEM??**

INTRODUCTION

PROBLEM SOLVING ELEMENTS

- PROBLEM ANALYSIS
- DECISION MAKING
- DECISION IMPLEMENTATION
AND FOLLOW UP

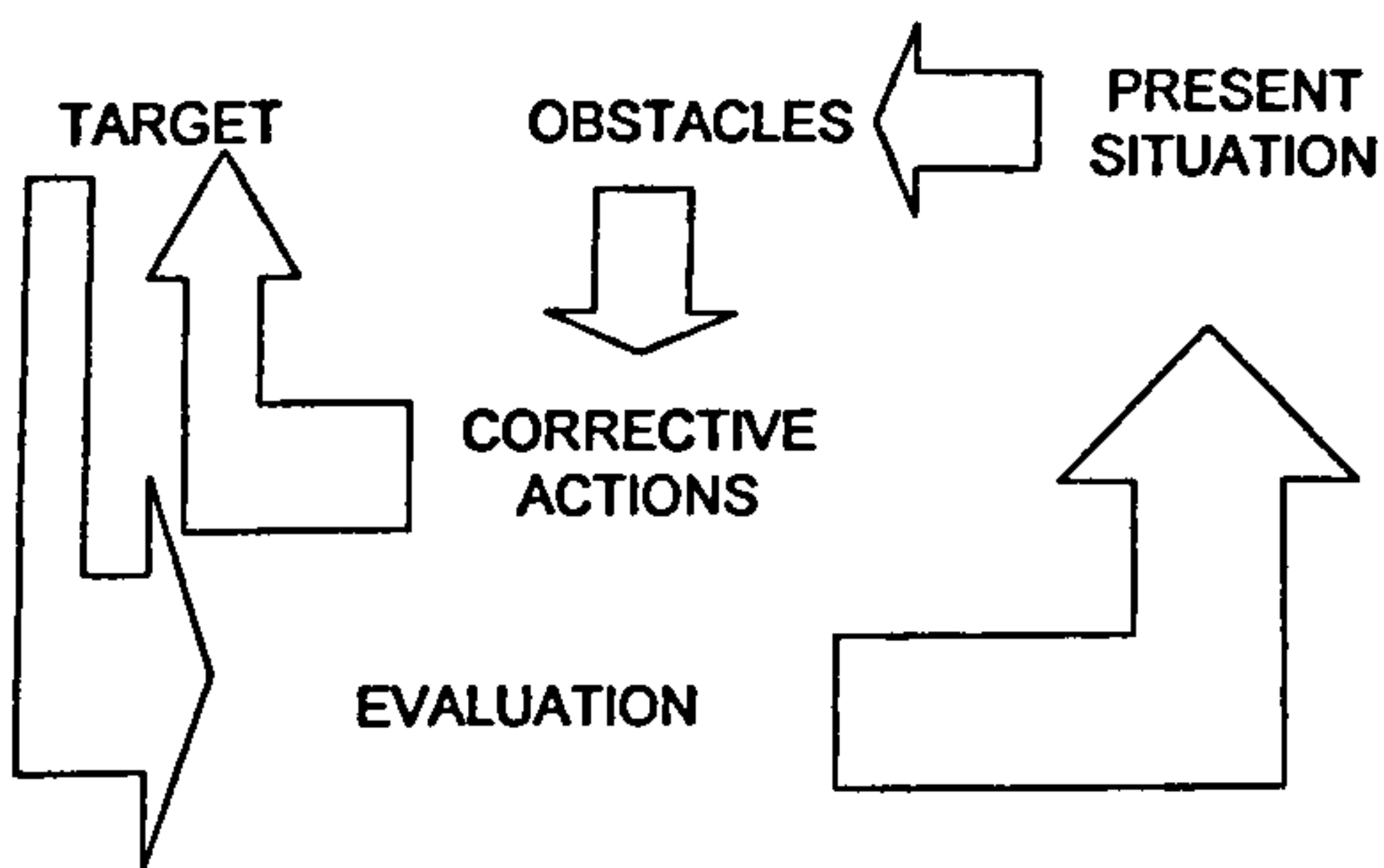
CLASSIFICATION OF PROBLEMS

- ACCORDING TO THE NATURE OF THE PROBLEM
- ACCORDING TO THE DEGREE OF DIFFICULTY OF THE PROBLEM

THE NATURE OF PROBLEMS

- 1-PERFORMANCE PROBLEMS (VISIBLE)
- 2-MAINTENANCE PROBLEMS

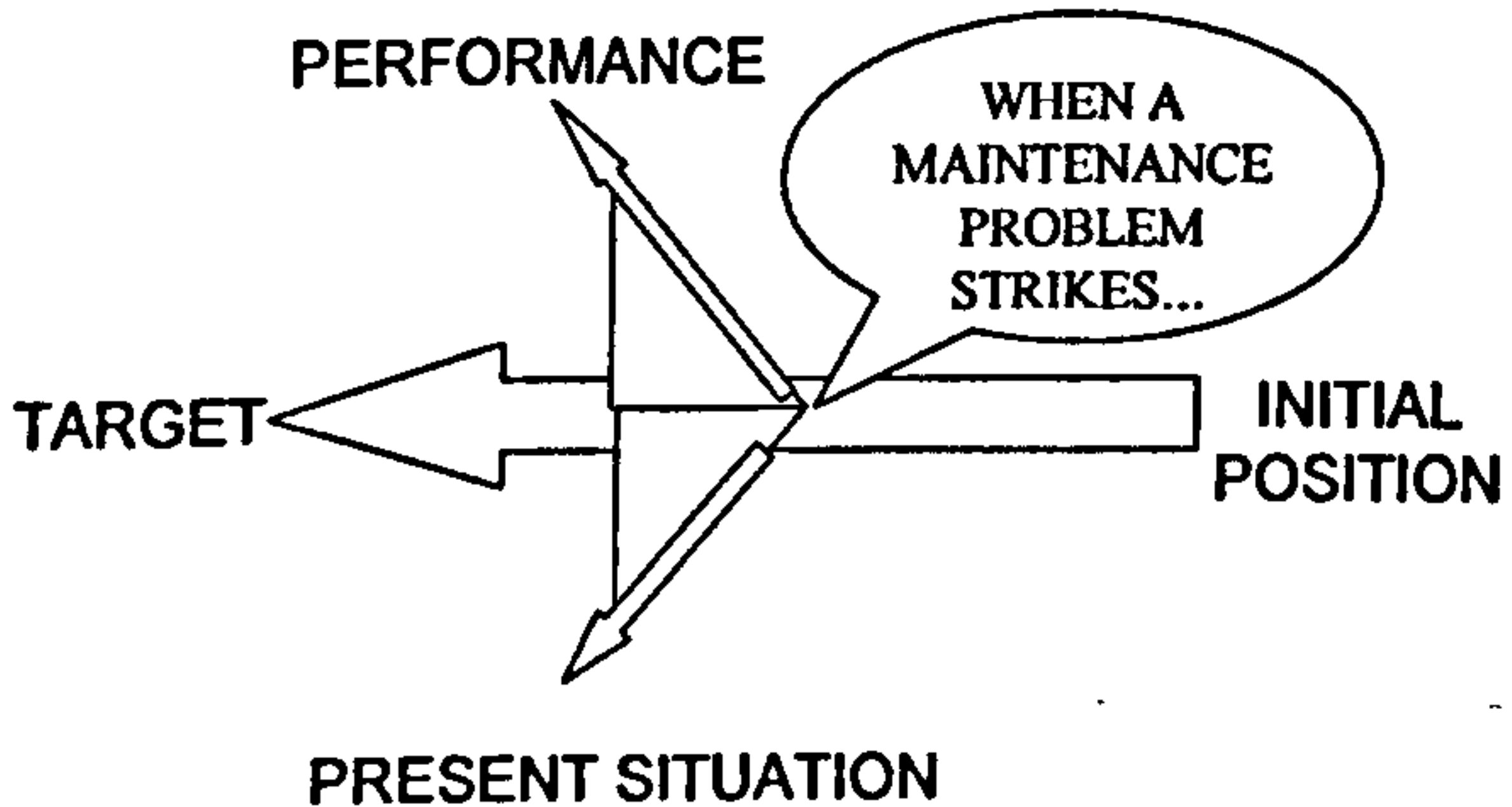
PERFORMANCE PROBLEM CYCLE



THE OBSTACLES

- BEHAVIOURAL
- ADMINISTRATIVE
- ORGANIZATIONAL
- ECONOMICAL
- TECHNICAL
- ENVIRONMENTAL

MAINTENANCE PROBLEM CYCLE

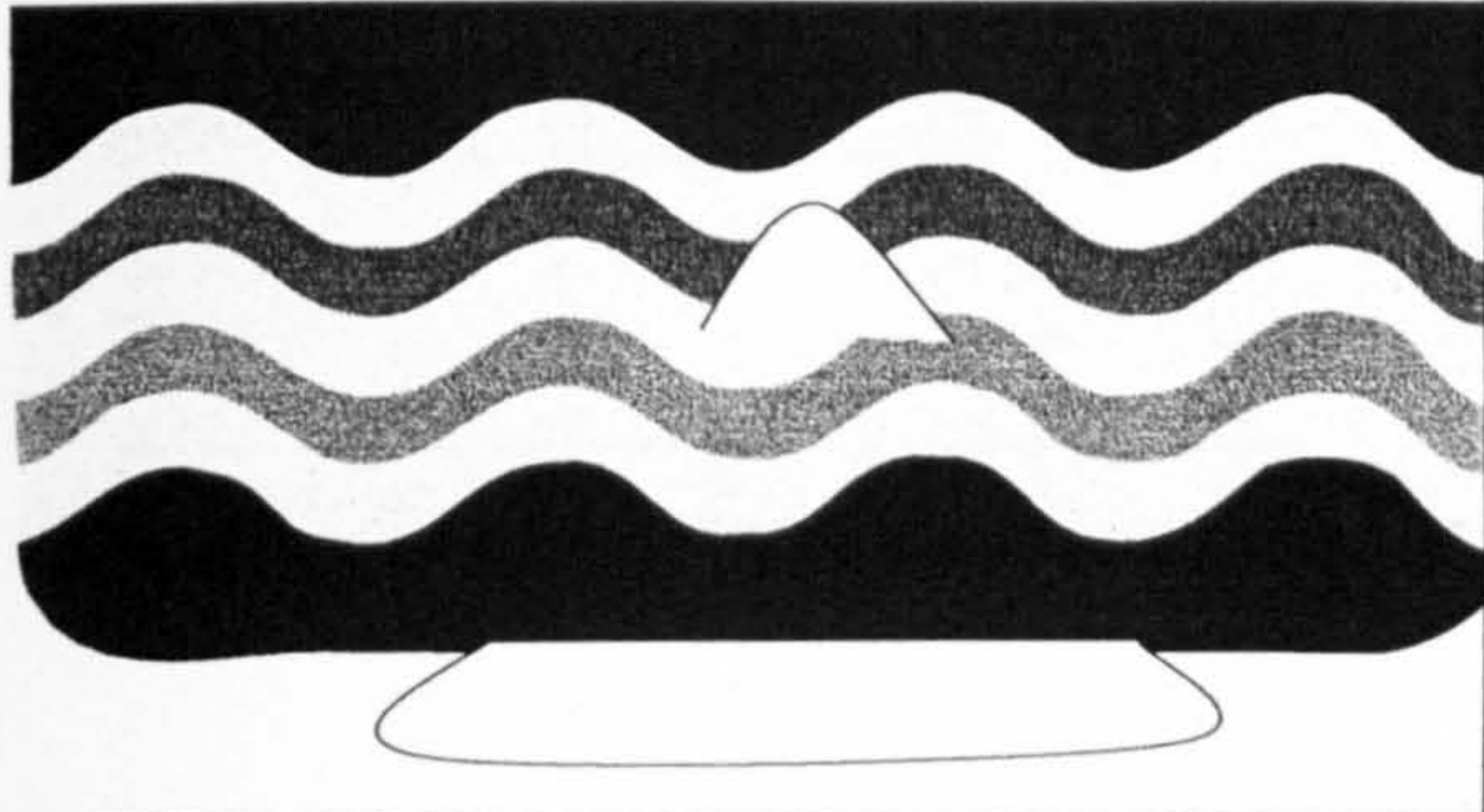


THE TYPES OF MAINTENANCE PROBLEMS

VISIBLE (ISLAND)

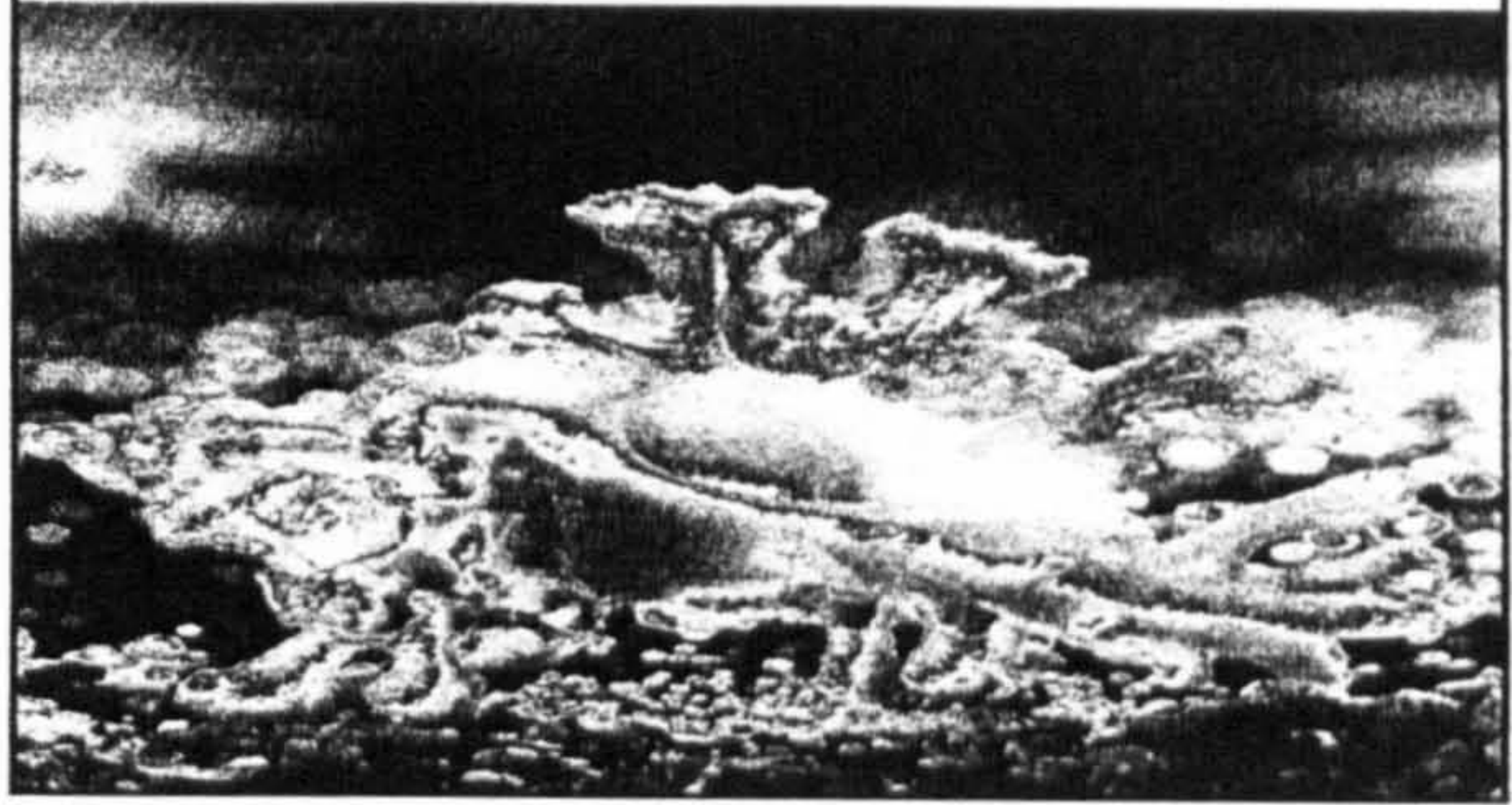


*THE TYPES OF MAINTENANCE
PROBLEMS*



*THE TYPES OF MAINTENANCE
PROBLEMS*

LATENT (SUBMARINE)



THE DEGREE OF DIFFICULTY

1-SIMPLE PROBLEMS

2-DIFFICULT PROBLEMS

3-COMPLEX PROBLEMS

THE DEGREE OF DIFFICULTY

1-SIMPLE PROBLEMS

- DEFINED AND WELL KNOWN DIMENTIONS
- DO NOT INTERFERE WITH OTHER PROBLEMS
- THE CAUSES OF THE PROBLEM ARE DEFINED
- CAN BE SOLVED BY SIMPLE OR PROGRAMMED DECISIONS

THE DEGREE OF DIFFICULTY

2-DIFFICULT PROBLEMS

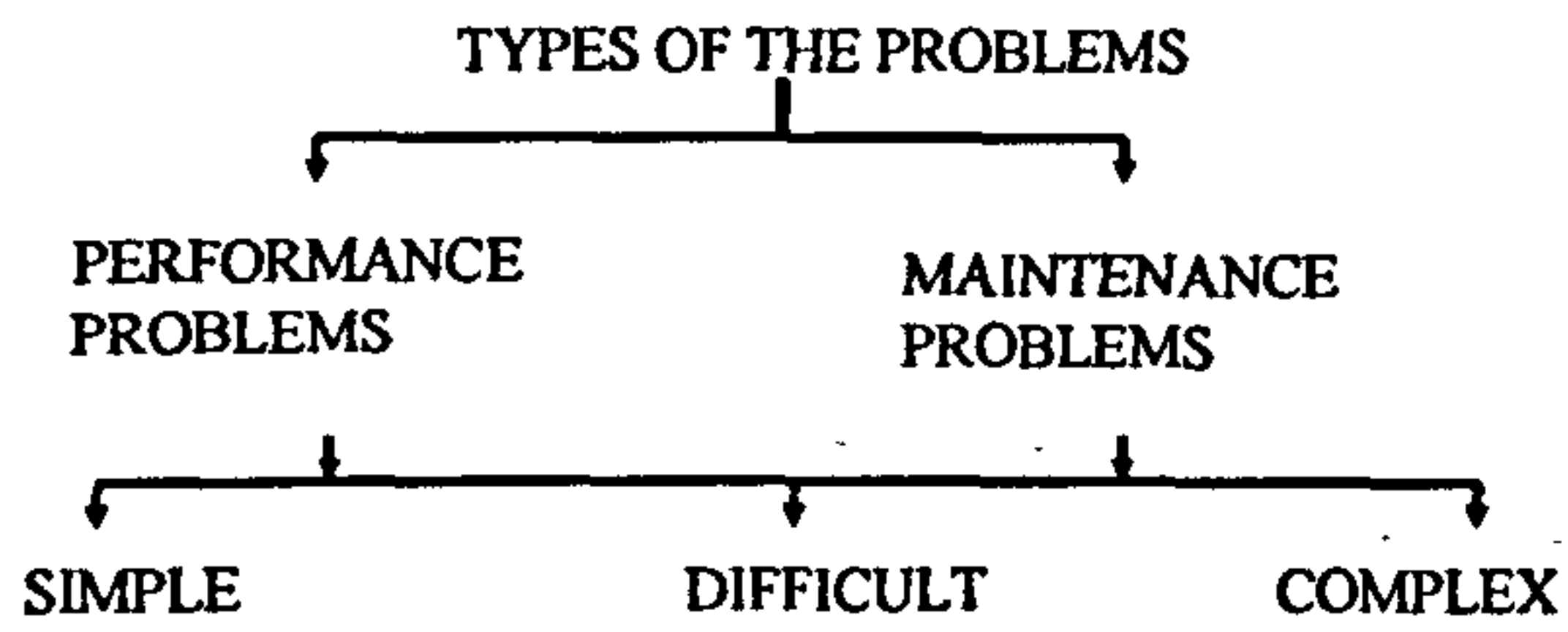
- INTERFERE WITH OTHER PROBLEMS
- COULD BE CAUSED BY CLEAR OR UNCLEAR FACTORS
- COULD BE SOLVED BY CREATIVE SOLUTIONS

THE DEGREE OF DIFFICULTY

3-COMPLEX PROBLEMS

- UNDEFINED
- CYCLIC INTERFERANCE WITH OTHER PROBLEMS
- BRANCHING
- NEED EXPERIMENTAL CREATIVE SOLUTIONS

WHAT IS THE PROBLEM???



PROBLEM ANALYSIS

PROBLEM ANALYSIS

THE STYLE OF ANALYSIS
STEPS OF THE ANALYSIS

PROBLEM ANALYSIS

THE STYLE OF ANALYSIS
INDUCTIVE STYLE
DEDUCTIVE STYLE

PROBLEM ANALYSIS

STEPS OF THE ANALYSIS

1. SPECIFY THE NATURE OF THE PROBLEM
2. SPECIFY THE DEGREE OF DIFFICULTY AND THE APPEARANCE OF THE PROBLEM

PROBLEM ANALYSIS

STEPS OF THE ANALYSIS

3. SPECIFY THE LEVEL OF DEVIATION
4. DEFINE THE PROBLEM CLEARLY

PROBLEM ANALYSIS

STEPS OF THE ANALYSIS

1. SPECIFY THE NATURE OF THE PROBLEM

THE SIGNS	THE TIME
THE PLACE	THE PERSONS

PROBLEM ANALYSIS

STEPS OF THE ANALYSIS

2. SPECIFY THE DEGREE OF DIFFICULTY AND THE APPEARANCE OF THE PROBLEM

RELATED AND STRIKING SIGNS	THE LAG AND STRIKING PERIODS
RELATED AND STRIKING PLACES	UNEFFECTED PERSONS

PROBLEM ANALYSIS

STEPS OF THE ANALYSIS

3. SPECIFY THE LEVEL OF DEVIATION

PLACE
TIME
PERSONS

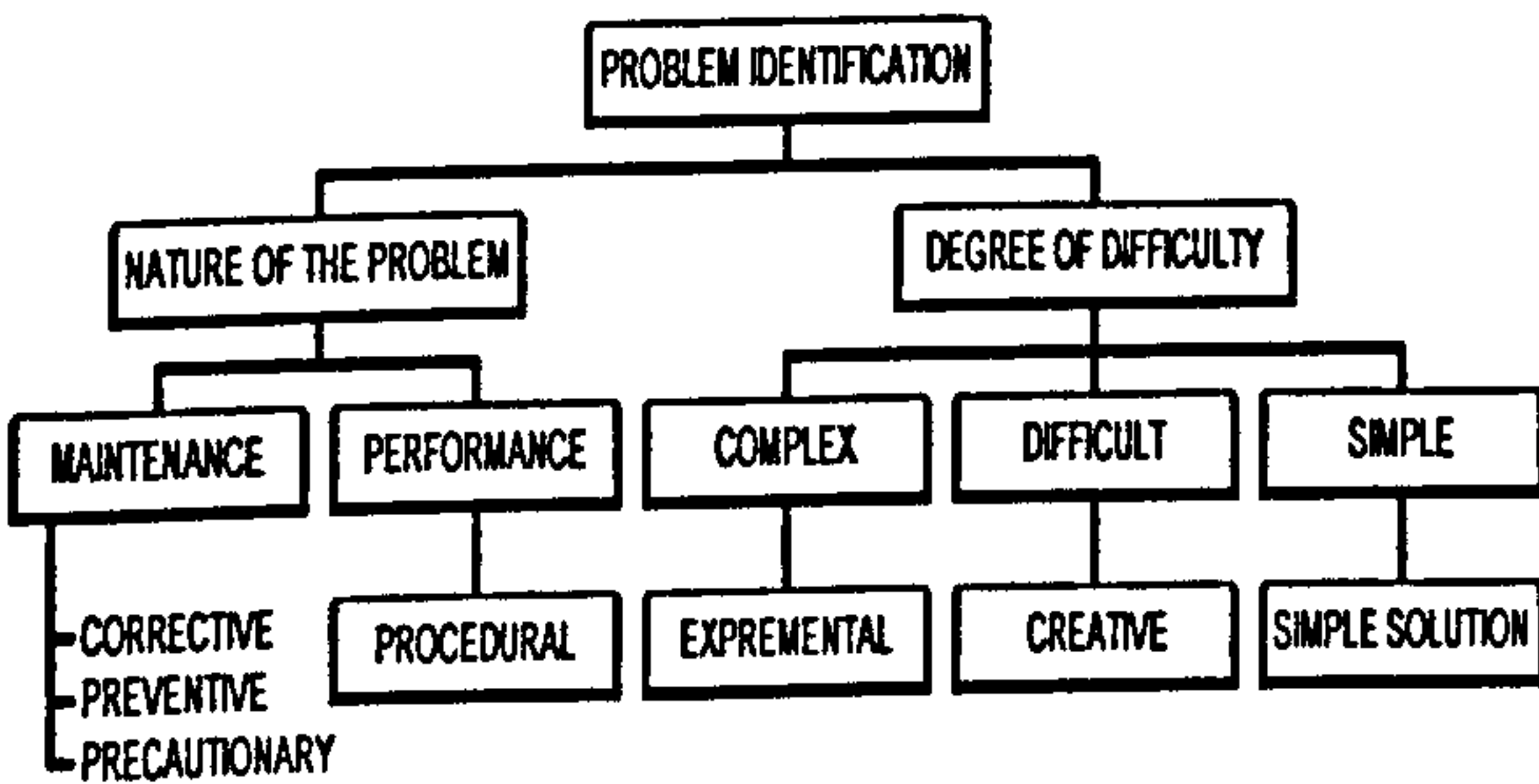
PROBLEM ANALYSIS

STEPS OF THE ANALYSIS

4. DEFINE THE PROBLEM CLEARLY

DRAW THE PROBLEM DIAGRAM
DESIGN AND DESCRIBE THE PROBLEM CLEARLY

PROBLEM ANALYSIS DIAGRAM



DECISION MAKING

DECISION MAKING

TYPES OF DECISIONS

TENTATIVE ALTERNATIVE SOLUTIONS

ALTERNATIVE SOLUTIONS EVALUATION

SELECTION OF THE BEST
ALTERNATIVE SOLUTION

DECISION MAKING

TYPES OF DECISIONS

ENDS-MEANS

ADMINISTRATIVE-OPERATIONAL

PROGRAMMED-NONPROGRAMMED

DECISION MAKING

TENTATIVE ALTERNATIVE SOLUTIONS

COMMITTEES

BRAIN STORMING

DELPHI TECHNIQUE

NOMINAL GROUP TECHNIQUE

DECISION MAKING

ALTERNATIVE SOLUTIONS EVALUATION

QUANTITATIVE AND QUALITATIVE

EFFECTIVENESS FEASIBILITY POLITICAL

ACCEPTABILITY CRITICALNESS

TIME FRAME OPPORTUNITY SOCIAL

DECISION MAKING

SELECTION OF THE BEST
ALTERNATIVE SOLUTION

STATE THE ACTUAL AND THE DESIRED
SITUATIONS

LIST DOWN THE SOLUTIONS ACCORDINGLY

CHOOSE THE BEST POSSIBLE ALTERNATIVE

DECISION

IMPLEMENTATION AND FOLLOWUP

DECISION

IMPLEMENTATION AND FOLLOW UP

SELECTION OF THE BEST
ALTERNATIVE SOLUTION

DECISION

IMPLEMENTATION AND FOLLOW UP

CONDUCT A PERIODICAL
EVALUATION ON THE
EFFECTIVENESS OF THE
SOLUTION

DECISION

IMPLEMENTATION AND FOLLOW UP

TRY ANOTHER ALTERNATIVE IF
THE RESULT OF THE
EVALUATION IS NOT
SATISFACTORY

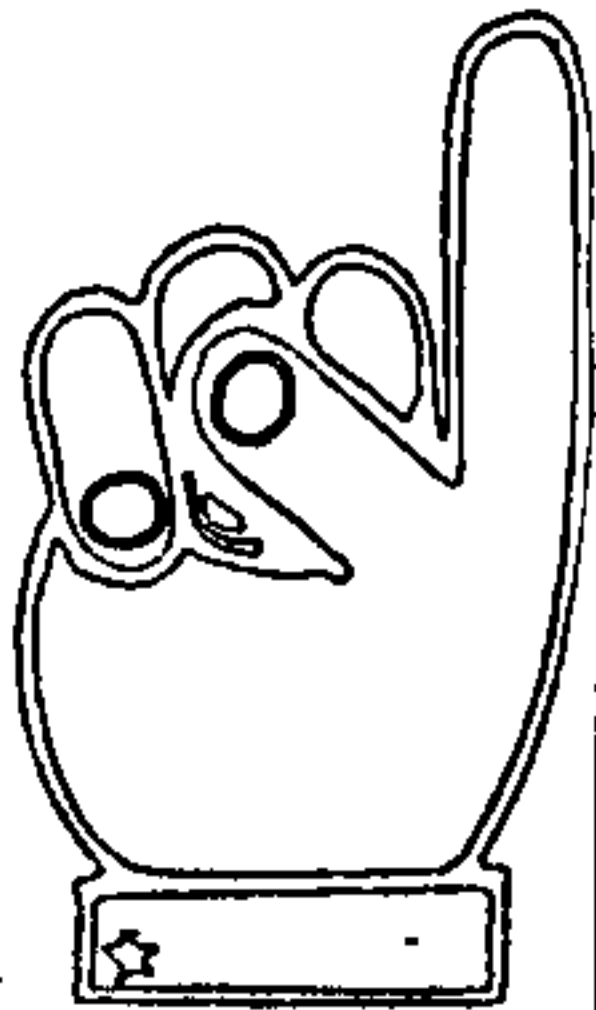
REMEMBER . . .

DO NOT DECIDE JUST
TO PLEASE OTHERS



REMEMBER . . .

BE A PART OF THE
SOLUTION RATHER
THAN A PART OF THE
PROBLEM



REMEMBER . . .

DECISION MAKER
FREQUENTLY DEALS
WITH UNCERTAINTY



REMEMBER . . .

SPEND MORE TIME
ON DEFINING THE
PROBLEM RATHER
THAN FINDING A
SOLUTION



THANK YOU



M.A. AL-GHAMDI

P.H.D. ACTION RESEARCH

Time Table
"Action Research Workshop "

No.	Function	Time
1	Registration and Introduction to the Workshop.	10 min
2	Introduction to Health Quality Management (Presentation)	20 min
3	Time Management (Presentation)	20 min
4	Leadership (Presentation)	20 min
5	Group Discussion	20 min
Break		10 min
6	Introduction to Problem Solving (Presentation)	20 min
7	Problem Analysis (Group Session on Patient Satisfaction Problems)	30 min
8	Results of Group Session	10 min
9	Decision Making (Presentation)	20 min
10	Decision Making (Group Session on Patient Satisfaction Decisions)	30 min
11	Results of Group Session	10 min
12	Participants' Views	10 min
13	Recommendations and Closing Session	10 min

APPENDIX NINE

WORKSHOP QUESTIONNAIRE

إستبانة ورشة العمل

1. Biodata:

1- معلومات شخصية:

1	Job title:	مسمى الوظيفة:	١
	<input type="checkbox"/> Head nurse	<input type="checkbox"/> رئيسة تمريض	
	<input type="checkbox"/> Registered nurse	<input type="checkbox"/> ممرضه	
	<input type="checkbox"/> Nursing technician	<input type="checkbox"/> فنية تمريض	
2	Ward:	القسم الذي تعمل فيه .	٢
	<input type="checkbox"/> Medical ward	<input type="checkbox"/> الباطنيه	
	<input type="checkbox"/> Surgical ward	<input type="checkbox"/> الجراحه	
3	Years of experience:	عدد سنوات الخبرة .	٣
	<input type="checkbox"/> 1-5 years	<input type="checkbox"/> ١ - ٥ سنوات	
	<input type="checkbox"/> More than 5 and less than 10 years	<input type="checkbox"/> أكثر من خمس سنوات وأقل من عشر سنوات	
	<input type="checkbox"/> More than 10 years	<input type="checkbox"/> أكثر من عشر سنوات	
4	Age:	العمر:	٤
	<input type="checkbox"/> Less than or equal to 30 years	<input type="checkbox"/> أقل من أو يساوي ٣٠ سنه	
	<input type="checkbox"/> More than 30 and less than 40 years	<input type="checkbox"/> أكثر من ثلاثين وأقل من أربعين سنه	
	<input type="checkbox"/> More than 40 and less than 50 years	<input type="checkbox"/> أكثر من اربعين وأقل من خمسين سنه	
	<input type="checkbox"/> Fifty years and more	<input type="checkbox"/> خمسين سنه فأكثر	
5	Gender :	الجنس :	٥
	<input type="checkbox"/> Male	<input type="checkbox"/> ذكر	
	<input type="checkbox"/> Female	<input type="checkbox"/> أنثى	
6	Nationality:	الجنسيه:	٦
	<input type="checkbox"/> Saudi	<input type="checkbox"/> سعودي	
	<input type="checkbox"/> Non Saudi	<input type="checkbox"/> غير سعودي	
7	Specialty	المؤهل	٧
	<input type="checkbox"/> Postgraduate in nursing	<input type="checkbox"/> دراسات عليا بعد الجامعه في التمريض	
	<input type="checkbox"/> University graduate in nursing	<input type="checkbox"/> شهادة جامعية في التمريض	
	<input type="checkbox"/> Health institute	<input type="checkbox"/> شهادة المعهد الصحي	
	<input type="checkbox"/> Nursing course	<input type="checkbox"/> برنامج تدريبي في التمريض	
8	How many training courses and lectures in quality management have you attended ?	كم عدد الدورات التدريبيه والمحاضرات التي حضرتها في مجال إدارة الجودة ؟	٨
	<input type="checkbox"/> None	<input type="checkbox"/> لم احضر دورات او برامج تدريب .	
	<input type="checkbox"/> 1-5 training courses and lectures	<input type="checkbox"/> ١ - ٥ دورات وبرامج تدريبيه	
	<input type="checkbox"/> More than five courses and lectures	<input type="checkbox"/> أكثر من خمس دورات وبرامج تدريبيه	

Your evaluation of the workshop

1. Is the information discussed in the lecture new to you ?	١- هل المعلومات التي نوقشت في المحاضرة جديدة عليك ؟
<input type="checkbox"/> Yes	<input type="checkbox"/> نعم
<input type="checkbox"/> No	<input type="checkbox"/> لا
<input type="checkbox"/> Some are new	<input type="checkbox"/> بعضها جديد
2. Is all of it practical?	٢- هل ممكن تطبيق كل هذه المعلومات ؟
<input type="checkbox"/> Yes	<input type="checkbox"/> نعم
<input type="checkbox"/> No	<input type="checkbox"/> لا
3- If No, why?	٣- إذا كانت الإجابة ب(لا) فما هي الأسباب؟
1.	-١
2.	-٢
3.	-٣
4. Do you (really, consider taking out 'really' implement them in your work?	٤- هل تقوم بتطبيقها فعلا في عملك ؟
<input type="checkbox"/> Yes	<input type="checkbox"/> نعم
<input type="checkbox"/> No	<input type="checkbox"/> لا
5. If you did not implement new information, what were the obstacles?	٥- إذا كنت لا تقوم بتطبيقها . . فما هي عوائق التطبيق؟
1.	-١
2.	-٢
3.	-٣
4.	-٤

6- Could these concepts be used to facilitate patient satisfaction?

٦- هل ممكن إستخدام هذه المفاهيم لتحقيق رضا المرضى؟

Yes

نعم

No

لا

7- If Yes, how?

٧- إذا كانت إجابتك ب (نعم) بين كيف؟

8- If No, why?

٨- إذا كانت الإجابة ب (لا) فلماذا؟

أشكركم على تعاونكم

*THANK YOU FOR YOUR
COOPERATION*

APPENDIX TEN

Attention : *The director of the hospital .*

Subject : Action research about nursing care in the inpatient unit of the hospital.

Introduction:

Action research is an effective approach in enhancing the quality of the work because it is the result of cooperation between the researcher and the practitioner. Since health services depend heavily on nurses in providing health care for patients, promoting their way of handling patients could add very much to the level of patients satisfaction. It is an education tool which provides nurses with practical skills in quality management, leadership and time management in order to analyze work problems and take the best possible action to solve them.

Objective :

Formulate a practical mechanism for nurses to achieve patients satisfaction in the inpatient unit through the support of the researcher to overcome any obstacles. The final model of this research could be utilized with certain modifications to raise patient satisfaction in other departments of the hospital.

Time frame:

The total period of the research is three months including biweekly meetings with quality department representative head nurses of the three shifts in the selected wards.

Methodology:

- 1) The medical and surgical wards will be the site of the research
- 2) Head nurses, staff nurses and quality department representatives of the three shifts in selected wards should be permanently on fixed shifts throughout the study period.
- 3) Head and staff nurses should attend the workshop which will be presented by the researcher before commencing the research. The topics of the workshop will be :
 - a. Essentials of quality management.
 - b. Leadership

- c. Time management
- d. Problem solving and decision making

Although the main target of this workshop is educating nurses in the four topics that will be presented and exploring the specific work environment of nursing services in the hospital, the workshop will also serve as a means of assessing their basic knowledge in quality concepts prior to any formal education about quality care. A questionnaire will be distributed to all attendees following the workshop to gather their views on this educational activity.

- 4) The workshop will be held for four hours and repeated for two days to allow all nurses to attend without affecting unit staffing.
- 5) Nurses should satisfy patients through the factors indicated in the patient satisfaction questionnaire.
- 6) Training of quality department representatives on how to fill in the patient questionnaire.
- 7) Survey patients satisfaction through a pre-designed questionnaire through the quality department representative.
- 8) Nurses should utilize good communication skills with patients in order to discover any obstacles hindering their satisfaction and attempt immediate resolution. Head nurses should prepare biweekly reports on a pre designed form.
- 9) Biweekly meeting between the researcher, the quality department representative and head nurses will be held to discuss the findings of the patient survey and compare them with the reports of the head nurses. Recommendations of the meeting will be the operational plan for the next two weeks.
- 10) The previous process will be repeated every two weeks during the three month study period.
- 11) The researcher will prepare a comprehensive report at the end of the research period. It will show the optimum procedures to assure patient satisfaction from the real working environment of the studied wards. With very minor changes , these findings could serve as a model for satisfying patients within hospital services. (sentence change)

Research requirements :

- 1) Approval of hospital management to implement the study.
- 2) Procure agreements from head nurses, staff nurses and quality department representatives to participate in the study for the entire study period.
- 3) Approval of patients to participate in the study at the beginning of the interview with the quality department representative.

- 4) All nurses should attend the workshop which will be held for four hours in one day before the start of the research.
- 5) Head nurses and quality department representatives should attend biweekly meetings with the researcher every two weeks for the study period.
- 6) All of the participant nurses should remain on the same shifts and place of work for the entire period.
- 7) Head nurses should be authorized to liaise with hospital management to facilitate whatever is needed to satisfy their patients after coordination with the researcher.
- 8) Head nurses should be authorized to arrange with any related department to satisfy patients after coordination with the researcher.

عناية : مدير المستشفى

الموضوع :

بحث أداء الممرضات في الأقسام الداخلية بالمستشفى .

مقدمه :

تعد بحوث الأداء (Action Research) من الأساليب الناجعة في تحسين أداء الأعمال ، إذ أنها خلاصة تعاون الباحث مع العاملين لبحث أدائهم وتصحيح المسار على بيئة العمل للوصول إلى أسلوب أمثل لتنفيذ الأعمال . وحيث أن الخدمات الصحية تعتمد بصورة كبيرة على قطاع التمريض في المستشفيات ونظرا لقربهم الحميم من المرضى لذا فإن حسن أدائهم لإعمالهم يساهم بصورة كبيرة في رفع درجة رضا المريض عن خدمات المستشفى بصورة كاملة . ويمثل أسلوب بحث الأداء أداة تعليمية لتزويد طاقم التمريض بمهارات عملية تتمثل في مجالات تحسين الجودة ومهارات القيادة والإبداع الإداري وحسن إدارة الوقت لصقل ملكة تحليل المشكلات واتخاذ القرارات لتقديم خدمة أفضل .

الهدف :

إعداد آلية عملية تمكن الممرضات من تحقيق رضا المرضى في الأقسام الداخلية من خلال مساندة ودعم الباحث لأعمال التمريض . ويتم ذلك من خلال البحث عن معوقات جودة العمل والعمل على تذليلها واتخاذ هذا الأسلوب منهجا لتحسين جودة الرعاية الصحية في سائر الخدمات بالمستشفى .

مدة البحث :

ثلاثة أشهر وتتم متابعته من خلال اجتماعات نصف شهرية بين الباحث ومندوب الجودة ورئيسات التمريض في المناوبات الثلاث في الأقسام المختاره .

إجراءات البحث :

- ١- تحديد أقسام الجراحة والباطنية بالأقسام الداخلية ليكون مرضاهم الداخليين مجال البحث .
- ٢ - تحديد رئيسات التمريض وسائر الممرضات في القسمين المذكورين وتثبيتهن في المناوبات الثلاث طيلة فترة البحث .

٣- حضور جميع الممرضات ورئيسات التمريض في الأقسام المذكوره بالإضافة إلى مندوبي إدارة الجودة بالمستشفى ورشة عمل يقدمها الباحث قبل بدء البحث وتشمل المواضيع التالية :

- i. أساسيات الجودة الصحية
- ii. القيادة والإبداع الإداري
- iii. إدارة الوقت
- iv. تحليل المشكلات واتخاذ

القرارات

ومع أن الهدف الأساس من ورشة العمل هذه تزويد الممرضات بالمعلومات المبينة أعلاه ومناقشتها من خلال بيئة العمل الخاصة بالمستشفى . إلا أنه سيتم الاستفادة من حضور الممرضات لمعرفة مفاهيمهن عن المعلومات الأساس عن الجودة مقارنة بما تم مناقشته في ورشة العمل قبل بدء بحث الأداء وذلك من خلال نموذج معد سلفاً يتم توزيعه وجمعه بعد ورشة العمل .

٤- سوف تعقد ورشة العمل لمدة أربع ساعات يكررها الباحث يومين متتاليين لضمان حضور كافة الممرضات بما لا يخل على أعمال أقسامهن .

٥- على الممرضات الحرص على إرضاء المرضى من خلال العوامل المبينة في استبانة حصر رأي المريض .

٦- تدريب مندوبي إدارة الجودة على تعبئة استبانة المرضى قبل خروجهم من المستشفى وشرح جميع المتغيرات الواردة في الاستبانة المذكوره لضمان ثبات ومصداقية المعلومات التي يدونونها .

٧- حصر آراء المرضى ومعرفة رضائهم عن الخدمات المقدمة في المستشفى من خلال استبانة معدة تعبا من قبل مندوب من إدارة الجودة بالمستشفى من خلال مقابلته مع المريض قبل خروجه من المستشفى وذلك بعد إصدار الطبيب المعالج تعليماته بخروج المريض فتقوم رئيسة التمريض بالقسم بإفادة إدارة الجودة لترسل مندوبها لتعبئة الاستبانة المذكوره .

٨- ممارسة الممرضات أفضل سبل الاتصال مع المرضى لمعرفة معوقات رضاه عن خدمة المستشفى من واقع العوامل المبينة في استبانة حصر رأي المرضى وتذليل تلك المعوقات سواء ما يختص منها بالخدمة التمريضية أو ماله علاقة بالأقسام الأخرى ذات العلاقة في المستشفى .

٩- تقدم رئيسة التمريض في كل مناوبة تقرير نصف شهري للباحث عن ماتم عمله على النموذج المخصص لذلك .

١٠- اجتماع جميع رئيسات التمريض في القسمين المحددين بالإضافة إلى مندوب إدارة الجودة مع الباحث لمناقشة نتائج استبانات المرضى والتقارير نصف الشهرية لبحث عوائق رضا المرضى خلال الفترة الماضية وبحث ما يمكن عمله في الفترة التالية من زمن البحث .

- ١١- يكرر العمل بالإجراءات السابقة كل أسبوعين على مدى الثلاث الأشهر المخصصة للبحث .
- ١٢- إعداد تقرير شامل في نهاية مدة البحث يقترح الآلية المثلى لرفع رضا المرضى عن خدمات المستشفى ليسترشد بها في تطوير أعمال التمريض بصورة خاصة ويمكن تحويل ما يلزم فيها لاستخدامها في تطوير بقية خدمات المستشفى .

متطلبات البحث :

- ١- موافقة إدارة المستشفى على إجراء الدراسة حسب ما تم إيضاحه في إجراءات البحث أعلاه .
- ٢- تحديد إدارة المستشفى رئيسات التمريض والمرضات ومندوب إدارة الجودة المشاركات في الدراسة والحصول على موافقتهم على ذلك .
- ٣- موافقة المرضى على الإشتراك في الدراسة وذلك في بداية مقابلة مندوب الجودة مع المريض .
- ٤- سماح إدارة المستشفى لعموم المرضات المشتركات في الدراسة حضور ورشة العمل التي ستعقد قبل بدء البحث ولمدة أربع ساعات وتعد الورشة في يومين متتاليين بحيث يحضر نصف عدد المرضات في كل يوم مراعاة لحسن سير العمل وعدم إخلال حضور الورشة بالإلتزامات العمليه .
- ٥- سماح إدارة المستشفى لجميع رئيسات التمريض المشتركات في الدراسة في الأقسام المختارة ومندوب إدارة الجودة حضور إجتماع نصف شهري لمناقشة تطور البحث .
- ٦- تثبيت عموم المرضات ورئيسات التمريض في الأقسام المحدده والمناوبات المحدده لهن طيلة فترة البحث (ثلاثة أشهر) .
- ٧- إعطاء رئيسة التمريض في كل مناوبة صلاحية الاتصال بإدارة المستشفى لتذليل ما قد يعترض رضا المرضى من عوائق وذلك بعد التنسيق مع الباحث .
- ٨- إعطاء رئيسة التمريض في كل مناوبة في الأقسام المختارة صلاحية الاتصال والإجتماع بالأقسام الأخرى ذات العلاقة لبحث أسباب عدم رضا المريض عن خدماتهم وإيجاد الحلول المناسبة لها وذلك بعد التنسيق مع الباحث .

APPENDIX ELEVEN

Knowledge, Attitude and Practice of Hospital Senior and Middle Management in Eastern Saudi Arabia towards Health Care Quality Programmes.

Introduction:

This survey has been prepared by Mr. Mohammed Ali AL-Ghamdi, the director of quality assurance department in the directorate of health affairs of the Eastern Province. The purpose of this survey is to gather information for a doctoral (Ph.D.) study through the University of Hull, U.K.

The specific objective of this questionnaire is to explore the main factors contributing to patient satisfaction and to end up with a practical plan to improve nursing care in the hospital which leads to improving health care quality in the hospital in general.

Note: (The interviewer explains all of the following notes for patients at the beginning of the interview):

1. All of the information gathered for this questionnaire will be coded to maintain its confidentiality.
2. Your acceptance to know your views through this questionnaire is considered as an implicit agreement to include your views among the study sample of this research.
3. If you have questions or need any further information, please contact the researcher:

Mr. Mohammed Ali AL-Ghamdi
Quality Assurance Department, Directorate of
Health Affairs, Eastern Province.
Telephone : 8432222 ext. 1110 and 1149
Fax : 8290107
Mobile : 0505859223

Thank you for your assistance. I hope the valid and reliable information that you offer, and the results of the study will be helpful to the decision makers in our country in developing and improving health care quality programmes.

If you are interested in the subject of the study write down your address. I will be glad to send you a copy of the abstract of the final dissertation

Name and address (optional):

Name :

Address :

e-mail :

Contact No. : Phone

: Fax

1. Biodata:

1	Nationality: <input type="checkbox"/> Saudi <input type="checkbox"/> Non Saudi
2	Residence: <input type="checkbox"/> Arban <input type="checkbox"/> Ruler
3	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
4	Age:
5	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow
6	Education: <input type="checkbox"/> Elementary school <input type="checkbox"/> Intermediate school <input type="checkbox"/> Hischool <input type="checkbox"/> Diploma after the highschool <input type="checkbox"/> Graduate <input type="checkbox"/> Postgraduate <input type="checkbox"/> Other (specify):.....
7	Occupation: <input type="checkbox"/> Professional (physician,engineer,pilot,.....) <input type="checkbox"/> Administrator (employee in governmental or private sector) <input type="checkbox"/> Technician (carpenter,electrician,plumber,.....) <input type="checkbox"/> Educator (teacher,headmaster,educational supervisor,.....) <input type="checkbox"/> Student <input type="checkbox"/> Other (specify):.....
8	What is your main source of health care : <input type="checkbox"/> Health centers and hospitals of ministry of health <input type="checkbox"/> Private dispensaries and hospitals <input type="checkbox"/> Aramco hospital <input type="checkbox"/> Military hospitals

Put a tick mark ✓ in front of each statement in the space according to the patients's choice :

2. Your satisfaction about nursing care

No.	Variables	Excellent	Good	Neutral	Not good	Not good at all
2.1	Your experience and expectations of nursing care.					
2.1.1	What was your previous experience of nursing care in this hospital					
2.1.2	What was your expectation of nursing care on admission?					
2.2	Physical environment of the hospital:					
2.2.1	What was the level of ventilation?					
2.2.2	What was the level of quiteness?					
2.2.3	What was the level of cleanness?					
2.2.4	What was the Quality of meals?					

No.	Variables	Strongly agree	Agree	Neutral	Do not agree	Strongly do not agree
2.3	Communication and information					
2.3.1	Nurses gave you information about the ward					
2.3.2	Nurses gave you information about the treatment plan					
2.3.3	nurses explain procedures before they are done					
2.3.4	information given by nursing staff made your hospital stay better					
2.4	Participation and involvement					
2.4.1	Nurses gave you the opportunity to participate in planning for your case.					
2.4.2	Nurses gave you the opportunity to participate in implementing the treatment plan					
2.5	Interpersonal relationship					
2.5.1	Nurses were attentive					
2.5.2	Nurses were patient in doing their job					
2.5.3	Nurses responded quickly when called					

2.5.4	Nurses respond to requests					
2.6	Medical and technical competency					
2.6.1	Physicians are competent in their job					
2.6.2	Nurses are competent in their job					
2.7	Influence of hospital system on staff					
2.7.1	There was a big variation between workers in different shifts					
2.7.2	The hospital system of work has its negative impact on staff productivity					
Overall satisfaction						
2.8.	What is your overall satisfaction of the health care provided to you during your stay in the hospital?	Very much satisfied	satisfied	Neutral	Not satisfied	Not satisfied at all
2.9	Do you have any suggestions which may improve nursing care in the hospital?					

معلومات واتجاهات وسلوك الإدارة العليا والوسطى في مستشفيات المنطقة الشرقية بالمملكة العربية السعودية تجاه برامج جودة الرعاية الصحية .

مقدمة :

أعد هذا المسح مدير إدارة ضمان الجودة بالمديرية العامة للشئون الصحية بالمنطقة الشرقية الأستاذ/محمد بن علي الغامدي وذلك لجمع معلومات لنيل درجة الدكتوراه من جامعة هل في بريطانيا .
تهدف هذه الاستبانة بصورة خاصة إلى التعرف على عوامل رضا المرضى ليطم إعداد خطة عمل لتحسين جودة الرعاية الصحية في التمريض خصوصا وفي المستشفى عموما من خلالها .

ملاحظات (يقوم جامع البيانات بإطلاع المريض على الملاحظات في بداية المقابلة):

- ١- سوف تعامل جميع المعلومات بسرية تامة ولضمان ذلك سوف ترمز ولن يذكر مايدل علي مصدرها في رسالة الدكتوراه النهائي .
- ٢- تعد موافقتك على التعرف على رأيك من خلال متغيرات هذه الاستبانة موافقه صريحة كريمة لإدراج رأيك ضمن عينة البحث .
- ٣- إذا احتجت إلى أي معلومات إضافية فلا تردد في الاتصال بالباحث على الهواتف التالية:

الأستاذ/ محمد بن علي الغامدي

المديرية العامة للشئون الصحية بالمنطقة الشرقية - إدارة ضمان الجودة

هاتف (٨٤٣٢٢٢٢) /تمويله ١١١٠-١١٤٩

فاكس (٨٢٩٠١٠٧)

جوال (٠٥٠٥٨٥٩٢٢٣)

أشكر لك قبولك لتعبئة هذه الاستبانة وآمل ان تسهر المعلومات الكاملة والصادقة التي ستفضلها بصورة خاصة ونتائج رسالة الدكتوراه هذه بصورة عامة في إفادة متخذي القرار في بلادنا لتطوير برامج جودة الرعاية الصحية . و إذا كنت مهتما بموضوع الدراسة فيسعدني ترويدك بملخص البحث بعد نهايته ، آمل كتابة أسمك وعنوانك ووسيلة الاتصال أدناه .

الأسم والعنوان (إختياري)

الأسم : _____

العنوان : _____

وسيلة الاتصال : العنوان الالكتروني (e - mail) : _____

الهاتف : _____

الفاكس : _____

الجوال : _____

١- معلومات شخصية:

١-١	الجنسية: <input type="checkbox"/> سعودي <input type="checkbox"/> غير سعودي
٢-١	مكان الإقامة : <input type="checkbox"/> مدينة <input type="checkbox"/> ريف (قرية)
٣-١	الجنس: <input type="checkbox"/> ذكر <input type="checkbox"/> أنثى
٤-١	العمر : سنة
٥-١	الحالة الإجتماعية : <input type="checkbox"/> أعزب <input type="checkbox"/> متزوج <input type="checkbox"/> مطلق <input type="checkbox"/> أرمل
٦-١	المؤهل: <input type="checkbox"/> إبتدائي <input type="checkbox"/> متوسط <input type="checkbox"/> ثانوي <input type="checkbox"/> دبلوم فوق الثانوي <input type="checkbox"/> جامعي <input type="checkbox"/> دراسات عليا فوق الجامعي <input type="checkbox"/> أخرى (حدد)
٧-١	العمل: <input type="checkbox"/> مهني (طبيب ، مهندس ، طيار) <input type="checkbox"/> إداري (موظف بوظيفه عامه غير محدد) <input type="checkbox"/> حرفي (بناء ، سباك ، كهربائي ، نجار) <input type="checkbox"/> يعمل في حقل التعليم (معلم ، مدير مدرسه ، مشرف تربوي) <input type="checkbox"/> طالب <input type="checkbox"/> أخرى (حدد)
٨-١	المصدر الأساسي لتلقي الخدمه الصحيه : <input type="checkbox"/> المستشفيات والمراكز الصحيه التابعة لوزارة الصحه <input type="checkbox"/> المستشفيات والمستوصفات الخاصه <input type="checkbox"/> مستشفى ارامكو <input type="checkbox"/> المستشفيات العسكريه

ضع علامة ✓ أمام كل جملة في المربع الذي يمثل إختيار المريض :

٢: مستوى الرضا عن الرعاية التمريضية في المستشفى

م	المتغيرات	ممتاز	جيد	متوسط	غير جيد	غير جيد مطلقا
١-٢	خبرتك وتوقعاتك عن الخدمة التمريضية					
٢-١-١	كيف كانت خبرتك عن الرعاية التمريضية في هذا المستشفى ؟					
٢-١-٢	كيف كنت تتوقع الرعاية التمريضية في هذا المستشفى قبل دخولك ؟					
٢-٢	ماهو تقييمك لبيئة المستشفى من حيث العوامل التالية :					
١-٢-٢	كيف كان مستوى التهوية ؟					
٢-٢-٢	كيف كان مستوى الهدوء ؟					
٣-٢-٢	كيف كان مستوى النظافة ؟					
٤-٢-٢	كيف كان مستوى الطعام ؟					

غير موافق إبدا	غير موافق	متوسط	موافق	موافق بقوه	المتغيرات	م
التواصل مع المرضات والمعلومات التي يزودونني بها						٢-٣
					المرضات زودوك بمعلومات عن القسم الذي تنومت فيه	١-٢-٣
					المرضات زودوك بمعلومات عن الخطة العلاجية التي خضعت لها .	٢-٣-٢
					المرضات يستشيرونك قبل بدء أي إجراء	٣-٣-٢
					المعلومات التي زودوك بها المرضات ساعدت على سرعة شفائك	٤-٣-٢
المساهمة والإشتراك						٤-٢
					المرضات يمنحن فرصة المشاركة في إعداد الخطة العلاجية .	١-٢-٤
					المرضات يمنحن فرصة المشاركة في تنفيذ الخطة العلاجية .	٢-٤-٢
العلاقات مع المرضات						٥-٢
					المرضات يعاملن المرضي بلطف	١-٥-٢
					المرضات صبورات على أداء عملهن	٢-٥-٢
					المرضات يحضرن إذا تم استدعائهن	٣-٥-٢

					المرضات يستجبن للطلبات	٤-٥-٢
الكفاءة الطبية في المستشفى						٦-٢
					الأطباء متمكنون من أداء أعمالهم	١-٦-٢
					المرضات متمكن من أداء أعمالهن	٢-٦-٢
تأثير نظام المستشفى على أداء العاملين						٧-٢
					لاحظت تفاوت كبير بين أداء العاملين في المناوبات المختلفة .	١-٧-٢
					أنظمة المستشفى مؤثرة سلبا على أداء العاملين .	٢-٧-٢
الرضا العام عن الخدمة الصحية في المستشفى						
غير مرضية مطلقا	غير مرضية	محايد	مرضيه	مرضيه تماما	ماهي درجة رضاك عن الخدمة الصحية المقدمة لك اثناء بقاءك في المستشفى؟	٨-٢
إذا كان لديك أي مقترحات لتحسين أداء الرعاية التمريضية في المستشفى ... ففضل بذكرها ...						٩-٢

HEAD NURSE BIWEEKLY REPORT

FOR THE PERIOD: FROM ----- TO :----- WARD: ----- SHIFT:-----

NO.	LIST OF VARIABLES	OBSTACLES	CORRECTIVE ACTIONS	RESULT	SATISFACTION LEVEL				
					Not satisfied at all	Not satisfied	neutral	satisfied	Very much satisfied
PHYSICAL ENVIRONMENT OF THE HOSPITAL									
1	VENTILATION								
2	QUIETNESS								
3	CLEANLINESS								
4	FOOD								

COMMUNICATION AND INFORMATION

	COMMUNICATION AND INFORMATION											
5	INFORMATION ABOUT THE WARD											
6	INFORMATION ABOUT TREATMENT PLAN											
7	NURSE INSTRUCTED PT. BEFORE PROCEDURE											
8	INFORMATION HELPED PATIENT TO RECOVER											

PARTICIPATION AND INVOLVEMENT

PARTICIPATION AND INVOLVEMENT									
9	PARTICIPATION IN PLANNING								
10	PARTICIPATE IN IMPLEMENTING								

INTERPERSONAL REALTIONSHIP

11	RESPECT																			
12	PATIENT																			
13	RESPOND TO CALL																			
14	RESPOND TO REQUEST																			

MEDICAL AND TECHNICAL COMPETENCY

15	PHYSICIAN COMPETENCE					
16	NURSE COMPETENCE					

INFLUENCE OF HOSPITAL SYSTEM ON STAFF

17	SHIFT VARIATION					
18	NEGATIVE IMPACT OF HOSPITAL SYSTEM					
19	What is your overall satisfaction about the health care provided in your ward?	Not Satisfied at all (1)	Not Satisfied (2)	Neutral (3)	Satisfied (4)	Very much satisfied (5)

NAME:----- SIGN.:----- DATE:-----